House of Commons
Health Committee

Revalidation of Doctors

Fourth Report of Session 2010–11

Volume I: Report, together with formal minutes and oral and written evidence

Additional written evidence is contained in Volume II, available on the Committee website at www.parliament.uk/healthcom

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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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Additional written evidence may be published on the internet only.

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¹ Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).
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1 Introduction

1. The General Medical Council (GMC) undertook a consultation on its proposals for the revalidation of doctors in early 2010. This consultation was the latest round of a discussion of this subject which has now been going on for over ten years. We therefore decided to undertake a brief inquiry into the reasons for slow progress, the measures that were being proposed and the reaction to them.

2. The Committee undertook this review in the knowledge that the GMC is a statutory body which reports to the Privy Council, and so it is not directly accountable to the Secretary of State for Health.

3. As Niall Dickson said in evidence:

   You described us as self-regulatory. We are accountable to you, actually. We are not accountable to the Secretary of State, but we are accountable to the UK Parliament.\(^2\)

4. Sir Donald Irvine argued that

   To ensure its continuing effectiveness, the GMC needs to be held to account for its management of medical regulation and medical education. It needs the discipline and indeed the support that can flow from public accountability, a fact the GMC itself recognised and sought when in 2006 it responded to the [Chief Medical Officer’s] report on revalidation.\(^3\)

   He said that the existing accountability arrangements through the Privy Council were “insufficient and lacking transparency” and that there was a need for regular select committee hearings to review the GMC’s work.\(^4\)

5. The Committee does not regard this as an arcane matter; it goes to the heart of the status of the medical profession as an independent profession which is responsible for setting and applying its own standards. The GMC was originally established in 1858 as the statutory regulator of an independent profession in which each practitioner was granted professional freedom but expected to recognise that with professional freedom comes professional responsibility. The GMC is the guardian of the standards which are implicit in that compact.

6. Even its most ardent advocate is compelled to recognise that the GMC has a mixed record in the discharge of that responsibility. However, the Committee supports the principle of an independent profession which accepts responsibility for setting and applying standards for its own members, provided it is not interpreted as a freedom from accountability.

\(^2\)Q 50
\(^3\)Ev w6
\(^4\)ibid, para 23
7. The current legislation makes the GMC accountable to the Privy Council; in the absence of a mechanism which makes this accountability effective we intend to exercise this function ourselves, on behalf of Parliament.

8. In the course of our inquiry we held two oral evidence sessions, one with the GMC and one with the British Medical Association and the Academy of Medical Royal Colleges, and received written submissions from the Department of Health and 36 other witnesses. We are grateful to all of those who contributed.
2 A history of revalidation

9. "Revalidation" is a broad term used to refer to the policy of proactively ensuring that practitioners who are registered to practise are still safe and competent to do so. This contrasts with the policy of investigating competence only when complaints are made or concerns are raised.

10. The GMC first proposed a formal process of revalidation in 2000. However, these proposals were eventually diluted to a requirement that all doctors should participate in annual appraisals conducted by their employers, and that employers should issue a statement every five years to confirm the absence of significant concerns.

11. A report in 2006\(^5\) by the then Chief Medical Officer for England noted that, following qualification, a doctor could go on to have a 30-year career without any further formal assessment of their continued competency. Public opinion research conducted for that report found that almost half of those asked thought that doctors were already subject to regular assessments, with one in five believing that this happened annually.

12. The then Government issued a White Paper in February 2007\(^6\) which concluded that, because of changes in public and professional opinion, it was no longer sufficient to assume that a professional continued to be up-to-date in their knowledge and fitness to practise throughout their career; this trust now had to be “underpinned by objective assurance”. In the White Paper, the Government proposed that all healthcare professionals should be required to complete a process of revalidation. There would be two main components to revalidation: “relicensing”, under which all professionals would have to demonstrate that they remained fit to practise; and an additional process of “recertification” for specialist doctors and GPs, who would need to demonstrate that they remained competent in their specialism.

13. The report of the Chief Medical Officer for England’s Working Group was published in July 2008 which set out next steps for implementing revalidation agreed between the GMC, the Department of Health, and the Academy of Medical Royal Colleges—the three key bodies with responsibility for revalidation.

14. These proposals for revalidation had three elements:

- to confirm that licensed doctors practise in accordance with the GMC’s generic standards (relicensing);
- for doctors on the specialist register and GP register, to confirm that they meet the standards appropriate for their specialty (recertification); and
- to identify for further investigation, and remediation, poor practice where local systems are not robust enough to do this or do not exist.

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5 Good Doctors, Safer Patients, Department of Health, 14 July 2006
6 Trust, Assurance and Safety: The regulation of health care professionals in the 21st century, Department of Health, Cm 7013, 21 July 2007
15. In March 2010 the GMC proposed that rather than having two separate elements—relicensing and recertification—there should be a single system:

We have concluded that revalidation will be simpler, more effective and more efficient if it operates as a single set of processes, rather than ... two separate strands.7

16. The consultation, from March to June 2010, was extensive:

During the course of the consultation we held or participated in around 130 events across the UK. We talked to more than 4,000 doctors, listened to their views and comments and discussed their concerns about revalidation. We also spoke to a range of employer organisations and representatives from patient groups across the four countries. By the time the consultation ended, on 4 June 2010, we had received nearly 1,000 responses.8

17. Following that consultation the GMC’s main proposals are as follows:

- Revalidation should be based on a single set of processes for evaluating doctors’ performance in practice.
- It should be based on a continuing evaluation of doctors’ performance in the workplace.
- There will be a network of responsible officers—all of them senior licensed doctors—who will make recommendations on whether or not doctors will be revalidated.
- The medical Royal Colleges and Faculties should not be directly involved in the responsible officers’ recommendations, but should have a quality assurance and advisory role.
- Trainees should secure revalidation as a result of successful progress through training.
- Licensed doctors not currently engaged in medical practice should be able to gain revalidation through a formal examination or assessment.
- The list of registered medical practitioners should indicate the field of practice on the basis of which a doctor has secured revalidation.9

18. When the GMC’s consultation was launched, it was intended that revalidation would be put in place in 2011. However, in June 2010 the new Secretary of State wrote to the Chair of the GMC to say that, having reviewed the current plans, “I do not yet have sufficient confidence that there will be time properly to gather and evaluate evidence on all aspects of revalidation and to amend plans in the light of the current pilots in the NHS. I therefore intend to extend the piloting period for a further year to enable us to develop a clearer understanding of the costs, benefits and practicalities of implementation ...”. In its

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7 Revalidation: the way ahead, Response to our revalidation consultation, GMC, 18 October 2010, para 45
8 Ev 36
9 Revalidation: the way ahead, Response to our revalidation consultation, GMC, 18 October 2010, pages 12–21
memorandum to us, the GMC says that “we are planning to launch revalidation in late 2012”.  

19. Against the background of this long and complex history, the Committee welcomed the description of the background and purpose of revalidation which was provided to it by the GMC in its memorandum to our inquiry:

   All doctors who wish to practise medicine in the UK must be both registered and licensed with the GMC. This applies whether they practise full-time, part-time, as a locum, privately or in the NHS, or whether they are employed or self-employed.

   Being registered and licensed with the GMC shows that a doctor has the necessary qualifications for medical practice and that he or she is in good standing. However, at present, it is essentially an historical record of qualification. It provides no information about the sort of practitioner a doctor has become or whether they remain competent and fit to practise.

   Revalidation aims to change this by updating what it means to be a registered and licensed doctor. Its purpose is to assure patients and the public, employers and other healthcare professionals that licensed doctors remain up to date and practising to the appropriate professional standards. Doctors who are unable to demonstrate this will lose their licence to practise.  

20. Responsibility for registering, licensing and revalidating doctors rests firmly on the shoulders of the GMC. Both the previous government and the Coalition have intervened in ways which have, for good reasons, extended the process. The result, however, has been, as we were told in evidence: “The pace of implementation of revalidation has been too slow. Under current proposals, regions that have not prepared for revalidation may be allowed further, unacceptable delays”. Now that “late 2012” has been set as the date of implementation, we look to the GMC to ensure that there are no further delays and that the current target date is achieved.
3 Purpose of revalidation

21. When it was initially proposed, revalidation appeared to be a tool for uncovering badly performing or potentially dangerous doctors. Revalidation, as now understood, however, is not merely a negative declaration that a doctor has not been found unfit to practise; it is a positive affirmation that a doctor is up to date and practising to appropriate professional standards.

22. In some of our evidence it has seemed that the requirement to identify doctors who are unfit to practice has been seen as almost an insignificant part of the appraisal process. The Academy of Medical Royal Colleges argued that the summative function of appraisal (is this doctor fit to practise?) should be dealt with very expeditiously, so that the process could then focus on the formative function (how can this doctor’s practice be improved?). In its evidence to us on revalidation the Royal College of Psychiatrists said that it emphasised the relative importance of quality improvement as the main benefit of revalidation. The public already has high confidence in the ability of their clinicians; a revalidation process that drives up standards and promotes excellence and quality throughout the profession will yield significant benefits which are much broader than just confidence in a regulatory process.

23. Conversely, the BMA, in its response to the GMC consultation, argued that the appraisal infrastructure that was being proposed was disproportionate if the principal aim was to deal with the issue of fitness to practise:

There is little value in spending large amounts of resource perfecting specialist frameworks for relatively little benefit, particularly when the GMC’s own current [Fitness To Practise] statistics show that core generic skills (communication, probity, health, insight and keeping up-to-date) are usually what leads to action against the registration of doctors. It would be eminently more cost-effective to target revalidation against the core generic skills of a doctor.

24. Niall Dickson told us:

Is it possible that revalidation will identify problems earlier? I certainly hope that it will be able to do that. Will it encourage doctors in the middle of the bell curve, where most of us are even if we think we are at one end of it, to be more self-reflective? I think the evidence is, from already good appraisal processes, that that happens. So I think it will affect the doctor in the middle, not in the sense that they are going to face something terrible that has never happened before, but I think it will encourage them to organise their supporting evidence; to make sure that they are doing the right continuing professional development; to have a chance to chat to somebody who is saying, ‘Do you think you ought to be able to do this?’ or get a bit of patient feedback to which, ‘Ah, I hadn’t realised that I was doing that and I might...
be able to correct that.’ These are all miles away from referral to the GMC. They are just things that should be happening anyway but they provide that level of assurance which we are not currently able to provide on our register.16

25. Specifically on the issue of whether revalidation would stop “another Shipman”, Una Lane of the GMC told us:

I think there is a general view that good local systems and good robust systems, if they produce the right information, and if that information is monitored appropriately, can identify outliers and at least enable a further investigation to take place. Once revalidation is introduced, will that mean that no doctor will ever deliberately or negligently damage a patient again? Absolutely not. We absolutely cannot say that. Do we think it can contribute to lowering the risk? Do we think that it can contribute to helping identify poorly performing doctors at an earlier point in the process? Yes, we think it can.17

26. Although the Committee agrees that the focus of revalidation for most doctors should be a commitment to practice improvement, it believes that the need to identify inadequate and potentially dangerous doctors must not be overlooked or diminished in the general move to use revalidation to eliminate unsatisfactory practice and improve overall performance.
4 Current issues

Doctors whose performance gives cause for concern

27. The attention of the Committee has been drawn to the limited consideration which was given in the consultation process to the question of how Responsible Officers or the GMC itself should respond in cases where they are concerned about the performance of an individual doctor.

28. Dr Keighley of the BMA said that:

One of the big gaps that we have is that there is no clarity about remediation and the costs of remediation for those doctors found lacking. There is the worry about taking time and effort away from organisations to do this when there are priorities to spend it on patient care.\[18\]

The BMA argued that remediation should be “fully funded to ensure equality amongst branches of practice”.\[19\] We were also told that there was a clear association between impaired fitness to practise and undeclared, unrecognised concealed, undiagnosed and untreated mental illness and/or addictive disorder. Those clinical conditions account for the vast majority of the 400 (approximately) cases arising from the medical workforce within the London Strategic Health Authority Area during [a two year period]... Once identified there is a good chance of successful treatment and consequently a real prospect for restoration of full capacity to practise.\[20\]

29. The Department told us:

The Department of Health established a Steering Group in 2010 to review the present arrangements for the remediation of doctors whose clinical performance is causing concerns ... The Group found many examples of very good practice, but also found that there was a need for greater consistency in the way remediation was managed and a need for more clarity about which organisations provide support to medical managers. Whilst the group concluded that as far as possible employers and contractors with doctors should manage the situation locally, there would continue to need to be access to external expertise. A report setting out the group’s proposals and options for the way forward is in the final stages of drafting and will be published in due course when Ministers have considered its implications and recommendations.\[21\]

30. The Committee finds it unsatisfactory that so little attention has been given to the issue of how to deal with doctors whose practice gives cause for concern. We regard this
as an important weakness in the current proposals which the GMC needs to address if the introduction of revalidation is to help sustain public confidence in the medical profession.

31. The Committee is concerned that instinctive use of the word “remediation” in cases where a doctor’s performance gives cause for concern may have the effect of prejudging the appropriate response to a particular set of circumstances. While it is important to ensure the rights and legitimate interests of individual doctors are safeguarded, the primary purpose of revalidation is to protect the interests of patients.

32. The Committee therefore recommends that the GMC publishes clear guidance to Responsible Officers about how they should deal with the cases of doctors whose performance gives rise to concern.

**Appraisal**

33. At the heart of the proposals for revalidation is appraisal. As Professor Malcolm Lewis of the Council of the GMC told us:

> ... it means that you are working within a system that allows you to be appraised on an annual basis. At that appraisal, you have an element of continued professional development which you bring to your appraisal and next year you establish whether you have achieved that or not and, if not, why not and what else might you have done. So that’s about professional development in the context of your work.

> Also, some patient and colleague feedback questionnaires which we are advocating should be at least once every five years within this system, which allows patients to feed into the process—that there is locally-held information about you, your clinical activity, any complaints and any significant event analysis, and that those are appropriately addressed within the organisation.22

34. The catch, so far as successful introduction of revalidation is concerned, is that appraisal, although it has been a requirement for some time, is neither uniformly effective nor indeed universally available. Niall Dickson, Chief Executive of the GMC, told us:

> ... at the moment, across the UK, some parts are quite well developed in terms of the appraisals that they do, but in some places it is pretty patchy and some doctors are not getting appraisals at all. The variation can be as somebody described it to me in respect of a GP in one part of the country—I won’t say where: the appraisal consisted of a discussion about their walking holiday. There is that on one level. So we want some degree of consistency, as you would, frankly, in any walk of life—this is not different, in that sense. We want a solid appraisal system which actually does tell you that the doctor is competent and fit to practise.23

35. Professor Sir Neil Douglas, Chairman of the Academy of Medical Royal Colleges, agreed with this assessment:

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22 Q 6
23 Q 7
It is in places in existence on an annual basis and effective. It is, I am afraid, still slightly patchy and that is one of our concerns. I think the first step towards getting a revalidation process in place has to be the introduction of effective appraisal for all doctors in all localities in all specialties in the UK in all four countries. If that can be achieved in a short time scale, then that will be a major step forward.\textsuperscript{24}

Professor Peter Furness, who leads on revalidation for the Academy, added that:

... the variation around the country in the implementation of appraisal also highlights our concern that the emphasis on local decision making in something like this has the potential for variation in how appraisal is administered and how standards are set around the country, because there has been a great deal of talk of setting standards but ... there will inevitably be a large degree of judgment. If there isn’t a great deal of national co-ordination, I fear that we will have variation in the standards just as we have had variation in the speed of implementation.\textsuperscript{25}

36. Dr Brian Keighley of the British Medical Association suggested that problems with appraisal were more of an issue for the secondary sector—“It is my view that appraisal and, flowing from that, revalidation is perhaps better established in primary care”\textsuperscript{26}—but agreed with others that implementation was patchy:

It is well established in parts of the country, as you were hearing, and yet there are trusts and hospitals where it has hardly taken place. There is also a large lacuna with the locum and sessional doctors, and some PCTs have been better at producing the infrastructure than others. I think before we move to what has been called ‘strengthened medical appraisal’ we need to get everybody participating at the initial level.

The other anxiety we have is perhaps lack of consistency across the country as to the types of appraisal that are being carried out. We hear anecdotally of some appraisals being a ‘cosy chat’ and others going on for two or three hours. I am now on my seventh annual appraisal and I think my interview lasts for about two and a half hours.\textsuperscript{27}

37. It is clearly unsatisfactory that there is such a degree of variation across the country in relation to appraisal, and unacceptable that some doctors are apparently not subject to appraisal at all. If an adequate appraisal system is not provided for all doctors, then revalidation, as currently envisaged, will not work. The GMC needs to satisfy itself that all organisations which employ doctors have satisfactory, robust and consistent systems of appraisal in place on a timescale that makes possible its objective of introducing revalidation in late 2012.
### Requirements on doctors

38. Another issue is the possible complexity of the process and the amount of information that doctors will be asked to provide. In its memorandum to the Committee, the GMC said that:

To meet its aims, revalidation must be relevant to doctors’ day-to-day practice and build upon systems that already exist in the workplace to support high-quality care. It must not create unnecessary burdens which hamper doctors in fulfilling their main concern of caring for patients ... Revalidation will therefore be based upon a local evaluation of doctors’ performance against national standards approved by the GMC. It will not involve a point-in-time test of knowledge and skills ... Doctors will need to maintain a folder or portfolio of information drawn from their practice to show how they are meeting the required standards. The information collected in their portfolio will provide the basis for discussion at their annual appraisal. For the purposes of revalidation it will be essential that the appraisal includes an effective evaluation of each doctor’s performance against the relevant standards. Work is ongoing to embed the required standards into the appraisal process.  

39. A number of concerns were raised with us. The BMA said that:

our confidence in the process was seriously undermined by the specialist standards frameworks that had been developed by the colleges. We felt that the college standards were not equitable, fair or proportionate to the extent that the process would have proved impractical, expensive, ultimately unworkable and would have diverted doctors away from direct care of patients. Many of the colleges had sought to provide a perfect revalidation system at the first attempt, instead of commencing revalidation with core standards and building on these during subsequent revalidation cycles—thereby, hopefully, enhancing quality over the coming years.  

The Academy of Medical Royal Colleges was critical of the need for doctors to demonstrate compliance with the GMC’s twelve attributes of Good Medical Practice. Professor Furness of the Academy, who has been appraised using this system under one of the revalidation pilots, told us "For each attribute we have a core question and then a set of supplementary questions. I think, if that is what the GMC expects, we are going to have a phenomenally laborious appraisal interview that focuses entirely on the summative, ‘Are you fit to revalidate?’ and we’ll have no time left at the end to do the formative, ‘How can we get better?’, which is what, for most doctors, appraisals should be about".  

40. Professor Furness was also able to comment on findings in some of the pilot projects about the length of time that doctors had taken to prepare themselves for their appraisal interviews:

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28 Ev 35  
29 Ev 39  
30 Ev 43  
31 Q 72
In those pilots, my understanding is that, so far, with regard to the gathering together of evidence people are claiming a very wide range of how long it takes, from one hour up to a couple of weeks or so. I am not sure how they arrive at that figure. With the appraisal interview, the length is varying from an hour to about three hours. Again, I am a bit surprised at the longer ones. One wonders what was having to be discussed. Of course there is a little while for recording things after that.\textsuperscript{32}

41. Others expressed concerns about the costs of the process. The Hospitals Consultants and Specialists Association told us that the costs of appraisal for the 37,000 consultants in England could be in the region of £74 million.\textsuperscript{33} NHS Employers told us:

While we support a proportionate approach to revalidation based on existing processes, there will nevertheless be both immediate and ongoing costs to be met, including the training and re-training of appraisers, identified remediation costs where doctors in difficulty are identified across the five year cycle, and supporting quality multi-source feedback. Employers need to be able to plan for those costs now in order to meet the significant challenges they face over the coming years to deploy available resources to meet increasing demand. The current revalidation model assumes an employer-led, management-based process when the future may be less structured.\textsuperscript{34}

42. The BMA said:

The lack of reference to the cost of revalidation and of remediation, severely undermine the case for successful implementation. There has also been little consideration of the indirect costs of the time that doctors will require to meet revalidation requirements instead of treating patients. In the current financial climate, with cuts to NHS funding already underway, it remains unclear how this process will be funded and by whom. What is clear is that the process must be fully resourced as the profession would fundamentally oppose any costs falling on individual doctors or, indeed, significant, additional costs falling on trusts and other organisations.\textsuperscript{35}

43. In response, Niall Dickson of the GMC argued that many of the costs that people expressed concerns about were not new costs:

There is no doubt that there has been some confusion about the cost of revalidation. ...Those things should be happening now. They should be happening across the system. The system has been funded to do those things. There are some additional costs...around revalidation but, in our view, they are not hugely significant. The big costs are having a proper system of clinical governance and a proper system of
appraisal. Those are things that the National Health Service has said they should be doing and should have been doing for some years.\textsuperscript{36}

44. It is clearly undesirable that doctors should be required to provide an immense amount of documentation for their appraisals. We agree that much of what is required should already be in place, and that if institutions have effective systems for clinical governance then information that is required for that use will also be available for appraisal.

45. Professor Lewis described the IT system that is used for GPs in Wales, which combines these two functions:

We have used an online toolkit since 2003. It’s the only way to have an appraisal in Wales... It is all web-based so the information is all stored on the website. There is also a revalidation dashboard light which goes from red to green as you complete various aspects of it. That allows the Responsible Officer to take a view of how people on the patch are progressing as individuals and collectively.

It links with clinical governance. There is a large protocol document around concerns and how they feed into and out of appraisal, so that link is made. The acceptance of the tool is almost universal. Obviously, with IT, there are a few people who will inevitably be laggards. We don’t have 100% uptake because there are always some people who are off on sick or maternity leave or are out of quarter or for whatever reason, but it is over 90% at any point in time.\textsuperscript{37}

He told us that they were now developing a similar system for secondary care, and also emphasised that it was invaluable for managing the appraisal process, as it was possible to see very easily who had and who had not been appraised.\textsuperscript{38}

46. It is clearly the case that the mechanics of the process should not be so complicated or onerous that they adversely affect the effectiveness of appraisal. We have heard some legitimate concerns that the requirements as described to us by the GMC might cause the process to be unnecessarily bureaucratic and time-consuming; on the other hand, Professor Furness told us that in his case preparation took just an hour. And while we are aware that IT systems are no panacea, the Welsh example as described to us indicates that it is possible to provide technical solutions to reduce burdens on the appraisees.

47. The Committee supports the approach set out in the GMC’s consultation review document aimed at making the process simpler and more flexible.\textsuperscript{39} In particular we agree that the different components of revalidation should be integrated into a single process, and that the requirements of that process should be integrated into the appraisal and clinical governance systems operated by employers.

\textsuperscript{36} Q 47
\textsuperscript{37} Q 54
\textsuperscript{38} ibid
\textsuperscript{39} Revalidation, The way ahead, Response to our revalidation consultation, GMC, 18 October 2010, para 211: that work should be done to streamline the Royal Colleges’ and Faculties’ specialty and general practice frameworks, making clear what is expected and what is optional; to refine the GMC’s framework based on Good Medical Practice to make it more flexible; and to ensure that all components of revalidation are integrated into a single process.
Patient and colleague involvement

48. Although we welcome the desire of the GMC to keep the process as streamlined as possible for doctors it is vital to ensure that the process allows for the voices of patients and colleagues to be heard. The Picker Institute, an organisation which champions patients’ views, said that:

As agreed by the [Chief Medical Officer’s] working group, the purpose of revalidation is not just to identify unsafe doctors, but to create continuous improvements in quality. Direct patient feedback on doctors’ performance can help assess core standards and is an essential tool for quality improvement. Patient feedback should be fully and properly integrated into medical appraisal at regular intervals, at least annually and achieving a representative sample of patients sufficiently large to ensure valid feedback.⁴⁰

49. Separately, Sir Donald Irvine, a former President of the GMC and now Chair of the board of Picker Institute Europe, told us:

I think that the GMC’s current plans are insufficient. A single small survey of patient experience every five years will contribute little if anything to the picture of a doctor’s performance capable of being assessed through evidence of experience.⁴¹

He also said that:

The GMC and the Royal Colleges need to tell the public and patients, in plain language, what standards of everyday practice they should use as the benchmarks against which to judge their own experiences with their own doctors. People do not have this information at present. It needs to be immediately accessible to every patient and every patient’s carer in the land. It would help patients to make fully informed choices of doctor. It would strengthen the leverage patients could bring to bear in securing improvement. And it would help to underpin revalidation decisions.⁴²

50. The Patients’ Association agreed that patients’ views were vital and also argued that a survey every five years was not adequate:

We consider the inclusion of patient evaluation as part of the revalidation process to be vital to ensuring the process genuinely ensures the suitability of a doctor to hold a licence is accurately reflected by the recommendations made by the Responsible Officer.

A minimum threshold of patient evaluation should be set taking into account average patient contact, likely response rates and the available time for collection. We believe a timescale of 5 years is unambitious. We would prefer a shorter time scale for the entire process but recognise the need to balance the burden on clinician time when developing this process. If revalidation is to be conducted on a 5 yearly basis
the collection of patient experience data should be spread across this period with a mechanism for bringing forward revalidation should concerns arise.\textsuperscript{53}

51. The need for patients’ views to be an integral part of the revalidation process is clear. We agree with the Patients’ Association that for there to be patient feedback only once during the five year cycle is unambitious. If part of the justification for the revalidation is the desire to maintain and improve public confidence in doctors then a greater degree of public involvement would be helpful.

52. The Committee also welcomes the commitment of the GMC to ensure that the revalidation process includes provision for hearing colleagues’ views. The Committee believes that although the relationship between professional colleagues should be supportive, the first responsibility of all professionals is to improve the standard of care provided to patients. It is often the case that it is working colleagues who have the clearest view of the strengths and weaknesses of individual doctors; the Committee therefore believes it is important that the revalidation process includes the opportunity (with appropriate safeguards) for input by the professional colleagues of all doctors.

53. \textbf{In its response to the consultation the GMC commits itself to further development of its proposals for colleague and patient feedback. We welcome this commitment; we hope the GMC will undertake a review of best practice in gathering the views of patients and colleagues and develop its proposals in the light of that review.}

\section*{Responsible officers}

54. One of the main concerns expressed during the consultation was on the role of the Responsible Officer (that is, the person making the recommendation on revalidation). Some thought that if, as proposed, the medical director of an organisation is the person designated, there might be some conflicts of interest. As the Academy of Medical Royal Colleges said in its memorandum:

\begin{quote}
The Medical Director has responsibilities to deliver the targets of the employing organisation. In some circumstances these could differ from, or even conflict with, the ideals of good practice. For example, a doctor whose standards are questionable might be essential to delivering a service and difficult to replace; would the Medical Director then be as stringent as with a doctor who delivers adequate care, but too slowly to meet Trust targets?\textsuperscript{44}
\end{quote}

55. Professor Furness, for the Academy, said that this potential conflict of interest was balanced, as with so many of these things, by the observation that the medical director is probably, in most circumstances, in the best place to sort out problems that come from the process and to understand how the environment that the doctor is working in may interact with the problems that the doctor may be having. Were it not for that conflict of interest, the medical director would be the best person ... we are all concerned that because this conflict of interest exists there have to be open
processes to ensure it doesn’t cause problems of the sort that we have identified and, if they are, that they are corrected very rapidly. It is one of the reasons for needing a good quality assurance process that looks at the outcomes, not just the process.\textsuperscript{45}

56. We believe the risk of conflicts of interest arising from the dual role of medical directors as Responsible Officers within the revalidation system, and members of the employers’ senior management team, is real.

57. We also believe, however, that this is the inevitable consequence of using appraisal as the basis of revalidation. Appraisal is part of robust clinical governance and is a key requirement of good management; it is therefore, inevitably, part of the responsibility of the medical director of the employer.

58. In the light of this unavoidable risk of conflicts of interest arising we recommend that the GMC publish clear guidance to Responsible Officers about how such conflicts should be handled. We also recommend that the GMC consider further what safeguards may be desirable to protect the interests of individual doctors in circumstances where they believe a conflict of interest may have influenced the decision of a Responsible Officer.

59. The Health and Social Care Bill\textsuperscript{46} proposes important changes to the management of the NHS. Following these changes it will be necessary to ensure that Responsible Officers are still appropriately placed. In respect of Responsible Officers now based in PCTs, Niall Dickson told us:

> Obviously, their role is going to disappear as Primary Care Trusts disappear and we have certainly asked the Government, “What is the new structure going to be?”, because we will require and the legislation will require that there should be Responsible Officers. Every doctor has to have a Responsible Officer. That will be in the law. So we need a new system.\textsuperscript{47}

He suggested that Responsible Officers might be “embedded in [commissioning] consortia”.\textsuperscript{48}

60. The GMC needs to satisfy itself within a timescale that will allow introduction of revalidation by 2012 that there is clarity about where Responsible Officers currently based in PCTs will be situated in future.

**Doctors with non-standard careers**

61. Some concern was expressed to the Committee about how doctors whose careers do not lie wholly within a single practice context will fit into the revalidation system. The BMA said in its memorandum:

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\textsuperscript{45} Q 87
\textsuperscript{46} Health and Social Care Bill [Bill 132 (2010–11)]
\textsuperscript{47} Q 34
\textsuperscript{48} Q 35
The consultation did not adequately address how locums, doctors with portfolio careers, retired doctors, those in non-mainstream roles, those in non-clinical roles (such as medical managers) and those who do not work in managed organisations as employees, such as private practitioners, would be able to complete this process ... The parties involved in revalidation need to consider the difficulty that such doctors may have in securing an annual appraisal and address this issue accordingly. The current options appear limited and potentially very expensive for some doctors. This suggests that there will not be equality of opportunity for all entitled doctors to revalidate.49

62. The Medical Defence Union told us that:

There are a significant number of doctors who are not in managed environments and who are not currently undertaking regular appraisal or collecting supporting information such as evidence of CPD. It is important, in the interests of fairness to all, that the GMC outlines the minimum requirements that doctors will have to fulfil as early as possible so that any doctors who are not currently in a position to provide such information can put systems in place to allow them to do so. Doctors must have an equal opportunity to collect sufficient evidence before they are required to revalidate.50

63. The GMC told us that some concerns were raised during the consultation:

Doctors in clinical practice generally were quite supportive of the proposals. The concerns, I think, were from groups of doctors who do different kinds of things—doctors who don’t necessarily see patients every day, doctors who are in medical management, Medical Directors in post and doctors who are clinical academics. I think what they were looking for was some further and more detailed information as to how this process would apply to them.51

64. The Government has addressed this issue in the Medical Practitioners (Responsible Officers) Regulations 2010, which provide that the Responsible Officer for the body for whom the doctor carries out most of his clinical practice is responsible for that doctor’s revalidation.52 The Responsible Officer also has a duty to take account of the work the doctor has undertaken for any other body.53

65. The Committee welcomes the clarification provided in the Medical Practitioners (Responsible Officers) Regulations 2010. It believes this clarification will resolve many uncertainties, but it looks to the GMC to provide a further detailed response to the other concerns raised on this subject in its consultation.
Doctors from elsewhere in the European Union

66. There has been at least one recent high profile fitness to practise case in which the doctor was from elsewhere in the EU and working as a locum. We asked Niall Dickson of the GMC how doctors from the EU would be incorporated into the process. He told us:

The Government have been ... very helpful. I believe they have recognised that this is a two-stage problem. There is a problem with UK legislation at the moment to the effect that it stops the GMC from doing any form of language testing, but there are also problems with the way the EU Directive is drawn up and the fact that, as a regulator, you have to establish doubt about the doctor’s ability to speak English before you can test, which is a sort of Catch 22. We are exploring ways in which we might be able to get round that.

Secondly, the Government is committed to working on the current review of the EU Directive and we have also been having talks with other regulators and with the Commission directly. Again, this is a slow process. So there is work being done on all that and we hope that we will be able to make some significant progress in the medium term on language and, certainly in the longer term, on language and competency. But I am not underestimating the obstacles involved in either of those things.54

67. He added that employers also had a role to play here:

I accept that there is a hole in our regulatory system because of the nature of the current EU law, but employers still have a responsibility to ensure that any doctor they employ or contract with is both fit to practise and fit for purpose, and because there is this gap in our system it puts a particular onus on employers who are taking on doctors from the European Union to make sure that those doctors that they employ and contract with are fit for purpose—the job that they are actually being given—as well as fit to practise.55

68. We regard the ability of a doctor to communicate effectively with his or her patient as fundamental to good medicine. As the body responsible for revalidation, and with a commitment to introducing it by late 2012, we expect the GMC to satisfy itself that it has the necessary powers to fulfil this role; if it is not satisfied (whether as a result of EU legislation or for any other reason) we expect it to say so publicly and report to Parliament what changes are necessary to allow it to fulfil its function effectively.
5 Conclusion

69. As we said at the beginning of this report, as a mechanism to improve the scrutiny of the GMC we now intend to exercise the accountability function nominally held by the Privy Council on behalf of Parliament.

70. In order to do this, we expect to invite the GMC to give oral evidence on its annual report each year. As we have gone through this inquiry, a number of issues have arisen that we feel would benefit from continuing investigation, such as:

- What happens in cases where the performance of an individual doctor gives rise to concern
- The operation of the appraisal system, and its consistent implementation across the country
- The administrative burden that appraisal and revalidation place on doctors
- The way in which patients and colleagues are involved in revalidation
- Where Responsible Officers who are currently based in PCTs will be sited in future
- The adequacy of the powers available to the GMC to ensure that doctors for whom English is a second language are able to communicate effectively with their patients.

71. We look forward to discussing these and other issues with the GMC at the first of these regular meetings later in the year.
List of recommendations

Introduction
1. The current legislation makes the GMC accountable to the Privy Council; in the absence of a mechanism which makes this accountability effective we intend to exercise this function ourselves, on behalf of Parliament. (Paragraph 7)

A history of Revalidation
2. Now that “late 2012” has been set as the date of implementation, we look to the GMC to ensure that there are no further delays and that the current target date is achieved. (Paragraph 20)

Purpose of Revalidation
3. Although the Committee agrees that the focus of revalidation for most doctors should be a commitment to practice improvement, it believes that the need to identify inadequate and potentially dangerous doctors must not be overlooked or diminished in the general move to use revalidation to eliminate unsatisfactory practice and improve overall performance. (Paragraph 26)

Doctors whose performance gives cause for concern
4. The Committee finds it unsatisfactory that so little attention has been given to the issue of how to deal with doctors whose practice gives cause for concern. We regard this as an important weakness in the current proposals which the GMC needs to address if the introduction of revalidation is to help sustain public confidence in the medical profession. (Paragraph 30)

5. The Committee is concerned that instinctive use of the word “remediation” in cases where a doctor’s performance gives cause for concern may have the effect of pre-judging the appropriate response to a particular set of circumstances. While it is important to ensure the rights and legitimate interests of individual doctors are safeguarded, the primary purpose of revalidation is to protect the interests of patients. (Paragraph 31)

6. The Committee therefore recommends that the GMC publishes clear guidance to Responsible Officers about how they should deal with the cases of doctors whose performance gives rise to concern. (Paragraph 32)

Appraisal
7. It is clearly unsatisfactory that there is such a degree of variation across the country in relation to appraisal, and unacceptable that some doctors are apparently not subject to appraisal at all. If an adequate appraisal system is not provided for all doctors, then revalidation, as currently envisaged, will not work. The GMC needs to satisfy itself that all organisations which employ doctors have satisfactory, robust and
consistent systems of appraisal in place on a timescale that makes possible its objective of introducing revalidation in late 2012. (Paragraph 37)

Requirements on doctors

8. It is clearly undesirable that doctors should be required to provide an immense amount of documentation for their appraisals. We agree that much of what is required should already be in place, and that if institutions have effective systems for clinical governance then information that is required for that use will also be available for appraisal. (Paragraph 44)

9. The Committee supports the approach set out in the GMC’s consultation review document aimed at making the process simpler and more flexible. In particular we agree that the different components of revalidation should be integrated into a single process, and that the requirements of that process should be integrated into the appraisal and clinical governance systems operated by employers. (Paragraph 47)

Patient and colleague involvement

10. In its response to the consultation the GMC commits itself to further development of its proposals for colleague and patient feedback. We welcome this commitment; we hope the GMC will undertake a review of best practice in gathering the views of patients and colleagues and develop its proposals in the light of that review. (Paragraph 53)

Responsible officers

11. We believe the risk of conflicts of interest arising from the dual role of medical directors as Responsible Officers within the revalidation system, and members of the employers’ senior management team, is real. (Paragraph 56)

12. We also believe, however, that this is the inevitable consequence of using appraisal as the basis of revalidation. Appraisal is part of robust clinical governance and is a key requirement of good management; it is therefore, inevitably, part of the responsibility of the medical director of the employer. (Paragraph 57)

13. In the light of this unavoidable risk of conflicts of interest arising we recommend that the GMC publish clear guidance to Responsible Officers about how such conflicts should be handled. We also recommend that the GMC consider further what safeguards may be desirable to protect the interests of individual doctors in circumstances where they believe a conflict of interest may have influenced the decision of a Responsible Officer. (Paragraph 58)

14. The GMC needs to satisfy itself within a timescale that will allow introduction of revalidation by 2012 that there is clarity about where Responsible Officers currently based in PCTs will be situated in future. (Paragraph 60)
Doctors with non-standard careers

15. The Committee welcomes the clarification provided in the Medical Practitioners (Responsible Officers) Regulations 2010. It believes this clarification will resolve many uncertainties, but it looks to the GMC to provide a further detailed response to the other concerns raised on this subject in its consultation. (Paragraph 65)

Doctors from elsewhere in the European Union

16. We regard the ability of a doctor to communicate effectively with his or her patient as fundamental to good medicine. As the body responsible for revalidation, and with a commitment to introducing it by late 2012, we expect the GMC to satisfy itself that it has the necessary powers to fulfil this role; if it is not satisfied (whether as a result of EU legislation or for any other reason) we expect it to say so publicly and report to Parliament what changes are necessary to allow it to fulfil its function effectively. (Paragraph 68)

Conclusion

17. As we said at the beginning of this report, as a mechanism to improve the scrutiny of the GMC we now intend to exercise the accountability function nominally held by the Privy Council on behalf of Parliament. (Paragraph 69)

18. In order to do this, we expect to invite the GMC to give oral evidence on its annual report each year. (Paragraph 70)

19. We look forward to discussing these and other issues with the GMC at the first of these regular meetings later in the year. (Paragraph 71)
Draft Report (Revalidation of Doctors), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 71 read and agreed to.

Resolved, That the Report be the Fourth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report, together with written evidence to be published.

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[Adjourned till Tuesday 8 February at 10.00 am]
## Witnesses

**Thursday 28 October 2010**

Niall Dickson, Chief Executive and Registrar, **Professor Malcolm Lewis**, Council member, and **Una Lane**, Director of Continued Practice and Revalidation, General Medical Council

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**Thursday 4 November 2010**

**Professor Sir Neil Douglas**, Chairman, **Professor Peter Furness**, Vice-Chairman and Revalidation Lead, and **Ms Kate Tansley**, Revalidation Project Manager, Academy of Medical Royal Colleges

Dr Brian Keighley, Working Party on Revalidation, British Medical Association

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## List of printed written evidence

1. Department of Health  
2. General Medical Council  
3. British Medical Association  
4. Academy of Medical Royal Colleges

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## List of additional written evidence

(published in Volume II on the Committee’s website www.parliament.uk/healthcom)

1. Dr Anton E A Joseph  
2. NHS Highland  
3. Sir Donald Irvine CBE  
4. Mencap  
5. Royal College of Anaesthetists  
6. British Cardiovascular Society  
7. Medical Protection Society  
8. Royal College of Surgeons of England  
9. Royal College of Paediatrics and Child Health  
10. Picker Institute Europe  
11. Dr Douglas G Fowlie  
12. Royal College of Psychiatrists  
13. Dr Allan Cole  
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Oral evidence

Taken before the Health Committee
on Thursday 28 October 2010

Members present:

Mr Stephen Dorrell (Chair)

Rosie Cooper
Nadine Dorries
Fiona Mactaggart
Graeme M Morris

Mr Virendra Sharma
David Tredinnick
Dr Sarah Wollaston

Examination of Witnesses

Witnesses: Niall Dickson, Chief Executive and Registrar, Professor Malcolm Lewis, Council member, and Una Lane, Director of Continued Practice and Revalidation, General Medical Council (GMC), gave evidence.

Q1 Chair: Ladies and gentlemen, thank you very much for coming at what is, in truth, reasonably short notice. The Committee felt, when the GMC published the response to its consultation on revalidation, that this was something we should look at as a relatively quick inquiry, taking evidence from yourselves at the GMC, from the Department and from the other interested professional representative bodies, in order to try to surface some of the issues that have come to light from the consultation.

This does seem to be quite a long, drawn-out process. I think I am right in saying that it was the year 2000—now 10 years ago—when the GMC first suggested that a licence to practise was not really adequate assurance from the public’s point of view. We are now 10 years on. It is nearly nine years since the Ian Kennedy report on Bristol, and I wondered whether you could begin by telling us how we got to where we are, and—perhaps this is the slightly harder-edged question—why it has taken so long to get to where we are.

Niall Dickson: First of all, thank you very much for inviting us. From our point of view, this is a good opportunity to explain where we have got to and where we need to get to over the next phase, which we believe is very important. I do not know whether you need me to introduce my colleagues, but Professor Malcolm Lewis is a GP in Swansea. He is the lead member of our Council responsible for revalidation and he is also Postgraduate Dean for General Practice in Wales. On my left is Una Lane, who is the Director of Revalidation and Continued Practice at the General Medical Council.

In answer to your question of, “Why has this taken so long?” I think there are two things at work here. To be honest, 10 years ago I am not sure that the profession was in the right place for taking this forward. I do not see any crowds of people outside my office at the moment with placards saying, ‘Give me my registration. Give it to me now’, but I do think that the profession has changed pretty significantly over the last 20 years and, in particular, over the last 10 years.

We very much regard revalidation not as a kind of private conversation among doctors or as something funny that the medical profession is doing, but as being part of a much wider safety and quality movement which has been gathering pace. It has been pioneered in this country, in the States and in Australia where there is now a real concentration, a recognition, that health is a safety-critical industry and that it has to do things that recognise that while doctors are able to do an enormous amount of good, they also, on the point that we give them registration, have the capacity to do considerable harm as well. So I think attitudes towards all that, and the quality of data and the ability to access that data, have all improved over time.

The second thing is, really, just the politics of it. While the Bristol Inquiry and the Shipman Inquiry were, in many senses, helpful in pointing to the right way of doing this, they also, in other ways, of course, made everybody stop and re-think the process again. I don’t think we are going to sit here and defend the fact that it has taken this long to get to where we are. I think we’re very much focusing on the fact that, certainly in the last couple of years, and especially in the last year, we think we’ve made very significant progress. We think there is a degree of consensus—as I say, not necessarily wild enthusiasm from every doctor, but there is a degree of consensus—among medical organisations, and indeed acceptance by our consultation of frontline doctors, accepting the principle of this, if we can get the practicalities right. We believe that there is political will throughout the UK, in the four parts of the UK. Obviously, just to underline the point that we are a UK organisation, in that sense your inquiry is a UK one, with your UK hats as well as your English hats—if I could put it that way—those of you who are English MPs.

Q2 Chair: Yes. We have responsibilities that reflect the responsibilities of the Department, I guess, in this area.

Niall Dickson: Which has both—two hats to wear.

Q3 Chair: Precisely. Your answer to my question about timing would appear to be, therefore, that you acknowledge that this has taken longer than it should have done.

Niall Dickson: Yes.
Q4 Chair: But it is now close to the top, if not at the top, of the GMC’s order of priorities, with a will to deliver it within the timescale set out in the document published a couple of weeks ago?

Niall Dickson: Unequivocally it is our top priority. This is, we believe, the most important thing that we are doing in advancing the quality of medical regulation and having an impact over the longer term in terms of patient safety.

There is a paradox at the heart of it. In one sense, it will be the biggest change in medical regulation for more than 150 years. On the other hand, frankly, the system should be doing what we are asking it to do anyway. Appraisal has been within GP contracts and consultant contracts for some years and for specialist doctors it has been in for a couple of years—good systems of clinical governance. As you pointed out, the Bristol Inquiry has been calling for that.

So we are basing the whole of our revalidation thing on good local systems of clinical governance. They are not universally in place but, to be fair, quite a lot of progress has been made over that period. We very much hope, and I believe, that the work that we’re doing now is acting as a catalyst and is encouraging organisations to put in place these systems of clinical governance.

Q5 Grahame Morris: I don’t know if perhaps I should direct this question to Professor Lewis, but thank you very much for submitting the written evidence.

Just in relation to the pilots that have been running, we are very keen to understand and learn lessons from the evidence base. What issues can you highlight for us—for the Committee? What lessons have we learned from the pilots in terms of the revalidation exercise?

Professor Malcolm Lewis: If I can start, perhaps Una might want to come in later on. It might be worth outlining for the Committee, initially, what the process of delivering revalidation for all doctors involves and then we can talk about what we are testing and how across the UK.

Q6 Chair: I think it would be very helpful to understand exactly what was going on in the pilots, to understand what exactly the issues were.

Professor Malcolm Lewis: The premise on which revalidation relies is that there is good clinical governance and good appraisal systems. I ought, maybe, to explain what exactly that means to an individual doctor working within the NHS. I can talk about this from a GMC level or from the processes we have put in place in Wales, but also as a GP in clinical practice. Essentially, it means that you are working within a system that allows you to be appraised on an annual basis. At that appraisal, you have an element of continued professional development which you bring to your appraisal and next year you establish whether you have achieved that or not and, if not, why not and what else might you have done. So that’s about professional development in the context of your work.

Also, some patient and colleague feedback questionnaires which we are advocating should be at least once every five years within this system, which allows patients to feed into the process—that there is locally-held information about you, your clinical activity, any complaints and any significant event analysis, and that those are appropriately addressed within the organisation.

Then we move into, if you like, the slightly darker side—where there are concerns about your practice, that these are managed appropriately at a local level and, if necessary, that there is some form of remediation, either locally, through the National Clinical Assessment Service assessments, or, ultimately, through the General Medical Council’s performance procedures. So that is the spectrum of clinical governance which includes appraisal.

What we are testing within the pilots is a range of items in terms of how that is working at a local level. We are testing appraisal in secondary care, for example, in Mersey. We have already done a major piece of work which concluded in 2009 on clinical governance and appraisal systems in Wales—what they look like, what the detail is in terms of good systems and whether those are in place. We have tested the role of potential affiliates within the links between the GMC and the Service and we have a proposal to roll out, on a slightly smaller scale, regional advisers to the Service in relation to local activity and to concerns about doctors and so on. So there are a number of things that are being tested and developed.

The scale of this, I believe—Una might correct me—is that we have something like 2,500 doctors who volunteered to get part in the various pilots that are running. They are, obviously, still not all completed and we have had this extension that the Secretary of State suggested we have in order to run the pilots through 2011 and to have conclusions by the end of next year, which will inform the process better.

Una, I am not sure whether you want to come in on that.

Una Lane: Yes. Just to put the pilots in some context, I think there is a challenge for us at the GMC. Chairman, you were speaking earlier about, “Are we committed to introducing revalidation?”, and we absolutely are, as Niall has said. The challenge for us is that it has to be a shared responsibility.

The process of revalidation is based on good local systems, mainly in the NHS but also in other healthcare organisations, both in primary and secondary care. It is a very complex landscape. We have health devolved in Wales, Scotland and Northern Ireland and 225,000 doctors with a licence to practise.

So we are absolutely dependent on the four Departments of Health, on employers and others, and on individual doctors, in order to introduce revalidation within the timescale that we’ve agreed. And the piloting—

Q7 Grahame Morris: I am sorry, but this is quite a fundamental point. It might be because I am dim, but I still can’t quite understand what the difference is with the appraisal in the pilots compared with the existing system. Would you just explain that to me, for my benefit, in simple terms?
Una Lane: I would be happy to, if I can; I hope I can. I just wanted to explain that the pilots are actually not being run by the GMC. They are being run by each of the four Departments of Health in each of the countries and are funded by each of the four Departments of Health. So, in the context of England, if I could speak about England, there are 10 pilot sites in primary and secondary care and there are a number of things that they are testing.

First, they are looking at a new framework for appraisal because, as Niall has said, every doctor should be having an annual appraisal; that has been part of their contracts for a number of years. There is an issue about the consistency of that appraisal and one of the things that is being tested is whether the appropriate standards, the professional standards that we set for all doctors at the GMC, can be embedded appropriately in the current appraisal system as it exists.

A couple of other areas that the pilots are looking at—and it may be that the Department, who I know are giving evidence next week or the week after, might be able to answer some of these questions in a little more detail—relate to the supporting information. So: “What kind of supporting information are healthcare organisations generating currently to enable doctors to reflect on their practice?”; “Does it look anything like the supporting information that we, at the GMC, are suggesting might be appropriate or that colleges and faculties are suggesting might be appropriate?”; “Is that kind of information readily available?”

It is also looking at the links. So: “How do the systems that healthcare organisations have locally link to professional regulators like the GMC?”; and perhaps, also, more broadly, “How can we quality-assure those processes locally?” I hope that gives a little bit of a flavour for the difference between what is happening currently and what might happen in the future.

Niall Dickson: I would just make a brief point. The answer is that at the moment, across the UK, some parts are quite well developed in terms of the appraisals that they do, but in some places it is pretty patchy and some doctors are not getting appraisals at all. The variation can be as somebody described it to me in respect of a GP in one part of the country—I won’t say where: the appraisal consisted of a round and we can forget about these two separations.

I just wanted to explain that the pilots are actually not being run by the GMC. They are being run by each of the Department of Health. So, in the context of England, if I could speak about England, there are 10 pilot sites in primary and secondary care and there are a number of things that they are testing.

Q9 David Tredinnick: On that point, many respondents thought that what they were being asked to provide was neither practical nor proportionate. So how are you going to address that?

Niall Dickson: We are going to make it more streamlined, Malcolm.

Professor Malcolm Lewis: Essentially, the position that we were in some time ago is that we had this separation of revalidation into the two component parts of re-licensing and recertification. Recertification was thought to be for GPs and doctors on the Specialist Register and re-licensing for all. It became incredibly complex because although the GMC sets the standards for revalidation, we had a situation where the colleges were charged with setting data sets for each of the individual specialties and when we asked them to do this the underlying principles were that there should be proportionality and that there should be fairness and equity across the specialties.

As we see, particularly from the BMA’s response to the consultation, that is, in fact, not where we ended up. We ended up with disparity and we ended up with some data sets that seemed to be quite extensive and, as you say, very difficult to deliver and unrealistic. I think that what we are having to do, as Niall says, is to come to a situation where we can get a product that is a reasonable product, if you like, of revalidation in the round and we can forget about these two separations. I think that we have to have a different logic applied to what we mean by “specialty standards” for the purpose of revalidation.

Where we are and what we are discussing with the Academy at the moment, who are charged with this work, is that we should get to a starting point where we have the GMC standards for revalidation which are laid out in a framework for appraisal and assessment, which includes bringing evidence to that template—and you have probably seen that template. Within those domains, if you bring evidence from your specialty—because if you are, say, a psychiatrist or a dermatologist, you work in that field—the evidence that you bring to your appraisal and the evidence about you locally, within clinical governance, is of your work and therefore of your specialty.
So I think that the starting point we need to get to is an acceptance of that fact as the compulsory or the core element of what doctors have to bring to appraisal against the GMC standards. Thereafter, if the specialties want to have a list of 100 things that doctors from that specialty can bring then that ought, initially, to be voluntary because we already have that core of evidence that comes from the specialty. The logic is that we are doing, essentially, what the result of the consultation exercise has asked us to do, which is to streamline, but to continue to make it relevant to the workplace and not to incur any additional workload on behalf of the various specialties.

David Tredinnick: I have one more question.

Professor Malcolm Lewis: What you have, essentially, is a situation where, if you have good clinical governance, as I have described it, in place and you have annual appraisal, as I have described it, in place linked to and to CPD and so on, doctors ought to be able to revalidate without actually doing anything additional to supplement that information because it is all collated in one place around the annual appraisal. I appreciate you want to come back on the point, but it might also be worth just making the point in terms of this being proportionate to what doctors are currently expected to do and comparing it to some of the international models. There are exams that are taken in the States, for example, on a voluntary basis, although about 80% of specialists do. But the reality of those exams is that they may not always be relevant to the doctor’s work. For example, if you have a paediatrician who becomes a neonatologist, which is looking after premature babies, the exam that they have to do is not necessarily about neonatology; it is about general paediatrics.

Q10 David Tredinnick: May I just come in?

Professor Malcolm Lewis: I am sorry.

Q11 David Tredinnick: Thank you for your explanation. As I understand it, where we have got to is that there is, basically, a core syllabus. Are we saying, then, that all doctors, regardless of where they are located, and whether they are in hospitals or in general practice or doing whatever, are going to be tested every year?

Niall Dickson: No. There is no proposal for a test.

Q12 David Tredinnick: I mean ‘appraised’.

Niall Dickson: An appraisal, yes.

Q13 David Tredinnick: Forgive me, I misused the word.

Niall Dickson: No, it’s okay. It is just to be clear.

Q14 David Tredinnick: Appraised, in a way, each year. So it will happen that every doctor will be appraised each year?

Niall Dickson: Every doctor will have an annual appraisal and that is already a requirement in the Health Service at the moment. All we are suggesting is that the appraisal should be consistent throughout the NHS.

Q15 David Tredinnick: But to be consistent they have to be different, given the work that each particular doctor is doing in their particular field.

Niall Dickson: Exactly. It reflects their practice.

Q16 David Tredinnick: So if you’re a hospital doctor it is slightly different.

My last question is this. You mentioned exams. Are you thinking of using any automated systems, as they do in America, where they test using computers and you basically punch holes in forms?

Niall Dickson: Under the current proposals, there is no proposal to subject doctors to additional examinations as part of the revalidation process. It is a system of ongoing appraisal within this idea of clinical governance, which means that, at local level, we are expecting doctors with the help of their organisations to be able to provide information about the quality of their practice—what they are doing; and that, once every five years, they test out what their colleagues and their patients think about their practice; that they are able to have some time to reflect on that practice with their appraiser, who will be properly trained; and that they will be able to reflect on that the following year.

For the vast majority of doctors, we accept that this process will simply become part of their natural professional life as, to be honest, it already is with quite a large number of doctors at the moment. But it is not universal and it does not, for example, apply terribly well in areas like locums.

David Tredinnick: Thank you very much.

Q17 Mr Virendra Sharma: So there will be a different level of appraisal. If a doctor is in the hospital, the “line management”, to use management language, will do the appraisal, but for the GP outside there will be an independent GP coming and doing the appraisal? Isn’t that the difference?

Niall Dickson: Not necessarily. I don’t know whether you want to expand on that, Una. It depends on the Primary Care Trust in England or the local Health Board once they are appointed. Those Responsible Officers are, in turn, responsible for putting the kinds of processes that we’re talking about in place, if they’re not in place already. So they need to ensure that every doctor is having an appraisal and that the systems that are in place in a hospital or in primary care enable the doctor to produce, or actually produce, the kind of information that some members were speaking about so that doctors can bring it to appraisal, reflect on their practice and perhaps see
where they are in relation to their peer group in primary or secondary care.

As far as the appraisers themselves are concerned, they will also, in turn, be doctors, usually, but not always, from the specialty in which the doctor works—almost always a GP in terms of general practice—and the appraisal and the output of the appraisal actually feeds into a recommendation from the Responsible Officer once every five years to the GMC.

So there are links—or the intention is, at least, that there should be links—between the individual doctor, the organisation at which he or she works and an annual appraisal process that links to an appraiser and a Responsible Officer who is responsible both for the Board, usually, but also for the processes that need to be in place, and better links, I think part of this process is about better links between national professional regulation and what happens locally in healthcare organisations. I don’t know whether that helps.

Q18 Chair: Can I just play back something to you? Listening to you, it does strike me. You said that the pilots that had been done were not, essentially, owned by the GMC; they were being run by the Department. You then went on to say that, “We are unclear,” and that, “There’s a discussion going on about the nature of the information on which the revalidation is going to be based.” It does sound as though this is a very early-stage process, given that we are 10 years on. That’s my reaction to what you say and I would like to hear your response to it.

Niall Dickson: I think the honest answer is that, at the moment, the situation we are looking at is patchy around the country but, already, there is considerable progress being made. For example, in Scotland they are talking about putting in enhanced appraisal for every doctor in Scotland along the lines that we are talking about from next year. They have made considerable progress in general practice—less so in secondary care, but they think they can do it across the whole country.

Malcolm may wish to comment, but GPs in Wales have had a form of advanced appraisal for quite a number of years; it is already an automated system and something they are absolutely used to. We do have some refining to do, some stripping out to do and some simplifying to do, but I think the broad structure of what we are attempting to do is a system of appraisal every year; that doctors must have access to some information—not vast amounts of information, but enough information—and that they should be collecting information about their continued practice and have it in an electronic folder that they can bring.

Again, all trainee doctors, of whom there are tens of thousands, do this as a matter of routine anyway. So we are adding bits and pieces to things that are already there to create a comprehensive picture, but it is not that we are, in that sense, at a very early stage.

Q19 Chair: You say, “We are doing it.” Is it the Department that is doing it? Ultimately, this is a process that is going to be owned by the GMC and, if the Department is doing it and you are saying that, actually, these pilots are not even a GMC process, I just wonder about the extent to which the GMC has been engaged in the pilots and the extent to which, therefore, the GMC conclusions from the pilots are your conclusions or the pilots’ conclusions?

Niall Dickson: It is not a simple “yes” or “no”, needless to say. I think we are part of a process. We are working with these partners in the different parts of the UK and they are conducting the pilots, but they are doing it in co-ordination with us and we are saying, “This is what we will require”, and we are having a discussion with them and the Service.

Ultimately, the Service has to put in good systems of clinical governance. We can’t do that. We want assurance that those systems are in place and that there is a workable system of appraisal which will give confidence to doctors, employers, us and patients. So we are very much working with them to do that, but they have to do the ground work, as it were.

Q20 Grahame Morris: Chairman, I would just like to relate to that on the timetable, if you do not mind. It is arising out of the joint Statement of Intent on revalidation. Just for the record, I was interested in the GMC’s view on whether it is possible to introduce revalidation across the whole UK by the end of 2012. Is that realistic?

Niall Dickson: I believe it is. Una.

Una Lane: I think what we say in the Statement of Intent—and this has been agreed and signed by the four Departments of Health and also by Sir Bruce Keogh, who is the Medical Director of the NHS in England—is we think that organisations should be ready on the ground to deliver what needs to be delivered to support revalidation by late 2012. I think by that we mean every doctor should be engaged in an appraisal process; Responsible Officers should be in place in every healthcare organisation; and we should have agreed supporting information that doctors bring to appraisal.

I think, perhaps, Chairman, going back to your point, we have not agreed the supporting information as yet and I think it is true that everybody has not signed up to exactly what that core information needs to be. But does everybody have a feel for what that might look like? I think we do and I think we are very close to getting agreement on that.

In relation to 2012, we think there needs to be a start date for revalidation. We think there needs to be a timetable so that every organisation is ready to deliver. We absolutely accept that not every doctor is going to be revalidated by the end of 2012. There are 225,000 doctors with a licence to practise in the UK, and we would like to think that we can begin revalidating some doctors late 2012.

But the next piece of work that we need to work on is, “What does roll-out look like thereafter, where do we begin, and do we need a further deadline to ensure that every doctor is in the process and every organisation is doing what needs to be done?”, and not just really for our purposes but to assure ourselves, ultimately, of the quality of care that is being provided to their patients at the end of the day because that is what this is all about. It is not about the GMC making...
some decisions and requiring doctors to do certain things. There is a purpose, which is about assuring patients, the public, employers and ourselves that doctors are qualified to do what it is they do and that they are maintaining their practice and are up to date. **Niall Dickson:** I think the date, for us, is important because if you don’t have a date—dare I say it—your predecessors could be sitting here in 10 years’ time saying, ‘Why have you spent another 10 years doing this?’ I think Una is right—we will need another date by which time everybody has got to be in. I am thinking of fairly shortly afterwards: I am not talking about another 10 years. Once we get the process going, we need to set another date so that everybody, by that time, has got to be part of the process. We don’t think that these milestones are unachievable, even in areas where they are not, perhaps, quite as advanced as, for example, in Scotland or Wales. **Chair:** Fiona has been trying to catch my eye.

**Q21 Fiona Mactaggart:** It is interesting talking now about dates which provide “stop points” because you have been describing this process as though it is a completely smooth transition from an existing system of appraisal into a system which, actually, has in it a much bigger sting in the tail than the present appraisal system has, it seems clear to me. I do not think I accept that, for the individual doctor, it is going to feel as seamless a transition as you imply. For it to succeed, I think there needs to be real confidence and trust among doctors about the process—actually, not what will happen in the revalidation process but, if they are at risk, what goes on there, where is the transparency, and do they really understand this, because I have a feeling that they don’t? I think that is where it might fall down and I want you to explain. **Niall Dickson:** I think we have got a significant communication job still to do. We are communicating with individual doctors and we will do a lot more of that. I think as the process becomes absolutely clear, it is easier to say, “This is how it will work. This is how it will affect you.” As far as it being much more serious now than it has ever been before, I think the sort of appraisal that we are talking about is not that doctors are subjected to some sort of great cross-examination and so on. It will be the form of appraisal that most people are used to in most walks of life; it is not different from that. As far as the revalidation bit is concerned, we see that as being almost an automatic process. We have said it and we will make it clear: for a doctor who passes through and is doing their appraisal year after year, nothing is going to happen. The Responsible Officer who decides not to revalidate a doctor is, in effect, saying, “This doctor’s fitness to practise seems to be impaired and I am referring them to the GMC.” That is no different than a decision Medical Directors have to make today. So we don’t see anything happening at that fifth year other than the sign-off process. What might happen is that, early on in this process, a problem might be identified, as, frankly, it should be at the moment. At that point, hopefully, action will be taken at an earlier stage than currently is the case.

**Professor Malcolm Lewis:** I think it’s worth emphasising that revalidation is new, it is coming and it is actually a positive affirmation of a doctor’s fitness to practise. There is nothing negative about it. It’s about demonstrating, through your appraisals and through clinical governance, that you are up to date and fit to practise, with some feed-in from patients, of course, through questionnaires. The other end of the spectrum that you referred to, where there are concerns and a need for more detailed assessment and, maybe, remediation—we have that already. It may not be universally applied across the UK; there may be differences between specialties, between hospital trusts and between Primary Care Trusts in the way that it is managed. That is an issue that needs to be addressed, but, in a way, it is a kind of parallel track to revalidation. Revalidation is the positive end of things. Remediation is not anything new, but it is something that needs to be addressed in parallel. **Una Lane:** Just to go back to your point about, “What is it that doctors are feeling about it?” what we are describing is what we think should happen, what is happening currently and what needs to happen. As part of our consultation earlier this year, we met with probably between 4,500 and 5,000 doctors across the UK. We had just over 700 individual doctors who responded to the consultation and, to be fair, almost all those responses were incredibly constructive. I think the vast majority of doctors agree, in principle, that revalidation needs to happen. Almost 90% of doctors who responded to us said, “Yes, it absolutely should be based on an evaluation in the workplace and what I actually do in practice. Yes, it does need to be on an appraisal process.” That doesn’t mean there aren’t some concerns. There absolutely are some concerns. Some other members have mentioned some of those concerns: “Is the supporting information reasonable?”, “Can I access it easily?” and, “Is it proportionate?” That is certainly a concern. And there are certainly some concerns about seeking patient feedback. So I wouldn’t pretend for a second that every doctor is looking forward to this with absolute glee. But perhaps the usefulness of some of the delays around this is that I think doctors are much more socialised to the idea of revalidation. The BMA supports revalidation in principle and was actually very positive in response to some elements of our consultation and in our response. It is a bit of a mixed picture but I think, in principle, there is an acceptance that it does need to happen. We have just got to make sure that it is proportionate and straightforward but that it is sufficiently robust that it can help to identify doctors at an earlier point in the process, when they are putting patients at risk. **Chair:** That’s a good cue. Sarah.

**Q22 Dr Wollaston:** Given that the purpose of revalidation is to assure patients and the public that their doctors are safe to practise, there are two key areas of concern that patients have. The first of those relates to the position of EU doctors. Could you clarify whether you have come to a decision about how we are going to slot EU doctors into this process,
because there have been a number of well documented patient deaths as a result? Secondly, there is the issue of whether or not this process of revalidation would have picked up doctors like Dr Shipman.

Niall Dickson: I will try the first bit and I will leave Dr Shipman to Una. As far as EU doctors are concerned, we are in discussions with the Department of Health at the moment. The Government have been, I think, very helpful. I believe they have recognised that this is a two-stage problem. There is a problem with UK legislation at the moment to the effect that it stops the GMC from doing any form of language testing, but there are also problems with the way the EU Directive is drawn up and the fact that, as a regulator, you have to establish doubt about the doctor’s ability to speak English before you can test, which is a sort of Catch 22. We are exploring ways in which we might be able to get round that. Secondly, the Government is committed to working on the current review of the EU Directive and we have also been having talks with other regulators and with the Commission directly. Again, this is a slow process. So there is work being done on all that and we hope that that might make some significant progress in the medium term on language and, certainly in the longer term, on language and competency. But I am not underestimating the obstacles involved in either of those things.

As far as revalidation is concerned, I think this is interesting. Revalidation does not completely solve the problem, but it does mean that, as Una mentioned before, when a doctor comes on to our register they immediately have to have a Responsible Officer. That Responsible Officer has a responsibility for ensuring that that doctor is working in a clinically-managed environment—in an environment in which there is proper clinical governance in place. So it is an extra safeguard and, for example, we might be able to say, if you are newly arrived on our register, wherever you are from, “We would require you to revalidate more quickly.” It could not be the next day; I think that would probably cause upset with the European Union if we said that. But, across the board, we might be able to say, “If you are new to the register it might be an idea to have a formal revalidation within a shorter period of time.”

So I think revalidation, because it provides you with that framework across all areas of practice—locums, doctors working on their own and doctors new to the register—may provide a little extra assurance.

Q23 Dr Wollaston: Do you see that it would be possible to ask doctors, before they can be on the performers list for a PCT—although PCTs, of course, might not be with us for much longer—that, if they want to be on a performers list, they have to have a Responsible Officer and, as part of having a Responsible Officer, there could be a language test at that point? Do you see that as a possibility?

Niall Dickson: That is, Malcolm may want to expand, but the answer is that employers already have that. I wrote to every employer in the country earlier this year, reminding them of their responsibility. I accept that there is a hole in our regulatory system because of the nature of the current EU law, but employers still have a responsibility to ensure that any doctor they employ or contract with is both fit to practise and fit for purpose, and because there is this gap in our system it puts a particular onus on employers who are taking on doctors from the European Union to make sure that those doctors that they employ and contract with are fit for purpose—the job that they are actually being given—as well as fit to practise. Malcolm.

Professor Malcolm Lewis: Yes. This process is already in place in parts of the UK. I know that to enter a performers list on my patch, if you have not worked in UK general practice, regardless of European legislation, you will undergo a language test and a performance communication test.

Q24 Dr Wollaston: Right. So that’s happening in Wales?

Professor Malcolm Lewis: That is happening. It has been happening for about three years.

Q25 Dr Wollaston: But that has not been rolled out into the rest of the UK?

Professor Malcolm Lewis: It is also happening in parts of England. I think that we may want to do this. We wrote to your predecessor—actually, your pre-predecessor—on this issue, outlining the processes that were in place. It was a joint document put together by the RCGP and COGPE, which is the UKGP Directors, outlining the detail of how this process might work and helping to draw attention to PCTs. The powers within the performers list rules do actually allow them to do this at the point of entry because we can’t rely on maybe getting somewhere with European legislation over a period of time that is undefined. So there is work in place and it is happening in parts of the UK now, but not universally.

Q26 Dr Wollaston: Would you be able to identify for the Committee which parts of the UK it is not happening in and why it is not happening in those parts?

Professor Malcolm Lewis: Not today, but I can certainly get back to you. The advice has gone out.

Q27 Chair: Absolutely. It would be very useful if you let us know because, in effect, those are parts of the UK where the fitness to practise is accepted but there is no effective test in place for fitness for purpose. Correct?

Niall Dickson: Correct, yes. We are not able to test the fitness to practise of doctors from the EU as we are for international medical graduates, whom we subject to both language testing and clinical testing and, of course, for UK doctors and so on. Una may want to pick up your question about Dr Shipman.

Una Lane: On your very straightforward question of whether or not it would catch another Shipman, I think we should go back to what Dame Janet Smith, as she then was, said in the Fifth Report of the Shipman Inquiry, which is now way back in December 2004. She wrote a whole chapter on medical revalidation and, at that time, the concept of revalidation was not very different from what we are proposing currently. It was, again, based on local systems of appraisal and
local good clinical governance systems. What she said at the time was not that that was wholly inappropriate but that the systems in 2004 were just not sufficiently robust—the governance systems weren’t appropriately in place, particularly in primary care, and she had some significant concerns about the robustness of appraisal back in 2004. She did think about whether good clinical governance systems and appraisal processes could catch another Shipman. Her view then was that if clinical governance systems were sufficiently robust and produced the right kind of information—for example, you are looking at mortality rates for Shipman at the time, particularly prescribing, and he was, I believe, an outlier—there was data available. It simply wasn’t being monitored.

So I think there is a general view that good local systems and good robust systems, if they produce the right information, and if that information is monitored appropriately, can identify outliers and at least enable a further investigation to take place. Once revalidation is introduced, will that mean that no doctor will ever deliberately or negligently damage a patient again? Absolutely not. We absolutely cannot say that. Do we think it can contribute to lowering the risk? Do we think that it can contribute to helping identify poorly performing doctors at an earlier point in the process? Yes, we think it can.

Dr Wollaston: Thank you.

Chair: Mr Sharma needs to go and he has some questions that would naturally have come later.

Q28 Mr Virendra Sharma: Doctors are at different stages in their careers; some have newly started while others have been in practice for many, many years. Was there any distinction between the responses that you received from doctors at different levels of career?

Niall Dickson: I do not know whether we had that information from them.

Q29 Chair: And could I couple with that not only the nature of the responses but also identifiable risks around doctors at different stages in their careers as well?

Niall Dickson: Okay. Do you want to comment on this, Una?

Una Lane: Yes, just in relation to the responses to the consultation. The responses came in a whole variety of forms and formats. We wanted to encourage as many people as possible to respond. So some gave us feedback during the events that we had and some completed the detailed form where they provided us with detailed information and a breakdown of who they were and what their ages were. But that was not true of every respondent. So in terms of a statistical breakdown, we don’t know that. What we do know is that there were different concerns for doctors who do different types of practice. Doctors in clinical practice generally were quite supportive of the proposals. The concerns, I think, were from groups of doctors who do different kinds of things—doctors who don’t necessarily see patients every day, doctors who are in medical management, Medical Directors in post and doctors who are clinical academics. I think what they were looking for was some further and more detailed information as to how this process would apply to them.

I think, separately, there were doctors who do quite a lot of locum work—peripatetic locums, in particular, who tend to move around quite considerably. They had concerns about how they might access supporting information, how that might look from their point of view and who their Responsible Officer would be. So I think we got a flavour from doctors in different kinds of practice in that sense. But in terms of a statistical breakdown, I think that’s more challenging as some doctors provided us with some of that information and some simply did not.

Niall Dickson: This is only anecdotal. The anecdotal evidence we have is that younger doctors are much more relaxed about this. Certainly doctors in training are currently required to do almost everything that we would be asking for anyway, so there wouldn’t be a big change and you are talking about tens of thousands of doctors there. So I think there probably is a difference, although we do not have the evidence to support this, that the middle and the younger end of the profession are less anxious. They are more used to this kind of environment. But we don’t have figures to support that.

Q30 Mr Virendra Sharma: Could I take it that it is the same, then, with the doctors in the hospitals and the doctors running their own practices as GPs?

Niall Dickson: About levels of difference between them?

Una Lane: I don’t think there was really any discernible difference between doctors in general practice and doctors in secondary care. Certainly from the doctors we’ve spoken to, appraisal is part of their contract. It is what they should be doing. They appreciate that. Their supporting information that they will be bringing to appraisal will actually come from their practice. So we certainly didn’t notice any discernible difference in speaking to doctors through the consultation process—or at least any difference between doctors in primary and secondary care.

Niall Dickson: Again, I think my guess is that if you are in Wales and you are in general practice and you are used to this appraisal process, it probably seems less alarming than if you have never had an appraisal at all.

Professor Malcolm Lewis: Yes, I think that’s right. The one thing that we have to put in place before we have the full package is the patient and colleague questionnaire. But I was at a meeting of our Associate Medical Directors for primary care recently, among others, and asked the question about their confidence levels in recommending to the GMC that GPs on their patch could be revalidated at that point in time. They felt, on the basis of the current systems, that they would be able to recommend 95%-plus at that stage. I think there is something about getting started there, really, and getting the fuller picture, adding in the questionnaires and filling the GMC’s template so that we can make a move. We can’t wait for that big bang because it will never happen.

Your question was about relative risk. It is quite difficult, but I think our perception is that doctors in
training are subject to a more rigorous supervision system. They go through various exams and assessments on an annual basis and they end up with a Certificate of Completion of Training or the equivalent. But if we keep it to a CCT—Completion of Training—for the moment, we feel that they really don’t need to do any more than they are doing because of that environment and that if the local clinical governance can be tied together with educational governance at the annual reviews that they undertake, so that any concerns are addressed, we could be happy to revalidate on that basis, and the Responsible Officer for them will be the Postgraduate Deans. That went down very well in the consultation, as you will have seen.

The coming of that would be that people would get into the system when they got their full registration, which is after the first foundation year and then, five years later, they would be expected to revalidate. If, as in general practice, they get a Certificate of Completion of Training prior to five years, in some cases, then that would be the next milestone and the clock would start ticking again for five years.

It is difficult then to think about how you look at risk. I suppose you could look at our fitness to practise statistics, which suggest that, particularly in primary care, it is a bit later on in their careers that doctors are more at risk. There are also things like isolated practice and so on that are risk factors. There are things that can be done about that and things that clinical governance and appraisal will be helpful with, because it brings people more into the fold. So we hope that this process that we are doing will also be a catalyst to reduce isolation, in a way.

Q31 Mr Virendra Sharma: To what extent was there a response from members of the public or from the organisations representing the patients? Was there a difference from the medical profession?

Niall Dickson: Again, Una will comment.

Una Lane: In all of these kinds of consultations it is always really challenging for organisations like ours to seek feedback from individual patients and individual members of the public, and we are absolutely aware of that. What we tend to do, as we did in these circumstances, is organise a series of events around the country. We had two big events in England—one in Manchester and one in London. They were day-long events. They were organised by an organisation called National Voices, which is an umbrella organisation for about 200 patient representative groups. So it is probably fair to say that, in relation to the responses we get through these kinds of consultation events, it does tend to be representative organisations and representative groups. But very often now our groups are representative of a really broad breadth of experience in all four countries.

We have done some separate polling with about 2,000 members of the public and you get some feel and feedback through that kind of process, but it is challenging to engage with individual members of the public with some issues and areas that are quite technical. So we tried to focus those events on areas that we thought might be interesting to patients and particularly focused them around patient involvement, patient experience and patient feedback to doctors—whether they had experienced it and their views of it. So it was probably a more focused consultation in that sense because a lot of patients and individual members of the public are not particularly interested in the technicalities of appraisal, to be frank.

Niall Dickson: There are two things that we would probably say. One certainly is that when you ask members of the public many of them think this thing happens already and are really quite surprised that it doesn’t happen. If you ask them, “Do you think that part of this process should involve talking to some of the doctor’s patients?” Overwhelmingly they say, “Yes, it should.” I think those are probably the two dominant features of the response. There is certainly a lot of support from patient groups who think that this ought to be up and running and probably think, rather as the Chairman implied, that it has been a long time coming.

Q32 Mr Virendra Sharma: Will there be any revision of the proposals to take account of the views of patients in the future?

Niall Dickson: Yes.

Una Lane: Absolutely. On the one hand, in relation to patient feedback, a lot of doctors respond really rather nervously. Many doctors are doing it already. I know in my own local surgery in London they seek regular feedback through questionnaires. Other doctors, who are not so used to doing that, are a little nervous about it. In fact, patients tend to respond extremely positively when asked to provide feedback about their doctors. It is doctors’ colleagues, I think, in many circumstances who tend to be a little more circumspect.

But a lot of patient organisations told us that that was fine as far as it went but that we needed to take into account some further developments around patient engagement and patient experience. There is a significant amount of work going on in a number of locations in hospitals, in particular about getting instantaneous and immediate feedback from patients. There is a significant amount of work going on around patient-reported outcome measures, for example, feeding into the process and we do, absolutely, have to take these kinds of developments into account.

Do we think that all these things would form part of the supporting information that doctors bring to appraisals in 2012? We have to be realistic and say no. We have to start from where we are, around the supporting information that is currently available. But will that look the same in 2020 or 2025 as it does in 2012? I don’t think so. So in that way I think we do need absolutely to hear what patients say. Of course, all of us are patients usually at some point in our lives and understand some of these concerns. But we think that we also need to start from where we are currently and patient feedback through questionnaires is a good and a useful place to start.

Mr Virendra Sharma: Thank you. Thank you, Chair.

Q33 Chair: Can we explore a bit the nature of the Responsible Officer and the issues that came out of
the consultation on that? Nadine, I think, would like to start.

**Q34 Nadine Dorries:** It is interesting that you should mention patient groups because last night a presentation to a number of patient groups included The Patients Association. They were concerned regarding, obviously, the GP consortia and the new format in which GPs will operate—and, actually, GPs are to be given additional freedoms in terms of commissioning and how they practise and develop their expertise. They were concerned about what checks and balances will be put on that. Obviously, it will come via the Responsible Officer. I have a number of questions. Could you tell me who is going to train this person? Where are you going to source them from? Did you envisage they were going to come from the PCTs? Exactly how is their role going to operate? And do you see revalidation running parallel with the new consortia? You started this in 2000? GP consortia have only known about this for a few weeks. How does that affect your proposals? I am sorry. I don’t know who wants to take those questions.

**Niall Dickson:** I will start and then I’ll refer over to Una.

We recognise that the landscape in England is changing. It is not changing so radically in Scotland, Wales or Northern Ireland, but in England the landscape around primary care and the commissioning of secondary care is obviously changing quite radically. The first point is to pay tribute to Medical Directors within Primary Care Trusts—it is not universal, but they have made significant advances, I think, in looking at the quality of general practice in their areas, helping to support that and beginning to introduce appraisal systems and all the rest of it. So that is good. Obviously, their role is going to disappear as Primary Care Trusts disappear and we have certainly asked the Government, “What is the new structure going to be?” because we will require and the legislation will require that there should be Responsible Officers. Every doctor has to have a Responsible Officer. That will be in the law. So we need a new system. Exactly where those Responsible Officers are is not a question that needs to detain people for months and years. They just need to make a decision about where is the right place for them to be. I think our only anxiety around this—and I don’t for a minute think that the Government would want to do this—is we wouldn’t want a Responsible Officer at so local a level that it was the four of us deciding which one of us will be our Responsible Officer. It has to be across a certain size for them to be able to fulfil their functions because what they are doing is not so much this business of yes-no to a doctor—”I’m going to revalidate/I’m not going to revalidate.” What they’re doing is overseeing a system of clinical governance and providing assurance that that is happening.

**Q35 Nadine Dorries:** So do you see a Responsible Officer as being one Responsible Officer per consortia?

**Niall Dickson:** They might be embedded in consortia. I don’t think it—

**Q36 Nadine Dorries:** Because some of the consortia, as we have already heard from a witness, may be on an almost regional basis. It will be huge.

**Niall Dickson:** It might be too big. Obviously, if a Responsible Officer was the Responsible Officer for too many doctors it would become difficult. So it has to be the right size. I think, for the Responsible Officer to be able to discharge their duties, which means you do need a critical mass. But, frankly, one Responsible Officer for the whole of England doesn’t sound terribly sensible to me.

**Q37 Nadine Dorries:** Has that decision been made? Has anybody done any work to see how many doctors a Responsible Officer could look after and what work he will be doing with those doctors?

**Niall Dickson:** I think the Government are currently thinking this through. We have put in our evidence as part of the responses but, as you know, there are quite a lot of bits of the White Paper where some of the detail still needs to be worked through. This is simply one of those areas.

What I don’t think is that it is a reason to jam on the brakes on revalidation and say that is because, in one part of the United Kingdom, they are reorganising. Wales has gone through a reorganisation, not of the same scale, but they actually used this as an opportunity to put in their Responsible Officers, get the thing in place and get going. So it is an opportunity to think through, “What is the right place for a Responsible Officer?” “What size should they be responsible for at local level?” and “Who are they accountable to at local and/or national level?”

**Una Lane:** As you know, Responsible Officers are not direct employees of the GMC, but they will be employed within the local healthcare organisations in exactly the same way as Medical Directors are currently. In many ways, the role of the Responsible Officer certainly appears to me to be simply putting the role of Medical Director on a statutory footing, because it is about assuring quality of care.

**Q38 Nadine Dorries:** But is it not more important than that because in terms of just the name, the words “Responsible Officer”, if we encountered another Harold Shipman-type scenario within the consortia, who would be the Responsible Person for that situation having occurred and for not having put in place the criteria to both identify and report that situation occurring? Would that be the role of Responsible Officer? I see this role as crucially important and yet it seems to be the role which has been the least thought through and almost dismissed in terms of its relevance.

**Una Lane:** I think you are absolutely right and it goes to the core, I guess, of the structural changes that are going to be put in place in England. It is not simply about revalidation or, in fact, even the role of the Responsible Officer, but about where responsibility for the quality of clinical care sits within the new structure.
The consultation on the White Paper has just concluded. We have submitted our views, which are exactly the points that you have made—that it is really important that there is clarity around the role of the Responsible Officer, where it is they sit and how they interrelate with performers lists currently in general practice or the kinds of responsibilities that PCTs currently undertake. Of course, we will be discussing this with the Department, officials and others as we move forward.

Professor Malcolm Lewis: The relationship between the Responsible Officer and the GMC ought, really, to be just in the context of recommending revalidation. They sit within the NHS. They are not really part of the GMC, so the governance around them ought to avoid any conflict of interest. The duty is to ensure that there is clinical governance in place and that there is a potential conflict of interest? Indeed, are we building a system of medical governance which is genuine self-governance through the GMC or is it all deeply imbued in the management structure of the NHS? It seems to me that a confusion of two trains happens. These are system issues rather than individual professional issues. The Responsible Officer again, for me, is one piece in that jigsaw. You are absolutely right. We need to make sure that that piece is correctly fitted into the system and that the locus of the Responsible Officer is the correct one.

Q39 Chair: There is another issue here as well, isn’t there, which is the relationship between the Responsible Officer as the local representative of the GMC as the professional self-governance, and the Responsible Officer as an employee of the NHS? Is there a potential conflict of interest? Indeed, are we building a system of medical governance which is genuine self-governance through the GMC or is it all deeply imbued in the management structure of the NHS? It seems to me that a confusion of two trains of thought is in danger of developing here.

Professor Malcolm Lewis: The relationship between the Responsible Officer and the GMC ought, really, to be just in the context of recommending revalidation. They sit within the NHS. They are not really part of the GMC, so the governance around them ought to avoid any conflict of interest. The duty is to ensure that there is clinical governance in place and that there is a potential conflict of interest? Indeed, are we building a system of medical governance which is genuine self-governance through the GMC or is it all deeply imbued in the management structure of the NHS? It seems to me that a confusion of two trains happens. These are system issues rather than individual professional issues. The Responsible Officer again, for me, is one piece in that jigsaw. You are absolutely right. We need to make sure that that piece is correctly fitted into the system and that the locus of the Responsible Officer is the correct one.

Q40 Fiona Mactaggart: Am I right in thinking that an individual only has one Responsible Officer? I’m sorry, this seems like a little thing but I suspect it will end up being a big thing, particularly when we are talking about individuals who do a little bit of doctoring here and a little bit of doctoring there and who have a locum thing here and a salaried contract there. That’s actually how people’s careers are nowadays, and I am quite concerned about someone who is working in south London, north London and East Anglia—a doctor who I met recently. Who is their Responsible Officer and how does that fit into the jigsaw?

Niall Dickson: They have to choose.

Q41 Fiona Mactaggart: They choose?

Una Lane: The Responsible Officer regulations and guidance have just been laid before Parliament. I am sure that the Department will be happy to answer some of those questions, but I will give it a try myself. In relation to Responsible Officers there is, actually, a hierarchy set out directly in the regulations as to how individual doctors link to Responsible Officers. It works through a grade. If you are a GP, for example, you can only be on one performers list and your Responsible Officer will be, currently, at the primary care organisation in which you appear in a performers list. Of course, that Responsible Officer needs to understand whether you work in other areas and that is really quite important, again, not just for the purposes of revalidation but so that organisations can understand whether there are concerns about a doctor’s practice in another location, for example. Then those links do need to be made and the Responsible Officers will have an important role in that. Lots of doctors work in a number of different areas across private care and NHS care, but there is a grade within the regulations that determines, as an individual doctor, which Responsible Officer you must report to. It is pretty straightforward for a lot of doctors, GPs on a performers list. Doctors who work mainly in an NHS Trust, for example, will link to a Responsible Officer there. There are some challenges, I think, around the edges of practice, but I think the Department is pretty confident that, for the vast majority of doctors in clinical practice, it will be pretty clear who their Responsible Officer is. If I could just perhaps go back to the conflict, please—

Q42 Chair: Just to interrupt you, the vast majority of doctors knowing who their Responsible Officer is isn’t quite the point, is it? Surely every doctor must know with total clarity who their Responsible Officer is?

Niall Dickson: I think probably the difficult area is, say, a doctor who is working on their own in Harley Street and so forth. But, again, they will be required to demonstrate to us that they have a Responsible Officer, that they are linking up with an organisation that will provide a clinical governance-style service that will provide them with that, that they are having
a proper system of appraisal and that it is a properly
governed process. So it is good that we are—

Q43 Nadine Dorries: Should it not also be the other
way round—that the Responsible Officer should be
responsible for demonstrating to you that he has seen
and knows the practice of that doctor? Should it not
work that way rather than the doctor demonstrating
that to you?

Una Lane: In fact, the way it works within the
regulations is that there are designated organisations
within the regulations who are required to appoint
Responsible Officers. Both the organisations and the
individual Responsible Officers have both
responsibilities locally in exactly the same way you
describe and, of course, have responsibilities and
duties towards us in relation to professional
regulation.

As I say, I don’t want to mislead the Committee in
any way. These are Department of Health regulations
with Department of Health guidance that are before
Parliament at the moment and it may be best that they
answer some of the detail around those regulations.

Niall Dickson: I am sure we will get the opportunity
to debate them.

Q44 Chair: I am sure, yes. Can I just have one more
go at this? Have you considered whether it is right, in
the plain vanilla case of somebody working in an NHS
hospital, that the Medical Director of the Trust should
also be the Responsible Officer? It seems to me quite
an important question of principle.

Niall Dickson: We have looked at that because there
has been some concern. I think quite a lot of the
concern in the early days was that, somehow, this
Medical Director would be doing the appraisals. As
we have described, most Medical Directors will have
hundreds of doctors. So they’re not going through, “I
don’t like the cut of his cloth” or whatever. That is
not the process that they will be going through.

What they need to do is to oversee a process—people
who are appropriately trained, the right appraisers are
allocated in terms of individual doctors and doctors
have access to the supporting information. When all
that is in place, the system will work. Exactly as now,
whether there was an appraisal system or not or
whether it was just that some colleague spotted
somebody else who they had a concern about, the
concern would come up to them as the Medical
Director. Actually, what they have to do as Medical
Director and Responsible Officer—dare I say it—is
exactly the same thing: what action is needed, are
patients at risk, what help and support do we need to
give to this doctor, or is it so serious that it reaches a
threshold where I have to refer to the GMC?

Really, revalidation doesn’t change any of this; it’s the
same process.

Q45 Chair: You have said it several times but,
exactly as now, is that a cause for concern or is that a
cause for reassurance?

Niall Dickson: I think it is a cause for reassurance for
doctors who might be concerned that, somehow, this
would be a new, unfair process which is being put in
place, because it isn’t in that sense. What I think it
will do, or we hope it will do, is identify problems
earlier. It will enable doctors to demonstrate on an
ongoing basis, both for themselves and for others, that
their practice is good. As Malcolm said, it is a positive
affirmation of that.

Q46 Chair: But it is a two-edged sword, isn’t it, the
argument, “Don’t worry. Everything is going to go
on as it is now”? Why are we seeking to introduce
revalidation? It is because the systems, as they have
been, haven’t worked.

Niall Dickson: In part, I think you are right. Is it
possible that revalidation will identify problems
earlier? I certainly hope that it will be able to do that.

Will it encourage doctors in the middle of the bell
curve, to be more self-reflective? I think the evidence
is, from already good appraisal processes, that that
happens.

So I think it will affect the doctor in the middle, not
in the sense that they are going to face something
terrible that has never happened before, but I think it
will encourage them to organise their supporting
evidence; to make sure that they are doing the right
continuing professional development; to have a
chance to chat to somebody who is saying, “Do you
think you ought to be able to do this?” or get a bit of
patient feedback to which, “Ah, I hadn’t realised that
I was doing that and I might be able to correct that.”

These are all miles away from referral to the GMC.
They are just things that should be happening anyway
but they provide that level of assurance which we are
not currently able to provide on our register.

Una Lane: And I suppose, as importantly, they should
act as a driver for those organisations who do not
currently have robust clinical governance systems in
place or who may not have Medical Directors in post
because, of course, the Responsible Officer
regulations place a statutory duty on organisations.

Our hope is that revalidation can help to drive some
of these further developments that are necessary and
drive a level of consistency that we know is not in
place currently because it is patchy.

Q47 Rosie Cooper: I’m awfully sorry. I was just
looking at the clock because of questions. Forgive me.
I was going to ask some questions about a
assessment you have made about the cost of
revalidation, the cost to hospital organisations and/or
individual doctors, whether you think people are
confused about the difference between revalidation
and appraisal and whether that is being used as an
argument against this whole thing. Really, I would like
to throw one in, which is this. We have talked today
about how long it has taken to get here—10 years—
and I have been struck by the conversation that,
“We’re looking back. We are trying to make progress.
We are trying to do stuff for today.”

Reflecting some of Nadine’s comments, you know
consortia are coming. Are you actually starting to
address the problems that are going to appear in the
next year or so and get ahead of those potential
problems addressing this, now, before it actually gets
here so that we are not actually going to be spending
years trying to make it right? What assurance do we
have that it is going to be okay?
Niall Dickson: I will start and then, maybe, just refer to Malcolm about the detail on the cost issue. I think there obviously is a concern, when resources start to be constrained and we have got structural reorganisation in England, that people may take their eye off the quality ball. I think that is a concern of which the Government and people at local level are aware. So I hope we don’t make some of the mistakes of the past, which were that when things are constrained you don’t start worrying about that. You just worry about the turnover of the system and so on. Revalidation, being part of the wider quality stuff, seems to me all the more important when you are going through both structural change and restrictions. Some will use it as an excuse to say, “Don’t do this now because we want to go off and worry about the fact that we’ve got less money than we used to have going forward.” My argument would be, “It’s all the more important that we absolutely concentrate on this area.”

There is no doubt that there has been some confusion about the cost of revalidation and whether the cost includes appraisal, and clinical governance. But those things would be happening now, they should be happening across the system. The system has been funded to do those things. There are some additional costs—and Malcolm may be able to give them—around revalidation but, in our view, they are not hugely significant. The big costs are having a proper system of clinical governance and a proper system of appraisal. Those are things that the National Health Service has said they should be doing and should have been doing for some years. Malcolm.

Professor Malcolm Lewis: Yes, and there is probably not an awful lot of detail to add to that. The Department in England are looking at costing at the moment and we have emphasised to the Department, outside of and within the UK Revalidation Programme Board, as has Sir Keith Pearson, who chairs that Board, that we don’t consider that things that ought to be in place can be attributed to revalidation as an additional cost.

So it is kind of repeating what Niall says, and I think that there is an unassailable logic in that, really. We can’t step back and say, “Actually, we are not going to have clinical governance and we’re not going to have appraisal.” Then the whole thing collapses, so we re-build it and blame the cost on revalidation. It is, to me and to everyone, really, a nonsense to do that. In looking at the costs, we would probably need to look at perhaps the additional local costs of a Responsible Officer in terms of the delivery of recommendations to the GMC, which is probably fairly minor. I think it is fair to say that universally applied questionnaires are not really out there just yet. So there will be an additional component cost to that and there are debates to have in terms of who pays—whether it is individual doctors or the organisation or whether the GMC pays it and adds it to the annual retention fee. There are all kinds of ways in which you could look at it, and I’m not advocating any of them today.

The other piece is that, internally for the GMC, there will be additional costs in relation to setting up the system to receive the recommendations and linking that to the register. So there are administrative costs internally which we haven’t bottomed out just yet, but that is all work in progress. Essentially, in terms of it being, financially, a light touch, I don’t think it could be any more light touch than it is because we are relying on these processes that ought to be there and, at the same time, driving those processes, in part through the Responsible Officer legislation, but also by the nature of what has to be in place to deliver.

It is one of the reasons why we haven’t gone down the exam route. I know that there will be people in the room who understand the nature of assessments and what they can be used for. Knowledge tests in the context of the breadth of all of medicine would be disastrous. You would have an enormous industry. It would be ages before you got the validity and the reliability sorted out and what would it tell you? It would tell you that people have knowledge; it would not be about what they do and how they relate to patients. So that’s why we have gone about it in this way. To look at performance in the way that we can look at it if these systems are in place is the most economical way of delivering what is probably the most reliable methodology.

Una Lane: I would just briefly like to say that we are acutely aware of our responsibilities around cost. We spoke a little earlier around supporting information, around some of the concerns that doctors and others raised with us about whether it is available currently and whether it is proportionate, and we think we absolutely have a role to play in ensuring that when revalidation is introduced in 2012, the kind of information that we think is appropriate is sufficiently streamlined and is the kind of information that is currently available.

Having said that, going forward from 2012, if we are looking for a system that is more robust and if we think that doctors, and surgeons in particular, for example, should have available to them outcomes of operations in surgery, should that information become more complex, will there be a cost attached to that? Almost certainly. But is that a cost of revalidation? I think our view would be that revalidation should be a by-product of those developing systems and that organisation should be looking to best practice in these areas in terms of identifying the kind of information that will help them to evaluate their doctors and help their doctors to evaluate their own practice against their peers. But we do have a responsibility, I think, at the GMC in the current climate, and always, to ensure that we are not suggesting an incredibly complex system that is not going to add any value and is not going ultimately to help to support good quality care for patients at the end of the day.

Q48 Rosie Cooper: Are you actually involved currently with the Department of Health, not just reflecting on where you are now but reflecting on the outcomes in the White Paper? How you will fit in there?

Niall Dickson: We are having ongoing discussions with the Department about where this will fit in. We have put in our evidence and we have ongoing
discussions with officials. It is not for us to determine what it will look like.

Rosie Cooper: No, no, no. Niall Dickson: But I think we do have an input to say these are the things that we would like to see to make revalidation work. I think there is a real and genuine commitment from the top of the Department all the way down to make this happen at an English level, and I think at a UK level as well. Obviously, the other parts of the UK are absolutely straining to get on with it.

Q49 Rosie Cooper: Do you see it posing any problems? That is really the question I am asking.
Niall Dickson: Do you mean the reorganisation, the restructuring? I think, to be honest, it is uncertain at the moment. I hope it won’t. I don’t see any fundamental reason why it should. I think the bigger question, of which revalidation is only a small part, is, “As you restructure, what effect does this have on the things that are happening on the ground?” One of the things that happens on the ground is a good appraisal process and so forth. If the reorganisation process is handled well, people shouldn’t notice that difference.

I look back on my past career. I think I spent 10 years at the BBC trying to explain to the great general public about the internal market and all that kind of stuff. I am not sure I really succeeded but the reality was that, while people argue about the merits of it and so forth, actually an awful lot of clinical care and so on went on anyway and was neither the worse nor the better for some of that. I think that, in some ways, making sure that the day job goes on while some of these structural changes happen is a challenge for the system. Having said that, the NHS is quite used to reorganisations. It has done a few in its time. I have a reasonable degree of confidence—

Rosie Cooper: I think the scale of this one might just be a bit different.
Niall Dickson: I hope that they will be able to go on doing this. I am sure that general practitioners and other health staff will be very determined to concentrate on the day job, albeit that some of the incentives and drivers and so on will change. That is what happens amidst that.

You described us as self-regulatory. We are accountable to you, actually. We are not accountable to the Secretary of State, but we are accountable to the UK Parliament. That is our role. So I think it was perfectly appropriate for him to make that decision if any of the bits of the UK had said, “We don’t think we are ready”. What we’ve got now, as a result of the Statement of Intent, is them all saying, “All things being equal, we think we can do this”. That gives us assurance because, while they are running the NHS rather than the private side, the NHS is so dominant in all four countries that that is the big bit we have got to work with. We do, as part of our governance arrangements here, work with the independent sector as well, and make sure that they, too, are at the right place.

Overall, we feel as if we have just overcome a big hurdle, that we have got real commitment from the four parts of the UK, and that we have got a date—so there’s something actually to aim for and we can set the milestones in place. Implementation is always a headache. There are bits and pieces, as you have rightly identified, that we need to tighten up on and we need to simplify and get straightforward. We are not pretending this system will be perfect when it launches, in the sense that it will identify every poorly performing doctor and so forth. But it will be a start. My view is that five to 10 years down the line, people will wonder what the fuss was about. It will become embedded in the system and it will start to provide a level of assurance that we are not currently able to make—and we haven’t, frankly, been able to make for the last 150 years.

Q51 Chair: I agree with that, but it follows also from what you have said, doesn’t it, that the GMC is responsible to Parliament so it is the GMC rather than the Secretary of State that is responsible to Parliament? We feel a freedom to question you—
Niall Dickson: Absolutely.

Q52 Chair:—to deliver revalidation within the timescale that you have now agreed with the Departments is a reasonable one to deliver.
Niall Dickson: Yes.

Q53 Chair: So it’s not unreasonable for us, during the lifetime of this Parliament, to be seeking to ensure that the GMC gives account to us of how progress is made towards that objective, which is the GMC’s objective rather than the Secretary of State’s?
Niall Dickson: I agree with that. I hope that our objective is shared—in fact, I know it is shared by the Secretary of State; he has made that very clear in both the UK and the English contexts. But, yes, that is absolutely right. We should account to you of how far we have got and how we are progressing this. The only point to make—I think Una referred to it earlier—is that we are a professional regulator. We are relying on systems to be able to do this. We are trying to ensure that those systems are in place and, in that sense, it is a shared responsibility. There is a responsibility on healthcare organisations in this country to put in place good clinical governance arrangements. There are responsibilities for system
You might want to look at the
It might be a question, again, that you
It seems small after these
Nicely—I'm sorry.
Are there any other questions?
We have used an online
Thank you. Thank you very much.
No. We have security
Yes, that's what I was
about two years ago.
robustness of it. It was looked at in detail by the GMC
periodically in order to come to a view on the
looked at by Healthcare Inspectorate Wales
on a quality-assurance basis annually. That will be
in the summary compared to the detail in the evidence
who has not had an appraisal. It can look at the detail
appraisals and interrogate the process of who has and
management toolkit. So the Service can manage
it links with clinical governance and so on, it is more
I think the important thing to mention is that because
people are and, also, at the GP site to see where they
will be able to look at the specialty site to see where
have an internal market. So the Responsible Officer
just be two sites. We have integrated primary and
Wales. So the scale of that is fairly big. It is pan-
piloted as part of the piloting process. We have got
care which is across all specialties and this is being
cartoons—try to make this thing as simple and straightforward as
I think they recognised that there were some
difficulties, as there often is around IT and around a toolkit—
Q57 Chair: If we already have a round wheel why
do we need to reinvent it?
Q58 Fiona Mactaggart: Yes, that’s what I was
asking. Why wasn’t the Welsh system imported?
Una Lane: It might be a question, again, that you
might want to put to the Department next week.
Fiona Mactaggart: Okay. Fine.
Nadine Dorries: Nicely passed.
Q59 Dr Wollaston: Difficulties due to—
Chair: Nicely—I’m sorry.
Q60 Dr Wollaston: You might want to look at the
different systems and compare them, but I know in
England, particularly, there was a great loss of
confidence around the fact that it wasn’t secure—
people’s personal data wasn’t secure. That, rightly,
caused a great deal of alarm among professionals. Did
you have that problem with the Welsh system?
Professor Malcolm Lewis: No. We have security
tested the new system in quite a lot of detail. We’ve
had penetration testing with hackers, people who
made their money from previous crimes and so on,
and we have got reporting on that. It seems to be
robust. It has built in a HTTPS thing. I am getting
confidence around the fact that it wasn’t secure—
England, particularly, there was a great loss of
different systems and compare them, but I know in

regulators for making sure that that is in place. So it
is not a single and sole responsibility, but we do feel
that we have got a leadership role in this. We think
we’ve exercised it in trying to get everybody up to the
point that they’ve now got and I think we recognise
that the next chapter, as it were—the implementation
chapter—is significantly challenging. But we are
confident that we can deliver.
Chair: Are there any other questions?

Q54 Fiona Mactaggart: It seems small after these
big strategic ones, but, in Wales, do they use an online
toolkit? When I talk to doctors in the pilots they moan
about the bureaucracy involved around the online
toolkit.
Professor Malcolm Lewis: For GPs?
Fiona Mactaggart: Yes.
Professor Malcolm Lewis: We have used an online
toolkit since 2003. It’s the only way to have an
appraisal in Wales. We have a team of about 80
appraisers and then appraisal co-ordinators at local
level, running teams of about 10 or so, which is part
of the quality-assurance process. It is all web-based
so the information is all stored on the website. There
is also a revalidation dashboard light which goes from
red to green as you complete various aspects of it.
That allows the Responsible Officer to take a view of
how people on the patch are progressing as
individuals and collectively.
It links with clinical governance. There is a large
protocol document around concerns and how they
feed into and out of appraisal, so that link is made.
The acceptance of the tool is almost universal.
Obviously, with IT, there are a few people who will
inevitably be laggards. We don’t have 100% uptake
because there are always some people who are off on
sick or maternity leave or are out of quarter or for
whatever reason, but it is over 90% at any point in
time.
We have developed a new toolkit now for secondary
care which is across all specialties and this is being
piloted as part of the piloting process. We have got
three hospital Health Boards involved in this in
Cardiff, Swansea and one of the rural ones in west
Wales. So the scale of that is fairly big. It is pan-
specialty so, for the Responsible Officer, there will
just be two sites. We have integrated primary and
secondary care now, and our market is gone. We don’t
have an internal market. So the Responsible Officer
will be able to look at the specialty site to see where
people are and, also, at the GP site to see where they
are in order to inform the decision.
I think the important thing to mention is that because
it links with clinical governance and so on, it is more
than just an appraisal toolkit. It is an appraisal
management toolkit. So the Service can manage
appraisals and interrogate the process of who has and
who has not had an appraisal. It can look at the detail
in the summary compared to the detail in the evidence
on a quality-assurance basis annually. That will be
looked at by Healthcare Inspectorate Wales
periodically in order to come to a view on the
robustness of it. It was looked at in detail by the GMC
about two years ago.

Q55 Fiona Mactaggart: I am interested that the
Welsh system seems so utterly seamless; that is not
the feedback that I have been getting from doctors
about pilots.
Niall Dickson: I think there is a recognition that some
of the tools in England have been made too
complicated. We are very determined, and I think this
has been addressed by the Department. I think there
is a commitment—

Q56 Fiona Mactaggart: Is there a reason why you
didn’t just import the Welsh system? I am sorry to
persist in this, but I think in practice—
Una Lane: I think the toolkit that is currently being
used at the 10 sites in England was specifically
developed for the purposes of the pilot. Again, my
understanding is that there have been some
difficulties, as there often is around IT and around a
toolkit—

Q57 Chair: And you’re holding the monkey?

Q58 Dr Wollaston: You might want to look at the
different systems and compare them, but I know in
England, particularly, there was a great loss of
confidence around the fact that it wasn’t secure—
people’s personal data wasn’t secure. That, rightly,
caused a great deal of alarm among professionals. Did
you have that problem with the Welsh system?
Professor Malcolm Lewis: No. We have security
tested the new system in quite a lot of detail. We’ve
had penetration testing with hackers, people who
made their money from previous crimes and so on,
and we have got reporting on that. It seems to be
robust. It has built in a HTTPS thing. I am getting
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caused a great deal of alarm among professionals. Did
you have that problem with the Welsh system?

Q59 Dr Wollaston: Difficulties due to—
Chair: Nicely—I’m sorry.

Q60 Dr Wollaston: You might want to look at the
different systems and compare them, but I know in
England, particularly, there was a great loss of
confidence around the fact that it wasn’t secure—
people’s personal data wasn’t secure. That, rightly,
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had penetration testing with hackers, people who
made their money from previous crimes and so on,
and we have got reporting on that. It seems to be
robust. It has built in a HTTPS thing. I am getting
more technical than I can justify now, so I will stop.
Niall Dickson: I will just say on England that I think
we are in a better place. You can ask the Department.
I think they recognised that there were some
difficulties. We are all absolutely committed to
making this thing as simple and straightforward as
possible, but not just a tick-box exercise. It is getting
that balance right and I think that the Royal Colleges,
the BMA, us—everybody—is, in that sense, in the
same place now about how we take this forward.

Q61 Chair: And you’re holding the monkey?
Niall Dickson: We’re holding the monkey.
Chair: Thank you. Thank you very much.
Q62 Chair: Sir Neil, thank you for coming to join us this morning to give evidence on what we regard as an important but brief inquiry into progress on revalidation and how we can take this forward. Could I ask you very briefly to introduce your colleagues? **Professor Sir Neil Douglas:** Yes. I am Neil Douglas. I am Chair of the Academy of Medical Royal Colleges. Peter Furness is a Vice-Chair of the Academy and also our lead on revalidation. Kate Tansley is our officer who leads on revalidation.

Q63 Chair: Thank you very much. I would like to begin, if I may, by asking questions about the basis on which the revalidation process is being developed—being developed, I have to say I think we feel, over quite a leisurely time scale since 2000. You might like to comment on that. But I would like to ask you a question in particular about the basis of appraisals. There are two related questions. There seems to be very broad support that the process needs to be based on a current appraisal system, but question one is how content are you that appraisals are now deeply embedded into the culture of practice and carried out effectively right through the system? Secondly, how realistic is it, or is it correct, to base it on appraisals when appraisal should be concerned about the whole range of quality of practice, whereas revalidation is presumably primarily concerned with practice that is verging on illegal and therefore very much at the bottom end of the quality scale? **Professor Sir Neil Douglas:** First, on the time scale, you are absolutely right that it has been leisurely. I was briefly on the GMC 10 years ago and revalidation was considered to be two years away at that stage, and it is now still two years away. I think one of the messages we want to give to you today is that we believe, this time, the time scale should be stuck to if we possibly can, even if it means that revalidation is introduced in a simple form initially and incrementally made slightly more complex, if necessary, thereafter. It need not necessarily start in the fully mature form.

Secondly, on appraisal, how content are we that it is fully fledged throughout the whole of the UK? It is in places in existence on an annual basis and effective. It is, I am afraid, still slightly patchy and that is one of our concerns. I think the first step towards getting a revalidation process in place has to be the introduction of effective appraisal for all doctors in all localities in all specialties in the UK in all four countries. If that can be achieved in a short time scale, then that will be a major step forward.

You ask about the conflict between appraisal, which has supportive elements, and revalidation, which has an element of summative assessment involved in it. Yes, there is a slight conflict there; however, the information being brought to the table in both settings is almost identical. It would be cumbersome and expensive in terms of time and therefore loss of clinical service to have two completely separate processes, I believe, to look at roughly the same sort of information.

We believe that it is a very, very small minority of UK doctors who will not reach the level required to be revalidated. To produce a cumbersome alternative system just for catching a few bad apples, which is not how we see revalidation principally focused, we think would be wrong.

Q64 Chair: Thank you very much. Taking the first of those two subjects and the variation around the quality of appraisal currently carried on, you have stressed the importance—and it must be right—that there has to be an urgent priority to secure a 100% effective appraisal round practising doctors. What are the steps that have to be taken? I guess the first question is why hasn’t that happened, given that it has been a commitment based on good practice for many years now, and what do we do that we haven’t done up until now to make certain that what has been recognised for years as good practice actually happens? **Professor Sir Neil Douglas:** Part of the reason that it hasn’t happened is there has been no absolute necessity for it and just the introduction of revalidation, hopefully with a definite timeline for everybody to be enrolled in this, will ensure that that happens. Partly it has been because it has sometimes been inconvenient for individuals to find times to meet with appraisers and all these sort of very mundane aspects that can be used as excuses if there is no absolute necessity for having the process in place. Peter, do you have anything you wish to add to that? **Professor Peter Furness:** I think that is accurate. I think the variation around the country in the implementation of appraisal also highlights our concern that the emphasis on local decision making in something like this has the potential for variation in how appraisal is administered and how standards are set around the country, because there has been a great deal of talk of setting standards but, as I think we
One of the things the GMC offered us last week was some evidence on which parts of the country have particular lacunae in terms of effective appraisal. If you had any information on that subject, we would welcome it.

Professor Peter Furness: I don’t have any hard information on that, and I would suspect that the GMC’s information will be better than mine. I could only offer anecdote and I don’t think that would be fair.

Chair: You wouldn’t be the first.

Professor Peter Furness: Some hospitals have not implemented appraisal at all. Others, like my own base in Leicester, have had fairly well-developed appraisal systems for some time. The Department of Health Revalidation Support Team has introduced pathfinder pilots around the country. Those units, I think it is now fair to say, are well ahead of the field in implementing a strengthened form of appraisal. But even there, with our contacts in each of the pilots, we can see there are some differences in the way it is being done in different sites.

Chair: Nadine Dorries would like to ask you some questions on the focus of revalidation.

Professor Peter Furness: I don’t think it is now fair to say, are well ahead of the field in implementing a strengthened form of appraisal. But even there, with our contacts in each of the pilots, we can see there are some differences in the way it is being done in different sites.

Chair: Nadine Dorries would like to ask you some questions on the focus of revalidation.

Professor Peter Furness: I wonder if you could give us an example of a good appraisal—where you think appraisals are happening that are good and how they happen. We have heard a number of stories about how appraisals take place, but can you give us an example of a good appraisal?

Q66 Valerie Vaz: One point I would ask for is an example of how it could differ.

Professor Peter Furness: I think a good appraisal should start with proper preparation, accumulation of information and consideration of that by the appraiser and the appraisee before the interview starts. The way in which that information is gathered together is important and the information should come from the employer as well as from the employed doctor. I am thinking principally in secondary care; there are other issues in primary care. It should be fairly clear to both sides of the appraisal interview, if there are issues, where those are before the interview starts, and there may be a need for a bit of clarification and making sure that all the information is there before the interview starts.

When an interview starts, I think it should focus initially on a fairly rapid assessment of, “Are there any areas of practice that are real causes for concern?” That is the summative “Should you achieve revalidation?” question.

As soon as that is satisfied, which it should be for the vast majority of doctors, we should move on to discussing, in turn, the various aspects of practice. I should have said, of course, that the areas of practice of the doctor should have been set out and defined beforehand. We can then discuss the various aspects of practice and how they should be improved, what the targets should be, specific achievable changes and improvements in the coming year, how they might be achieved, how the institution and the doctor can work together to make those targets achievable and set that out so that that can be reviewed next year at the next appraisal interview—in a nutshell. That is for most doctors.

Of course, if there is a serious problem identified, then you have to get into a slightly different mode and start addressing what impact there might be for patient safety, how that is going to be sorted out, whether formal remediation is necessary, what steps might be necessary to ensure that patient safety is assured, and you are off down a slightly different channel, with a different emphasis at the very least.

Q67 Valerie Vaz: One point I would ask for is an example of how it could differ.

Professor Peter Furness: Some hospitals have not implemented appraisal at all. Others, like my own base in Leicester, have had fairly well-developed appraisal systems for some time. The Department of Health Revalidation Support Team has introduced pathfinder pilots around the country. Those units, I think it is now fair to say, are well ahead of the field in implementing a strengthened form of appraisal. But even there, with our contacts in each of the pilots, we can see there are some differences in the way it is being done in different sites.

Chair: Nadine Dorries would like to ask you some questions on the focus of revalidation.

Q68 Nadine Dorries: When you take specialities on top of that, and doctors who have particular specialisms, if you were to adapt that generic form of appraisal which you have just described to doctors who have specialist skills, wouldn’t you then be making the appraisal process expensive, complex and difficult, because you have just described what is already a quite comprehensive appraisal? Will that not do for all doctors? Will that generic form of appraisal system not suffice?

Professor Peter Furness: I don’t think so because what I have described is pretty generic and what I was meaning was that the information gathered together before the interview should relate to what the doctor does. You start with setting out clearly what the doctor’s practice is, bringing information along with regard to that, as we have set out in our written submission—evidence of the quality of practice, what people think of what you are doing and what you are doing to keep up to date. I should think that applies to any employee or any practitioner of any sort, not just medicine. We have had a great deal of head-scratching about the unusual forms of medical practice that some doctors undertake and I think that that approach would result in quite different sorts of information being brought to the appraisal interview, depending on the nature of practice, but the overall structure could remain as I describe without it being overly complicated. I am not sure how that would result.

What I have seen as a source of increased complication is the GMC’s prescription of these 12 attributes, some of which, for some doctors, are extremely difficult. Some of them are rather vague. For example, I am personally a histopathologist; I work in a laboratory and don’t see patients, so patient feedback is not part of the information that I would bring along to the revalidation interview. That is absolutely obvious if you look at a description of my area of practice. If you are, say, a medical coroner involved in medical legal work, then the same things apply. If you focus on evidence of the quality of what you do, what people think of it and so on, that will guide what is appropriate information to bring along and we would anticipate the Colleges providing additional guidance on what was appropriate so that we didn’t have an overly complicated approach.
Q69 Nadine Dorries: Can I get this clear because we have, obviously, a wide range of specialties? If you had a doctor who was particularly specialised and highly skilled in one particular area, would you think that the person who carries out the appraisal on that doctor has to be somebody who is equally skilled in the same area?

Professor Peter Furness: As we set out in our written submission, I think that one should seek for the appraiser to be as close as possible to the appraisee in the area for the reasons you have identified: the two would need to understand the area of practice they are talking about, specifically because we are not talking about measurements of quality. We are talking about judgments of quality, inevitably, especially when it is someone particularly specialised. I would not be in a good position myself to evaluate the quality of a neurosurgeon, for example.

It would be impracticable to say it should always be in the same specialty because some people are just so specialised that that is not practicable, but it should be, I think, someone who understands a related area. Of course, if you only have a small number of people in one specialty then that is another problem. If you have several, they might be a bit too close to each other to be objective, and you have to bear that in mind and consider it. There will be some circumstances where it is not possible to have appraiser and appraisee from the same specialty. I think if that is the case then the appraiser should try to appraise several individuals from that smaller specialty so that they can get a feel for the spread of what happens. It is a difficult balancing act with pressures on each side.

Nadine Dorries: It is, and what you have just described does sound quite complex and could be the reason why this process has been on the table for 10 years.

Q70 Valerie Vaz: Can I just ask how long it is currently taking for the doctor and the appraiser to go through this process—getting the portfolio together?

Professor Peter Furness: You will be receiving evidence from the Department of Health, I believe, and the Revalidation Support Team. I think the best information that I have on that currently is from the pathfinder pilots, which we have accepted—everyone has accepted—illustrate a need for simplifying the process. In those pilots, my understanding is that, so far, with regard to the gathering together of evidence people are claiming a very wide range of how long it takes, from one hour up to a couple of weeks or so. I am not sure how they arrive at that figure. I personally went through that process and it took me an hour.

With the appraisal interview, the length is varying from an hour to about three hours. Again, I am a bit surprised at the longer ones. One wonders what was having to be discussed. Of course there is a little while for recording things after that.

I think part of the problem there is that when we have looked at the number of pieces of information that people are bringing along to the appraisal interview, it has apparently varied from about three to over 100, and that is clearly something that needs to be clarified and sorted out, and the 100 perhaps explains the comment, “It takes me a week to get it together.”

Q71 Chair: Can I just feed back to you what I am hearing from you and what we heard from the GMC last week? I will make the same point to you as I made to them. This all sounds very “early stage” for a process that we are asked to believe has been piloted as something that is less than two years away from implementation with clear ideas about how it will actually stand.

Can I just read what Professor Lewis said to us in evidence last week on this balance between the generic and the specialist? He said: “what we are discussing with the Academy at the moment, who are charged with this work, is that we should get to a starting point where we have the GMC standards for revalidation”—and that is the starting point. “Thereafter, if the specialties want to have a list of 100 things that doctors from that specialty can bring then that ought, initially, to be voluntary.”

That doesn’t seem to be quite the culture that we are hearing from you for a process that we are asked to believe has been piloted.

Professor Peter Furness: Yes, I am afraid I disagree fairly profoundly with that statement. To start with, the use of the word “standards” is causing difficulties because the GMC uses the word “standards”, and if you look at what they have set out, “attributes” is a better word. They have 12 attributes, which is a list of aspirational—“aspirational” is the wrong word. They have a list of general terms. It is really a check-list of things a doctor should cover. It doesn’t say anything about “how well”.

Then when you start trying to drill down into what information should be brought along to support those standards, because of the variation in medical practice, we have largely got pieces of information rather than how good those pieces of information should demonstrate your practice to be. So the word “standards” has been used to gloss over a problem, and I think the standards will inevitably come down to a large element of judgment, and what we have been talking about so far is mostly what sort of information you will bring along to support those standards.

The GMC has recently passed back to us a couple of documents based on one that we put to them by way of making this process simpler and more efficient. They went up from three types of information to eight and set out what they thought doctors should provide and then, as you have said, tacked on at the end, “Other specialties can add what they want as well.” We think that—

Q72 Chair: One hundred items—voluntary?

Professor Peter Furness: Entirely inappropriate, in my view. I think the core elements of evidence of your standards of practice will vary between specialties. What we want to do is discuss how those key elements like outcome data and proficiency testing, which happens in some specialties, should be judged in the context of the individual specialties. That is core stuff. That is not tacking it on the end, and it will vary between specialties. We think we can make that
relatively simple for individual doctors. The GMC is pushing for this generic and, I think, slightly woolly approach, with the specialties tacked on the end. That worries me profoundly. I don’t think it will work.

The other document the GMC has given us in relation to this process is a list of questions relating to their 12 attributes. For each attribute we have a core question and then a set of supplementary questions. I think, if that is what the GMC expects, we are going to have a phenomenally laborious appraisal interview that focuses entirely on the summative, “Are you fit to revalidate?” and we’ll have no time left at the end to do the formative, “How can we get better?” which is what, for most doctors, appraisals should be about. I have only had those papers a few days so this is an ongoing discussion, but it does worry me that if this is the direction in which the GMC are going it doesn’t look like streamlining to me.

Professor Sir Neil Douglas: One of the major problems, I think, is that for the majority of specialties you cannot press a button on your computer and get quality outcome data at all. You can for general practice, mainly, and you can for surgery, but for my practice I can get absolutely nothing other than the fact of how many patients I have seen, and even then some of them will not be my patients.

Q73 Chair: What is your practice?

Professor Sir Neil Douglas: I am a respiratory physician. The IT systems will improve with time and, therefore, yes, 100 is clearly a ludicrous number. But at the moment we have to give people the sort of areas they can come up with evidence from that shows they actually are safe because there isn’t a single button they can press to get something that says, “I am a good doctor.”

Q74 Chair: Starting from where you are, which sounds like quite a long way apart from the GMC, how quickly are you going to get to a formula that can genuinely be piloted on the basis that “This is something that we are ironing out the detail on”, before rolling it out nationally?

Professor Peter Furness: I think we are further apart from the GMC than I thought we were about a month ago because of these documents that have just appeared. In that time I have also personally gone through a strengthened appraisal because I am employed at one of the pilot sites. That has influenced my thinking as well, and I can see that there is no one in the GMC that I am meeting who is a doctor who has actually gone through the process.

I am hoping that we will get to agreement very quickly because it is perfectly clear that we all want the same thing. But at the moment my impression is that the 12 attributes that the GMC have set out were designed for assessing problem doctors, and they insist on those being up front almost as a sort of item of faith that cannot be challenged. I think if they can agree that those slip into the background and they should be brought out if a problem emerges—if we can agree that—we are very close to coming together. If they insist on those 12 attributes being ticked off mechanically at each appraisal interview, I think we are quite a way apart.

Q75 Nadine Dorries: Can you give us an example of what it is in the pilots that you have experienced that, after 10 years of this being on the table, has brought you in about the last month to change your mind or to have different thoughts? What was it in particular?

Professor Peter Furness: I went through the pilot as a doctor being appraised in Leicester and I gathered together all the supporting information as instructed, actually in paper form rather than scanning it in and uploading it to a computer, which is what some sites are expecting.

I then went into the software which is unique to Leicester—it is not being used by the other pilot sites—and mapped all the various bits of information that I had against the 12 GMC attributes and was asked some, frankly, fairly banal questions about how I was justifying the attributes and so on, and realised that I was using the same piece of information multiple times. One piece of information would be relevant to about five or six of those 12 attributes, and I thought, “This is not efficient.” I also looked at the information I had gathered together in a different way and thought, “Well it falls into these three categories. Why can’t we present it that way? It will cover the 12 attributes in the background.”

Q76 Nadine Dorries: So it was just duplicated?

Professor Peter Furness: It was duplicated, yes.

Q77 Valerie Vaz: What are the three categories?

Professor Peter Furness: The evidence of the quality of what you do, which can cover various things, outcome data and whatever—audit; evidence of how people perceive what you do, which is multi-source feedback, patient feedback, letters of complaint and that sort of thing; and evidence that you are keeping up to date, which is continued professional development, and all the Colleges have schemes to cover that.

Frankly, if there was a problem with performance, I think an appropriate spread for a specialty that covered those three areas would pick up something which a good appraiser could then focus on. If there’s a problem, it is entirely appropriate to bring out the GMC attributes and what the GMC says about that, focus on that and drill down and sort it out. But, otherwise, starting with the 12 attributes, it becomes the wrong way around.

Q78 Nadine Dorries: Do you know what the other pilot schemes are doing?

Professor Peter Furness: The other pilot schemes are all following the approach that the GMC set out to start with. They are using different software. All the other pilot schemes are using software developed by the Revalidation Support Team, which has been causing problems. But that is another story we mention in our written submission. So they are all following the framework of an appraisal interview that goes through the 12 attributes.
Q79 Nadine Dorries: Can I just ask how long it takes to get all the evidence together? As you are experienced in the pilot, how long did it actually take you to get everything you needed together to begin answering the 12 questions?

Professor Peter Furness: That depends on how you count the timing. If you count the time taken—

Q80 Nadine Dorries: In hours and minutes?

Professor Peter Furness: No, no. If you count the time it takes to do all the activities, the continued professional development, the audit, the things that doctors ought to be doing anyway, you would very readily get to the week, two weeks or more that some people have quoted.

Q81 Nadine Dorries: Hang on a second. You are saying it would take a doctor two weeks to get the evidence together—two full weeks? Sir Neil is shaking his head next to you.

Professor Peter Furness: No, no. We would be doing that anyway. In my own case, knowing that this was coming, I had gathered together in a filing cabinet a bit of paper every time I got something that was relevant to appraisal. Pulling that dossier out, plugging it into the system and presenting it to my appraiser a couple of weeks before the meeting took me an hour.

Nadine Dorries: Okay.

Professor Sir Neil Douglas: But that depends how organised you are.

Q82 Chair: It raises an interesting question—which is possibly, but only possibly, outside the scope of the revalidation inquiry—which is whether in the modern world it is part of what it means to be a professional to keep the evidence of your own practice.

Professor Peter Furness: Indeed.

Q83 Nadine Dorries: But if you are a professional you should be doing what your specialty and your skill enables you to do, should you not, rather than concentrating on having to keep evidence of what you have been doing as you go along?

Q84 Chair: But how can you be confident of how good you are if you are not measuring yourself by the evidence of what you do?

Nadine Dorries: It is quality outcomes.

Q85 Valerie Vaz: There is the quality of the legal profession as well.

Professor Peter Furness: I think we have illustrated the difficulty of working out how much time is consumed by this process and, therefore, how much it costs.

Q86 Valerie Vaz: How does that apply to you—about the complaints procedure—if you don’t necessarily have patients, because you don’t, do you?

Professor Peter Furness: Yes. I didn’t have any complaints, which is not surprising. It’s possible. If I did have complaints it could well be from other doctors. I was amused to find it suggested that complaints were an expected item of a doctor’s portfolio, but that is another story.

Chair: A 360-degree appraisal of chairmen is going to get into trouble soon if we don’t move on.

Q87 Dr Wollaston: Could I come on to the issue of conflict of interest and the role of responsible officers? Essentially, if the medical director has responsibilities to deliver the targets of an employing organisation, does that not—I think you have pointed it out in your evidence to the Committee—immediately raise the possibility of a conflict of interest? I wonder if you could elaborate your views on that.

Professor Peter Furness: Yes, it does. From the very first day having medical directors as responsible officers was suggested I think that potential conflict of interest was identified. It’s balanced, as with so many of these things, by the observation that the medical director is probably, in most circumstances, in the best place to sort out problems that come from the process and to understand how the environment that the doctor is working in may interact with the problems that the doctor may be having. Were it not for that conflict of interest, the medical director would be the best person.

Given that balance, it is not surprising that we have had different opinions expressed, and, as I think I mentioned, some of the medical Royal Colleges have said it should not be the medical director; it should be someone completely independent. That view is, I believe it is fair to say, in the minority because others see the value of having the medical director as the responsible officer, but we are all concerned that because this conflict of interest exists there have to be open processes to ensure it doesn’t cause problems of the sort that we have identified and, if they are, that they are corrected very rapidly. It is one of the reasons for needing a good quality assurance process that looks at the outcomes, not just the process.

Q88 Dr Wollaston: Could you, for example, see in a place like Stafford that that could have been an issue? Where there are organisations aiming for targets, do you think that is an issue?

Professor Peter Furness: That is an excellent example.

Q89 Dr Wollaston: Can you think of any other places where that might have contributed to problems—specific examples?

Professor Peter Furness: It is difficult to think of examples. I suppose, whenever something goes wrong in a hospital, historically one could say, “Could revalidation have spotted that problem and sorted it out?” We have not actually had this process yet so the problems are, in a way, theoretical, but I think we all understand what they are.

Q90 Chair: Is it something that was covered in the pilots—the different ways? Were any of the pilots predicated on the assumption that the responsible officer was somebody other than the medical director?

Professor Peter Furness: I don’t think so. Again, you can get a more reliable answer from the Revalidation Support Team who are running the pilots. I think they are all medical directors. Do you know, Kate?
Ms Kate Tansley: I know that the West Midlands pilot is looking specifically around issues of responsible officers, so there might be some useful information coming out of that.

Q91 Dr Wollaston: Did they use people other than medical directors in that pilot site?

Ms Kate Tansley: Not that I know of. I know that there is one London PCT where this has come up, because the person who is the medical director currently is not a doctor and therefore would not be eligible to become a responsible officer. They are looking at that and how that could be resolved because they do feel that person, apparently, is an extremely useful person so they don’t want to lose them.

Q92 Chair: Do those Colleges that take the view there is a conflict here, and a serious issue, have a way of addressing the point that there are advantages in having a medical director? Do they have a way of bringing those advantages to the table without bringing in the personality of the medical director?

Professor Peter Furness: In my opinion, no. They may disagree.

Q93 Chair: Valerie, you are done. Are there any other points? Is there anything else that you would like to raise or draw our attention to in your written evidence, or indeed that has arisen in the conversation?

Professor Sir Neil Douglas: I’d like just to go back to the three points that Peter was making on item 11 of our written submission about simplifying the 12 attributes down to three. Two of the three are absolutely generic and the other one, which is on quality, is, by its very nature, specialty-specific. Whilst I accept entirely we should be as generic as we possibly can, I do think to have a totally generic system that does not have the individual bringing along evidence about how good his practice in that specialty is would be a complete nonsense. So it needs to have a specialty component to it as well.

Going back to the question of whether the appraiser should be from within the same specialty, yes, I agree it should be, in broad terms, from within the same specialty. As many of you will know, there are, I think, 58 specialties recognised by the GMC. I think it has to be down to that level of granularity. For example, I’m a respiratory physician, as I have said, and there are at least eight, in practice, different things that respiratory physicians can do, so it should be down to the level of a respiratory physician to appraise me but not to somebody who works in sleep medicine, which is what I do most of my stuff in.

Q94 Chair: Thank you very much. That was an informative session. You have a challenge, I think, to get there by December 2012.

Professor Sir Neil Douglas: Indeed.

Professor Peter Furness: May I make one further point? It is not really set out in our written statement but touches on the discussion about the pilots. The time scale for the pilots is set. We are not yet quite clear what will happen in the additional period of time that the Secretary of State has indicated we have after those pilots finish.

We are a little worried about the evaluation of the pilots. One point that is perhaps not absolutely obvious is that those who participated in the pilots have been largely voluntary, which means that those doctors who know they have a problem, one might guess, aren’t volunteering. So there may be differences when revalidation goes live and it becomes mandatory for everyone in terms of the outcomes and the need for remediation. These are issues we are having discussions about. It just struck me that we had talked about the next steps and it was not made clear in our written submission.

Chair: That is a not unimportant point, I would have thought. Thank you very much.

Examination of Witness

Witness: Dr Brian Keighley, Working Party on Revalidation, British Medical Association, gave evidence.

Q95 Chair: Good morning, Dr Keighley. Thank you very much for joining us this morning. I think you heard the evidence being presented by the Royal Colleges. I would actually like to start off by asking how you reacted to the evidence that you have just heard.

Dr Brian Keighley: I think, in general terms, we would perhaps be a little more positive than the evidence I have just heard. We made a response to the GMC consultation, and I think the GMC have made significant steps to address some of those concerns. I do recognise that this new system is producing a lot of anxiety. I think that perhaps is more apparent in the secondary sector of care, in the area of specialist practice. It is my view that appraisal and, flowing from that, revalidation is perhaps better established in primary care, and I think you heard very positive evidence from Malcolm Lewis last week.

Q96 Chair: Indeed. We heard positive evidence from Malcolm Lewis. What I am also focused on is the fact that in the written evidence from the BMA you place considerable emphasis on the fact that effective revalidation will, in your words, “Depend on the successful implementation of strengthened appraisal, when for many doctors ordinary appraisal has never been successfully implemented.” There were various other quotations I could take out of your written evidence which suggest that there is considerable unease within the BMA about where we are in the effective implementation of effectiveness of revalidation based on appraisal.

Dr Brian Keighley: I think our first anxiety is the fact that it is so patchy. It is well established in parts of the country, as you were hearing, and yet there are trusts and hospitals where it has hardly taken place. There is also a large lacuna with the locum and sessional doctors, and some PCTs have been better at
producing the infrastructure than others. I think before we move to what has been called "strengthened medical appraisal" we need to get everybody participating at the initial level. The other anxiety we have is perhaps lack of consistency across the country as to the types of appraisal that are being carried out. We hear anecdotally of some appraisals being a "cosy chat" and others going on for two or three hours. I am now on my seventh annual appraisal and I think my interview lasts for about two and a half hours. I think also what is important is that some of the evidence you have heard is about finding bad doctors. I think the GMC are right to stress that the vast majority of doctors in this country are doing a good job. The purpose of revalidation to my mind is not the weeding out of bad doctors primarily. It came out of the Bristol heart scandal and was to encourage doctors to indulge in reflective practice. That is what we are encouraged to do in my type of appraisal, and I think there has to be a degree of challenge. I want my appraiser to be friendly; I want her to understand my problems; I want to be able to share things with her. But, at the end of that appraisal, I want her to produce just that degree of challenge which makes me reflect upon my practice, about how I can improve, about areas of weakness. The important thing about revalidation, as opposed to appraisal, is that it is a five-year—not a fifth-year—process. It is not a binary decision. As I approach my retirement, I find it more difficult to remember things and I think, if that is reflected back to me, in a year’s time I would show how I would rectify that potential area of weakness. I am in a practice where most of the other doctors are women, so most of the women self-select those doctors and I become de-skilled in areas of gynaecology and family planning. I reflect that to my appraiser and she says, “Well, what will you do about it?” I would put something into place, and a year later I will present to her what I have done to address an area of developing weakness. When you get to the situation of poorer or weaker doctors, the great advantage of a five-year process is that you will pick up, hopefully in years one and two, an area of doubt, and produce some plan to address that area of practice and, hopefully, at the end of the day, we will have less doctors coming into the Fitness to Practise procedures of the GMC.

Q97 Dr Wollaston: I think that is a very important point. We would all accept that an appraisal should be a challenging process that is about personal development, but the public would like to be reassured that the process will also pick up at an early stage those doctors who are failing. Do you yourself feel it is possible to deliver both with revalidation?
Dr Brian Keighley: I think revalidation is part of an armamentarium of methods that failing doctors should be picked up on. What I think we have to remember, however, is that the GMC sitting in London or Manchester cannot do that, and it must rely on proper clinical governance. Part of the lack and part of the delay in the system, to my mind, is that clinical governance, which should be an intrinsic part of a National Health Service that spends so much of the nation’s resource, should be in-built, and it is very patchy.

Q98 Dr Wollaston: That brings me to the next point. In your response to the consultation, the BMA said that many doctors facing Fitness to Practise procedures are those doctors working in areas where there is little or no robust system to conduct revalidation. I was just wondering whether you could share with the Committee where you think that is happening. Which areas are you referring to?
Dr Brian Keighley: I am sorry, can you just repeat that?

Q99 Dr Wollaston: Yes. Are you able to say which parts of the country the BMA is referring to when, if you like, the implication is that the areas that need it most are the areas that don’t have it, where we are seeing most doctors who are facing Fitness to Practise procedures?
Dr Brian Keighley: I think perhaps we were more referring not to geographical areas but areas of practice and areas where there are not managed environments.
Dr Wollaston: Right.
Dr Brian Keighley: A lot of these doctors are in the private sector and do not have clinical governance structures, do not have managed structures and do not have peer review. Those are the areas where it is going to be hardest to establish this.

Q100 Dr Wollaston: I’m sorry, did you say areas of private practice?
Dr Brian Keighley: Areas of private practice, I think, because they are outside the management structure of the health service, and even people who work almost as a single practitioner in a very esoteric specialty will have overview from nurses with whom they work and other clinicians. So there are areas perhaps, especially in the city, where some doctors are working completely outside the health service in a niche area of practice and that is the area where perhaps there is most difficulty in providing the overview.

Dr Wollaston: Thank you.
Chair: Valerie, are you following up on this?
Valerie Vaz: No.
Chair: Okay. Can I go to Nadine and then to you?

Q101 Nadine Dorries: I have a question about something that you wrote in your response to the revalidation consultation. You said that the proposals “depend on the successful implementation of strengthened appraisal, when for many doctors ordinary appraisal has never been successfully implemented”. Does the lack of successful implementation mean that an appraisal isn’t done, and what do you mean by that in effect? Can you just elaborate on those statements?
Dr Brian Keighley: In some trusts and in some areas of the country, NHS directives that appraisal is part of the contractual arrangements of NHS doctors, for reasons of prioritisation, have just not taken place. Some people have done it with enthusiasm; in other areas it has slipped down their list of priorities.
Sometimes, when it has been carried out it has been carried out half-heartedly and without much rigour, or the challenge that I was talking about before.

Q102 Nadine Dorries: Are you saying that these doctors—the GPs who have not had this process that you are talking about who fall into that category—will find it difficult to accept a strengthened appraisal because they have not even had a successful appraisal?

Dr Brian Keighley: I think it is easier to go on a graduated step, but this type of appraisal that we are talking about—I think the Chairman was talking about professionalism—should not be something that is unachievable or something that is particularly frightening. But it does worry us that where appraisal is not working well in many parts of the country—we are now talking, or the Validation Support Team is talking, about strengthened medical appraisal—it is not being uniformly applied now. I think, as a matter of urgency, it does need to be generally applied and then I think the standards of appraisal and the challenge that’s given should incrementally increase.

Q103 Nadine Dorries: You have quoted some areas where it is working well. Can you give us an example of a good successful appraisal? Where do you know that a good successful appraisal process or model is being implemented and taking place? Can you quote one to us?

Dr Brian Keighley: Scottish Primary Care, Welsh Primary Care, many trusts.

Q104 Nadine Dorries: We heard evidence from Wales last week. You think that is a good pilot, one we could look at and you think it is working well.

Dr Brian Keighley: You don’t actually need pilots to see where appraisal is actually working well. The National Health Service Education Board for Scotland has trained appraisers. We have a model now to move it into secondary care appraisers. With the short lines of communication in Scotland and one national body who is underpinning the system, I think it is working well in primary care for the most part in Scotland and is certainly not as patchy as in England. It is much more patchy in secondary care in Scotland, and there are issues that our consultants have about changing the nature of the appraisal because we feel it is a terms and conditions item, but we have now entered into a dialogue with the SGHD and we are moving forward on that.

There is a desire in professional terms to make this work because it is, I think, important—more than weeding out bad doctors. The principal thing that the GMC are trying to deliver, and which we would support, is to give the public assurance that doctors are remaining up to date and that once they pass their primary medical degree at the age of 24 they actually do something more, and they are giving the public that assurance that they are up to date and that they are reflecting on their practice.

When you think back to Bristol, the heart surgeons in Bristol were all very well-meaning and highly skilled doctors, but they had not reflected on their morbidity and mortality rate. The main driving force for this is to make doctors pause and think, and to have an outside agent, which is an appraiser, that will help them do that and give the appropriate degree of challenge. It’s a very positive thing. I think the thing that worries the BMA is some of the details. We would now like to see the GMC—I was myself a member of it for 14 years—take leadership of this and to take it forward and not to rely so much on partners and stakeholders.

Q105 Nadine Dorries: Just to conclude, you were in the audience and you heard the evidence that was given prior to you coming in. You heard a description of an appraisal, which was the gathering of the evidence and the preference that it goes down to three categories. Could you tell me, of that evidence you heard, how would that measure against your description of a strengthened appraisal? Would you describe that as a strengthened appraisal, a successful appraisal or a basic appraisal?

Dr Brian Keighley: I think a strengthened medical appraisal must be predicated on data. One of the biggest problems we have is the inability of the secondary sector of care easily to produce that data. They have incompatible IT systems, and you heard Neil Douglas talk about not being able to bring useful information in his highly skilled area of practice.

In general practice, I think perhaps it is a bit easier. We are used to appraisal because for 30 years I have been a training practice. So every three years I have to jump through several hoops and people look at my prescribing, my referral rates and how I relate to my patients, and I look after all the health and safety stuff that cascades upon us. We go through that on a regular basis.

Q106 Nadine Dorries: What we have talked about is a model, and it is required that it has an application to fit both the primary and the secondary sector. Could that be where the rub is—that it is difficult to get a model? In the secondary sector you have doctors or housemen moving from department to department, from patient to patient, from ward to ward, and it would be difficult, even with the best IT system in the world, to constantly track where those housemen and those doctors were moving and the patients that they were working on and dealing with. Should there be a model which is one for the primary sector and one for the secondary sector? Is it because we are trying to find one overarching model that we have been stalled, and it has not been applied and we are still where we are today?

Dr Brian Keighley: I think the reason for the delay is that the revalidation agenda has been hijacked by events, steered by events, in a political sense. We were ready in the GMC when I was a member to launch revalidation five years ago, and it was at a very much lower tariff than was proposed by various suggestions from the Department of Health and the CMO at the time. That is where affiliates came from and it now seems to have gone away. That is where the split between re-licensing and re-certification came from. Fortunately, I think we are now rewinding to something which is much more reasonable—
Q107 Nadine Dorries:—which would fit both sectors?

Dr Brian Keighley: In both sectors. Because what we are looking at, I think, are core values. If you revalidate a neurosurgeon, there aren’t many people who will get into the depths of what he does, but he will know whether he is keeping up to date. He will know how he relates to patients; he will know if he throws scalpels at his nurses in the middle of the operating theatre. Those are core values. I think that is what revalidation is about. It is not a detailed forensic examination of everybody’s individual practice. It is about core values—about being a doctor. Part of being a doctor is keeping up to date and relating well to your patients, your management, your staff and everything else.

Q108 Dr Wollaston: Can I ask about the evidence that we heard from Dr Furness? He talked about three areas, broadly: evidence of the quality of what you do, evidence of how others perceive what you do and evidence that you are keeping up to date. Would you agree with his assessment that that should be the key to revalidation?

Dr Brian Keighley: I think the Colleges are trying to simplify things, which in some ways is ironic because they were asked a few years ago to complicate things. I think Good Medical Practice is a very powerful document, not in what it says but what it doesn’t say. It is not that thick—it is that thick and it gives you principles. I think it is important that that seminal document is interpreted for different specialties. I was part of helping to write the first edition of Good Medical Practice for General Practitioners, and other specialties did the same. I think, broadly, your appraisal should be mapped not religiously, but to the broad principles laid out in the interpretation of Good Medical Practice for your specialty.

Q109 Valerie Vaz: I want to turn our attention—briefly, because of the time—to the pilot schemes, and the question comes out of what you have been saying. Do you know exactly what they have been demonstrating and what we can all learn from them and, given the previous comment, that only the good ones are volunteering for them?

Dr Brian Keighley: I think the pilots are important. Unfortunately, some of the pilots that are going on at the moment are predicated on what the GMC asked for, which was much more complicated. I think it is important that there is enough time, even if it is going to lead to slightly more delay, to evaluate the pilots and to act upon the lessons that we learn. The pilots, I understand—I don’t have detailed information but I can get that from the office—are somewhat running into the sand. They are delayed. There are people dropping out. There is a great deal of frustration with the revalidation toolkit and the software, which I think is a shame because there are other systems that work well, and the pilots are not about testing the toolkit; they are about testing the principles. There are important lessons being learnt from the pilots but they will need to be retested and recalibrated with the GMC’s newer, simpler approach.

Q110 Valerie Vaz: Do you know who is actually on these pilot schemes?

Dr Brian Keighley: I know they are around the country, that some are primary care, some are secondary care, some are mixed and some are looking at different aspects. The information that’s coming out is mixed. It is usefully pointing out some of the problems in terms of overcomplication. Certainly, it is pointing out some of the difficulty that some doctors are having in producing the data to support the process. In that context, isn’t it surprising? With the NHS and clinical governance, one would have thought the systems would be there for those reasons alone and they are not. I think that is one of the difficulties.

Q111 Valerie Vaz: What are they actually testing? You are saying that the mechanical aspect of it isn’t working so some people are getting frustrated with it. But what about the medical side? What are they actually testing? Do you know?

Dr Brian Keighley: I think they are testing the standards, they are testing the process, they are testing the relationships and they are testing the ability to produce the data and, yes, a change in regulation this large really should be going through a pilot. As I say, I don’t have exact details, but we can certainly give you reports on that and will be very happy to send that in to you.

Q112 Chair: One of the very strong themes that comes out of this evidence is, frankly, a disagreement between different stakeholders about the balance between generic and specialist knowledge. Several times in the course both of the evidence you have given this morning and the written evidence, it seems to me that, from your standpoint, the Royal Colleges are to some extent the villains of the piece here with their emphasis on the need to focus on what doctors actually do in their day-to-day practice and the evidence of the specialist service they deliver. Am I getting something wrong here?

Dr Brian Keighley: I think the Royal Colleges were asked to produce some work, which they did, and, unfortunately, I think that it was overcomplicated. I think we have to remember that revalidation is about all doctors and the Royal Colleges, certainly my own, are about excellence. I think it is also important to remember that if you take a cohort of good doctors, 50% of them will be below average. It is a question of pitching the standards that you are looking at at the correct level, and I think for revalidation, which is looking after all doctors, that should be pitched at competence and not necessarily at excellence. Maybe that is some of the difficulty.

I am not sure how important the Colleges are to give that kind of advice now that the processes are merged, because our experience in fitness to practise or the GMC’s experience in fitness to practise cases is not really about how someone ties off an artery in the middle of an operation. It is more about not listening to the patient, not keeping up to date or letting your personal opinions impinge on consultations. It is much more fundamental than that. The Colleges have an important calibration role as long as they understand...
that what they promote is excellence, and what we need is competence.

Q113 Chair: We could do with a bit of excellence too presumably, but I understand. There is clearly a dilemma that we started off talking about with the Royal Colleges—whether, in their language, this is summative or formative. I have to say I was quite attracted by their presentation, which said, “Let’s first establish whether there is a fitness to practise issue and, if there isn’t, move on to a quality agenda.” What is wrong with that approach?

Dr Brian Keighley: I would have reversed that. I think revalidation is about reflective practice and about public assurance. Clinical governance and other methods should be picking up people who are poor doctors. Revalidation, to my way of thinking, is a backstop. Harold Shipman has been mentioned. It was in the Royal College submission that Harold Shipman would probably have passed revalidation, which is worrying.

What we want revalidation to do—I remember Liam Donaldson saying it—is to move the mean of the bell curve two clicks to the right so that everybody improves, dragging the tail with it. That is done by encouraging all doctors, not just the enthusiasts, to advance and to keep up to date.

Q114 Chair: That is actually in conflict with what you were arguing, isn’t it? Moving the bell curve two notches to the right you can achieve by moving everybody. Actually, if revalidation is purely around minimum fitness to practise, it isn’t about moving the bell curve two notches to the right. It is about eliminating to zero the people at the bottom end notches of practice. They are two different things.

Dr Brian Keighley: I think if you move the bell curve there is still a trailing edge and that is where your problems will be. Revalidation will help to identify those people, but in a professional context that is not what it is about. Revalidation is giving assurance that you are keeping up to date. It is giving people opportunities to reflect on their practice, to indulge in improvement, peer review—a very positive process.

At the end of the day, if the responsible officer is not able to make a recommendation, it is not his binary decision. It then goes to the GMC for consideration, if there is a case to answer, so it’s not the RO’s decision to end a career.

Q115 Dr Wollaston: I think the public would be rather distressed to hear that revalidation wouldn’t pick up the Dr Shipmans of this world and also that it wouldn’t, possibly, pick up those doctors that the public are currently very concerned about, such as Dr Ubani, that are coming in working as locums. Do you not see any possibility for revalidation having a role in actually doing what the public expect it to do?

Dr Brian Keighley: I don’t want to be too negative about that aspect; I think it is a by-product. But would the public not be much more concerned if the Bristol heart surgeons or some other situation was not being reflected upon?

Q116 Dr Wollaston: Absolutely, but I think the public would expect it to deliver both.

Dr Brian Keighley: Consider them both, but I think the Bristol situation was a systems thing.

Q117 Chair: What I think Sir Ian Kennedy found was not that it was systems: it was a lack of willingness to use information that was available to the entire clinical community.

Dr Brian Keighley: Yes. They weren’t reflecting.

Chair: Yes. “Funking” might be the word.

Q118 Valerie Vaz: You had some concerns about the costs of revalidation and where that would fall. Could you just expand on that?

Dr Brian Keighley: I have said in print that the last thing we want at any point in time is half the nation’s doctors going up the M6 to test the other half—that is the extreme. But we are living in straitened circumstances, and we have anxieties that the opportunity costs of all this could at the end of the day detract from patient care and the time that doctors have to spend on it. It should be as simple and as straightforward as possible. It would be ironic if we allowed a system to develop and then found that there weren’t the resources to support it. Yes, we have concerns about the costs.

Q119 Valerie Vaz: Where would you see the costs falling?

Dr Brian Keighley: There are financial costs. One of the big gaps that we have is that there is no clarity about remediation and the costs of remediation for those doctors found lacking. There is the worry about taking time and effort away from organisations to do this when there are priorities to spend it on patient care. We also have the added anxiety in England—I wish you well—of throwing the health service up in the air and seeing where it lands. Where are you going to put the responsible officers in PCOs that are not going to exist and strategic health authorities that are not going to exist? There are grave anxieties about the costs of that.

Q120 Chair: You are tempting us down long avenues that are slightly outside the scope of the revalidation inquiry—relevant too, though. Is there any element you would like to cover that we haven’t covered in the session this morning?

Dr Brian Keighley: I think just to say that the BMA represents doctors’ interests, but we also are there to represent patients’ interests and the best interests of the health service. We think that the GMC’s latest response is far more practical than previously.

Time scales are important and I think there needs to be a co-operative spirit to take things forward, but the GMC has to learn from its experience. It can be a dogmatic organisation and I think it has to work with the doctors that we represent because revalidation and regulation, at the end of the day, can only be done with consent. They are nearer to it than they were but there are still big issues that we will have to work out working together.
Q121 Chair: Do you think that it is realistic to resolve these areas of current debate within a time scale that allows revalidation to become effective before the end of 2012?

Dr Brian Keighley: I think 2012 is a target and I hope it is a realistic target. The Revalidation Delivery Boards—I am on the one in Scotland; Mark Porter and Laurence Buckman are on the England one—are the ones that will sign off and it is very important that they don’t sign off the process and make it go live, until everything is in place and is reasonable. I think there is a chance we will do it by 2012, but if it wanders, hopefully it won’t wander too far from that.

Q122 Chair: Is there not a need for there to be a set of milestones? It’s no good waiting till we are halfway through 2012 and then concluding, “Oh, we’re not going to make it by December,” is it?

Dr Brian Keighley: I think Niall Dickson covered this last week. He said that, yes, they will make a big effort to get everything in by 2012 and then there will be a second date by which they will sweep up everyone. We believe that there is an irony in putting the easy things first—because that is where we suspect there are least problems—and leaving the hardest bits till last. If it is going to come in for the vast number of doctors where there are least problems, then there must be a hard and fast rule that everyone is swept into the system and the hard cases are involved very soon thereafter.

Chair: Thank you very much. Thank you for coming.
Introduction

1. There are currently no formal systematic regulatory arrangements to ensure that doctors in the United Kingdom are up to date and fit to practise. However, in 2005 MORI found that nearly half of the public believed that all doctors were already regularly assessed\(^1\) to ensure that they were performing well, with one in five believing that this took place every year. Research carried out earlier this year for the GMC by Opinion Matters\(^2\) showed that the vast majority of patients thought that such a system would increase their confidence in their doctor.

2. Revalidation seeks to introduce mechanisms to assure patients, employers and fellow professionals that doctors remain safe to practise throughout their career. Revalidation will build on existing processes, such as annual appraisal, strengthening them to meet the needs of regulation and to ensure greater consistency. For the vast majority of doctors, the more systematic annual appraisal will provide the basis for reflective practice and improvement, an essential developmental process. For the small proportion of doctors about whom there may be concerns, the strengthening of local clinical governance and a more objective annual appraisal provides the means for identifying problems earlier and either putting in place remediation or, if not possible, taking steps to remove them from clinical practice.

3. As the Secretary of State, Andrew Lansley, set out in his letter to the GMC on 28 May 2010, the Government wishes to see the introduction of an effective and proportionate system of revalidation, which will support all doctors in their innate professional desire to improve their practise still further. A copy of this letter is attached at Annex A.

The Role of the Department of Health

4. The overall responsibility for leading the work to introduce the revalidation of the medical register rests with the General Medical Council (GMC), but the Department of Health has a critical role to play in contributing to the design of the system and enabling its implementation within in England:

— the Secretary of State for Health has a United Kingdom-wide strategic policy responsibility to ensure that there are effective systems in place to ensure high professional standards and protect the public from poor quality medical care;

— the Department of Health is responsible for bringing the legislation for revalidation into force;

— the Department has a responsibility to ensure that the system is proportionate and does not place undue burdens on doctors themselves or, on those who employ or contract with doctors in England in the public and private sectors; and

— the Department currently has a role in ensuring that the NHS in England is prepared for the introduction of revalidation, by funding and overseeing the NHS Revalidation Support Team, (although this role will pass to the NHS Commissioning Board as the Department of Health steps back from direct engagement with operational matters in the NHS).

Background

5. The concept of a limited form of revalidation for hospital consultants was first proposed in the Merrison Committee’s report on medical regulation in 1975, but it was not until the late 1990s that the GMC began detailed plans for a universal system of assurance. After considerable debate within the medical profession, the GMC were poised to initiate a system in April 2005 that was largely based on annual appraisal.

6. With the publication of the Fifth Report of Lady Justice Smith’s Shipman Inquiry, the then Secretary of State for Health, now Lord Reid of Cardowan, suspended the plans. The Inquiry criticised the GMC’s plans as insufficiently objective to provide adequate assurance to the public. The Secretary of State commissioned Professor Sir Liam Donaldson, then Chief Medical Officer, to review the proposals. His report, Good Doctors, Safer Patients,\(^3\) published in 2006, set out detailed proposals for a new and more rigorous approach to revalidation, consisting of 44 recommendations that would introduce a major programme of reform. The key aspects were:

— The process of revalidation should consist of two components of recertification and relicensure. First, all doctors would need to renew a doctor’s licence to practise and therefore their right to remain on the Medical Register (“re-licensure”); secondly, for those doctors on the specialist or GP registers, “re-certification” and the right to remain on these specialist registers, to be certified through a direct relationship with the relevant Royal College or specialist society.

— The emphasis in both elements was to be a positive affirmation of the doctor’s entitlement to practise, not simply the apparent absence of concerns.

\(^1\) http://mori-ireland.com/researchpublications/researcharchive/poll.aspx?oItemId=433
\(^2\) http://www.gmc-uk.org/news/6853.asp
\(^3\) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137232
The General Medical Council would appoint and employ a qualified doctor, known as a “GMC Affiliate”, in every organisation in the United Kingdom that employed doctors, to manage complaints and administer the system of revalidation.

Each GMC Affiliate was to be paired with a member of the public, who should be trained in regulatory and disciplinary procedures. Together, they should operate as part of a wider team within each organisation. This team should include existing complaints management staff and should have administrative support.

The development of a clear, unambiguous set of standards should be created for generic medical practice, set jointly by the General Medical Council and the (Postgraduate) Medical Education and Training Board, in partnership with patient representatives and the public.

The process of NHS appraisal would be standardised and regularly audited, and should in the future make explicit judgements about performance against the generic standards.

An independent organisation should be commissioned to design and administer the 360-degree feedback exercise required for appraisal and licence renewal.

The relevant medical Royal Colleges would play an active role in the Specialist certification. This process should rely upon membership of, or association with, the relevant medical Royal College, and renewal should be based upon a comprehensive assessment against the standards set by that college. Renewal of certification should be contingent upon the submission of a positive statement of assurance by that College.

Following public consultation on the report, the Government published a White Paper on professional regulation, Trust, Assurance and Safety—The Regulation of Health Professionals in the 21st Century, in February 2007. In consultation on the Chief Medical Officer’s proposals, the British Medical Association, Royal Colleges and employer bodies expressed strong concerns that the proposed system of GMC Affiliates would be expensive and difficult to implement in practice, a criticism accepted by the Government. Instead, the White Paper proposed that, to ensure proportionality, local oversight of revalidation and clinical governance should be enabled by strengthening the existing system of medical directors through the creation of the role of the “responsible officer”.

An expert working group, chaired by Sir Liam Donaldson, was established to discuss the proposals for medical revalidation in greater detail. The group included representatives from patient organisations, the profession, employers, regulators, the BMA and the three devolved administrations. The group’s report “Medical revalidation—principles and next steps” was published in July 2008. The report confirmed that the purpose of medical revalidation was to ensure that licensed doctors remain up to date and continue to be fit to practise. Revalidation would consist of a single process with three elements:

1. to confirm that licensed doctors practise in accordance with the GMC’s generic standards (relicensure);
2. for doctors on the specialist register and GP register, to confirm that they meet the standards appropriate for their specialty (recertification); and
3. to identify for further investigation, and remediation, poor practice where local systems are not robust enough to do this or do not exist.

It was agreed that revalidation would take place over a five year cycle; that it should be built upon existing processes and that a local evaluations of a doctor’s performance should form the basis of a single process to ensure both relicensure and recertification. The group recognised that this would involve strengthening existing appraisal and clinical governance systems.

To take forward the development of these proposals in England and to provide practical support to NHS in England, the Department established the NHS Revalidation Support Team (RST). The Department has also provided substantial funding to the Academy of Medical Royal Colleges to support the development of speciality specific standards. The Department also developed legislation which enabled the GMC to issue all doctors with a license to practise.

THE CURRENT MODEL

In the model for revalidation which is currently being piloted, the recommendation that a doctor should be revalidated, and effectively re-licensed, will depend on satisfactory completion of five annual appraisals, 360-degree (“multi-source”) feedback from patients and colleagues, evidence of continuing professional development, reviews of complaints and relevant information about clinical outcomes. For specialist recertification, each College has drawn up specialty specific standards and assessment methods to enable specialist practice to be assessed.

At the heart of strengthened appraisal is a new core module, based on the GMC’s publication “Good Medical Practice” which covers four domains of practice, encompassing 12 attributes. In the model currently being piloted, all doctors would need to show, over the five-year period, that they met generic standards for each attribute, as well as the specialist standards set by the Royal Colleges in the case of GPs or doctors on the specialist register.
13. Under this model, trained appraisers assess and evaluate the quality of evidence each year at the annual appraisal, advising doctors on where they need to develop their evidence in order to secure revalidation. Every five years, the responsible officer would make an evidence-based judgement about whether a doctor should be recommended to the GMC for revalidation. Although the recommendation would be the personal responsibility of the responsible officer, Boards will be accountable for the systems and processes that are in place to support those recommendations. For GPs and doctors on the specialist register where concerns about a doctor’s evidence have been raised, the responsible officer may need to consult the relevant Royal College before making a recommendation.

14. The approach is designed to give the GMC and patients assurance that each doctor continues to meet the requirements of Good Medical Practice in a structured way that reflects the job the doctor actually does.

15. The emerging consensus during consultation by the General Medical Council, and from the early experiences of the current pilots, is that the system is overly complex. Following the Secretary of State’s letter on the need to ensure processes are proportionate, the GMC and other key organisations are now drawing plans for a much simpler system for piloting in 2011.

Piloting

16. The Revalidation Support Team set up the current pathfinder pilots to test many of the components of revalidation described above. These started in January 2010 and will conclude in April 2011. The pilots have three main objectives:

- To test whether the proposed components of medical revalidation, such as strengthened medical appraisal, are practical and as efficient as possible, whilst at the same time achieving the desired outcome.
- To produce an evidence base regarding costs and benefits of certain elements of medical revalidation, as well as the whole, to shape the development of the policy and inform a full business case for the implementation of medical revalidation.
- To provide proof of concept and build understanding and support within providers of medical care (the NHS in the first instance), and within the medical profession, for the implementation of medical revalidation.

17. The pilots will provide information about:

- Collecting the necessary information for appraisal.
- Appraiser training.
- The appraisal discussion.
- The work of the appraiser before and after the appraisal discussion.
- The role of the responsible officer in relation to revalidation.

18. They will measure how long each of the tasks takes, and how much they are likely to cost. The pilots will look at which bits of the process were most valuable, and which could be simplified, and attempt to quantify the benefits from the process.

19. The pilots are being independently evaluated by Frontline consultants, in collaboration with Durham University. Their first interim report will be published during November on the Revalidation Support Team’s website. The report will provide a valuable baseline about the costs of existing appraisal processes.

\[4\] http://www.revalidationsupport.nhs.uk/
20. A pathfinder pilots strategy oversight group meets on a monthly basis to review progress on meeting the pilot objectives and on how risks are being managed and mitigated. The membership of this group includes the General Medical Council (GMC), Department of Health (DH), Academy of Medical Royal Colleges (AoMRC), British Medical Association (BMA), NHS Employers and pilot project leads. The group reports to DH and from there to the GMC’s UK Revalidation Programme Board. Each pilot site has its own project board with a College and BMA representative.

21. As of 26 October 2010, 258 strengthened medical appraisals had been carried out across the pilot sites, because of the timing of the medical appraisal cycle. It is therefore too early to draw any definitive conclusions. A further interim evaluation report is scheduled for January 2011. However, the main appraisal period in the NHS is during the first quarter of the calendar year, and so we expect the next report to be indicative rather than conclusive.

22. To support the pathfinder pilots an electronic toolkit was developed on behalf of DH to help doctors to compile their portfolio. There was extensive user testing of the system but many initially found it counter-intuitive and frustrating to use. Some of this has been due to compatibility problems with older NHS systems. Subsequent versions of the toolkit and further training have improved the situation considerably, but these problems with information technology are an important lesson from piloting which will need to be resolved if the system of revalidation is to prove practicable for professionals.

23. Although the Department of Health procured an appraisal portfolio tool to support the current pilots, it does not intend to provide a central tool to the NHS in England when revalidation is implemented nationally. The Revalidation Support Team will be working with those organisations who will participate in revalidation to agree common standards and data security for information systems to ensure good interoperability. Local organisations will then be able to contract locally for any tailored support that they need from a range of private providers of information technology support who have extensive experience in developing software that meets the needs of doctors and employers. A number of professional organisations, including the Royal College of General Practitioners and the British Medical Association are already developing software tools to support revalidation.

NHS Readiness

24. The RST has an important role in supporting NHS organisations in England in assessing whether there current systems of clinical governance, information management and appraisal are fit for purpose to support revalidation. The RST has developed a simple self-assessment framework, Assuring the Quality of Medical Appraisal (AQMAR).

25. Strategic Health Authorities in England coordinated a baseline survey using the AQMAR framework during the second half of 2009 and responses were obtained from over 90% of NHS organisations. As the exercise was developmental, no external calibration or validation of the self-assessment findings was performed, and it is possible Trusts may have overstated or understated their position.

26. Positive findings from the exercise included a strong foundation and good infrastructure for both appraisal and clinical governance systems in all sectors, with strong engagement in appraisal at both organisational and individual levels, and examples of good practice in all areas and in all sectors. It is notable that the leadership, support and development of appraisal systems was more established in primary care, whereas the systems of clinical governance, clinical audit and patient safety were more developed in secondary care.

27. Development priorities included the need to improve the integration of appraisal and clinical governance systems and to improve the standard of the information used to monitor activity, performance and quality. In secondary care, appraisal systems required further development and strengthened reporting/accountability arrangements and in primary care weaknesses were apparent in clinical governance and patient safety reporting arrangements between the GP practice and the PCT. A number of areas were identified where central advice and guidance would be helpful, for instance whole practice appraisal, managing conflicts of interest and assessor training.

28. As a result of this project, SHAs and NHS organisations have developed new capacity and expertise and there is an improved understanding within the service of the organisational requirements needed to achieve readiness for revalidation. Progress will be tested again in early 2011, and an early task for responsible officers will be to assure themselves and their Boards that local clinical governance systems are fully ready for revalidation and that systems are in place to ensure all doctors are able to participate in effective annual appraisal arrangements.

Responsible Officers

29. Responsible officers will be a new statutory role for designated organisations, although in the NHS the position is generally likely to be filled by existing Medical Directors. The Medical Profession (Responsible Officers) Regulations 2010 were laid before Parliament on 26 July 2010. Subject to Parliamentary approval, the draft Regulations will come into force on 1 January 2011. The draft Regulations set out how an individual doctor will be connected to a designated body and therefore to a responsible officer.
The intended role of the responsible officer will be to improve the quality of care delivered by doctors they are connected to; to support doctors through revalidation and ensure that organisations achieve improvements to local clinical governance.

In practice, responsible officers will need to be satisfied that sufficient information has been produced by each doctor to demonstrate that the doctor meets the relevant professional standards. Where concerns exist about a doctor’s practice the responsible officer will need to ensure that they have gathered the relevant evidence, investigated the concerns thoroughly, and taken appropriate action. They will make a recommendation to the GMC on the individual doctor’s continued fitness to practise which will be based on an assessment of all the relevant information.

Designated organisations will be required, subject to Parliamentary approval, to nominate or appoint their responsible officer from 1 January 2011. The variety of ways in which doctors work means it is not practicable to designate all organisations that employ (or contract with) doctors. The responsible officer regulations therefore focus on those doctors that have the highest impact on the health of patients. They designate organisations that deliver healthcare, and organisations with a role in setting policy and standards for the delivery of healthcare.

It will be the responsibility of any designated organisation to put in place effective, robust systems of clinical governance. The responsible officers will have to ensure that these systems are functioning and that they are effective.

Although the structures of the NHS in England will change over the next few years, during 2011 responsible officers will start to prepare the NHS and the private sector for revalidation. The regulations will be amended to reflect these structural changes as the duties of new organisations are clarified. For primary care, GP Consortia will have responsible officers in place prior to the dissolution of Primary Care Trusts. The Government will be discussing with employers and the professions the arrangements for ensuring effective reporting arrangements for responsible officers in consortia.

The Department of Health is working with the Revalidation Support Team to commission a training module for responsible officers which will be delivered in 2011.

It will be for responsible officers and organisations in consultation with the GMC and the profession to decide how they will phase revalidation cycles so that it is manageable for individual doctors.

**Responsible Officers—Potential Conflicts of Interest**

Some professional bodies have expressed concern that Responsible Officers will have potential conflicts of interest, either from their personal relationships with doctors for whom they are responsible, or through a conflict between their professional and organisational loyalties. It is essential that all doctors are treated with fairness and consistency. Provisions have been made in the regulations for the handling of conflicts of interest or appearance of bias, for example, where there are conflicts of interest between the responsible officer and individual doctors.

However, provisions for conflicts of interest between responsible officers and their organisations have not been made. All doctors who have a management or supervisory role for other doctors already manage on a day-to-day basis any tensions between the needs to ensure high professional standards and values and the needs of employers and service provision. Medical Directors already address concerns about doctors in their organisations, whether through local performance management or disciplinary systems, or through referrals to the GMC. The Government believes that in the vast majority of cases, medical directors will be guided by their professional values to manage such issues fairly and in the best interest of patients. The alternative, of an entirely independent structure of Responsible Officers in every healthcare organisation in the United Kingdom, would replicate the system of GMC Affiliates proposed in 2007, which professional bodies rejected during consultation as disproportionate, impracticable and unaffordable.

**Remediation**

The Government is clear that as the new arrangements provide for more effective systems to identify concerns about doctors, they must also provide for more effective arrangement for remediating, where possible. It is important that any identified weaknesses in performance can be addressed quickly before they become problems. Where problems are identified, where possible, action should be taken to support doctors in returning quickly to safe and autonomous practice. This is not only to ensure fair arrangements are in place for professionals who require support, but also to ensure that the benefits of significant public investment in the training of medical professionals are not lost to patients and the public.

Responsible officers will be expected to take early action where they identify that a doctor is failing rather than waiting for the end of a revalidation period. The Department of Health established a Steering Group in 2010 to review the present arrangements for the remediation of doctors whose clinical performance is causing concerns. The Group reviewed existing evidence about the way in which concerns are initially investigated and how appropriate remediation is accessed. The Group found many examples of very good practice, but also found that there was a need for greater consistency in the way remediation was managed and a need for more
clarity about which organisations provide support to medical managers. Whilst the group concluded that as far as possible employers and contractors with doctors should manage the situation locally, there would continue to need to be access to external expertise. A report setting out the group’s proposals and options for the way forward is in the final stages of drafting and will be published in due course when Ministers have considered its implications and recommendations.

GMC Consultation

41. The GMC consulted on its plans and proposals for how revalidation would work in practice between 1 March and 4 June 2010. They received over 940 written responses to the consultation, 700 of these from individuals. On 18 October this year, the GMC published its response to the consultation. This was supported by a joint statement of intent from the four administrations and the GMC 5.

42. Five key themes came out of the consultation:

— Ensuring that revalidation is as streamlined, straightforward and proportionate as possible;
— Ensuring the revalidation model is flexible;
— Ensuring that revalidation is affordable for both individuals and organisations;
— The need for further detail; and
— The need for further testing and evaluation.

The GMC will be working on all of these themes over the coming year with DH and the other delivery partners.

Simplification

43. There is near unanimity amongst all involved in the design and implementation that the current proposals for revalidation need to be simplified and streamlined to ensure proportionality. In doing so, it will be important to ensure an effective balance between sufficient national consistency of requirements to provide adequate assurance about medical professionals on the one hand, and sufficient room for local flexibility and judgement to enable processes to be unbureaucratic and genuinely support all doctors in improving their practice. It is important that a proper desire for as light a touch approach as possible does not lead to a repeat of the criticism of the system which was abandoned by the GMC in late 2005. The key to striking the right balance lies in effective evaluation and testing of proposals on the ground, so that employers and doctors can give first hand evidence on how the new systems add value and how much time and resource they take.

44. The pathfinder pilots will start to identify how the proposed model can be simplified. The RST will work with employers and the profession to identify which aspects of the current proposals are most onerous, and which are of most value to appraisees, appraisers and the responsible officer. This analysis will inform decisions on how best to streamline the process such that it remains robust, offering the assurance that patients have the right to expect, but which is affordable and makes effective use of doctor’s time.

45. The further year of piloting and testing, which the Secretary of State announced in May 2010, will allow the streamlined processes to be developed and tested, and allow organisations more time for to prepare for revalidation. The introduction of a system of responsible officers, providing stronger assurance at local level, is likely to mean that the number and complexity of national requirements can be reduced significantly.

Implementation Strategy and Timetable

46. The scale and complexity of the revalidation programme combined with the potential costs and professional concerns means that there has been a broad consensus that a “big bang” approach to implementation should be avoided. The current strategy is for a piloted and phased introduction over a period of years, evaluating independently to learn more about costs and practicalities. Revalidation will start to go live as different parts of the country have in place the systems to make it work effectively, and as different specialties are ready to engage, although with a clear endpoint by which time all doctors must participate

47. The Statement of Intent sets out a timetable for assessing readiness for the introduction of revalidation. An assessment of the readiness of the National Health Service and other healthcare providers will be made in Summer 2012. If this is positive and the cost benefit assessment for implementation of revalidation in England is also positive and agreed by the Secretary of State, the intention is that the implementation of revalidation should begin in late 2012.

Revalidation Support Team Work Programme 2011–12

48. To support this implementation timetable the RST’s work programme sets out arrangements for completion of the current phase of piloting; simplification of the current arrangements to enable further piloting in 2011 and support to the NHS in England in ensuring that is prepared for an assessment of readiness in the

summer of 2012. This will enable the Secretary of State to decide whether he is satisfied that the proposed approach to revalidation is proportionate and affordable and the health sector in England is suitably prepared.

49. The added year of testing will also provide the opportunity to explore how revalidation will work in two important settings:
   - doctors not in fixed employment, including locums and peripatetic doctors; and
   - doctors working outside an organisational structure where there are no governance arrangements, or in organisations where the governance arrangements are not robust.

50. The RST will be working with the profession and employers to simplify, streamline and clarify the appraisal framework which will support revalidation, including the overall model of appraisal; the evidence needed for appraisal; the minimum outputs needed from appraisal; the content of appraiser training; and guidance for organisations, doctors and appraisers.

51. The RST will also be leading on the development of Responsible Officer training and support; supporting the local improvement of clinical governance systems; systems for managing appraisal locally, including information technology; and improving local systems of remediation.

52. These two work streams will be supported by cross-cutting work to test and evaluate the emerging processes, with emphasis on the doctors and organisations where risk may be higher. There will also be a programme of communication and engagement, to ensure broad support for the final system from all the key organisations, including patients and public, with a clear understanding of responsibilities.

Conclusion

53. The challenge now for the GMC and the four Departments of Health is to ensure that the simplified revalidation system is proportionate, supported by the profession as an aid to improving practice, and robust enough to identify and tackle poor performance at an early stage. The system must support doctors in their ambition to remain up to date and fit to practise throughout their career and deliver the highest quality of patient care. Through proper testing and evaluation on the ground, and with an effective infrastructure of responsible officers locally, the Department is confident that the GMC will be able to implement a system for revalidation which enhances and sustains the high level of confidence that the public have in the medical profession in the United Kingdom.

November 2010

Annex A

28 May 2010

Professor Peter Rubin
Chair
General Medical Council
Regent’s Place
350 Euston Road
London
NW1 3JN

SUBJECT: RESPONSE TO GENERAL MEDICAL COUNCIL CONSULTATION ON MEDICAL REVALIDATION

Dear Peter

Consultation on Medical Revalidation

I am keenly aware of the commitment that the GMC, professional bodies, the NHS, independent sector, patient groups and devolved administrations have all shown to the task of developing, challenging and testing practical and effective approaches to the introduction of medical revalidation. I do, therefore, very much welcome your consultation, setting out the proposals that are the result of that commitment and collaboration. I look forward to seeing the outcome of the consultation and to understanding the way that it will help to shape the piloting and implementation of the policy.

Revalidation is something that the public expect their doctors to undertake and, if implemented sensitively and effectively, is something that will support all doctors in their innate professional desire to improve their practice still further. We need strong evidence on what works for both patients and the profession to ensure that this is the case.

For the NHS in England, having reviewed the current plans, I do not yet have sufficient confidence that there will be time properly to gather and evaluate evidence on all aspects of revalidation and to amend plans in the light of the current pilots in the NHS. I therefore intend to extend the piloting period for a further year...
to enable us to develop a clearer understanding of the costs, benefits and practicalities of implementation so that it can be paced in a way that is affordable, supports high quality care and makes effective use of doctors’ time.

This extended period will also mean we can ensure that there has been full engagement with the profession, the service and the public before a decision to move to full implementation. I know that the service will be closely scrutinising the plans and will want to ensure that the benefits are robust and achievable and the costs affordable when decisions are being made about the speed of final rollout. In particular we will need to be able to assure doctors, employers and commissioners that the proposals for medical appraisal and the Royal College standards are proportionate ones.

Organisational readiness and, in particular, having Responsible Officers in place, are essential elements to ensuring the NHS is ready for revalidation. It is our intention to lay regulations on responsible officers before Parliament shortly. The role of the Responsible Officer goes beyond revalidation and I am keen to ensure that the service can quickly achieve the improvements to local clinical governance that their appointment will enable.

The Department does have some comments on some of the more technical issues you raise in your consultation and I will ask my officials to send a separate response covering these points.

I know we are meeting in the near future and look forward to developing a productive working relationship, us both having a keen interest in patient safety and public protection.

I hope you find this early steer helpful.

Rt Hon Andrew Lansley CBE MP
Secretary of State for Public Health

Written evidence from the General Medical Council (REV 02)

INTRODUCTION

1. The General Medical Council (GMC) is the independent regulator of doctors in the UK. The GMC protects, promotes and maintains the health and safety of the public by ensuring proper standards in the practice of medicine.

2. We do this in four ways:
   (a) By controlling entry to and maintaining the list of registered and licensed doctors.
   (b) By setting standards for and co-ordinating all stages of medical education and training.
   (c) By determining the principles and values that underpin Good Medical Practice.
   (d) By dealing firmly and fairly with doctors whose fitness to practise is in doubt.

BACKGROUND TO THE DEVELOPMENT OF REVALIDATION

From registration to revalidation

3. Patients trust doctors with their lives and wellbeing. They need to have confidence that doctors are competent and abide by high ethical standards. One of the ways in which the GMC ensures that trust is through the registration and licensing of doctors in the UK.

4. All doctors who wish to practise medicine in the UK must be both registered and licensed with the GMC. This applies whether they practise full-time, part-time, as a locum, privately or in the NHS, or whether they are employed or self-employed.

5. Being registered and licensed with the GMC shows that a doctor has the necessary qualifications for medical practice and that he or she is in good standing. However, at present, it is essentially an historical record of qualification. It provides no information about the sort of practitioner a doctor has become or whether they remain competent and fit to practise.

6. Revalidation aims to change this by updating what it means to be a registered and licensed doctor. Its purpose is to assure patients and the public, employers and other healthcare professionals that licensed doctors remain up to date and practising to the appropriate professional standards. Doctors who are unable to demonstrate this will lose their licence to practise.

The origins, context and history of revalidation

7. Our approach to revalidation began to be developed in 1998 when the then President of the GMC argued that it was no longer sufficient for a doctor’s continued registration to be based solely upon an historical record of qualification. Instead, it should be dependent upon continuing participation in, and contribution to, quality assured practice based on clear professional standards.6

6 The Policy Framework for Revalidation: A Position Paper, GMC, 2004
8. This vision for a more modern form of medical regulation was informed by a series of high profile public inquiries, most notably the Bristol Royal Infirmary Inquiry. One of the recurrent themes of these Inquiries was the failure of local systems of regulation within the health service to detect and address serious problems with a small number of doctors.

9. As the national regulator, it is for the GMC to set out the principles which doctors must follow in their everyday practice. But the GMC is not an employer and is not in a position to monitor adherence to those principles on a day to day basis. This required a more effective system of local clinical governance within healthcare institutions. A more proactive GMC focused on encouraging good practice, coupled with robust local systems for identifying and acting upon poor practice would contribute to improving the quality of patient care overall, while helping to ensure that poor practice could be identified and acted upon more easily before problems became serious.

10. The model for this more robust approach to regulation was to be based on the system for doctors’ annual appraisal in the workplace. This local review of each doctor’s practice would provide the foundation for a decision by the GMC, normally every five years, about whether a doctor remained fit to practise and should be revalidated.

11. The fifth report of the Shipman Inquiry, published at the end of 2004, led to the decision that plans for the introduction of revalidation should be put on hold pending a wide ranging review by the Chief Medical Officer (CMO) for England into medical regulation as a whole. A similar review of non-medical regulation was also launched.

12. The CMO’s report, Good doctors, safer patients was published in July 2006 and contained some 44 recommendations covering medical regulation as a whole, including revalidation. This was followed in February 2007 by the Government White Paper Trust, Assurance and Safety—The Regulation of Health Professionals in the 21st Century.

13. Although the Shipman Inquiry report, the CMO’s report and the White Paper all contributed to the strengthening of revalidation, they have not fundamentally changed the original model. That is a model founded upon the need for robust local systems of clinical governance and appraisal generating the evidence by which doctors will demonstrate to the GMC on a regular basis (normally every five years) that they remain up to date and fit to practise.

HOW REVALIDATION WILL WORK

14. To meet its aims, revalidation must be relevant to doctors’ day-to-day practice and build upon systems that already exist in the workplace to support high-quality care. It must not create unnecessary burdens which hamper doctors in fulfilling their main concern of caring for patients.

Collection and evaluation of information in the workplace through annual appraisal

15. Revalidation will therefore be based upon a local evaluation of doctors’ performance against national standards approved by the GMC. It will not involve a point-in-time test of knowledge and skills.

16. Doctors will need to maintain a folder or portfolio of information drawn from their practice to show how they are meeting the required standards. The information collected in their portfolio will provide the basis for discussion at their annual appraisal. For the purposes of revalidation it will be essential that the appraisal includes an effective evaluation of each doctor’s performance against the relevant standards. Work is ongoing to embed the required standards into the appraisal process.

17. Most doctors already have an annual appraisal, so the evaluation of their practice through appraisal will be nothing new. In this way, we avoid having to create a new and separate evaluation infrastructure purely to serve the needs of revalidation. This approach will also help doctors and their appraisers to link their performance to national standards, and to identify and address any areas for action long before they are required to revalidate.

Revalidation recommendation to the GMC by the “Responsible Officer”

18. To revalidate a doctor, the GMC will require assurance that he or she is meeting the required standards and that there are no known concerns about the doctor’s practice. The revalidation recommendation will come to the GMC via the doctor’s local Responsible Officer.

19. The Responsible Officer will be a senior, licensed doctor. In a healthcare organisation, this is likely to be the Medical Director. For GPs, the Responsible Officer is likely to be from the healthcare organisation on whose performers’ list they are included.

20. The Responsible Officer will have statutory responsibility for evaluating the fitness to practise of doctors associated with that organisation. In England, Wales and Northern Ireland they will also be responsible for ensuring that the system of clinical governance (including appraisal) necessary in their organisation is capable of supporting doctors in meeting the requirements of revalidation. In Scotland, this additional responsibility is already covered by existing legislation and organisations.
21. To make a revalidation recommendation to the GMC, the Responsible Officer will rely on the outcome of the doctor’s annual appraisals over the course of five years, combined with information drawn from the clinical governance systems of the organisation in which the doctor works. The Responsible Officer will also be able to draw upon advice and expertise from others, such as the medical Royal Colleges and Faculties in relation to the relevant specialty standards.

Revalidation decision by the GMC

22. The Responsible Officer will make a recommendation to the GMC, but it will be for the GMC to decide whether the doctor concerned should be revalidated.

23. We are confident that the vast majority of doctors will have no difficulty meeting the standards for revalidation. These doctors will retain their licence to practise until their next revalidation is due. This will generally be after a further five years.

24. Where there are concerns about a doctor’s practice these should be identified as early as possible and, where possible, addressed through appraisal and the relevant local clinical governance processes.

25. We do not expect action on known concerns to wait until a doctor is due to be revalidated by the GMC since early action at a local level will reduce the risk of problems escalating and of harm to patients. Where serious concerns about a doctor’s fitness to practise are brought to the GMC’s attention they will be investigated through our existing fitness to practise procedures and may result in action against the doctor’s registration.

Revalidation Consultation: The Way Ahead

26. On 1 March 2010, we launched a three month public consultation on our revalidation proposals. During the course of the consultation we held or participated in around 130 events across the UK. We talked to more than 4,000 doctors, listened to their views and comments and discussed their concerns about revalidation. We also spoke to a range of employer organisations and representatives from patient groups across the four countries. By the time the consultation ended, on 4 June 2010, we had received nearly 1,000 responses.

Conclusions from the Consultation

27. The vast majority of those who responded to our consultation told us that they supported our overall approach. It was nevertheless clear from the thoughtful reactions that we received that there is more work to be done. This work spreads across five main themes.

Theme 1: Ensuring that revalidation is as streamlined, straightforward and proportionate as possible

28. Respondents were rightly keen that the system should minimise the amount of time that doctors have to spend away from their patients.

29. Many were concerned that some aspects of our proposals would be too complex and onerous for individual doctors and their employers. There was particular concern about the difficulty of collecting some of the information that doctors would need to bring to their appraisal.

30. We are therefore working with our partners to review how the proposals and some of the components of revalidation can be streamlined.

Theme 2: Ensuring the revalidation model is flexible

31. Doctors work in a wide variety of different roles and settings. Many respondents commented on the need to ensure that the model is sufficiently flexible to accommodate doctors in non-clinical and non-mainstream roles so that they are able to demonstrate their continuing fitness to practise.

Theme 3: The potential costs of revalidation

32. Concerns were raised about the potential costs of revalidation, particularly in relation to the costs of embedding effective local systems of clinical governance and appraisal.

33. Our work to streamline our proposals will help to address these concerns. However, effective local systems of clinical governance and appraisal necessary to support the delivery high quality patient care should already be in place. The cost of good clinical governance (including the costs associated with training and remediation) are costs that are inherent in the provision of high quality and safe healthcare. They are not attributable to revalidation. Revalidation is simply the by-product of those systems operating properly.

34. Nevertheless, we are committed to a separate analysis of those specific costs which solely relate to the introduction of revalidation and those costs must be seen in the light of the associated benefits to patients and the public, doctors and employers.
Theme 4: The need for further detail

35. Many respondents sought more detail about our proposals. The support shown for our approach to revalidation overall will now enable us to map out the process in greater detail.

Theme 5: The need for further testing and evaluation

36. Many respondents highlighted the importance of sufficient testing before revalidation is introduced and the need to evaluate the outcome of the piloting work that is currently being undertaken. We fully agree.

Letter from the Secretary of State for Health

37. On 1 June 2010, the Secretary of State for Health wrote to the Chair of the GMC, Professor Sir Peter Rubin, confirming his commitment to revalidation and making clear that it is “something the public expect their doctors to undertake”. At the same time he emphasised the need to gather further information about the practicalities, costs and benefits of the process through an additional year of pilot testing.

38. We have welcomed this move. The decision to extend piloting in England will ensure that the systems upon which revalidation will depend are sufficiently robust without being burdensome or bureaucratic for doctors or employers. It very much confirms the feedback we have received from our consultation.

A Statement of Intent

39. As further evidence of the UK wide commitment to revalidation, on 18 October 2010 we agreed and published a statement of intent with the Chief Medical Officers for England, Northern Ireland and Wales, the Deputy Chief Medical Officer for Scotland and the Medical Director of the NHS in England. The statement confirms the commitment of the four health departments in the UK, and all our key partners, to the delivery of a system of revalidation, based on robust local systems, that supports high quality care in the organisations and practice settings where that care is delivered.

Next Steps

Timetable and milestones

40. We are planning to launch revalidation in late 2012. This timetable will be dependent on NHS employers and other healthcare providers ensuring that they have the local systems in place to support the revalidation of their doctors.

41. The following criteria will need to be met for an organisation or an area to start the process and we will be working with our partners across the UK on the timescales to deliver these milestones:
   - Responsible officers in place in the designated organisations.
   - All doctors participating in an annual appraisal process.
   - The GMC standards embedded in local annual appraisal.
   - Agreed core information that doctors should bring to appraisal.
   - Process in place for delivery of Responsible Officer recommendations to the GMC.
   - Agreed strategy for remediation where performance concerns are identified.

42. An assessment of readiness will be undertaken in 2012 before the Secretary of State for Health can agree to the commencement of the relevant legislation.

20 October 2010

Written evidence from the British Medical Association (REV 04)

Executive Summary

1. The General Medical Council (GMC) proposed a revalidation model whereby the satisfactory sign-off of five annual appraisals would form the basis of a recommendation to the GMC that a doctor is fit to practise. Revalidation is intended to be a positive affirmation that doctors are safe, rather than just an absence of concerns. This seems relatively simple and is widely supported—and yet the stakeholder organisations developing revalidation are developing systems that are controversial, difficult to implement, highly complex and have been repeatedly delayed for many years now. This is happening despite the introduction of medical appraisal in 2001.

2. We believe that the most important reason for this is the aspiration to develop a perfect system and launch it fully formed. The decision was taken to develop Strengthened Medical Appraisal (SMA) which would include a requirement to provide positive proof against four domains and twelve attributes defined by the GMC, to provide that using tools that were themselves controversial, to pilot this in several sites and to use a computerised application to run the individual SMAs.
3. It is now clear from the responses to the GMC’s 2010 consultation that there is a consensus that the structure of SMA has been overcomplicated in its pursuit of excellence and should be cut back from the aspirational to the achievable. Furthermore, initial reports from the revalidation pilot sites indicate that the greatest barriers to progress are the amounts of information required and the obligation to use the Revalidation Pilot Toolkit (RPT), a deeply disliked piece of software.

4. Despite this, those with a commitment to the domains, attributes and specialty frameworks remain fixed on their use, even though the systems are widely criticised. Those with a commitment to the RPT remain fixed on its use, even though the progress on pilots is falling far behind schedule.

5. It is time to return to the original intention—the individual positive affirmation through satisfactory progress through the appraisal system. This is the reason that medical appraisal was introduced—to facilitate the eventual introduction of revalidation. And yet the current implemented appraisal system, a clinical governance tool with some potential, has remained undeveloped over the last decade while attention and resources are put into inventing an overcomplicated SMA.

6. The “search for excellence” strategy for revalidation has been shown not to be effective—it has been repeatedly delayed. It would be better to take what we have, and implement the principle of revalidation on medical appraisal, and then incrementally guide and improve that system to develop as a clinical governance tool. The alternative is to remain fixed on our current path simply because we cannot embrace the thought of learning from experience.

INTRODUCTION

7. The BMA welcomes the opportunity to provide a written submission to the Health Select Committee Inquiry on the revalidation of doctors. The BMA is a voluntary, professional association that represents all doctors from all branches of medicine across the UK. Over 110,000 practising doctors are members, as are nearly 20,000 medical students. The BMA is an independent trade union, a scientific and educational body and a limited company, funded largely by its members.

8. The recent consultation documents from the GMC provided the most comprehensive statement to date on how revalidation would work. Following the release of the GMC consultation, the BMA sought to clarify its position on revalidation and published seven absolute requirements for the process if it is to be workable and maintain the support of the profession. These requirements are as follows:

   — The introduction of revalidation must be cost effective and not put undue strain on the NHS.
   — There must be equality of opportunity to revalidate.
   — Pilots must run independently, be fully evaluated with results published and fed into subsequent pilot stages.
   — Medical Royal College standards for recertification must be equitable, fair and proportionate.
   — Knowledge tests should form no part in assessing a doctor’s fitness to practise, whether as part of the GMC’s generic standards for relicensure or College standards for recertification—and any MSF system must be validated.
   — There must be a mechanism to deal with conflicts of interest with responsible officers (ROs)—including an appeals process to an independent scrutineer.
   — Remediation must be fully funded to ensure equality amongst branches of practice.

9. The GMC consultation brought into perspective many of the concerns that the BMA had with the process and provided us with the opportunity to submit a detailed critique of the plans. Following the submission of our response, the Secretary of State for Health announced his intention to extend the pilots in England. This pilot extension, the revision of the GMC’s plans and most recently, the publication of the White Paper, has caused further widespread uncertainty about the concept of revalidation, the direction it is taking and the timescales involved.

10. The GMC launched their response to the consultation on 18 October 2010. The GMC pledged to make the system simpler, more cost-effective and flexible, taking into account the needs of doctors working in non-mainstream roles and outside the NHS. The BMA is pleased that the GMC has committed to act on many of our key concerns although we remain apprehensive by the lack of detail that underpins the revision of the GMC plans for revalidation. We are further concerned by the simplistic analysis that has been used in the GMC consultation response, where quantitative data appears to have taken precedence over qualitative data to the point that significant concerns have been put aside. As such, whilst we understand the need for a clear path to implementation, this must not be at the expense of ensuring that the process is right and has the confidence of doctors. Consequently, it is essential that the extended pilots in England are fully evaluated and any issues adequately addressed as part of the “test of readiness”8, before any possible launch later in 2012.

11. The BMA supports the principle of revalidation and is heavily involved in the development of the process through various stakeholder groups and pilots. However, our engagement with the process should not be seen

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8 Statement of intent, October 2010
as an endorsement of the current plans. The profession’s concerns with the process must be addressed satisfactorily, for revalidation to be implemented successfully, for patients to be assured of the quality of care offered by their doctor and for the BMA to support the introduction of revalidation.

The GMC Proposals for Revalidation

12. The GMC proposed a model whereby the satisfactory sign-off of five annual appraisals would form the basis of a recommendation to the GMC that a doctor is fit to practise. Revalidation is intended to be a positive affirmation that doctors are safe, rather than just an absence of concerns.

13. Doctors will undertake a form of strengthened appraisal and collate a portfolio of evidence to demonstrate that they meet the necessary standards. This supporting evidence will be drawn from their day-to-day practice and will include patient feedback, clinical audit and participation in CPD. Over the course of the five-year revalidation cycle, doctors will be expected to meet the various standards that have been set by the GMC. For those doctors on the GP or specialist registers, the GMC will take note of recommendations from the Medical Royal Colleges on specialty specific issues when setting these standards.

14. Each doctor will relate to a responsible officer (RO) who will assess the portfolio and provide the GMC with a recommendation on the doctor’s fitness to practise. All organisations that employ licensed doctors will need to provide the RO function. These roles will be introduced in January 2011, subject to the forthcoming parliamentary debates on the draft RO regulations. As well as being responsible for providing a recommendation to the GMC, they will be expected to support and guide doctors through the process, and, in England, will also have further responsibilities relating to clinical governance.

15. The GMC consultation sought to finalise various component parts of the process. The four sections of the consultation document set out:

- How revalidation will work
  The process and the basis on which decisions to revalidate will be made.
- What doctors and employers of doctors’ services will need to do
  The standards that doctors will need to meet and the supporting information required.
- Patient and public involvement in revalidation
  The role of patient and colleague questionnaires.
- How and when revalidation will be introduced
  The timetable for the introduction of revalidation and rollout of the process.

The BMA Response to the GMC Consultation

16. Whilst the BMA was able to agree with a number of the GMC proposals, such as the decision to combine the two processes of relicensing and recertification, our confidence in the process was seriously undermined by the specialist standards frameworks that had been developed by the colleges. We felt that the college standards were not equitable, fair or proportionate to the extent that the process would have proved impractical, expensive, ultimately unworkable and would have diverted doctors away from direct care of patients. Many of the colleges had sought to provide a perfect revalidation system at the first attempt, instead of commencing revalidation with core standards and building on these during subsequent revalidation cycles—thereby, hopefully, enhancing quality over the coming years.

17. We believe it would be much better to develop a robust and workable system, concentrating on core standards, and grow it organically into a fully-comprehensive revalidation system that commands the confidence of both the public and the profession. The development of extensive specialty frameworks does not appear to be proportionate and is of limited value considering the GMC’s own current Fitness to Practise (FitP) statistics show that core generic skills (communication, probity, health, insight and keeping up-to-date) are usually the areas that lead to action against the registration of doctors, as opposed to specialty specific issues.

18. There were two significant omissions in the consultation documents, both of which remain fundamental to the process of revalidation. The lack of reference to the cost of revalidation and of remediation, severely undermine the case for successful implementation. There has also been little consideration of the indirect costs of the time that doctors will require to meet revalidation requirements instead of treating patients. In the current financial climate, with cuts to NHS funding already underway, it remains unclear how this process will be funded and by whom. What is clear is that the process must be fully resourced as the profession would fundamentally oppose any costs falling on individual doctors or, indeed, significant, additional costs falling on trusts and other organisations. Using revalidation as a mechanism to identify poorly performing doctors, improve standards of care and reassure the public may prove over-ambitious in the current financial climate. Only a small number of doctors are likely to be identified as requiring further support and training, whilst the recent GMC survey demonstrates that the public already have a high degree of confidence in the medical profession.¹² In light of this, the revalidation model proposed by the GMC in its consultation documents appeared disproportionate and potentially too expensive and complicated a means of protecting patients from a tiny minority of unsafe doctors.

¹² Patients say regular check-ups will help increase their confidence in doctors, GMC press release, 29 April 2010
19. The DH has estimated that revalidation could lead to a 27.5% increase in the number of local investigations due to the increased scrutiny of performance of doctors. The DH argues that this will not however lead to a subsequent increase in GMC investigations due to the role of early intervention and remediation. It is evident therefore that remediation is expected to play a significant role in this process. Currently approximately 20% of investigations result in remediation but this may rise by around 25%.\(^{10}\) With these figures in mind, it was surprising that the issue of resources required for remediation was not addressed in the consultation. The availability of remediation is currently patchy and this needs to be resolved in order for revalidation to work effectively. The BMA has spent the last decade trying to seek clarity on how resources would be made available for remediation without success. Unless this is resolved and it is made clear where the responsibility for providing remediation lies, revalidation will not work and the system will fail to deliver anything to society.

20. Whilst we acknowledge that medical directors appear to be best placed to assume the RO role, given that they undertake some of the responsibilities already, we believe that this could result in conflicts of interest in some parts of the UK, particularly where medical directors have a corporate board responsibility. These conflicts could be between the RO and organisation and also between the RO and individual doctors. The RO has the distinct functions of overseeing clinical governance, supporting doctors through the revalidation process and of making a recommendation to the GMC regarding each doctor’s continued fitness to practice. These three roles have different lines of accountability, thus creating conflicts of interest. As such, the only solution that avoids any conflicts of interest is for some designated organisations to appoint or nominate an RO whilst also maintaining a separate medical director position.

21. The consultation did not adequately address how locums, doctors with portfolio careers, retired doctors, those in non-mainstream roles, those in non-clinical roles (such as medical managers) and those who do not work in managed organisations as employees, such as private practitioners, would be able to complete this process. This includes a wide range of career variations; medical academics for instance may be at risk from dual jeopardy unless it is made clear that their appraisal must be Follett-compliant. It also includes those who work overseas for a significant period during the revalidation cycle and whose overseas work may not conform with the current system for providing evidence for appraisal. The parties involved in revalidation need to consider the difficulty that such doctors may have in securing an annual appraisal and address this issue accordingly. The current options appear limited and potentially very expensive for some doctors. This suggests that there will not be equality of opportunity for all entitled doctors to revalidate.

22. The BMA welcomed the consultation proposals suggesting that the colleges should not be directly involved in the recommendations made by the responsible officer to the GMC regarding a doctor’s revalidation. A direct role for the colleges (ie sitting on local panels) would have been an unacceptable conflict of interest between their roles as membership organisations and a new role as a quasi-regulator of their members/fellow doctors. The primary role of the colleges should be to devise and maintain the specialty standards frameworks. Whilst we accept that the colleges will be in a position to provide advice and guidance to appraisers and responsible officers, this should not prevent other organisations from providing their own advice. Quality assurance in this process should be a responsibility of the GMC and not of the colleges. Whilst advice may be sought from colleges, it should not be to the extent of abrogating the prime responsibility the GMC holds as regulator.

23. Revalidation should not be implemented until workable proposals have been developed for all doctors; it should then be applied to all groups of doctors within a defined period of time. We should, however, bear in mind that many doctors facing PIP procedures are those doctors working in areas where there are either weak or absent local systems available to conduct revalidation. The proposals contained within the consultation suggested that revalidation will be introduced last into those areas, where it is most needed, and first into the areas where it is least needed. Implementation of revalidation in the “easy” areas first will simply lead to a “high-cost, low-benefit” ratio with relatively few troubled doctors being identified, compared with dealing with the higher proportion of doctors in the “hard” areas who may have more complex problems (ie “low-cost high-benefit” group). The GMC’s response to the consultation does not appear to have taken these concerns on board.

24. The pilots must run independently and be fully evaluated with results published and fed into subsequent pilot stages. Presently, the pilots are scheduled to run concurrently.\(^{11}\) We believe that this is the wrong approach as it does not allow sufficient time between each stage to fully consider the implications of the respective evaluations. There is a real risk that the process of revalidation will not be adequately tested and thought through if the pilot process and its timescales continue in this way.

25. It is important that patients and the public have an input into revalidation, primarily limited to quality control, calibration and, ultimately, to participation in fitness to practise procedures. The proposed involvement of multi-source feedback is compromised by the lack of validated tools, thus far, in the development of revalidation.

\(^{10}\) Responsible officer impact assessment, Department of Health, July 2010: http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Regulatoryimpactassessment/DH_117786

\(^{11}\) Revalidation Projects and Pilots, GMC Programme Board, December 2009 states that “in some cases, depending on the readiness or preparedness of organisations, phase two and phase three could run concurrently. Indeed phase three may become part of the initial roll out or implementation of revalidation, as part of an early adopter initiative.”
26. The statement of intent\textsuperscript{12} pledged to make the system simpler, more cost-effective and flexible, taking into account the needs of doctors working in non-mainstream roles and outside the NHS. The BMA is pleased that the GMC has committed to act on many of our key concerns although we remain concerned by the lack of detail that underpins the revision of the GMC plans for revalidation. Given the scale of the revisions to the GMC plans, along with the continued uncertainty about the implications of the White Paper, a considerable amount of work needs to take place before the process is implemented.

27. The BMA is represented on each of the stage 2 pathfinder pilots in England, as well as similar pilots in the devolved nations. These pilots involve around 3,000 doctors across 10 sites and are primarily testing strengthened appraisal and the role of the RO. To date, the pilots have been significantly disrupted by the use of an inadequate electronic toolkit and this has led to participants withdrawing from the process in some cases. Concerns with the toolkit continue to dominate the pilots and it is evident that the participants have to spend a significant amount of additional time to prepare for their strengthened appraisal because of it.

28. Whilst there is an expectation that these pilots will provide “more information and learning about how these [specialty] frameworks work in practice,”\textsuperscript{13} it should be noted that the frameworks currently being tested are those outlined in the GMC’s original consultation documents. A consensus has since emerged that these frameworks are overly-complicated and a process of simplification, outwith the pilots, has begun. As such, further testing of the revised frameworks will be required.

29. We are not involved in the pilots of GMC affiliates in London and West Yorkshire. Nonetheless, this piloting highlights the importance of identifying the full costs—both financial and in terms of clinical and managerial time, of implementing all aspects of revalidation before the process is implemented. There is a risk that revalidation is developed into a robust process that could work, only to find that there are insufficient funds to finance it. The KPMG evaluation of the pilot was positive towards the affiliate model but the subsequent high costs led it to explore a number of lesser alternatives, none of which were tested as part of the original pilots.\textsuperscript{14}

30. In light of our response to the GMC consultation, the BMA welcomed the decision to extend the piloting so that we can be assured that the benefits of revalidation are seen to be robust and achievable. As stated in the Secretary of State’s letter, the pilot extension will “enable us to develop a clearer understanding of the costs, benefits and practicalities of implementation, so that it can be paced in a way that is affordable, supports high-quality care and makes effective use of doctors’ time.” The BMA looks forward to continuing to work as part of the UK Revalidation Programme Board to help ensure revalidation delivers the assurances patients and the public deserve, as well as the support doctors require to help them continually improve their practice.

Conclusion

31. The BMA is pleased that the GMC has acknowledged many of our concerns and we wait to see how the process is revised and streamlined to ensure that it is fair, proportionate and workable. As the owners of this process, the GMC must be pro-active in overseeing this work and, in particular, a significant revision of the specialist standards that have been put forward by the colleges. From the BMA’s involvement in the process, in the stakeholder groups and in the pilots, it is evident that those taking forward the process need to realise that failure to respond to the legitimate concerns of the profession, even if we assume that the various problems discovered by the pilots are adequately resolved, will result in the failure of revalidation. The BMA remains committed to the principle that there is a need for patients to be reassured that their doctor offers a satisfactory quality of care. We look forward to supporting the introduction of revalidation when these issues are addressed.

\textsuperscript{12} \url{http://www.gmc-uk.org/news/8054.asp}
\textsuperscript{13} Paragraph 134, GMC consultation response, October 2010
\textsuperscript{14} GMC affiliates pilots: final report of the KPMG evaluation, November 2009: \url{www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109274}
Written evidence from the Academy of Medical Royal Colleges (REV 05)

The Academy attempts to develop and present a consensus view of its constituent medical Royal Colleges and Faculties.

The Academy and its constituent organisations are charities, existing to maintain and improve the standard of healthcare provided to patients. They are not Trades Unions and do not take part in negotiations on terms and conditions of service.

The Academy and its constituent organisations therefore speak from the perspective of doctors and with the expertise of doctors, but with the intention of maximising the best interests of patients.

**Summary**

— The Academy supports the introduction of revalidation.
— The current proposals aim to make the annual appraisal interview satisfy summative and formative functions. We strongly support this aim. We believe that it is possible, but not easy; there is a risk that a rigid, formal emphasis on the summative elements might produce an inappropriate and inefficient process.
— We wish to streamline the process. We suggest that the GMC’s insistence on checking against 12 “attributes” of good practice at every appraisal is a source of unnecessary complexity. We suggest a simpler alternative that is based on the 12 “attributes”, but which makes their involvement less overt and mechanical (see Paragraph 12).
— It must be accepted that to assess an individual doctor in the context of his/her form of practice will demand some subjective judgements to be made. The need for good, consistent judgement has implications in training, provision of advice, quality assurance and other areas. We fear that these areas have not yet been adequately considered.
— The proposed revalidation process results in potential conflicts of interest. These need to be eliminated or acknowledged and managed.
— Quality assurance is vital and must include quality assurance of outcomes, not just quality assurance of process.
— We have concerns about the potential consequences of enthusiastic reliance on relatively untested IT systems.

**Evidence from the Academy of Medical Royal Colleges**

1. The Academy supports the introduction of medical revalidation. We have worked with all the relevant agencies in an attempt to develop an acceptable and effective system of medical revalidation and to satisfy the responsibilities placed on Medical Royal Colleges in the White Paper, “Trust, assurance and safety: The regulation of health professionals”. We believe that we are close to defining a workable system.
2. We do not wish this submission of evidence to appear negative. Much has been achieved. However, there remain tensions and unresolved questions in a number of areas and it is appropriate for this submission to concentrate on these problems.

**How to assess doctors?**

3. After qualification, the practice of different doctors diversifies enormously, to an extent that makes it impossible to use formal examinations to assess competence. To attempt to do so would be hugely expensive and for many specialist doctors the result would be unfair and irrelevant to their practice. We therefore support the plan to use an enhanced, structured form of appraisal to deliver revalidation. Only in this way can revalidation assess a doctor in the specific context of his/her own practice. Unfortunately, such a system of individual assessment brings problems, notably in respect of defining appropriate standards and ensuring that every doctor is judged fairly against those standards.

**Summative or formative?**

4. It is inevitable in any profession that a few practitioners will fail to maintain appropriate professional standards. Informal discussions suggest that the identity of these doctors is often known to their colleagues, but in the absence of a regular objective evaluation it can be very difficult to force such doctors to improve (or to cease practising). It is therefore appropriate for revalidation to attempt to provide a “summative” tool by which such doctors can be identified with sufficient confidence for appropriate action to be taken.
5. But it is acknowledged that the large majority of doctors practice to high standards. For them, a process designed only to identify inadequate standards risks being a waste of time and resources.
6. Revalidation need not waste resources. Even good doctors often find it difficult to assess their own strengths and weaknesses. It is therefore a legitimate goal of revalidation to provide objective “formative”
assessment of the strengths and weaknesses of good doctors, to help them to improve still further. For most
doctors, confirmation that the minimum standard has been achieved should be as swift as possible, so that
resources can be focused on further improvement.

7. The current proposals aim to make the annual appraisal interview satisfy summative and formative
functions. This is probably possible and certainly desirable, but not easy. It will demand highly skilled
appraisers in large numbers. We believe that whether or not it succeeds will need to be monitored.

*How to make appraisal efficient and effective?*

8. The proposals for revalidation centre on the annual appraisal of each doctor. Through this process, each
doctor will be expected to demonstrate compliance with the 12 “Attributes of good medical practice”, as
developed by the General Medical Council (GMC) from its publication, “Good Medical Practice”.

9. The Medical Royal Colleges were asked by the GMC to set out how doctors in each specialty should
satisfy this requirement. We did as we were asked, but we believe that the resultant specialist frameworks of
evidence for revalidation, as tested in the Pathfinder Pilots, have proved to be cumbersome and inefficient.
This view is supported by the results of the GMC’s recent consultation.

10. We suggest that the GMC’s 12 attributes were developed in the context of the GMC’s experience in
assessing doctors with problems in performance. They are well suited to the summative assessment. But for
most doctors, the complexity of the 12 attributes makes proving adequate performance too time-consuming.
Single items of information about a doctor’s work can map variably to multiple attributes; too much time is
spent considering the mapping, ticking boxes.

11. The GMC has defended its emphasis on the 12 Attributes of GMP with reference to the results of its
recent consultation. But that consultation offered no alternative, nor did it ask how the Attributes should be
integrated into revalidation. It also showed an overwhelming demand for the system to be made simpler and
more proportionate. There is a conflict between these two requirements. We believe that streamlining the
system depends upon making the involvement of the 12 Attributes less overt.

12. We therefore suggest that, having first defined the doctor’s area of practice, the annual appraisal should
start with the doctor undertaking three tasks:

(i) Provide and discuss evidence of the quality of the care you deliver (including outcome measures,
audit, peer review, referral practice, formal proficiency tests as appropriate). The nature of the evidence
that should be submitted, and its evaluation, will inevitably differ considerably between specialties.

(ii) Provide and discuss evidence of what others think of your overall performance (including patient
feedback, multi-source feedback from colleagues, complaints, compliments etc.). This element will
vary less between specialties, although some differences are inevitable—for example, some doctors
do not interact directly with patients.

(iii) Provide and discuss evidence of how you keep your professional knowledge and practice up to
date (ie continuing professional development). The Colleges already provide detailed guidance on
CPD, but the appraisal process should check that the CPD is appropriately tailored to the doctor’s
individual needs.

Simple statements around probity and health may also be demanded by the GMC to complete the coverage
of the “12 attributes”.

13. If the structure of such a portfolio of evidence has been pre-defined so that the information presented
covers the GMC’s 12 attributes then we do not see any reason also to test each doctor mechanically at each
appraisal against each “attribute” in turn. In practice, to do so generates complexity and additional work,
without benefit. If the spread of evidence presented by a doctor is incomplete or raises any cause for concern,
the process can pursue a summative verification of practice against the GMC’s 12 attributes. If not, it should
pursue a formative approach towards further improvement.

14. It is our belief that if doctors are presented with an objective, independent evaluation that questions the
quality of their practice, most will strive to improve their standards. The proposed five-year revalidation system
gives doctors time to do this. As a result we hope that the need for formal remediation processes (or the non-
availability of a positive recommendation for revalidation) will be relatively infrequent. If it is not, then the
quality of the revalidation system must be examined as closely as the quality of the doctor’s practice. Quality
assurance is discussed below.

**Defining Standards; the Unavoidable need for Good Judgement**

15. The White Paper charged the Medical Royal Colleges with setting standards for “recertification”. The
subsequent merger of “relicensing” and “recertification” into one process, “revalidation”, has strong practical
arguments in its favour, but the result has been to diminish the role of the Colleges.

16. The GMC defined generic standards on the basis of its publication “Good medical practice” and the
associated 12 “Attributes of good medical practice”. The Medical Royal Colleges were then asked by the GMC
to set out how, in the context of each specialty, a doctor should produce information or evidence to demonstrate compliance with each of these 12 “Attributes”.

17. This has not been achieved. The results so far contain a few objective measurements, but most represent a discussion of the forms of documentation and evidence that a doctor might provide to satisfy the GMC’s Attributes. They do not define what the content should be. For example, it is easy to say that doctors should undertake some form of audit of their practice each year. It is much harder to define in advance what should be audited and what represents an acceptable result from such audit.

18. This is in part an inevitable consequence of the huge diversity of medical practice. Revalidation not only has to cover GPs and hospital consultants with extremely specialist and overlapping areas of practice. It must cover forensic pathologists, public health physicians, research doctors in pharmaceutical industry, expert witnesses, health tribunal doctors, medical managers and educators of many varieties, and so on.

19. The diversity of medical practice makes it impossible to use formal postgraduate examinations as a revalidation tool, as discussed above. But it also makes it inevitable that the evidence presented, being assessed against the individual doctor’s area of work, can only be assessed by the application of good judgement, not mechanical measurement. This cannot (and must not) be reduced to a tick-box exercise.

20. The need for good judgement as part of this process is problematic, because it raises the possibility of poor or inconsistent judgement. We believe that this has been inadequately discussed. It has been widely assumed that medical revalidation can be delivered on the basis of objective measurements. We do not believe this to be the case.

COVERING UNUSUAL AND COMPLEX FORMS OF MEDICAL WORK

21. Revalidation has been developed and piloted almost entirely in the context of NHS practice. We remain concerned that doctors in unusual types of medical practice will find it difficult to comply with the “12 attributes” approach of the GMC, and we commend the simplified approach set out above as a way to resolve this.

22. Some doctors undertake several radically different forms of work. It is self-evident that they must maintain their standards in all of them, but it is not yet clear how this will be confirmed. It is a matter of concern that the process could be extremely onerous.

23. Some doctors work in several different institutions or environments; sometimes undertaking similar work in each, sometimes radically different types of work in each. It is self-evident that information from all these workplaces should be available at the appraisal process, but it is as yet not entirely clear how this will be achieved. There are concerns that commercial confidentiality and other barriers will inhibit the flow of the necessary information.

DELIVERING GOOD AND CONSISTENT JUDGEMENT

24. We suggest that the delivery of good judgement of the quality of practice is possible only if the appraiser understands the appraisee’s work, so wherever possible both should be from the same or a similar area of practice.

25. We suggest that good judgement will require appraisal training in the context of the specialty in question, not merely generic training.

26. We suggest that if there is any hope that the delivery of this process is to be consistent across the UK, then this training will have to be developed and preferably delivered on a national basis. The Medical Royal Colleges anticipate that they will have a leading role in developing and delivering this training, but we are concerned that an adequate source of funding to support this work has not yet been identified.

27. Despite our best efforts, it is inevitable that judgements will vary to some extent. This has a number of consequences:

(i) Over the five year cycle, each appraisee should be evaluated by a number of different appraisers.

(ii) Uncertainty and disagreement is inevitable, so we should be prepared for it. An efficient mechanism should be available by which appraiser and appraisee can obtain independent advice. To ensure consistency, this too should be coordinated at a national level. The Medical Royal Colleges expect to have a role in delivering this advice, but to do it well will demand resources and a source of funding has not yet been identified.

(iii) A quality assurance system is vital. This is discussed below. It should assess the quality of judgement, not just the quality of process, and it should start at the appraisal interview, not at the recommendation of the Responsible Officer.

CONFLICTS OF INTEREST

28. The inevitable need for good judgement, rather than mechanical measurement, makes it particularly important to avoid conflicts of interest in those who make the judgements.
29. A conflict of interest is generated by the proposal that the Responsible Officer, who makes the final recommendation on revalidation to the GMC, should normally be the Medical Director. The Medical Director has responsibilities to deliver the targets of the employing organisation. In some circumstances these could differ from, or even conflict with, the ideals of good practice. For example, a doctor whose standards are questionable might be essential to delivering a service and difficult to replace; would the Medical Director then be as stringent as with a doctor who delivers adequate care, but too slowly to meet Trust targets?

30. There are of course many other potential sources of conflict of interest, including personal and financial sources.

31. There are differences of opinion within the Academy as to how this problem should be addressed. Some Colleges take the view that the Medical Director should not be the Responsible Officer. Others take the view that the Medical Director is a reasonable choice, as he/she is in a good position to understand problems and deliver solutions; the problem of conflicts of interest should then be managed by recognising the conflict and having transparent processes to deal with it.

32. Whatever the outcome of this debate, it is agreed by all that part of the solution will be to have a robust quality assurance system, whereby poor decisions can be identified and corrected. Responsible Officers and appraisers must themselves be subject to revalidation; those who repeatedly make poor decisions (in either direction) should be subject to the same processes as doctors who make poor decisions in other areas of medical practice.

**Quality Assurance**

33. The need for quality assurance of revalidation has been widely accepted. However, action has been based largely around quality assurance of process, such as the AQMAR tool developed by the Revalidation Support Team. There has been comparatively little work done on the quality assessment of outcomes. We believe that this is at least as important as process, and arguably more important, because of the need to monitor the quality of judgements made, as discussed above.

34. The GMC has had some preliminary discussions with us about how to achieve quality assurance of judgement, but as yet with no firm decisions and no pilot testing.

35. To deliver independent audit of revalidation decisions will be technically difficult and will have resource implications. This must not be allowed to derail the process, because it is essential if patients and doctors are to have confidence in the system. We note with concern that the GMC consultation report mentions only “a possible GMC programme of sampling and auditing” (our emphasis).

36. We believe that quality assurance of judgement should take several forms.

   (i) Whenever a decision is made not to recommend revalidation, but the subsequent GMC Fitness to Practise Panel decides that revalidation is appropriate, there should be a detailed external review of the revalidation process in the relevant institution.

   (ii) Conversely, if a doctor who has achieved revalidation is found by the GMC (by some other route) to be unfit to practise, there should be a detailed external review of the revalidation process in the relevant institution.

   (iii) There should be ongoing selective independent audit of the judgements made by responsible officers and, if possible, appraisers.

37. To make an audit of outcomes more efficient, it should be targeted on areas or institutions that are regarded as “high risk”. The GMC has developed preliminary proposals as to how this might be achieved. These mechanisms will need to be monitored and updated.

38. We believe that our Fellows and members of the public will expect the Medical Royal Colleges to have a prominent role in quality assurance of revalidation, especially in quality assurance of outcomes.

**Making it Cost-effective**

39. We anticipate that there will be disagreements about the overall cost of introducing revalidation. To a large extent this is because of a lack of clarity about what items should be included in the cost. If all doctors were already participating fully in all the various elements—appraisal, CPD, audit, and so on—then the cost of tying these together into a revalidation system should not be huge and will, we believe, represent acceptable value for money. However, we are far from such full participation in all these elements, so in practice the overall increase in cost may be considerable.

40. However cost is measured, we have a duty to make revalidation as efficient as possible, consistent with its achieving its aims of protecting patients from bad doctors and helping good doctors to get even better.

41. We should not accept that the model initially implemented is necessarily the best, but should strive for continuous improvement of efficiency. We should periodically review whether the system is delivering value for money.
42. We believe that the pilots undertaken so far have identified ways to improve efficiency and that ongoing feedback and evaluation of the pilots will provide more. As a result we welcome the Secretary of State’s decision to delay implementation by one year. It would have been unwise to implement revalidation immediately the Pathfinder pilots have concluded, without time to analyse the results.

**Information Technology**

43. We are particularly concerned about IT support. This was initially identified as an essential tool to make revalidation more efficient, but (despite considerable expense) the e-tool commissioned by the Revalidation Support Team for the Pathfinder Pilots is proving to be cumbersome, unreliable and unpopular.

44. We understand that when revalidation “goes live” there will be no “officially approved” system of IT support and that commercial suppliers will be invited to offer their products to individual organisations. This may well be a good method to ensure the development of good solutions over time, but it means that revalidation will “go live” using relatively untested software.

45. This leads us to suggest that, at least in the initial implementation, revalidation should be designed to demand as little reliance on IT support as possible. For example, systems that demand that all documentary evidence to be presented at appraisal is scanned and uploaded to a central server risk heavy resource utilisation at best, and could easily make revalidation impossible for some doctors.

**Deciding when to “Go Live”**

46. We agree with the proposals outlined by the GMC. A date by which all doctors must be involved in revalidation must be set and publicised well in advance.

*November 2010*