House of Commons
Health Committee

Revalidation of Doctors

Fourth Report of Session 2010–11

Volume II

Additional written evidence

Ordered by the House of Commons
to be published 1 February 2011
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.

Committee staff

The staff of the Committee are David Lloyd (Clerk), Sara Howe (Second Clerk), David Turner (Committee Specialist), Steve Clarke (Committee Specialist), Frances Allingham (Senior Committee Assistant), and Ronnie Jefferson (Committee Assistant).

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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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Written evidence

Written evidence from Dr Anton E A Joseph (REV 03)

Revalidation and Clinical Governance

The now celebrated definition of Clinical Governance, introduced by Sir Liam Donaldson is given below.

“National Health Service organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish”

The introduction and practice of clinical governance was not straightforward and was not well understood in the early days. Dame Janet Smith in her Shipman Inquiry Report was perhaps the most important individual to express her concerns. She stated, “I personally did not find that definition easy to understand and it did not seem surprising, that in the early days at least, there was a great deal of confusion and uncertainty in the medical profession about the concept of clinical governance and about what it would mean in practice.” Perhaps she gave in, to a degree of intellectual snobbery!

The GMC in its consultation document place a high level of clinical governance in the revalidation process. It should however be noted that the above definition is for an organisation and revalidation is needless to emphasise is for the individual. There has been little acknowledgment of this in their post consultation document, in spite of the arguments given here below.

1. Revalidation should be kept simple. While it is appreciated that the GMC consultation should cover all aspects of revalidation, an enormous amount of time and money has been spent in what might have been approached in a simpler and more logical manner. Obviously my submissions to the consultation process has not been taken into account.

2. I therefore kindly request the select committee to give consideration to the following basis for revalidation. This is based on aspects of clinical governance and defined for the individual as:

3. A framework in which an individual is held responsible to comply rigorously with the guidelines for good medical practice, assessed for the provision of high quality healthcare and the maintenance of the means by which it can be delivered.

This identifies what is expected of each individual and is precise in its requirement.

4. There are three components incorporated in this definition:

   — Held responsible for good medical practice—Requirement to abide by the guidelines laid down by the GMC, the Royal Colleges, DoH and other relevant organisations.

   — Assessed for the provision of high quality healthcare—through the pathways set out for the revalidation process: appraisals and, above all, through audit. The GMC independently recognised “that all doctors must be able to demonstrate that they can continue to be fit to practise in their chosen field”. Faced with mounting criticisms the GMC moved away from the initially chosen routes to demonstrate Fitness to Practice. However there has been significant criticism about appraisal being the preferred route chosen by the GMC, not least by Dame Janet Smith. Perhaps the best means of assessing delivery of service would be through the well established and widely practised audit system: a measure of performance through outcomes. This could resonate with the original purpose of the GMC, namely Fitness To Practice.

   — Maintenance of the means by which it can be delivered—Continuing Personal Development, adherence to evidence based practice. Achieving aims and objectives clearly set in advance.

It is my view that the fulfilment of these three components would comply with the requirements of clinical governance and would provide the key components for revalidation. It will establish the individual’s fitness to practice: the whole purpose for revalidation

5. Appraisals clearly will be the mainstay to help career development. Several components of the appraisal system will contribute to the above three categories.

An appraisal system operating on a one to one basis will be subject to criticism. It will be subject to abuse. It is an invitation to abuse. The majority of doctors will abide by the requirements and follow a legitimate path. It is almost certain that a small number will abuse the system. Dame Janet Smith was highly critical of the appraisal system. A fancy name does not reduce the possibility of fraud. The enhanced appraisal if practised is better than the previous version. A mountain has laboured and brought forth a mouse as far as credibility of the scheme goes. It is a matter of time before malpractices get exposed and would not be long for another Dame roundly criticise the GMC for persisting with it. It would be an indictment of the profession not the GMC.

6. This presentation dares challenges the respected and admired concept of Clinical governance as defined at present which was formulated for the institutions. Revalidation is for the individual and therefore an appropriate definition as above should be invoked.
The GMC is proceeding relentlessly believing revalidation can rely on clinical governance which few people are in a position to define as applicable to an individual. The delay to implementation of revalidation may have given us some breathing space.

7. Alternatively a description of Clinical Governance incorporating governance for the individual and for the institutions should be formulated combining the two.

8. In the pre clinical governance era the individual took all the responsibility and the blame. Sir Liam’s concept of CG is a great advance in shifting significant responsibility on the institutions. However the pendulum has now swung too far with the individual out of the picture at a time the government is pushing decentralisation.

Delivery of health care can only be achieved through harmonising the corporate responsibility and the individual responsibility.

**REVALIDATION AND CLINICAL EXCELLENCE AWARDS SCHEMES SHOULD BE MERGED: A LOGICAL AND ECONOMIC MOVE**

As is being rolled out the Clinical Excellence Awards (CEA) Scheme and the Revalidation scheme for the hospital consultants will run in parallel. This is totally wasteful in time and money. It was the intention of the previous government that two thirds of all consultants would have received awards at the time of retirement. The following description applies to hospital consultants but can be extended to all doctors and general practitioners.

— CEA’s are rewards for doctors making contributions over and above their contractual requirements. The ACCEA requires doctors to provide evidence for revalidation for consideration for awards.

— It should never happen that a doctor could possibly receive a CEA and at the same time does not satisfy the requirements for revalidation. If it does there is something grossly wrong with the process.

— It is therefore reasonable to conclude that all doctors who receive awards would and should fulfil the requirements for revalidation.

— Is it necessary for two separate committees to decide this independently.

— Should a consultant who was found worthy of an award be required to prove being worthy of being revalidated. It would be a farcical set up if the consultant fails to be revalidated.

— The vastly experienced awards committees that function in each trust could be expected to recommend the suitability of the individual for revalidation to the Responsible Officer: a technical requirement due to an ill thought out law on Responsible Officers. Revalidation cannot at present be undertaken by a committee. It is the responsibility of the RO to make the recommendation to the GMC, but surely the RO can take advice.

— The decision to revalidate or not supported by a committee will have a greater credibility than if it is to be based on the evidence gathered by the RO alone. Perhaps the law needs to be amended.

— The awards committees function in each Trust. Above all they serve on the committees for no remuneration.

It is not possible in this brief submission to expand the details. The DoH should be required to give consideration to similar schemes that utilise currently operating schemes. The schemes could be synchronised for consultants applying for award to be considered for revalidation in the first instance or simultaneously.

**RESPONSIBLE OFFICERS**

Highly inappropriate powers have been provided to the ROs’ in the revalidation process. The number of challenges by consultants is bound to rise if it is an individual’s decision. So called safeguards will not prevent a significant increase in the number of Wendy Savages’. Any recompense is always too late for the individual. An individual performing this function is highly unacceptable to many. It is most popular among medical directors who will automatically assume the role. One must pause to ask why!!

*October 2010*

**Written evidence from NHS Highland (REV 06)**

**ENHANCED APPRAISAL—NHS HIGHLAND**

**SUMMARY**

— Scottish Government contracted NHS Highland in December 2009 to pilot enhanced appraisal of consultants employed by NHS Highland.

— Interim report presented on 26 October 2010 to Scottish Government’s 3rd Annual Regulation Conference, with final report due December 2010.
— Pilot led by Consultant Orthopaedic Surgeon and supported by the Academy of Medical Royal Colleges and Faculties in Scotland and by the Scottish Government’s National Appraisal Leads Group.
— 28 consultant volunteers recruited and trained by NHS Education Scotland (NES) in enhanced appraisal, and are currently in the process of each appraising one other consultant.
— 360 degree multi-source feedback (MSF) has been undertaken with patients and colleagues.
— Volunteers are feeding back on their experience of delivering enhanced appraisal and the challenges involved.
— Quality review being undertaken by NHS Quality Improvement Scotland (QIS).

1. The Scottish Government was keen to “effectively implement within Scotland the UK policies set out in the Government White paper on Regulation of Health Professions, taking account of the differing needs of, and structures, services and agencies within, a devolved health service in Scotland”1.

2. NHS Highland was contracted in December 2009 to pilot the feasibility of enhanced appraisal across a cohort of consultants from different specialties. The pilot is supported by the Academy of Medical Royal Colleges and Faculties in Scotland and by the Scottish Government’s National Appraisal Leads Group.

3. The documentation which is being piloted was developed by the Scottish Government’s National Appraisal Leads Group, designed by the Medical Director NHS Fife, and building on the GMC’s Good Medical Practice framework of four generic domains with 12 attributes.

4. 28 consultants across 13 specialties have completed enhanced appraisal training delivered by NHS Education Scotland in conjunction with GP and Secondary Care trained tutors. Only two of these consultants subsequently had to drop out of the pilot.

5. 360 degree multi-source feedback from patients and consultants is being analysed by Peninsula Group, and quality assurance is being undertaken by NHS Quality Information Scotland.

6. The final report will be available from the Scottish Government by the end of December 2010.

November 2010

Written evidence from Sir Donald Irvine CBE (REV 07)

INTRODUCTION

I was the President of the GMC responsible for the introduction of revalidation policy in 1998, and earlier chairman of the GMC Standards Committee which initiated the development of the GMC’s Good Medical Practice.

Today, in partial retirement, I chair the Board of Picker Institute Europe, a UK charity which assesses and publishes patients’ experience of health care; I am a board member of Picker Institute Inc in the USA; I chair the Ethics Committee of Dr Foster Intelligence; I am a Vice-President of the Patients’ Association and President of Age UK Northumberland; and I am an Honorary Professor in the Department of Medicine and Health in the University of Durham. I am also a patient myself.

This experience gives me a fair insight into patients’ expectations of doctors and their performance.

SUMMARY

— The most critical question today is whether the GMC, medical profession and government have the will to make revalidation work effectively for patients, without further delay.
— The GMC should tell the public, in plain language, what standards of everyday practice they should expect from their doctors.
— Greater clarity is needed on the standards thresholds to be used for revalidation and in the underpinning fitness to practise procedures.
— The place for an assessment of knowledge within the context of continuing professional development should be reconsidered.
— The GMC should require published clinical outcomes data for revalidation in all specialties where this is feasible.
— The GMC’s plans for assessing patient experience are insufficient, and should be reconsidered from first principles.
— Non mainstream doctors who cannot supply evidence of performance of sufficient quality for revalidation should take an examination.

— The potentially important relationship between revalidation and commissioning should be explored and developed.
— The GMC should be held to account by Parliament in future through public hearings held by the Health Select Committee.

**CONTEXT**

In considering progress with revalidation, there is important historical context which is relevant and needs to be restated here so that we can be clear why we are where we are today. For the last half century and more the British medical profession has enjoyed a generally good reputation with the public. This reputation, based on the conscientious practice of a majority of doctors, has tended to obscure the fact that over a long period of time the profession, perversely, has been prepared to tolerate mediocre or very poor practice from a minority of its members. The reasons include self-interest expressed through a misplaced sense of collegiality (i.e. we must all stick together), and the lingering survival of early 20th century ideas of professional autonomy which still lead some doctors to think that, once “qualified”, they have virtually unfettered discretion as to the standards of practice they will choose to follow subsequently.

4. Over the last 30 years or so successive governments have attempted to deal with this problem by making the profession more accountable for the performance of its doctors, mainly through contract of employment measures in the NHS. None have been successful—hence the continuing problem. Revalidation, actually an initiative by the GMC itself following the failures in paediatric cardiac surgery at Bristol Royal Infirmary, was designed to provide a nationwide solution through the use of the ultimate power of licensure on a continuing basis. Revalidation thus replaces reactive professional regulation with a proactive system in which doctors become personally responsible for demonstrating regularly that they continue to be fit to practise in their chosen field.

5. Not surprisingly, the GMC has encountered a strong rearguard action from within the rank and file of the profession designed to try and make sure that the process of revalidation would be as benign, undemanding and unchallenging as possible. The challengers have demanded, for example, that appraisal should be essentially formative and developmental—a “cosy chat”- never robust and summative; direct, objective evidence of competence and performance should be avoided where possible; and the public should be excluded from individual revalidation decisions.

6. The challenge nearly succeeded when, in 2001, the GMC, under strong pressure from the BMA and others, was persuaded to water down its originally reasonably robust proposals to an annual appraisal unsupported by direct evidence of performance. “Five satisfactory appraisals equals revalidation” is how the press described it. The government of the day, by its inaction, seemed to agree, and protests from some within the profession (myself included) fell on deaf ears. It was Dame Janet Smith, in her Shipman Inquiry, who brought matters to a head by showing that the GMC’s latest proposal had been weakened to a point where it would not comply with the new legal requirement for revalidation, namely, that revalidation should be “an evaluation of a doctor’s fitness to practise”(1). Dame Janet’s analysis caused the government and the GMC to revert to the original evidence-based approach by means of another review completed by the Chief Medical Officer of England in 2005(2).

7. The price of this period of appeasement has been a huge delay in implementing this potentially significant contribution to patient safety. Compounding this, organised medicine is still—with some notable exceptions—reluctant energetically to develop and use methods suitable for assessing established doctors’ performance and the outcomes of medical care. Thus, the critical question today is whether the GMC, the medical profession and the government have the will, singly and together, to give the public and patients the assurance they expect of good practice from all doctors practising in the UK in future.

8. **ESTABLISHING REVALIDATION**

Against this background, I offer the following comments on the way the GMC proposes to establish revalidation. Since I support the direction of travel and the general approach they should be taken as suggestions for improvement to current methods.

9. **A benchmark for patients**

Good Medical Practice is excellent and should be used as the foundation for revalidation. However, it is written primarily for doctors. 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.
10. Clarity on the bar for standards

The GMC needs to tell the profession and the public what threshold of practice it intends to use for revalidation. Is it to be optimal practice, which is the best that can be achieved under normal practising conditions? That seems to be what patients instinctively expect. Or is it to be something less than that, a minimum standard, and if so how minimal is the minimum? The question applies to decisions made in the course of the revalidation procedures themselves, but equally to the GMC’s fitness to practise procedures. These latter procedures are the backstop for revalidation; they will be the means by which the GMC finally decides, in cases of doubt, whether a doctor can continue to have an unrestricted license to practise.

11. The question was explored in 2004 by Dame Janet Smith, at the time of her Shipman Inquiry (3). The nub of the argument, set out in paras 26.98, 26.180 and 26.181 of her report, is that the “remarkably low” standard above which doctors will be revalidated does not square with the claim that revalidation gives an assurance that the doctor is “up to date and fit to practise. Today it would appear that some GMC panels are still giving doctors the benefit of the doubt, signing off some doctors as fit to practise when colleagues who have referred them, or who have done preliminary investigations, or who have attempted remediation, still have serious concerns.

12. This matter must be clarified urgently and resolved, once and for all, for if the foundation for continuing licensure is shown to be unsound the whole revalidation exercise becomes pointless in terms of protecting patients. If nothing else, The Health Select Committee could assist all concerned by helping the GMC and the profession to get to an answer which is right for patients as soon as possible. It all boils down to how determined the GMC, the medical profession and the government—all three—are prepared to be in making sure that the public are properly protected from the insufficiently competent doctor.

13. The assessment of knowledge

In the development of revalidation few things have been more contentious than the question of whether doctors’ knowledge should be tested. For patients, the matter seems straightforward—in the 2005 government survey on revalidation the public put being up to date at the top of their priority list, with outcomes second (4). It would be difficult for doctors to be able to claim to be up to date without being able to show that they know what they are supposed to know and therefore that they know what they are doing. It is a self-evident truth that modern medicine is heavily dependent on knowledge coupled with higher order problem solving skills. The medical profession in the USA has acknowledged this by making a knowledge test the only mandatory part of their national Maintenance of Certification (ie revalidation) procedures (eg 5, 6). And it is almost certain to apply when relicensure becomes operational.

14. However, in the UK the profession is divided. On the one hand the BMA has said that as a matter of “principle” knowledge testing should form no part of revalidation (7). This sits rather oddly given that the profession is proud of the excellent assessment instruments which it uses rigorously and systematically in the training which leads to basic qualification in medicine and subsequently in the preparations for specialist or general practice. On the other hand there is the approach being taken by the Society of Cardiothoracic Surgeons of Great Britain and Ireland (8). Even though they are the only specialty to record and publish their powerful clinical outcomes on a continuous basis, they have in addition decided strongly to recommend to their members that they should complete an on-line SESATS formative assessment of knowledge and problem solving skills every five years, as part of their continuous professional development. Indeed they plan to offer this assessment without charge as part of their service to members.

15. My own view is that our cardiac surgeons (and the Americans) are right on the need to assess and demonstrate essential knowledge as one element of the evidence for revalidation. This is especially true in those subjects where it will be very difficult to develop valid measure of outcome—general practice, and geriatric and psychiatric medicine are examples—and where checking knowledge and skills would be an economical and effective alternative. I hope that the Select Committee will commend the stance of the UK cardiac surgeons, and ask the GMC to explain why other parts of the profession should not do something similar. I am sure the public would appreciate the degree of added objectivity and rigour such an approach would bring, at minimal cost to the doctor and no cost to the taxpayer.

16. Clinical outcomes

Well developed clinical outcomes are an excellent indicator of clinical performance and, wherever possible, must become the central part of the evidence for revalidation. I have referred earlier to the data produced by the UK cardiac surgeons to illustrate the point. Their evidence of clinical success, reported day by day by individual surgeons, is very impressive. It contributes to quality in its own right and will be their basic evidence for revalidation. I am struck by the impact that their imperative for quality data has had on forcing improvement in the quality of clinical governance and patient care. Their motivator was Bristol. Now, revalidation must become the motivator needed to generalize from their experience across the broader spectrum of medicine. We have no other instrument with comparable reach and the potential power to change practising culture. Therefore, I would urge the GMC to be ambitious and far-sighted, to raise its game, to require outcome data for revalidation from other specialties—especially others in surgery—to drive quality in the NHS. The time is
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propitious because of the declared commitment of The Coalition government to give priority to clinical outcomes. This is the way of the future.

17. Patient experience

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.

18. I agree with comment being submitted by the Picker Institute Europe that this strand of evidence needs to be rethought from first principles. With the deferred date for implementation introduced by the government there is an opportunity to do just that. This is a fast developing aspect of healthcare where new instruments and technologies have the potential to bring more sophistication to assessment than is envisaged in the GMC’s current plans.

19. Non mainstream doctors

I fully appreciate the difficulty some doctors in this category will have in being able to produce evidence of performance of an acceptable quality. Since, inevitable, relatively little is known about the capability of many of these doctors, I believe they should be revalidated early in the introductory cycle. Think of the locum Dr Ubani—I suggest that his basic clinical deficiencies would have been detected, and loss of life prevented, if he had been properly assessed for revalidation before being allowed to practise here. So I think the GMC should grasp the nettle, and ask these doctors to complete a five yearly assessment. This was first mooted as an obvious solution some years ago now. Many of them might be quite relieved to have uncertainty removed. The start-up assessment instrument could be PLAB, which is up and running, and successful.

20. Commissioning

If commissioning is to be successful, commissioners will want to seek evidence that the medical practitioners from whom they will purchase care will, amongst other things, be capable of providing personal medical care of a good standard. Successful revalidation should be the indicator of that standard. By the same token, patients will want to know that general practitioners commissioning care on their behalf are themselves in good clinical standing, and therefore to be trusted by them with commissioning decisions. In this context, everything points to the importance of establishing revalidation from the outset as a reliable indicator of clinical quality and modern professionalism, and therefore as an important component of commissioning.

21. The GMC’s accountability to Parliament

Lastly, I mention accountability because I believe that the current method of holding the GMC to account by Parliament is insufficient, and should therefore be reconsidered.

22. The GMC, as the medical licensing authority, carries the ultimate responsibility for the effectiveness of the professional regulatory system. Parliament gave it the power to license doctors, to hold the specialist and general practice registers, and to have overall supervision of all stages of medical education. Only the GMC can say who shall practise medicine in the UK and who shall not. Ultimately only the GMC can say what “goodness” and “poorness” mean, in terms of doctors’ competence and performance. Therefore, the public is utterly dependent on the integrity of licensure and specialist certification.

23. 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 recognized and sought when in 2006 it responded to the CMO’s report on revalidation. Subsequently, the government strengthened the reporting requirements from the GMC to the Privy Council and specified that copies of these reports should be laid before each House of Parliament.

24. This mechanism is insufficient and lacking in transparency. For these reasons I wish to revive a proposal I first put forward in 2001(9). Parliament should establish a Select Committee mechanism for conducting a regular review of the GMC, rather like US Congressional Hearings, designed to hold it to account for the integrity and good performance of all regulatory functions for which it is ultimately responsible. The Committee, armed with thorough analysis of its performance prepared by an independent organisation like the National Audit Office, would question the chairman and chief executive of the GMC, in front of the television cameras, about the Council’s stewardship of medical regulation and medical education. Ideally, there would be a transparent mechanism for letting the public ask questions also. Dame Janet Smith’s methods of assessing the GMC’s performance in the Shipman Inquiry give an excellent insight into how such reviews could be made to work well. They would give the public the chance to judge for itself whether the medical profession continues to meet expectations.

25. References


3. The Shipman Inquiry, see pages 1057, 1083–85.


October 2010

Written evidence from Mencap (REV 08)

Mencap is the UK’s leading learning disability charity, working with people with a learning disability, their families and carers. We want a world where people with a learning disability are valued equally, listened to and included. We want everyone to have the opportunity to achieve the things they want from life.

MENCAP’S RESPONSE

Mencap believes that revalidation needs substantial overhaul if it is to truly protect all patients, including those with a learning disability. This work needs to also be considered in the context of improving the fitness to practice work of the registering bodies.

At present, people with a learning disability experience significantly higher levels of illness than the general population, including diabetes, asthma and heart conditions. People with a learning disability are 58 times more likely to die before their 50th birthday than the general population.

Doctors, working in any healthcare setting, have a critical role to play in ensuring that patients with a learning disability are able to not only live longer, but also live healthier. Revalidation is crucial in ensuring that healthcare delivered to all patients, including those with a learning disability, delivers consistently high outcomes. Current GMC proposals round revalidation are too heavily weighted in favour of the convenience of doctors, rather than ensuring better outcomes for patients.

Mencap are pleased that the Health Select Committee has chosen to look at how the revalidation of doctors works. Mencap believes that revalidation needs substantial overhaul if it is to truly protect all patients, including those with a learning disability.

Healthcare for All (commissioned by the Department of Health in response to Mencap’s Death by Indifference report) highlighted revalidation as a key method for driving standards of care and avoiding premature death. While the Department’s recent 6 Lives Progress Report (2010) showed that there have been improvements to services, families across the country still continue to tell Mencap about the poor experience they have received from many doctors, including:

— Doctors making little effort to communicate with a patient with a profound and multiple learning disability.
— Carers saying that input is routinely ignored by doctors.
— Evidence of doctors making prejudicial quality of life assumptions, particularly around Do Not Resuscitate orders.
— Frequent diagnostic overshadowing by doctors, who see the disability and fail to act early to tackle the underlying, and often worsening, health condition.

Mencap believes that improving health outcomes for patients with a learning disability will require both an attitudinal shift as well as a strong and inclusive revalidation process requiring doctors to make reasonable adjustments. Mencap believes that doctors should be asked to provide evidence as to how they have made reasonable adjustments for people with a learning disability (as well as their carers) in order to be revaluated. Such evidence could look at how doctors have adjusted their practice in ways such as:

— Intervening earlier when coming into contact with a patient with a learning disability, particularly when the patient is non-verbal.
— Doctors’ level of understanding by the doctor of mental capacity legislation.
— As well as some of the more “low level reasonable adjustments” including: information provision, longer appointment lengths, linking with community teams (or secondary medicine)—and how these have led to better health outcomes.

Mencap believes all doctors should be able to consistently offer good care for all patients. Current GMC proposals appear to be far too weighted in favour of not inconveniencing doctors. They make almost no reference to patient safety—a clear omission in Mencap’s view.

The proposed GMC timescale for revalidation of five years also feels too far tilted towards the interests of doctors and institutions rather than ensuring the confidence of patients with a learning disability.

Mencap welcomed the GMC proposals for engaging the public in the revalidation of doctors. Their consultation proposed that patient views would be garnered through patient survey, conducted by the hospital or GP surgery. This poses three difficulties:

— Having a learning disability necessarily means having a difficulty in communication—extra effort needs to be made to record the views and experiences of patients with a learning disability.
— If a person’s experience with a GP has been poor, the willingness of the patient or to engage with an survey not in accessible formats (such as easy read pictures and symbols) is likely to be low.
— Those that experience the worst outcomes may be least well represented in patient feedback.

Mencap believes revalidation should make explicit reference to the fact that for many people with a learning disability, written communication is not possible and other options, including support, should be offered as a routine.

**Conclusion**

The rights of patients with a learning disability are protected by law.

It is vital that revalidation ensures that doctors provide practical evidence as to how they have made reasonable adjustments for patients with a learning disability, if we are to continue to drive up health standards.

*November 2010*

**Written evidence from the Royal College of Anaesthetists (REV 09)**

**Summary**

— The Royal College of Anaesthetists (RCoA) supports the General Medical Council’s (GMC) intention to ensure revalidation is as streamlined, straightforward and proportionate as possible. The call for simplification by some responders to the GMC consultation should not, however, result in a system that is unfit for purpose; namely one that does not adequately provide assurance to the public that doctors are fit to practise with no concerns about quality of care and patient safety.
— We support current plans from the Department of Health and NHS Revalidation Support Team for a system of strengthened medical appraisal that is both formative and summative. It is important that appraisal adequately considers the generic and specialist standards that doctors are required to meet. A framework and system must also be place that facilitates self-reflection on personal and team practice and performance. The RCoA has already taken steps to support anaesthetists (both appraisers and appraisees) preparing for strengthened medical appraisal through developing guidance and educational resources and activities.
— The specialist standards set by the Royal Colleges should help define any framework for appraisal and revalidation so that the process is relevant and meaningful for specialty doctors. The anaesthesia, intensive care and pain medicine specialty standards should act as signposts and provide guidance as to the knowledge areas, skills, attitudes and activity levels that all anaesthetists are required to demonstrate, and in doing so, provide assurance to the public that revalidation is robust and fit for purpose. We recognise further work needs to be done as to presentation of the specialty standards in reducing the complexities perceived in revalidation. In particular, in relating the standards to two key areas—in defining the attributes or qualities expected of anaesthetists, intensive care and pain medicine specialists and, secondly, in defining acceptable levels of supporting information in terms of quality, quantity and how it is produced for discussion at appraisal.
— We support a structured system of peer or colleague feedback in deriving supporting information for revalidation. Workplace colleagues are well placed to offer an informed opinion as to a doctor’s professional skills and behaviour and there is clear evidence that this feedback is beneficial for informing on an individual’s professional development planning. If an appropriate system is in place it will provide a well informed and balanced source of information and insight about a doctor’s professionalism.
— In regard to patient feedback in revalidation we believe more work needs to be done in establishing an evidence base as to its validity (as a source of information about a doctor’s professionalism) and added value (in terms of quality and compared to other, already existing, sources of evidence demonstrating patient satisfaction with health care and services). Specifically, in regard to anaesthesia, it is our current opinion that patient questionnaires are not appropriate in generating supporting information due to the nature of work in this specialty and clinical relationships with patients—they may, however, be more relevant to the practice of pain medicine.

— The current GMC proposals for quality assurance must be developed to consider both processes and outcomes, adequate sampling sizes and a positive role for the Royal Colleges. In gaining the buy-in or support of doctors for revalidation they must be assured that it is not solely a GMC process but one that has been validated by expert external and independent professional bodies such as the Royal Colleges. Our concept of quality assurance also extends to one of providing specialty specific advice and support to appraisees and appraisers so that appraisal is delivered consistently, equitably and to acceptable levels.

— We welcome the GMC’s statement that the introduction of revalidation is a shared responsibility involving the regulatory authorities, Royal Colleges and other key stakeholders. However such an embrace does necessitate an explicit course of action for each stakeholder involved, which is coordinated and strategic, making best use of individual expertise and at the same time reducing the duplication of effort and work. The GMC will no doubt be at the centre of all this and a good effective working relationship with the Royal Colleges, via the Academy of Medical Royal Colleges, will be essential in introducing revalidation.

BACKGROUND TO THE RCoA

1. The Royal College of Anaesthetists (RCoA) is the professional body responsible for the specialty of anaesthesia throughout the United Kingdom. Our two Faculties of Pain Medicine and Intensive Care Medicine look after the professional interests of doctors in these specialties. The activities of the RCoA are varied, but include the setting of standards of clinical care, organising a system of continuing professional development and the provision of guidance and support to our 14,500 Fellows and Members.

2. As a specialty anaesthetists, intensive care and pain medicine specialists are the single largest group of hospitals doctors. Their major role lies in providing anaesthesia during surgery, but this role is ever widening and anaesthetists are also involved in the preparation of surgical patients, the relief of post-operative pain, in obstetric units, in cardiac arrest teams, in intensive care units, in accident and emergency departments, in chronic pain management, in acute pain teams, in dentistry, in psychiatry for patients receiving ECT, as well as the provision of sedation and anaesthesia for patients undergoing radiology and radio-therapy procedures. Anaesthetists, intensive care and pain medicine specialists are also widely involved in the teaching and training of undergraduate medical students, postgraduates, nurses and many other paramedics. They may also lead or manage the various departments in which they play a major role such as day surgery, operating theatres, recovery units, high dependency units, critical care services and resuscitation services.

SIMPLIFICATION AND STREAMLINING

3. The RCoA supports the GMC’s intention to ensure revalidation is as streamlined, straightforward and proportionate as possible. However this intention and calls for simplification should not diminish the robustness of the overall process so that revalidation is no longer fit for purpose. Contextualising this statement is that revalidation must be about providing assurance to the public that doctors are fit to practise with no concerns about quality of care or patient safety; and also the process must be a positive one in motivating formative development within the profession. Over-simplification may well challenge these principles.

4. The robustness of the process is, in our opinion, dependent on the specialty standards that doctors will need to consider when revalidating. The specialty standards set by the Royal Colleges represent the core values held by specialty doctors and the minimum levels of practice expected of them. Diminishing the recognition of these specialty standards during appraisal will represent an over-simplification of the revalidation process. Whatever framework for appraisal and assessment is finally decided upon the specialty standards should define the main elements or attributes that make up that framework. Without consideration of the specialty standards, appraisal will be meaningless and not relevant to a doctor and their specialist practice.

STRENGTHENED MEDICAL APPRAISAL

5. The RCoA agrees that a strengthened form of annual appraisal should be the vehicle in delivering revalidation for doctors. We are monitoring the Department of Health/NHS Revalidation Support Team’s work and proposals for strengthened medical appraisal and have taken proactive steps in supporting appraisers and appraisees within such a system. This includes:

— Producing interim guidance on supporting information for presentation at appraisal. The items of supporting information listed are benchmarked against specialty standards set by the College. We have identified which items are “core” and therefore providing a minimum data-set and checklist to help anaesthetists prepare for appraisal.
Ev w10  Health Committee: Evidence

— Developing series of online video clips demonstrating how the summative (assessment) and formative (professional development) elements will work within a single appraisal process. The videos also demonstrate how specialty specific issues can be discussed within the framework provided by the generic GMC attributes.

— Through focus groups we have also developed opening and supplementary questions for each of the 12 GMC attributes covered in appraisal. The questions should encourage reflection and responses from appraisees to confirm that they are meeting the generic and specialty standards that define each attribute. These questions are generic enough to be used in the appraisal of doctors practising in other specialties. We have informed the GMC as to this work and for their consideration in producing national guidance on appraisal.

— Developing a training programme to enable Lead Appraisers to train and provide advice to appraisers in their departments (at a local Trust level) as to the anaesthesia specific requirements and standards in appraisal. The training will consider the quality of supporting information presented and the specialty benchmarks against which the information will be evaluated.

6. The interim guidance, video clips and questions are freely available from the RCoA website: http://www.rcoa.ac.uk/revalidation.

7. The overall focus of this work is to consider the necessary anaesthesia specific requirements in strengthened medical appraisal. The appraisal will be specialty specific as the discussion will focus around what an individual anaesthetist, intensive care and pain medicine specialist does in their practice and the supporting information presented. In evaluating this information and performance, an appraiser will need make a judgement by considering the specialty standards set by the College and that all anaesthetists, intensive care and pain medicine specialists are expected to meet. The outcomes of five successful appraisals, all based on what a doctor actually does in practice and benchmarked against specialty standards, will provide a robust platform upon which a Responsible Officer can make a positive recommendation to the GMC for a doctor to revalidate. It will also provide robust re-assurance to the public that a doctor is fit to practise in their specialist area.

Specialist Standards

8. The specialty standards set the parameters for acceptable practice in anaesthesia, intensive care and pain medicine. The standards represent the minimum benchmarks that all are expected to meet, rather than levels of excellence; although in striving for this higher level anaesthetists, intensive care and pain medicine specialists can use these standards to reflect on practice and identify knowledge areas, skills and attitudes for professional development. The specialist standards therefore exists for summative (assessment of performance against predefined and explicit benchmarks) and formative (professional development towards excellence) purposes—both of which are mirrored in the principles underpinning revalidation. The specialist standards should not be neglected therefore in the simplification and streamlining of revalidation.

9. Work does need to be undertaken, however, in presenting these specialist standards so that it is made clear what is expected of doctors when revalidating and in reducing the complexities associated with the process. There is a need, we believe, to clearly distinguish the applicability of specialty standards to two different areas:

— In defining the attributes or qualities of a doctor in our specialty.

— In defining acceptable levels of supporting information in terms of quality, quantity and how it is produced.

10. In the first instance, we have mapped the specialty standards from The Good Anaesthetist and The Good Pain Medicine Doctor (RCoA, 2010) against the 12 GMC attributes so that the GMC’s framework for appraisal and assessment is meaningful for anaesthetists and related to their specialty practice. The standards from these documents are themselves derived from standards of practice documents published by the RCoA, Association of Anaesthetists of Great Britain and Ireland and specialists societies. These are key documents specifying standards of acceptable and safe levels of practice in the specialty.

11. In presenting items of supporting information for appraisal, specialty standards also exist in determining the content, quality and how these items should be produced. The RCoA publication Raising the Standard (2006), for example, prioritises those audits that should be undertaken within departments of anaesthesia, intensive care and pain medicine. details the best standards as to data collection, stipulates benchmarks and recommends actions to be taken to complete the audit learning cycle. Whilst the methodology is generic, specialty elements must be considered in relation to data collected, benchmarks and acceptable targets in the specialty. Another example is supporting information derived from colleague multi-source feedback (MSF). Specialty guidance will be published recommending who and how many (i.e. surgeons, nurses, operating department practitioners, trainees) should provide feedback to anaesthetists, to capture a representative picture of an anesthetist’s skills and performance in the workplace. Specialty standards will therefore provide an objective benchmark for appraisers in judging whether supporting information, which is likely to be specialty specific, is acceptable or not. Our next task is to present these standards in a way that is succinct and easy to understand for the purposes of revalidation.
COLLEAGUE AND PATIENT FEEDBACK

12. A valid and reliable system of colleague multi-source feedback (MSF) providing informed supporting information about a doctor’s practice will no doubt contribute, in a positive sense, to their professional development. Feedback identifying areas to address, against the relevant GMC attributes, through the personal development plan will be a positive aspect of the appraisal and revalidation process. However underpinning this rationale is one of validity and reliability of the supporting information. Developing a valid and reliable MSF for the medical profession is an ongoing concern for many stakeholders, including the GMC and the Royal Colleges. Setting the ground rules, for example, as to the selection of appropriate colleagues to provide valid and reliable feedback as to an anaesthetist’s skills and behaviours is an important part of the overall process.

13. We question, however, the applicability of patient questionnaires in providing an informed, valid and reliable source of supporting information of a doctor’s performance in some specialties such as anaesthesia and intensive care medicine. In anaesthesia, situations where it may be seen as appropriate to capture patients’ views are at the pre-operative stage, i.e. immediately after a pre-operative assessment or visits, yet this may not be the case in practice. For example, anaesthetists involved in high turnover operating lists, where patients have already been pre-assessed by others in an out-patient clinic setting, will have an average of 20–30 minutes to see 6–8 patients during their very brief pre-op visit; the two types of encounter are so different it is impossible to expect the anaesthetists to have comparable feedback. It may not be appropriate to ask a patient to fill in a questionnaire at the early post-operative stage either, as their judgement may be impaired as a result of the effects of their anaesthetic. It will difficult for patients in intensive care, for obvious reasons, to provide any response as to a doctor’s skills and performance. There are more general concerns, regardless of specialty, about patient questionnaires in revalidation. For example, patient feedback may reflect shortfalls in the overall health care experience due to problems related to nursing care and organisational issues causing lack of continuity in medical care rather than due to the performance of an individual doctor. We also question the added value of patient questionnaires, in terms of the quality of supporting information it provides against other already existing, sources of evidence demonstrating patient satisfaction with their health care.

14. Our current opinion, therefore, is that current patient questionnaires are not appropriate in generating informed, valid and reliable supporting information for doctors in anaesthesia or intensive care medicine. The RCoA does, however, intend to try and develop appropriately validated and reliable patient feedback questionnaires.

QUALITY ASSURANCE

15. We are disappointed that the GMC proposals for quality assurance (QA) envisages a role for the Royal Colleges that is restricted to providing information and data and defines these organisations, who set the specialty standards for the profession, as a contributor and not as a partner with a positive role in the QA process. The GMC will in effect be quality assuring a process by which they are also responsible for making the decision as to whether to revalidate a doctor. Denying the Royal Colleges a positive role will arguably make it more difficult to convince doctors about the benefits of revalidation that are broader than patient safety. It can be argued that to gain the buy-in of doctors, they must be assured that it is not solely a GMC process but one that has been validated through QA by expert (specialist standards setters) external and independent professional bodies such as the Royal Colleges.

16. We welcome the GMC’s proposals to quality assure the organisational processes and frameworks involved in revalidation. We would welcome more details, however, as to how individual outcomes and decisions to revalidate will be quality assured. Revalidation is a high-stakes process involving an individual’s license to practise on one hand and on the other, assurance, to the public, that doctors are practising to acceptable levels with due regard to patient safety issues. We accept that quality assuring 100% of outcomes may not be possible, due to logistical and financial reasons, but serious consideration should be paid to arriving at a sufficient sample size to reassure the profession and public that revalidation is fit for purpose.

17. The GMC should consider the involvement of a panel of senior RCoA representatives in reviewing a sample of anonymised portfolios and decisions in regard to anaesthetists being revalidated. If there was significant disagreement as to the number of positive revalidation decisions in the sample this might highlight deficiencies and problems in the system. A similar arrangement should be in place for other specialties involving the relevant Royal Colleges.

18. Quality assurance is also about ensuring that the specialty elements of appraisal are delivered consistently, equitably and to acceptable levels, locally and nationally. To achieve this, our interpretation of a positive role in QA therefore includes providing advice and support as to specialty issues to individual anaesthetists, intensive care and pain medicine specialists, appraisers (who may not be from the same specialty) and Responsible Officers (likewise). We are planning to develop our existing national network of clinical Regional Advisors or develop a new network of Regional Professional Advisors to provide on the ground expert advice.
and support. In implementing this plan will require adequate resourcing so that our advisors are fully trained and systems are put into place and managed.

Dr Andy Tomlinson
Senior Vice President and Revalidation Lead

November 2010

Written evidence from the British Cardiovascular Society (REV 10)

SUMMARY

— The British Cardiovascular Society supports the concept of revalidation as a “streamlined, straightforward and proportionate process”.
— We believe that there is a danger that the process as currently outlined could result in expenditure of considerable unnecessary effort by individual doctors.
— The BCS has developed a simple template for revalidation of cardiologists.
— National clinical audits provide a potential mechanism for the development of risk stratified and benchmarked clinical outcome data that could be used to support revalidation and more generally to drive quality improvement.
— Funding of some important national clinical audits is at risk.
— The BCS believes that key national clinical audits should be centrally funded.
— Professional societies have a key role to play in the development of risk stratified outcome models from national audit data and need academic and financial support to do so.
— The cost of supporting national audits and development of outcome models will be a small fraction of commissioning expenditure for any specialty.
— For specialties where national audit data is not readily available, accreditation of services against nationally agreed standards could provide an alternative means of providing supporting information on objective assessment of performance for individual doctors.
— Professional societies should have a role in assisting Responsible Officers in evaluating doctors who are at risk of failing to achieve revalidation.

1.0 BACKGROUND

The British Cardiovascular Society (BCS) is the Professional Society representing all those working within cardiovascular health, science and disease management. Its members who are cardiologists and cardiovascular physicians support the concept of revalidation as a “streamlined, straightforward and proportionate” process. A key aim of the Society is to improve the quality of cardiac services within the UK and we see revalidation as an important component of this process. The Society and its affiliated subspecialty groups have a strong track record of national data collection through the Central Cardiac Audit Database (CCAD) and we believe that so far as is possible supporting evidence for revalidation should be derived from validated national audit data.

2.0 EVIDENCE

2.1 There is a widespread perception that current proposals for revalidation are too complicated and could result in expenditure of considerable extra time and effort by individual practitioners. This has been highlighted in the responses to the GMC consultation. We agree with this concern and view it as a strong argument for the use of routinely collected national audit datasets where these are available.

2.2 The BCS has developed a template for revalidation of cardiologists based on the three domains of knowledge, skills and professionalism:

These proposals were widely supported by the membership. It is likely that our proposals will require some modification as the process of revalidation matures but we believe that the underlying principles are sound.

2.3 Central to the skills based domain is a hierarchy of supporting evidence such that provision of appropriate risk stratified outcomes benchmarked against national audit data and demonstrating continuing competence removes the requirement for any additional locally collected data.

2.4 There are currently seven national clinical audits (NCA) of cardiac topics with varying degrees of data completeness. Some such as the database on cardiovascular interventions of the British Cardiovascular Intervention Society and the MINAP database have extremely high rates of data submission. These were not initially set up to provide supporting evidence for revalidation but provide a rich resource of data that can be routinely collected at low cost.

2.5 The White Paper “Liberating the NHS” states that existing NCAs should be expanded to a wider range of conditions and to increase their validity, collection and use. It also indicates that NCAs should produce
clinical outcome data as well as process data. Many existing NCAs could in principle be adapted to serve the purposes of revalidation by providing risk stratified outcome data. Since in many cases the mechanisms to collect such data already exist little additional local infrastructure would be required to make these audits universal. This would be a highly cost efficient way to provide high quality supporting professional information.

2.6. Funding of NCAs is currently haphazard. Identification of a number of mandatory core NCAs with secured central funding is essential for the agenda outlined in “Liberating the NHS” and would greatly assist the development of revalidation.

2.7 The active engagement of Professional Societies such as the BCS is key to the success of both revalidation and more generally the provision of meaningful outcome data. Professional Societies have a role in defining datasets and appropriate outcome measures. Societies will need academic and statistical input to build and apply risk models against which individual performance can be benchmarked and will need to be supported financially to do this. However the cost of such analysis will be only a small fraction of the overall commissioning expenditure for a specialty and cheaper than the alternative of multiple duplicative processes at local level. There is an expanding evidence base that high quality care is cost effective care.

2.8 There is a public expectation that doctors demonstrate their continuing competence. The BCS supports the publication of appropriately risk stratified benchmarked individual outcome data where this is applicable. This is only possible with full data collection, sophisticated modelling and agreement on what constitutes an outlier.

2.9 Some medical specialities do not lend themselves so easily to provision of robust outcome data and other measures need to be used. In cardiology this includes cardiac imaging. The imaging groups affiliated to the BCS have developed departmental quality assessment and improvement processes, otherwise referred to as accreditation. It is our view that a cardiologist practicing in an imaging department that has met nationally agreed standards including systematic quality control should meet the requirements under the skills domain (or objective assessment of performance) without the need to provide additional supporting evidence in this domain. Since these processes are standardised they remove the requirement for duplicative local efforts and will be cost effective. There are many other areas where appropriate use of standardised accreditation or peer review processes could be used to provide supporting information in this way.

2.10 The BCS believes that the structures of revalidation should be as simple as possible. Some general information, such as description of practice and statements on health and probity are mandatory for all doctors. In our view confirmation of ongoing competence in the skills domain as described above accompanied by evidence of completion of CPD against the full range of clinical activity (knowledge domain) and satisfactory completion of peer and patient feedback (Professionalism) will in the great majority of instances provide all the additional information required for revalidation.

2.11 The GMC has not yet fully defined the process for handling the situation where a Responsible Officer has concerns about an individual doctor’s fitness for revalidation. The BCS believes that Professional Societies should have a role in supporting the Responsible Officer by providing expert advice and evaluation where required.

November 2010

Written evidence from the Medical Protection Society (REV 11)

SUMMARY OF RECOMMENDATIONS

1. The government must ensure that the public has a proper understanding and realistic expectations of the purpose of revalidation.
2. The process of revalidation must be accessible to all doctors who wish to revalidate, regardless of their portfolio of practice.
3. The costs of remediation should be borne centrally to reflect the benefit that it will bring to the wider public.

INTRODUCTION

1. The Medical Protection Society (MPS) is the leading provider of comprehensive professional indemnity and expert advice to more than 270,000 doctors, dentists and other health professionals around the world. We have over 100 years’ experience of the medicolegal environment and operate in 40 countries around the world. In the United Kingdom we have around 170,000 doctors, dentists and other healthcare professionals in membership comprising around 50% of all doctors and 70% of all dentists.

2. As a mutual, not-for-profit organisation we offer members help, on a discretionary basis, with legal and ethical problems that arise from their professional practice. This includes clinical negligence claims, disciplinary and professional regulatory investigations, inquests, complaints and general ethical and professional advice.
3. MPS welcomes the commitment from the GMC to simplify and streamline the proposals for revalidation\(^2\). However although we support the principles behind revalidation, we have concerns that as currently drafted, our members may face issues in relation to public expectations, fairness and remediation. These are outlined below.

**KEY ISSUES**

*Realistic expectations*

4. MPS would like the government to ensure that the public has realistic expectations about the purpose of revalidation. Although it may help to identify poorly performing doctors at an earlier stage, it cannot eliminate poor practice or stop wilful criminal behaviour in doctors such as Harold Shipman.

5. It must be remembered that although revalidation will be an important and valuable tool, it will be just one of several measures that should be in place to demonstrate to patients and the public that doctors are keeping their knowledge and skills up to date and are fit to practise.

*Fairness*

6. MPS believes the process of revalidation must be accessible to all doctors who wish to revalidate, whilst at the same time being robust and not putting excessive burdens on doctors or employers.

7. It will be absolutely essential to pilot revalidation in a wide range of specialties, both clinical and non-clinical, to ensure that the process is fit for purpose, achievable and sufficiently flexible to accommodate the wide range of practice undertaken by licensed doctors in the twenty-first century. There currently appears to be a wide range of differing levels of detail in the specialty specific frameworks produced by the Royal Colleges.

*Remediation*

8. Revalidation will identify doctors in need of some level of remediation and it is very important that the resource implications are properly recognised. MPS welcomes the recognition that the costs of good clinical governance, including remediation, should be seen in the light of their associated benefits to patients and the public, doctors and employers. In order to reflect this, we strongly believe that the costs of remediation should be borne centrally.

9. We believe that all doctors should be provided with the framework to support remediation. In particular, thought must be given to how doctors working as locums can access remediation in the same way as doctors in regular employment.

**November 2010**

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**Written evidence from the Royal College of Surgeons of England (REV 12)**

**SUMMARY**

- The College supports the introduction of a revalidation system.
- The leadership of and ultimate responsibility for revalidation must lie with the GMC.
- The GMC needs to set out clearly the remaining tasks and who has delegated responsibility for them.
- The independence and impartiality of responsible officers is not assured and more needs to be done to monitor them.
- The move to implement revalidation as organisations become ready does not represent a risk based approach. The GMC needs to proactively support lagging organisations.
- Following a risk based approach, further work is needed to ensure that systems are in place to revalidate appropriately locum doctors and doctors working solely in the independent sector.
- The importance of specialty difference must not be lost in the rush to produce a simple system.
- A consistent approach to appraisal must be championed by the GMC.
- Whole practice appraisal must be supported by responsible officers and all health organisations.
- Revalidation is an opportunity to improve existing systems and processes to collect and analyse information about the outcomes of health care.
- Medical Royal Colleges should have a clear role in the quality assurance of revalidation.
- The role of PCTs and SHAs within the regulations needs to be reconsidered in light of changes to these organisations which the Government has announced.

\(^2\) GMC Revalidation: A Statement of Intent (October 2010).
EVIDENCE

1. The Royal College of Surgeons of England supports the introduction of a revalidation system. Our hope is that revalidation will:
   (a) Provide a way for doctors to prove that they meet high standards of practice.
   (b) Protect patients through early identification of problems and strong clinical governance.
   (c) Reassure patients that their doctor is fit to practice.

2. The College has supported the work done over the last 11 years to introduce a revalidation system. The various set backs have been frustrating but it is clear that even the anticipation of revalidation has improved the clinical governance landscape. Nevertheless there is still much more work to be done.

LEADERSHIP

3. The Royal College of Surgeons of England is clear that revalidation must be led by the profession and to that end the General Medical Council (GMC) must have overall responsibility. To date the College has encouraged the GMC to take a leadership role. However, we have been somewhat disappointed by the GMC’s apparent failure to clearly set out how it expects the revalidation project to proceed. In particular it has not been clear what the GMC expects other bodies to do including the role of the Colleges. It is our opinion that this has led to delays and duplication and is the reason why the system has been criticised as being overly complex. It appears that this is now being remedied.

4. We recognise that the four UK departments of health are concerned about the impact of revalidation on their health services and have therefore taken a proactive role in preparing for revalidation. Revalidation should be a UK-wide regulation system so that any patient in the UK can expect that their doctors are being revalidated to the same standards in a consistent way. It is not clear to what extent the GMC has oversight of these implementation activities. The GMC needs to retain the right to approve or veto systems in order to ensure that consistency and fairness is maintained.

5. Looking forward, the GMC urgently needs to set out in very clear terms, what tasks are left to complete, who will be responsible for completing them and who will sign them off. It is only then that broader stakeholders such as Medical Royal Colleges, specialty associations and patient groups can identify how and when they can provide input to the development of standards, rules and systems. This will also minimise any future duplication.

6. It is clear from the GMC’s report on their consultation that a pragmatic approach is being taken to the implementation of revalidation focusing on information already widely available. This is sensible but the risk is that the most relevant types of supporting information for specialists may be ignored. Revalidation should be subject to continuous renewal which should make revalidation even more straightforward. Over time it will be possible for the profession to develop better forms of supporting information to replace those currently available. The support of the GMC and departments of health will be critical.

7. The College, even as an identified partner, is still unclear what revalidation in its entirety will look like. Doctors have even less idea about what will happen and what they need to do to prepare. They are receiving conflicting messages from a variety of sources further adding to the confusion. The GMC needs to act authoritatively setting clear timescales for implementation and needs to make communication with doctors a priority.

RESPONSIBLE OFFICERS

8. The College remains concerned about the responsible officer role. We are supportive of revalidation having a local dimension because it allows local circumstances to be taken into account and will strengthen clinical governance. However, placing processes at a local level opens up the potential for the revalidation process to become conflated with employment issues. Revalidation is about demonstrating performance against professional standards and while this overlaps with what an employer requires from its employees, other dimensions such as revenue raising are simply irrelevant.

9. As it currently stands the College does not believe that effective safeguards have been introduced to ensure that the revalidation process will not be the subject of interference from employer led processes. We acknowledge that it may be impractical to change course before implementation but the GMC should make it a priority to assess, within the first two years of revalidation if the potential conflict is proving a reality. If this is the case then the GMC should consider whether an independent network of locally based responsible officers might prove a better alternative.

10. The GMC has not fully expressed how it will interact with responsible officers. Responsible officers will be supervised to some extent by their own responsible officers; but these will be provided by the four departments of health rather than by the GMC. Therefore it is not clear how the GMC will monitor the work of responsible officers directly in order to ensure that local systems and the revalidation recommendations made by the responsible officers are in line with GMC expectations.
RISK BASED APPROACH

11. The GMC is understandably keen to implement revalidation as soon as it can. To this end their approach is to begin revalidation in the healthcare environments when they are ready. By definition those organisations with the best systems where doctors are likely need the least monitoring by the GMC will be first. The organisations with the poorest systems will begin revalidation much later even though the doctors working in those systems may be currently less well monitored and as a consequence pose a greater risk. In order to mitigate the effects of poor systems leading to greater risk due to delay the GMC should proactively identify such organisations and work with them to improve their systems and implement revalidation as early as possible. An agreed “start by” date is essential so that organisations can be held to account.

12. It is relatively easy to identify some of the key groups that pose a risk because they work outside of the “managed” healthcare environment. These groups are sometimes termed orphan groups. Several groups concern us, in particular: peripatetic locum doctors, doctors working wholly in the independent sector (particularly those in the cosmetic sector) and doctors coming to the UK from overseas for limited periods of time.

Locum doctors

13. Peripatetic locum doctors provide a vital service to the UK healthcare system. They provide cover at times of pressure and the service relies on their flexibility. However it is clear that they are not adequately covered by trust clinical governance systems and that locum agencies provide variable monitoring based on reports received from trusts. It will be much more difficult for peripatetic locum doctors to gather information for revalidation and for this information to be verified. The College has recognised this problem and is working on gathering together standards for locum surgeons. The GMC needs to work with the Colleges and others to consider what advice can be given to locums, and their appraisers, about acceptable adaptations to the revalidation process.

14. We are especially concerned about locum doctors who do not have NHS practice and are not registered with an approved locum agency through which to obtain their responsible officer and appraisal. These doctors are supposed to be served by their Primary Care Trust or Local Health Board. Apart from the fact that these organisations are not familiar with surgical practice, in England Primary Care Trusts will soon cease to exist. The GMC and government urgently need to address this.

Independent Sector

15. The College has established a working party to draw together standards for cosmetic surgery, both for the individual and for surgical services. Revalidation will be included as a regulatory mechanism for upholding these standards. This work is due to conclude in Summer 2011.

16. The broader issues related to doctors working wholly in the independent sector are yet to be fully addressed. We welcome the pilot work undertaken by Independent Healthcare Advisory Services (IHAS) but we are concerned that the responsibilities of healthcare organisations are not fully understood and compliance will be low. It is important that advice be given to the independent sector to ensure that they make suitable provision for the introduction of revalidation, including supporting whole practice appraisal. Revalidation does present costs but it is not acceptable for organisations to put off enhancing clinical governance systems. The GMC and Care Quality Commission need to work together to address this.

DOCTORS COMING TO THE UK FROM OVERSEAS FOR LIMITED PERIODS OF TIME

17. The GMC has stated that doctors coming to the UK will need to be licensed and are therefore subject to revalidation. However there is almost no detail on how this will work in practice. The issues are similar to those concerning peripatetic locum doctors where their work is not subject to a continuous regime of clinical governance. These doctors pose a particular risk that must be addressed as a priority.

SPECIALITY DIFFERENCES

18. Following the publication of the white paper, Trust, assurance and safety, the Medical Royal Colleges were quite clear that revalidation would contain a significant specialty element and that their responsibility was to set relevant standards complementary to the generic Good Medical Practice standards. Quite quickly it became apparent that the separation of relicensure and recertification was cumbersome and confusing. Rightly it was abolished in favour of something more streamlined. We supported the reunification in the belief that all surgeons, not those just on the specialist register, would be covered by standards relevant to surgeons.

19. However, we are increasingly worried that the push towards simplification marks a move away from specialty standards and towards a one-size-fits-all approach. This must be resisted. We support the efforts to ensure consistency of terminology and the identification of essential items of supporting information across medicine. However specialty specific difference must be accepted. For example we have determined that outcomes data form an integral part of a surgeon’s revalidation portfolio but such data would not be so relevant.

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for other specialties and it is right that they not be required to replicate this. We would not approve of a move to make outcomes data an optional form of supporting information for surgeons. Where available it must be presented.

APPRAISAL

20. Strengthened medical appraisal is the core process for revalidation. Existing appraisal needs to be enhanced and extended to include an assessment element for revalidation. The College is concerned that the GMC appears to have left the four UK departments of health to undertake this task without guidance from the GMC about what it expects. In order to make sure that revalidation applies equally all over the UK appraisal must be designed with a consistent philosophy and with common elements. For example the Revalidation Support Team for England has developed an appraisal system that promotes a small number of items of supporting information being put forward for inspection by the appraiser. An alternative approach might be that the appraiser chooses items to review from a long list of available information. The College has concerns about the Revalidation Support Team’s approach but it is not clear if our lobbying on this issue should be directed at the Department of Health or the GMC.

21. The College has long advocated whole practice appraisal. Patients need to be assured that their surgeon’s work is of a high quality in all areas of their practice across all sectors. This means that information for appraisal is drawn from all places of work providing an overall picture. We are pleased that the GMC makes note of this in its documents but we are concerned that there is less commitment to this on the ground. We were disappointed that the responsible officer regulations did not include a duty to provide information to facilitate whole practice appraisal. We believe that the GMC should issue guidance to responsible officers making it explicit that the GMC expects whole practice appraisal to take place.

OPPORTUNITY TO IMPROVE SYSTEMS THAT RECORD OUTCOME DATA

22. The College would like to inform the committee about the College’s aspirations for the use of outcome data. Revalidation presents a unique opportunity to commit surgeons and their employers to enhancing participation in clinical audit and to bring surgeons closer to the routine data collected on their behalf in order to develop this into a more clinically meaningful resource. In the NHS in England Hospital Episode Statistics (HES) is the largest and most complete data set about healthcare. Initially developed for administrative purposes, it has become far more reliable over recent years due to the focus on payment for activity within the NHS. Revalidation presents the opportunity to further develop this data set to better understand NHS activity and the quality of care provided to patients. This is in line with the coalition government’s agenda to widen access and openness about NHS data as outlined in the current consultation Liberating the NHS: an Information Revolution.

23. Understanding health outcomes is never easy. There are always numerous factors to take into account and results are rarely clear cut. Nevertheless, the College has worked with the surgical specialty associations to identify for the first time particular sets of operative procedures that describe the practice of specialist surgeons, along with a simple range of outcome indicators that can be derived from HES. This will enable comparison and benchmarking between units and between individual surgeons and will provide an essential source of supporting information for revalidation. Much support from the Department of Health and the NHS Information Centre will be required to realise the potential of this work which, if implemented, will further the aims of the government in its information strategy.

24. The College believes that, even in the short term, outcomes data can form a part of revalidation through a combination of national and local clinical audits, routinely collected data (HES) and self collected data (personal log books). However, for surgeons and the public to have confidence in these data, there must be a commitment from the government, the GMC and the profession to invest time and effort into improving the quality of information to support outcome measurement. We are clear that the drive to streamline the revalidation process must preserve specialty difference and the standards the profession has set.

QUALITY ASSURANCE

25. A transparent and robust quality assurance process is essential to ensuring the success of revalidation. The revalidation process itself is mostly devolved with very little GMC involvement. For that reason the quality assurance process must be thorough and involve routine checks as well as investigations triggered by anomalies. We understand why the GMC is keen to work with systems regulators in order to not duplicate and create a burden but the GMC must retain control of quality assurance overall.

26. The quality assurance process should focus on two elements:
   (a) Revalidation systems in organisations
   (b) Individual revalidation recommendations and decisions

   The GMC should take a risk based approach to this, targeting identified high risk institutions but retaining an appropriate degree of randomisation in its approach.
November 2010

**Written evidence from the Royal College of Paediatrics and Child Health (REV 13)**

*The Royal College of Paediatrics and Child Health (RCPCH) represents paediatricians in career grade posts (consultants and specialty, staff and associate specialist grade (SSASG) doctors) and paediatricians in training. We support the evidence presented to the Health Select Committee by the Academy of Medical Royal Colleges but have additional evidence to present.*

The information presented draws from data formally collected from the RCPCH membership between late 2008 and mid 2010 by means of surveys, focus groups and consultations, and informally from discussions at paediatric meetings and conferences.

**SUMMARY**

The RCPCH supports the recent GMC decision to simplify the process of revalidation. We present evidence from paediatrics to support the general principles that the first steps of the process should be to ensure that all the workforce:

- Undertakes a process of strengthened appraisal;
- Undertakes peer multisource feedback (with a validated tool selected by their organisation);
- Undertakes patient/carer feedback with a tool validated/selected by the specialty (in the case of paediatricians by the RCPCH);
- Should have the process of revalidation properly audited (to seek out false positive and false negative results) by a robust quality assurance process.

**EVIDENCE FROM THE ROYAL COLLEGE OF PAEDIATRICS AND CHILD HEALTH**

1. The RCPCH supports the introduction of medical revalidation, and within the newly GMC announced timetable by 2012.

2. We believe that paediatricians are generally in agreement with, and compliant with, current procedures within their organisations and are not outliers in the current process, which makes the evidence presented here more relevant and robust.

**APPRAISAL**

3. We support the introduction of a structured review of a doctor’s practice via a process of strengthened appraisal. However a RCPCH survey suggests that approximately 70% of all paediatricians have had appraisals and that availability of appraisal systems and processes for paediatricians is not UK-wide. (More than 30% of SSASG doctors have not had an appraisal).

4. There is a lack of clarity around how doctors on the GMC register working outside the UK will be supported through appraisal and ultimately revalidation. This is especially relevant to a number of paediatricians. There is anecdotal evidence that a significant number of these doctors wish to remain GMC registered with a licence to practice. More work is needed.

5. Consistency of appraisal is essential to effect robust revalidation outcomes, and there is a recognition of the need for appraiser training, both to cover generic expectations of GMC and Colleges. However there is currently no intention to provide a national appraiser training scheme, supplemented by speciality additions as needed.

**GMC AND SPECIALTY FRAMEWORKS FOR REVALIDATION**

6. Even with clear guidance, an appraiser will need to exercise judgement to determine whether the content of supporting information demonstrates fulfilment of an attribute. This can be reduced by discussion and interdisciplinary exchange of concepts and ideas. Appraiser training nationally is essential to ensure consistency of judgements made.
SUPPORTING INFORMATION

7. Paediatricians support a range of supporting information types as part of revalidation including MSF, patient feedback, CPD, audit, and case based discussion. But to ensure revalidation is manageable, the types of supporting information required at the outset may need to be restricted.

8. The level of assessment remains to be clarified—assessment should be at the level of “fit to practise” rather than expecting standards of excellence, however attractive these standards may seem in terms of presentation.

MULTISOURCE FEEDBACK (MSF) AND PATIENT FEEDBACK

9. Paediatricians are generally supportive of revalidation. However, fewer than 50% of paediatricians have undertaken a peer-based MSF in their organisation. The majority of paediatricians who have undertaken MSF indicated it was worthwhile. Implementing this as a core component of revalidation is a priority.

10. NHS Trusts which have undertaken multisource feedback for their consultants have usually chosen to run one model which fits all specialties. Specialty-based models, though attractive, are more expensive and potentially more complex to process, understand and incorporate into the revalidation process in a standard way.

11. Specialty patient feedback tools are required. The RCPCH has developed a paediatric carers of children feedback tool (PaedCCF) to cover this gap. Our current analysis shows that 25 parent/carer feedback forms per doctor are needed to provide a reliable measure. While this may set a standard for patient and carer feedback tools, there are also major resource implications.

12. Not all doctors will be able to obtain patient feedback through questionnaires however e.g. those working in safeguarding, and alternative methods should be allowed.

CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

13. CPD as a core component of revalidation is supported by paediatricians, but evidence shows that not all paediatricians can meet current College CPD scheme requirements. Workplace restrictions may currently affect doctors’ abilities to access CPD e.g. lack of time, funding or opportunities. In addition, GMC principles for CPD include a focus on demonstrating reflection and learning outcomes, which are challenging for many doctors to capture and quantify.

REMEDICATION

14. Careful consideration is needed for this. A range of support is required (from self help to support by national organisations) but the current focus as part of revalidation appears to be on more in depth support. The aim must be to address issues before they become serious concerns that will affect a revalidation recommendation.

QUALITY ASSURANCE OF REVALIDATION

15. Quality assurance of revalidation must cover both process and outcomes e.g. revalidation decisions. Quality assurance of outcomes needs to include an audit of all those who fail the revalidation process and a sampling of those who have passed.

16. Paediatricians would expect to be involved in quality assurance with the GMC to ensure decisions are made fairly and equitably within the specialty.

RECORDING SYSTEMS

17. The RCPCH agrees there is a need for a fully functioning electronic revalidation system to support data storing, content reflection, sharing and review by appraisees, appraisers, Responsible Officers and quality assurance bodies. The system must be secure and meet patient confidentiality protocols.

18. Central support is needed to avoid implementing untested IT systems.

RESOURCES FOR REVALIDATION

19. Paediatricians are clear that the cost and time required to implement revalidation must not be to the detriment of patient care and frontline services.

20. Systems and processes must be put in place to ensure the system is effective, low in bureaucracy and not just a tick-box exercise. Anecdotal evidence from pilot sites suggests that information-gathering is time consuming, current IT systems intended to simplify this process are instead prolonging and complicating the process. Untested requirements e.g. MSF may further increase time and cost factors. Ongoing funding to develop and support revalidation is not as yet clear.

November 2010
Written evidence from Picker Institute Europe (REV 14)

Picker Institute Europe is a not-for-profit organisation that makes patients’ views count in healthcare. We:

— build and use evidence to champion the best possible patient-centred care;
— work with patients, professionals and policy makers to strive continuously for the highest standards of patient experience.

About Picker Institute Europe

1. Picker Institute Europe developed the methodology of measuring patient experience in the UK. It has carried out numerous national patient surveys for the national survey programme and is now the single coordinating centre for these surveys under the Care Quality Commission. It also provides patient feedback to over 100 NHS trusts every year, using a variety of methods including “near real time” feedback.

2. Picker Institute Europe has worked over several years on the development of medical revalidation. It was a member of the Chief Medical Officer’s high level group, leading to the White Paper, “Trust, assurance and safety: the regulation of health professionals”; and of his working group on medical revalidation, which produced the 2008 report: “Medical revalidation—principles and next steps”. This document affirmed that patient feedback would form part of the evidence base for appraisal and revalidation.

Summary of Current Concerns

3. Revalidation was developed in the interests of patients, but that focus keeps being obscured. The Select Committee on Health’s Inquiry is a timely opportunity to help the medical profession regain that focus.

4. In this submission, Picker Institute Europe wishes to highlight the following points, from the perspective of an organisation focusing on patient-centred healthcare—and the role, within it, of direct feedback from patients.

— No further delays. 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. We propose that all regions should be ready to introduce revalidation by a deadline of 18 months after the early adopters begin.

— Full integration and regular use of patient feedback. As agreed by the CMO’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.

— Now is the key time to review and clarify the role of patient feedback. The medical profession remains unclear and unfocused with regard to the role and value of patient feedback within appraisal and revalidation. The current hiatus presents an important opportunity to re-open discussion, with the involvement of relevant patient-focused organisations. We would respectfully request the select committee to recommend this opportunity must not be missed.

Introduction

5. Picker Institute Europe wishes to comment on two issues within the Inquiry: the way in which the GMC proposes to establish revalidation, and the responses to the consultation and the GMC and UK health departments’ statement of intent issued on 18 October. We will cover these issues together.

6. Our concern throughout is that revalidation should be implemented in the foreseeable future, with the experiences of doctors’ patients fully and effectively integrated into their appraisal and revalidation, in such a way as to assist continual improvements in quality.

Background

7. Patients expect their doctors to be fit to practice, to be effectively regulated, and to be monitored for their competence. Most patients assume that regular monitoring does take place. Medical revalidation was developed in response to high level concern that adequate checks were not in place, and that this posed risks to patient safety and was not conducive to achieving high quality care.

8. Revalidation, and associated appraisals, depend upon the regular gathering of good quality information about doctors’ performance. At the launch of the White Paper, “Trust, assurance and safety”, in 2007, the then minister for health and the Chief Medical Officer confirmed that this information would include direct feedback from the doctor’s patients. Subsequently, in 2008 the CMO published “Medical revalidation—principles and next steps” which formally included patient feedback within the proposals for “multi-source feedback” which all doctors would need to collect.

9. Methods of collecting patient feedback—measuring patient experience—have been available in England since at least 1998, when Picker Institute Europe conducted the first national patient survey (of primary care) for the Department of Health. Many of the “core questions” in the national patient surveys can be used, or
adapted for use, in assessing the performance of individual health professionals. There are also many instruments developed by academic researchers, designed specifically to assess the quality of individual consultations with patients. For example, a recent review by Picker Institute Europe for the King’s Fund identified 15 relevant questionnaires designed to study patient engagement in primary care alone.\(^4\)

10. Since at least 2008, various parties have been developing patient questionnaires for the purpose of revalidation. The General Medical Council has developed its own questionnaire; the Royal College of GPs has approved at least three other instruments.

11. Hence there is no shortage of well developed, tested and validated questionnaires and indicators which can be used, or further adapted, to provide doctors with their patient feedback.

12. Patients cannot be expected to report on the clinical competence of their doctors. However, they can report aspects of their own experience in consulting doctors, which are relevant indicators of the quality of the care being provided.

13. For example, communication skills are key to correct diagnosis, understanding patients’ symptoms, choosing the appropriate treatment option, and co-ordinating the patient’s care with others.

14. Patient experience questionnaires would typically include questions about these communication aspects. Those used in national surveys include:

   — Did the doctor listen carefully to what you had to say?
   — How much information about your condition or treatment was given to you?
   — When you had important questions to ask a doctor, did you get answers that you could understand?
   — Did the doctor treat you with respect and dignity?

15. A key question used consistently in the national surveys is about the level of involvement the patient had in any decisions made:

   — Were you involved as much as you wanted to be in decisions about your care and treatment?

16. These questions are based on what patients say is most important to them. They are directly relevant to the duties and required competencies of doctors: Good Medical Practice (2006) contains a duty for all doctors to work in partnership with their patients, including involving them in decisions. GMC guidance has further elaborated this duty, by advising doctors that consent to treatment must be sought in the context of shared decision making with the patient;\(^5\) and by requiring all undergraduate doctors to demonstrate these competencies in order to qualify.\(^6\)

17. Patient experience is recognised as central to healthcare quality. The NHS Next Stage Review\(^7\) defined quality as three components—safety, effectiveness and patient experience—and this formulation has been explicitly accepted by the coalition government.\(^8\)

18. This recognition is driven by increasing evidence that the success of healthcare depends significantly on the extent to which patients are engaged in it. Evidence from 280 high level and systematic research reviews, synthesised for the Department of Health by Picker Institute Europe, shows that engaged patients are, for example, more likely to choose appropriate treatment, less likely to choose highly interventionist options, more likely to adhere to chosen treatment (such as a course of medication), more confident to cope with their condition and its impact on their lives, and more likely to adopt preventive approaches such as attending appropriate screening.\(^9\)

19. Direct patient feedback, then, is both achievable and highly relevant to care quality and to the assessment of doctors’ competence to carry out their duties.

**The Approach to Implementation and the GMC’s Response to its Consultation**

**Doctors’ uncertainty about patient feedback**

20. Over the last four years it has become clear that many doctors are uncertain and fearful about the collection and use of direct patient feedback. For example, only 67% of respondents to the GMC’s 2010 consultation supported the involvement of patients in feeding back through questionnaires—even though Department of Health and GMC policy is unambiguous about this requirement.

21. Likewise, in a recent survey of GPs by the King’s Fund, 57% of respondents thought that patient surveys were the least effective approach to quality improvement.\(^10\)

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\(^6\) Tomorrow’s Doctors, GMC, London 2009.

\(^7\) High Quality Care for All, Department of Health, London 2010.

\(^8\) Equity and excellence: liberating the NHS, Department of Health, London 2010.

\(^9\) This evidence is published at www.investinengagement.info.

\(^10\) Capturing opinions from the front line, King’s Fund, London, 2010.
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22. This is in part understandable. Responses to the consultation also showed a clear preference for basing appraisal on information that is already routinely collected; but patient experience is not yet routinely measured at the level of individual doctors, and doctors are unfamiliar with its evidence base, methods and significance.

23. However, it may also be in part due to medical prejudices. Research studies and programmes relating to patient-centred healthcare have concluded that many doctors are resistant to concepts and language of patient-centred healthcare. Patient feedback is sometimes regarded as irrelevant, or wrongly perceived as being about patients “rating” their doctor. The communication, partnership and shared decision-making that are required by Good Medical Practice are often derided as “fluffy stuff”, “touchy-feely”, or things that nurses can do but doctors don’t need to worry about.

24. It is however important to note the increasing recognition and acceptance of patient feedback as a valid and important measure of the quality of care within national professional organisations and associations. The Society for Cardiothoracic Surgery for example, a pioneer of transparency in the publication of performance data, is currently developing its own patient experience measurement tools with a view to publishing patient experience data alongside data about the clinical outcomes achieved by individual clinicians.

Lack of clarity on the role and use of patient feedback

25. For the above reasons, the role of direct patient feedback in appraisal and revalidation has often been misunderstood and downplayed in the development of plans for revalidation.

26. In its consultation document, the GMC characterised patient and public involvement as a way of inspiring confidence in the way that revalidation will work. Picker Institute Europe emphatically disagreed, arguing that:

“The patient experience is a core dimension of “quality” in health and should be positioned as a core dimension of doctors’ competence and performance. We do not see this reflected in the GMC’s approach.”

27. In its response to the consultation (which quotes the above passage), the GMC makes the robust statement that “Patient and public involvement is expected, and will be included in revalidation”. It recognises patient feedback as an important “developmental tool” for doctors. However, it also continues to position patient and public involvement as “critical to ensuring confidence in revalidation”.

28. The point remains that in the face of doctors’ fears and uncertainty, the way the GMC positions patient feedback, is critically important. It should give an unequivocal lead to the medical profession—in line with the duties it promotes in Good Medical Practice—that the patient experience, as reported by patients, is a core part of the quality of doctors’ performance and requires regular monitoring and, where necessary, remedial attention.

29. In response to concerns expressed by various respondents to its consultation—that patient feedback questionnaires may not be “robust” or reliable, or may be too onerous to administer—the GMC proposes further review work, to assure itself and others about the nature of the surveys.

30. We consider this unnecessary—this is already a well researched area. Royal Medical Colleges have moved beyond this position, to examine and approve specific questionnaires. We would urge the GMC to involve recognised academics with expertise in patient experience measurement from an early stage, and to conclude the review as rapidly as possible.

31. More generally, we remain concerned that, even at this late stage in the development of revalidation, the role and use of patient feedback remains at best unclear, and at worst, disputed and undermined. The current hiatus, while piloting is established and conducted, offers a very important additional opportunity to clarify these matters.

32. We therefore respectfully request the select committee to recommend that the opportunity should now be taken to initiate a further debate and discussion aimed at clarifying the role of patient feedback within appraisal and revalidation. This should be a balanced debate, involving patient-focused organisations and the medical profession as widely as possible.

Frequency, consistency and significance of patient feedback

33. Our concern remains that, in the planned approach, which is the responsibility not only of the GMC but also of other bodies including the Department of Health, patient feedback will be collected and used:

— with less commitment and recognition than other types of information;
— infrequently; and
— inconsistently.

Commitment and Recognition

34. In its consultation document, the GMC described patient feedback as “useful supporting information”, reinforcing the view of many doctors that such information is marginal. In its response to the consultation the

11 See, for example, Seeing the person in the Patient, Goodrich J and Cornwell J, King’s Fund, London 2008.
GMC revises this to: “one of a range of types of supporting information that doctors will collect to demonstrate their practice at appraisal”. This at least gives more of an appearance of equality with other data.

35. We reiterate our contention that patient experience information is capable of being used to assess core elements of the quality of doctors’ care-giving. These include mandatory aspects of the “patient partnership” duty in Good Medical Practice, such as:

— listening to the patient;
— explaining the patient’s condition;
— giving information about all treatment options, including that of doing nothing, and their associated risks;
— answering questions in a way that the patient can understand;
— supporting the patient to care for himself and to adopt appropriate behaviours;
— involving the patient (to the extent that they wish) in discussions and decisions about their health and healthcare— (and achieving consent to any treatment in this context).

36. We also reiterate that the evidence shows that where these competencies are absent from consultations, care and treatment will be less effective as well as being a poorer experience for the patient.

37. It is incumbent on the GMC to defend and promote its standards, and to exercise leadership in this field.

38. The risk here is that doctors, their supervisors and clinical peers, and responsible officers, may underestimate the significance of any patient feedback that is collected, and therefore may not act upon it. They may believe it relates only to “people skills”, not to core best practice.

39. This would be unfortunate, since, as the GMC notes, patient feedback is an important developmental tool for reflective practice. In Picker Institute Europe’s experience, regular assessment of the patient experience, with attention to trends over time, is a particularly useful quality improvement tool when used by those who are committed to acting on its results. It is a sensitive measure of whether changes that are designed to improve quality are having an effect where it matters most—in their effect on patients.

FREQUENCY

40. However, to be used effectively for quality improvement, patient feedback should be gathered frequently enough to be able to give a picture of performance over time, including the impact of any changes that doctors have made to their practice as a result of previous data.

41. In this respect the current proposal—that patient feedback might be gathered only once every five years—is wholly inadequate and places a question mark over the utility of collecting it at all.

42. There is a clear contradiction between the GMC’s statement that patient feedback is “is one of a range of types of supporting information that doctors will collect to demonstrate their practice at appraisal”—and its proposal that the feedback will not be gathered annually for appraisals.

43. We believe that patient feedback should be gathered at least annually, to be used in each appraisal. Annual collection of feedback is not onerous. “Medical Revalidation: principles and next steps” noted in 2008 that “Many trusts already ensure annual MSF [multi-source feedback] as part of local clinical governance processes.” If so, then patient feedback should be part of that MSF. It should have parity with colleague feedback.

44. If patient feedback is only collected one in five years, it will be impossible to interpret the findings from one revalidation period to the next. Changes to results will be impossible to assign to any of the many possible causal factors occurring in such a long period. A five-yearly set of either good or poor results could easily be attributed to “luck” with a particular cohort of respondents.

45. Changes are somewhat easier to attribute in an annual cycle. However, we note that in acute hospital trusts, the gap of a year between results of the annual inpatient survey became a criticism used by hospitals who felt they were having to wait too long to measure the impact of improvement plans. As a result, increasing numbers of hospitals are now adopting more frequent patient experience measurement (“near real time” feedback, monthly or even fortnightly).

46. We also ask the select committee to note the context in which revalidation will be introduced. The government is committed to much greater and wider use of patient experience measurement across the NHS, including near real time feedback. It seeks the rapid establishment of information systems that will allow patients to see service-level reporting of healthcare quality.

47. In short, the proposals for implementing revalidation are falling well behind the curve of the development of patient experience information, quality information, and information for choice in the English NHS. This is a potentially serious issue, which needs to be taken into consideration.

48. We respectfully request the select committee to consider Picker Institute’s alternative proposals, that:
— patient feedback should be used at every annual appraisal, and therefore collected at least annually;
— there should be formal consideration of establishing more frequent and continuous collection of patient feedback data, tailored to the doctor’s service settings and patient characteristics where relevant, to enable both early alerts to weak performance on patient experience, and early assessment of the impact of any improvement actions;
— where patient experience data give cause for concern, a remedial action plan for improving performance and monitoring patients’ experiences of care should be agreed and implemented. Doctors should be required to submit real-time evidence of compliance with the plan to their appraiser and Responsible Officer until repeated patient experience surveys demonstrate satisfactory performance.

CONSISTENCY

49. In its response to the consultation, the GMC makes clear that it does not intend to establish a “central” system for collecting patient feedback. It also notes that questionnaires which it makes available will need to be administered independently.

50. These statements imply a devolved approach in which local workplaces, or even doctors themselves, will choose which instruments to use, how and when to administer them, what assistance and which third parties to contract.

51. While we understand the good reasons for wishing to devolve quality management to a local level, where people “own” the results, Picker Institute Europe is also conscious of the real risks this poses to the consistency of patient experience measurement. Here we offer the benefit of lessons from co-ordinating (and participating as a survey provider in) the regulator’s national patient surveys in both primary and secondary care.

52. Staff and service settings vary considerably in their expertise, confidence, capacity and willingness to co-operate to administer patient feedback questionnaires consistently and in accordance with agreed methodologies and protocols.

53. Inconsistencies are not acceptable to medical professionals. If, for example, one doctor receives poor feedback from his patients, but a nearby colleague or a similar specialist is perceived to have “skated by” using a different method, or the same method administered or reported in a different way, there will be complaints of unfairness that will undermine the validity of patient experience data.

54. Similarly, if one region takes a “maximalist” approach to data collection, and another a “minimalist” approach (in terms, for example, of numbers of patients or numbers of questions/indicators), it will be unacceptable to those being appraised.

55. Hence whatever system is established must be capable of delivering consistency—it is the same thing as credibility, especially in a profession which is so ruthlessly evidence-based.

56. In the national survey programme, inconsistencies are ruled out as far as possible by using a combination of devolution and co-ordination:
— A single standard questionnaire is used, providing “core” indicators that are comparable between the trusts and departments being surveyed—but trusts can, should they wish, use additional tested questions according to their own needs.
— Each NHS trust administers its own survey. It may or may not choose to employ an independent contractor for this. However, a rigorous administration method is laid down, to which trusts and their contractors must adhere. Central co-ordinators provide regular advice and assistance to trusts, as well as quality assuring their implementation.
— A minimum sample size is stipulated. Again, however, it is open to individual trust to seek a larger sample where they believe it is helpful and justifiable. Larger samples produce richer results.
— There is a competitive market in survey contracting, but within a managed “framework”, which means that survey providers must be approved for these purposes. This helps to ensure that all independent contractors work to similar standards and follow the approved methods.

57. We do not argue that this system must be exactly replicated for medical appraisal and revalidation, but we would point out the benefits of co-ordination to all parties.

58. Everyone in the system knows with confidence that they are measuring the same things, in the same way.

59. Everyone in the system knows with confidence that they are not being disadvantaged by any variance in the number or character of the questions, or by undue variations in sample size.

60. Everyone in the system knows where to go for advice—and that the advice they receive is the same as would be provided to everyone else.
The results are comparable between all trusts (nationally); between trusts within a region; and between trusts of similar type, or size. Importantly, where a consistent method is used for repeat surveys, results are comparable over time, and can show whether performance is improving or deteriorating on any specific indicator.

Local workplace organisation and administration of patient experience measurement carries a substantial risk of poor process, poor data quality and considerable expense.

Poor process can include the introduction of bias. This is likely if staff directly involved in patient care administer the questionnaires; or if patients complete them while still within a care setting on which they still feel dependent.

Poor process can also include undue variation in sample size, or in demographic sampling, leaving uncertainty about the representativeness of the data.

With regard to confidentiality, local devolution also carries a serious risk that individual patients will be identifiable.

We would therefore respectfully request the committee to consider recommending that the General Medical Council should review the potential benefits of a managed, co-ordinated and quality assured system for organising and administering patient feedback collection.

TIMESCALE FOR IMPLEMENTING REVALIDATION

Medical revalidation, and the associated improvement in medical appraisal, have already been in development for nearly a decade. This is too long. No further undue delays should be tolerated. Patients expect—and have a right to expect—that the quality of their doctors is regularly assessed and assured. This is about the safety, effectiveness and appropriateness of the healthcare that citizens receive.

The GMC’s consultation proposed a phased approach to implementation that would potentially give organisations that are not ready an additional five years after 2011. The majority of those responding to the consultation apparently agreed.¹³

This potential extension is perverse because it apparently licences organisations with clinical governance systems that are not fit for purpose to continue in that state. It is unacceptable because patients and the public expect the NHS to have these systems in place now.

Picker Institute Europe believes, and asks the committee to consider, that:

— the introduction of revalidation should drive improvement, not encourage complacency;
— a firm target date should be set for revalidation to go live, with the expectation that all areas and healthcare organisations will implement revalidation from that date;
— those areas or organisations that appear not to be ready should receive targeted assistance to achieve the implementation date.

Roughly 18 months remain for piloting. While the early adopters are engaged in piloting (or learning from it), weaker organisations should be putting their systems in order. Therefore:

— organisations should be required to be ready to introduce revalidation within 18 months of early adoption;
— organisations should be required to introduce revalidation within 24 months of early adoption.

November 2010

Written evidence from Dr Douglas G Fowlie (REV 15)

I seek to emphasise:

— The vital link between failed revalidation and mental illness.
— The importance of establishing specialised clinical services.
— The prospects for effective Remediation when “hidden” illness is identified.
— The economic and public safety benefits arising from endorsed services.

1. I am Clinical Advisor to the Practitioner Health Programme [www.php.nhs.uk]. I contributed written and oral evidence to the Shipman Inquiry on behalf of the Royal College of Psychiatrists. The submissions were incorporated into Dame Janet Smith’s 5th report.

2. I am a project member for the development of competencies under the Health for Health Professionals initiative. The document Enhanced Competencies for Psychiatrists was submitted to the Department of Health by the Royal College of Psychiatrists on 31 March 2010.

¹³ We note, however, that while it remains committed to a phased approach, no time period is specified in the GMC’s own response to the consultation.
3. I have been involved in providing and promoting clinical services for clinical staff for 30 years. I am licensed to practise by the General Medical Council [1319934] in general psychiatry and old age psychiatry and am recognised as having special experience in addictive disorders.

4. I sat on Dame Deirdre Hine’s General Medical Council Health Review Group. It recommended Departmental recognition of the need for dedicated clinical services for doctors.

5. Subsequently Sir Liam Donaldson’s Regulatory Review proposed establishing specialised services to deal with mental illness and addictive disorder in clinicians.

6. A White paper commitment led to the prototype Practitioner Health Programme being commissioned by the Department of Health.

7. The imminent report on the first two years work at php highlights the 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 that period [an annual prevalence of about 0.4%].

8. Clinical conditions which compromise insight, alter mood, interfere with perception and impair memory, intermittently or progressively, are diagnosable in their early stages. The illnesses may, on occasions, be preventable.

9. Behaviour which is inconsistent with revalidation may be determined by these identifiable disorders.

10. Once identified there is a good chance of successful treatment and consequently a real prospect for restoration of full capacity to practise. Eligibility for revalidation would likely then be restored.

11. Dedicated clinical services which are trusted and accessed by doctors, are endorsed by employers and are validated by the General Medical Council would seem to provide a means of promoting public safety.

12. If that tripartite consideration prevails then the Remediation component of Revalidation would be enhanced given the limited prospects for remediation when doctors are found unfit to practise for other reasons [not associated with ill health].

13. The importance of recognising doctors’ idiosyncratic approaches to their own health and it’s management was re-emphasised in the Report of the working group on the Health of Health Professionals [Department of Health, 5 March 2010]. Recommendation 4.7 calls for clarity in dealing with health concerns within revalidation procedures.

14. Fostering the principles embodied in the founding of the Practitioner Health Programme and supporting a specialised approach in clinical services for clinical staff [including doctors] throughout the United Kingdom would uncover an economic saving. Greater numbers of expensively trained clinical staff would be likely to return to effective working in a shorter time.

15. Those benefits would become doubly relevant to the general public through shortening any periods of ineffective practice and/or discontinuity of care.

16. My point in making this brief submission is to emphasise that Revalidation will probably unmask numbers of doctors manifesting complex reasons for becoming unfit to practise. The likeliest remediable cause within that group will be mental illness coupled with addictive disorder.

17. The chances of making a correct diagnosis, formulating and implementing a recovery plan and promoting rehabilitation are enhanced by espousing the principles underpinning the provision of clinical services for doctors.

18. A UK network of psychiatrists, general practitioners and occupational health physicians with enhanced competencies could form the core of that dedicated clinical response.

19. An endorsed specialised service would become complimentary to the appraiser, medical director and responsible officer roles identified in the revalidation proposals.

20. Adding the numbers of doctors likely to need remediation because of illness augments the overall justification for promoting clinical services for these invisible patients.

The detail underpinning this submission can be provided at the Health Committee’s discretion.

Dr Douglas G Fowlie MB ChB, FRCPsych
Consultant Psychiatrist and Honorary Research Fellow—University of Aberdeen.

November 2010
Written evidence from the Royal College of Psychiatrists (REV 16)

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

We are pleased to respond to this consultation. This consultation was prepared by Dr Laurence Mynors-Wallis: Registrar.

1. SUMMARY

1.1 The Royal College of Psychiatrists strongly supports revalidation. College members, whilst having understandable concerns about bureaucracy and potential time taken from direct patient care, have accepted revalidation guided by the aims set by the College which are listed below:

— revalidation must command the confidence of patients, the public and the profession;
— revalidation should facilitate improved practice for all College members and fellows;
— the process should identify those whose practice falls below acceptable standards and give advice and monitoring to allow revalidation to be reconsidered; there should be early warning of potential failure so remedial action can be taken;
— the process should allow those who are working to College standards to revalidate without undue difficulty or stress;
— there must be equity across the specialties, independent of differing areas of practice, working environments and geographical location;
— revalidation should be affordable and flexible, starting simple to allow further development; and
— the process should incorporate as far as possible information already being collected in clinical work and use existing tools and standards where available.

1.2 The College is clear that revalidation is not, and should not be, about identifying the few bad doctors. Whilst this may happen in a few cases, other governance systems should pick up failing doctors and concerns should immediately be addressed.

1.3 Revalidation must be about supporting doctors in their endeavour to deliver high quality and improving healthcare. The success or failure of revalidation will depend to what extent this aim is achieved.

2. GMC Proposals for Revalidation

2.1 Revalidation for psychiatrists will involve a robust annual review with an experienced colleague (an appraisal) at which the doctor being appraised will provide evidence that they are meeting professional standards. The appraiser will use this evidence to identify any necessary developmental actions and discuss evidence required for future appraisals. It is expected that this process will be collaborative with the professionals working together.

2.2 The purpose of collecting supportive evidence for appraisals, over the five-year cycle, is not to tick boxes showing that a particular standard has been met, but rather to enable the psychiatrist to collect a body of meaningful information that will demonstrate continuing fitness to practise. It is expected that this process will facilitate ongoing professional development, the aim of which is to improve the standard of care that each psychiatrist provides for patients.

2.3 It will be clear from this description of revalidation that the role of the appraiser will be crucial. The appraiser must be an experienced doctor, trained to assess the standards expected for psychiatrists and mindful of the significant obligations that appraisal places upon him or her to undertake a robust and rigorous process. Appraisers must be supported in this important role with both training time and access to peer review.

3. College Concerns

3.1 Revalidation and the medical member of the tribunal reviewing detention under the Mental Health Act

3.11 The College has a particular concern about the revalidation proposals with regard to doctors who sit as a medical member on mental health review tribunals. It is proposed at present that these doctors do not need to be revalidated but they will simply need to be registered doctors.

3.12 The College believes this is wrong. Doctors who make important decisions about detention and hence liberty of patients must be revalidated. This will assure patients and their carers that the doctors being asked to make important decisions about continuing detention under the Mental Health Act are up to date and fit to practice.

3.13 It is difficult to know what credibility a medical member would have in going against the decision made by the treating psychiatrist, if the treating psychiatrist is a revalidated doctor and the review tribunal panel doctor is not.

3.14 We believe that patients should have a choice; they may not wish to be assessed by a non revalidated doctor. The College believes it unlikely that many detained patients, who are often significantly unwell, will
be unable to make the distinction between a registered doctor without a license to practice and a revalidated
doctor, even if this is explained.

3.2 Responsible Officers

3.21 In England there continues to be some uncertainty as to whether responsible officers in managed care
organisations will be the medical director. The Royal College of Psychiatrists believes the medical director is
well placed to be the responsible officer. He or she already has a responsibility for ensuring good clinical
governance within their organisation and this involves ensuring that the doctors within their organisation are
fit to practice. The College is aware that there could be a concern about potential conflicts of interest. However
it is already the case that the medical director is expected to highlight clinical concerns. Medical directors will
be readily aware of the difference between a colleague in their organisation meeting the professional
requirements of revalidation and the different requirements of a Trust wishing a doctor to work in a different
way.

4. Current GMC Pilots in London and West Yorkshire

4.1 The Royal College of Psychiatrists is participating in the current revalidation pilots. Whilst we support
many aspects of what the GMC is piloting, the College has two concerns:-

4.11 The current system of dividing good medical practice (the generic standards for all doctors) into four
domains and twelve attributes is not ideal. There are some attributes that can easily be measured, others
are more subjective or can only be measured when they don’t occur. The College in its submission to the
GMC consultation recommended reducing the number of areas being assessed at appraisal. The three key
headings are as follows:

(a) Demonstrating good clinical care;
(b) Relationships with patients and colleagues; and
(c) Continuing Professional Development.

4.12 The supporting technology. It will be crucial if revalidation is to work for there to be a working
electronic portfolio within which revalidation information can be collected and stored, both for clarity of
information required and quality assurance. The College is concerned that the current electronic system
used within the NHS in England has been withdrawn as a free service for doctors. This seems a retrograde
step. It cannot be the case that appraisal information should continue to be stored in lever arch files on
doctors’ shelves. Nor should it be the case that each College develops a separate system for collecting
information.

5. The Speed of Implementation

5.1 Whilst the College understands the desire to ensure that information from the current revalidation pilots
is collected and analysed before revalidation is implemented, on balance the College believes that revalidation
should start soon. There have been discussions about revalidation for well over a decade. The proposals as
they exist should not be a surprise for any individual doctor, and indeed should ensure that all doctors practice
at what should be seen as minimum standards.

6. Standards set for Psychiatrists

6.1 Revalidation and appraisal provide the opportunity for a psychiatrist to reflect upon their work with an
experienced colleague and to develop a plan for subsequent professional development in the subsequent year.

6.2 The Royal College of Psychiatrists has established a clear framework of evidence that psychiatrists will
present at appraisal. The College has been mindful of the need to start with a simple and readily understood
process, building on what is already in place. The standards expected for psychiatrists over a five-year cycle
are as follows:-

6.21 Providing evidence of good clinical practice. The College is recommending that this is done in two
ways; firstly via at least two audits, per five-year revalidation cycle, of significant areas of clinical practice.
The purpose of this is to demonstrate within key areas of practice the extent to which the doctor and
multi-disciplinary colleagues are meeting agreed standards, providing the opportunity to correct these
standards and then re-evaluate them the subsequent year.

On an individual level, each doctor will be required to discuss clinical cases, chosen at random, with a
colleague, the colleague providing feedback and identifying good areas of clinical practice and areas for
improvement. This is known as case-based discussion and in pilot work has been viewed enthusiastically
by consultant psychiatrists.

6.22 Feedback from patients. The patient experience is a key aspect of healthcare quality. The College
has developed and evaluated a robust system of seeking anonymised feedback from patients. It is expected
that this will be used at least once in a five yearly cycle, alongside local collection of patient feedback. It
is expected at appraisal that the psychiatrist will demonstrate how they have adapted their practice
according to feedback received.
6.23 Feedback from Colleagues. Almost all psychiatrists work within a multi-disciplinary team. Feedback from colleagues within the team, as to strengths and weaknesses, is helpful in developing the psychiatrist to be a key player and clinical leader within the team.

6.24 Clinical outcomes will become increasingly important over the coming years. The Royal College of Psychiatrists is recommending a range of outcomes to be used across mental health. The routine use of outcomes to inform the patient’s progress and the practice of the doctor is an important measure to improve patient care.

6.25 Reflections upon complaints or serious untoward incidents. Each psychiatrist will be expected to reflect upon, learn lessons as appropriate and take any necessary action following a complaint or adverse incident. This will be reviewed at appraisal.

6.26 Continuing Professional Development. Each psychiatrist will be expected to demonstrate that they are fully compliant with the College’s standards for continuing professional development.

7. Role of Medical Royal Colleges

7.1 The Royal College of Psychiatrists will have an important role in ensuring the success of revalidation, in the following areas:

7.11 Leadership. The College has been clear that it supports the processes of revalidation and hence has sought to allay the concerns of its members. This has been achieved by focusing on the aims set out above.

7.12 Setting clear and measurable standards for revalidation. The College updated the standards expected for all psychiatrists (Good Psychiatric Practice, Third Edition) in 2008 in order to ensure that the professional standards set were measurable and provided a clear foundation for revalidation.

7.13 Provide training and support for appraisers. Although appraisal can be seen as a generic activity, the interpretation of the College standards requires specialist expertise.

7.14 Supporting employers in assisting doctors who require remediation and further training.

November 2010

Written evidence from Dr Allan Cole (REV 17)

This submission is from Dr Allan Cole as an individual. He is an experienced Medical Director; having been in such a post in one of the largest acute Trusts (University Hospitals of Leicester) in the country from 1993–2009. In this post, he was one of the first to introduce appraisal to consultant medical staff. He is the lead and pilot Responsible Officer for the Pathfinder pilot of revalidation in Leicester, which is one of the 10 pilot sites. He is a past Chairman of the British Association of Medical Managers. He is now a Medical Director within the Revalidation Support Team.

Summary

— The GMC’s proposal to use regular annual appraisal as one of the essential elements of revalidation is likely to be effective.
— The proposal to use Responsible Officers in Designated Organisations (usually the Medical Director) is fully supported.
— The 12 attributes and four Domains of Good Medical Practice as defined by the GMC should remain the principle behind revalidation.
— The GMC’s opinion that the supporting evidence provided by doctors should directly map to the 12 attributes may be difficult to work in practice.
— To ensure clarity, there is a need to be more specific about the mandatory evidence required.
— The reviewer pilot must be allowed to be completed and inform the final form of appraisal.
— It is essential that the formative and supportive part of appraisal is not over-shadowed by the demands of revalidation.
— It is important that the governance and accountability arrangements for the implementation of revalidation are clear and effective.
— Training of appraisers and Responsible Officers is important to assure both quality and consistency.
— How the process of appraisal and revalidation is quality assured needs to be addressed.
— There is a need to identify what organisations will be “Designated” (and thus who the Responsible Officer will be) for GP’s in primary care after the changes proposed in the recent white paper.
— The extra year for implementation is strongly supported as being likely to improve the quality and effectiveness of the process.
THE WAY IN WHICH THE GMC PROPOSES TO ESTABLISH REVALIDATION

1. Appraisal for medical staff was adopted as a desirable activity for doctors more than 15 years ago and since then, as the benefits have been recognized, various initiatives from employers and professional organisations have been intended to make appraisal a necessary activity for several different purposes. However, there was little agreement about how appraisal should be undertaken and the implementation of appraisal has been patchy with some organisations and individuals having a reasonably comprehensive system while others have played little more that lip-service to the activity.

2. The GMC has proposed that appraisal should be one of the key components of the revalidation process. However, those that first developed medical appraisal, found that a supportive, developmental and formative process was the most beneficial and acceptable method of implementing it. Such an appraisal system though does not lend itself immediately to the more summative and judgmental process that is required for revalidation. However, it was widely agreed that the use of appraisal for revalidation was a sound and sensible proposal and work was therefore started to adapt medical appraisal to be fit for purpose for revalidation.

3. The term Strengthened Medical Appraisal (SMA) was coined to describe the improvements that were required in the medical appraisal process in order to support revalidation. A paper was prepared in November 2009 by the Revalidation Support Team (RST) which proposed a methodology which was to be used during the pilot project for revalidation called the Pathfinder Project which started in early 2010.

4. The Pathfinder pilot will not formally report on its findings until June 2011 although there will be an interim report in the coming months. The findings of the pilot must be allowed to inform the final form of appraisal although the need for streamlining and simplification as well as the evolving debate within the profession has allowed work to start on developing the SMA into a Medical Appraisal Framework (MAF). This work is currently being undertaken by the Revalidation Support Team, who are working in conjunction with all stakeholder organisations. This will include coordination as far as possible with similar work in the devolved administrations of the UK. and will be complete by the time revalidation is expected to go live in 2012.

THE FURTHER DEVELOPMENT OF THE GMC PROPOSALS

5. There are two distinct aspects of medical appraisal and this needs to be recognised:
   — the parts of appraisal which are intended to help individual doctors develop themselves, their career and their strive towards excellence. In this part, there will be challenge but there will not primarily be judgement. Partaking in this aspect of appraisal might become mandatory but the content will not lend itself to the type of judgement that will be required for revalidation.
   — the part of appraisal needed for revalidation, will be judgemental about the appropriateness of education and training, reflection and quality assurance activity that an individual is involved in compared to their particular practice. The aim is to make a judgement that an individual doctor is appropriately safe and up to date.

It is this second part that required strengthening when SMA was introduced. The word “strengthened” has been interpreted as the provision of a greater volume of evidence but it would be better interpreted as the need to provide certain information on a mandatory basis.

6. The use of the Domains and Attributes of Good Medical Practice - the GMC has defined four domains and 12 attributes which form the core of what constitutes “Good Medical Practice” (GMP) and expects that recommendations for revalidation from Responsible Officers on individual doctors, will essentially confirm adherence to these. It is entirely logical therefore that SMA proposed that appraisal should be informed by evidence collected by individual doctors which would directly map to one or more of these attributes. However, in practice this appears to be more difficult and less precise than at first envisioned. It may be difficult therefore to support the GMC’s view that evidence should be directly mapped to the 12 attributes.

7. This difficulty emanates from the nature of the attributes which are of necessity quite general and subjective because they are required to describe the principles of Good Medical Practice applying in all circumstances. As an example, whilst it is obviously entirely correct that a doctor must adhere to this attribute— “apply knowledge and experience to practice”, providing specific evidence of this is unlikely to be comprehensive and will tend to result in superficiality. The other extreme which has also been found is that some have felt the necessity to produce extraordinary amounts of information in an attempt to be comprehensive which has become far too onerous for all (and probably counter-productive).

8. There is a need therefore when practically implementing appraisal for revalidation, to have a clearer understanding of the type of evidence that is expected in order to fulfill the expectations of the GMC for the purpose of revalidation against the 12 attributes.

9. To this end, the MAF is likely to propose that evidence is separated into areas which should apply to all doctors in whatever activity they are engaged:
   — A summary/description of all activity within their practice as a doctor;
   — A record of activity in training and keeping up to date;
— A description of contribution to quality assurance systems for an individual’s practice, outcome data where feasible;
— Feedback from patients, colleagues and staff:
  (a) Patient questionnaires;
  (b) Colleague feedback; and
  (c) A record of all complaints and serious incidents.
— Self-declaration regarding health and probity.

10. A summary/description of all activity within their practice as a doctor

The importance of this is that in order to assess effectively a doctor’s safety and fitness to practice, it is essential that an appraiser has a complete view of the type(s) of practice the appraiser is engaged in and this has to be in some detail. While a job plan may be helpful information in this regard, it is unlikely to be sufficient. There is a need to know the types of patients, the volume of cases and the medical techniques used. This description should be inclusive of private work of all sorts, teaching, research, professional duties, management etc.

In some specialties a log book could be provided but may be over-detailed for the purpose—a summary of work would be easier for an appraiser to assimilate. Thought needs to be given to the best format or formats for this information.

11. A record of activity in training and keeping up to date

The purpose of this is for the appraiser to be able to assess whether the doctor is undertaking sufficient continuing education and mandatory training to enable the individual’s practice to remain safe and up to date.

Many of the Medical Royal Colleges are producing guidance on what they consider appropriate in their specialties. However, many individuals over time, practice in quite narrow areas of the specialty or even in areas which are not directly within the remit of their own specialty. This means that the assessment of adequacy of education and training needs to be done locally by the appraiser. When necessary, the appraiser will of course be able to take advice from colleagues in or outside a Trust to help support this assessment.

12. A description of how an individual ensures their practice is quality assured

It is necessary that all doctors consider how their practice is measured. There is a huge variation in how this is done in different areas of medical practice.

The term Clinical Audit has often been used to describe some of these activities but it means different things to different people. The type of activities include:
— Contribution to a national register.
— Individual outcome data.
— Team outcome data—this may be gathered formally through hospital data but can also be less formal when doctors work in teams:
  — Attendance at specialty and inter-disciplinary meetings could be included where applicable (eg MDT’s).
  — Specific QA activity (eg in Pathology).
— Individual collection of complications and compared with published evidence.
— Etc. etc.

An appraiser will need to assess the appropriateness of the quality assurance activity for the appraisees’ particular practice. Where a practice involves a very high risk of serious consequences, it is likely that the requirement for QA will be more rigorous than in a practice with less risk of serious consequences. Similarly, where doctors are working in teams and where the quality of the whole team is measured and known to be good, then there may be less need to provide information on an individual (and indeed it may not be very easy either).

Again, the Medical Royal Colleges will provide helpful advice on this but the assessment will need to be made individually by an appraiser because of the heterogeneity of practice between different individuals.

13. Feedback

Appraisees will need to provide feedback on their practice. It has been agreed that a formal MSF will normally only be required every five years and there is not yet clarity about how this should fit in with other forms of patient questionnaires.

Negative feedback in the form of complaints will also need to be presented to appraisers, who need to ensure that appropriate actions and reflection have resulted and whether there is any untoward pattern to the complaints.
14. Health and Probity

An assessment of health and probity will be required

15. The developmental part of Appraisal

The requirements of revalidation have made it necessary to make considerable changes to the appraisal that was originally developed for medical practitioners. It is of great importance that the demands for the more basic and judgmental part of appraisal for revalidation, do not displace the beneficial and supportive part of appraisal that has been developed previously.

Much has been written about how the more formative appraisal should be undertaken and how this helps doctors develop and improve their practice and how it augurs excellence. The continued development and strengthening of this is important for the profession and the patients. The more subjective nature of the contents of this, does not lend itself to the black and white judgments needed for revalidation.

If the GMC decided, it might be possible to make participation in such activity mandatory but it is unlikely to be feasible to make qualitative assessment of such appraisal—in other words all that could realistically be recorded was whether it was done or not done.

16. The questions that need to be answered by an appraiser in each year and at the end of a five year revalidation cycle.

At the end of an appraisal, the key outputs are a summary, a professional development plan and a series of set statements made by the appraiser. These statements are designed to apply to all practitioners but they may be too general and non-specific to allow an effective assessment summary of doctors in different specialties. The MAF will address this issue and work with others to define the questions that need answering in order to support effective revalidation.

This approach will require professional skill and judgement which underlines the need to have effective training for appraisers, which will not only ensure the quality of the process but also contribute to consistency. The appraiser may ask for guidance from elsewhere—Colleges or local colleagues.

OTHER COMMENTS

17. The process of revalidation and conflict of interest

Revalidation will be informed by Responsible Officers (RO’s) in “Designated Organisations”. The plan is that RO’s will be doctors in a Board level position which inevitably means that they are likely to be the Medical Director. Arguments have been put forward that this could become a conflict of interest but as the MD’s themselves are accountable to the GMC, this conflict is likely to be minimal except in some exceptional cases, such as with relatives. On the other hand there is a great advantage in the Medical Director being the RO because that will ensure that the responsibility for clinical governance and revalidation will coincide. This is of over-riding importance. the proposed process of revalidation is therefore fully supported.

18. Doctors employed in other ways

There are a significant number of doctors working independently, as locums or in other situations. All will require an RO and testing is being undertaken on how the process will work in these various situations. Indeed there is a question as to who will be the RO for primary care doctors after the planned demise of PCT’s which is proposed in the recent white paper and this issue will need to be addressed in the near future.

19. Leadership for Revalidation—there is a need to ensure there is complete clarity about responsibility and leadership of the implementation of revalidation. There are many stakeholders in the process which provides ample opportunity for confusion. The GMC as regulator may be the obvious organisation to lead on the implementation but it may not have the skills to implement revalidation without great dependence on many different partners—particularly the DH. The accountability needs to be absolutely clear.

20. Quality Assurance—there is a need to identify the most appropriate and cost-effective methodology of external quality assurance and who will undertake this.

21. The extra year- The extension of piloting by a further year announced by the Secretary of State in June has been of great importance in allowing the proposals and work so far to be adapted into a practical, affordable and effective tool for the revalidation of doctors. Without the extra year the Pathfinder pilot would not have been completed and its findings incorporated into the final methodology. It is not intended to use the extra year to extend the existing Pathfinder pilot but to use the time to ensure that its results can be used properly and to test specific aspects further (such as Multi-source feedback).

November 2010
Written evidence from the Royal College of Radiologists (REV 18)

1. The Royal College of Radiologists (RCR) has approximately 8,300 members and Fellows worldwide representing the disciplines of clinical oncology and clinical radiology. All members and Fellows of the College are registered medical or dental practitioners. The role of the College is to advance the science and practice of clinical oncology and clinical radiology through a range of activities, including setting and maintaining the standards for entry to, and practise in, the specialties of clinical radiology and clinical oncology, and arrangements for continuing professional development (CPD) in both specialties.

2. This response outlines the RCR’s views and approach to revalidation. The RCR has consistently advocated a straightforward, proportionate and practicable concept of revalidation. The RCR piloted this approach in 2008. This response details our views on revalidation and outlines the method of our revalidation pilot and the outcome. We conclude that a workable and equitable system of revalidation should be implemented to maintain the confidence of doctors and patients in the process.

It accepts that revalidation will occur through a system of strengthened medical appraisal and we do not address this aspect.

3. The RCR’s Approach to Revalidation

   The RCR has remained consistent in its approach to this subject since the publication of the White Paper: Trust, Assurance and Safety (1) in 2007. It believes that the process should be straightforward, easy to integrate into a doctor’s normal working life and, without undue expenditure for the health service or stress for the individual, provide reassurance to patients and employers that a doctor has no problems to address in either their general professional performance or specialist practice.

4. We believe this to be the essence and spirit of revalidation, rather than the provision of reams of documents which allow much variation in the evidence and could actually mask an underlying problem. We contend that a uniform approach and simple system is eminently feasible. The current RST pathfinder pilots use a complex system, which early reports suggest is very cumbersome from an IT perspective; in addition the general attributes of a doctor and the specialist aspects of their performance within the pilot are completely separate, and most importantly, the evidence is not the same for all doctors.

5. This variation in the type and quantity of evidence runs the risk of introducing unfairness, which if allowed to propagate through into the revalidation system risks producing legal challenge, potentially discrediting the system. Variation has been difficult to overcome because Colleges had made specific plans for recertification, in some cases quite complex, involving the building of electronic portfolios and appraisal systems, prior to it being merged back into a single process of revalidation. The Medical Royal Colleges were asked by the GMC to set out how doctors in each specialty should revalidate. They developed specialist frameworks which were “bolted on” to the RST developed pilot system, and are being tested in the pathfinder pilots. Reports from pilot sites suggest that the system is unwieldy. The RCR suggested to the Academy in July of this year that it would be better to streamline the frameworks into one generic template which embedded and incorporated specialty data within the generic questions. The Academy agreed with this suggestion and has subsequently liaised with the GMC about it.

6. In the current pilots there is a complex system of electronic mapping of all the evidence across to the GMC 12 attributes which is again not uniform, and appears cumbersome.

7. The RCR’s Suggestions

   (a) There now needs to be firm leadership of this process, as it is currently unclear to doctors at least, who is in charge. Early reports from the pilot scheme risk reducing confidence in the process developed by the Revalidation Support Team, the GMC has consulted but not yet given any specific guidance, and the profession has not yet been able to develop a suitable scheme, agreed by all.

   (b) Clarity of the roles and responsibilities of the various bodies would be helpful at this stage, although it would not be unreasonable to suggest that the GMC should dictate the system by which it would accept a recommendation to renew a doctor’s licence. We therefore suggest the GMC should lead, whilst working closely with the NHS in the four UK countries and the Academy. However we hope that complex mapping systems to GMC attributes can be avoided.

   (c) It is necessary to develop a much simpler system with a single set of evidence for every doctor as soon as possible, without waiting for detailed feedback from the pilots.

   (d) The process for assessing those whose conduct or professional capability is questioned should be clear before revalidation is introduced, as should the methods of remediation.

8. An Example of a Simple System

   In 2008 the RCR piloted a process of what was at that time still recertification. This included a small number of volunteers (31), but the returns were evaluated by a panel at the RCR which included a patient representative (chair of the RCR Clinical Radiology Patients’ Liaison Group). The conclusion of the assessors
following analysis of the anonymised returns was that this system would allow a judgement to be made on whether there were likely to be any significant performance or behavioural issues to address.

9. The pilot was based on the simple premise that an adequately performing doctor should be able to demonstrate:
   (a) Satisfactory peer/colleague and, where appropriate, patient judgement of performance.
   (b) Evidence that they acknowledge, and interact with colleagues to learn from error.
   (c) That they monitor and can demonstrate their own personal performance.
   (d) That they keep up with developments in their specialty or area of practice.

10. This translated into four core pieces of evidence which would capture all specialist performance and could be customised for any specialty or any type of practice:
   (i) **Multisource feedback, and where appropriate, patient feedback** once in five year cycle
   (ii) **Annual evidence of reflection on discrepancy, learning cases or error** examples could include: reflection on an individual error or learning case, attendance at morbidity and mortality or radiology discrepancy meetings, reflection on incidents or near misses.
   (iii) **One piece of evidence annually on their own professional performance** (Colleges and professional bodies should advise on these) but examples could include personal audit or outcome results, peer review, online self-testing results, personal review of cases or team audit. The choice should be tailored to individual practice, possibly with advice from the appraiser on an annual basis in the personal development plan to ensure sampling of whole practice.
   (iv) **Satisfactory Continuing Professional Development (CPD) record.**

11. These pieces of evidence cover, we believe, all the requirements of the recertification part of revalidation, and much of the relicensing requirement. To address all revalidation criteria we would suggest the addition of, for example, the following very straightforward information:
   (v) **Jobplan and workload.**
   (vi) **Record of complaints, significant incidents, and praise.**
   (vii) **Health record and personal statement.**
   (viii) **Statement of probity.**
   (ix) **Mandatory training record.**

This system or some variant thereof would, we contend, be proportionate, fair, and workable for all doctors.

**RCR Revalidation Templates and Tools**

12. The RCR has provided guidance on how to produce the relevant evidence for appraisal/revalidation, together with simple tools and templates, mostly on a single sheet, to be completed for the doctor’s record (2). They can be downloaded and stored electronically by the individual, uploaded into any appraisal system, or indeed printed out for paper-based appraisal. Such tools could however be nationally developed for the generic aspects of a doctor’s practice, with a choice of specialty specific templates produced by relevant Colleges and professional bodies.

**Conclusion**

13. The RCR’s view is that revalidation should be uniform across the profession and requires the same type of evidence for all doctors; that relevant evidence should not be difficult to obtain or time consuming to complete, and taken together, would capture the doctor’s whole practice in relation to their obligations under the GMC’s definition of Good Medical Practice. It would provide reassurance for most doctors that they remained fit to practise. To maintain the confidence of doctors and patients in this process after such a long gestation period, it is important that a workable and equitable method for revalidation should be developed without undue further delay.

14. It is also important that a clear route for the further assessment, and, where appropriate, robust and fair systems to deal with retraining and remediation, of those whose performance is called into question should be in place by the time revalidation is implemented. Without this, major problems are likely to arise for appraisers, responsible officers, employers, those doctors whose practice is in some way called into question and the patients they care for.

15. **References**


*November 2010*
Written evidence from the Royal College of Physicians (REV 19)

The Royal College of Physicians (RCP) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing over 20,000 Fellows and Members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

1. EXECUTIVE SUMMARY

— The Royal College of Physicians supports the introduction of revalidation in the UK in 2012 as a means of promoting and enhancing the quality of care that physicians provide to their patients and the public.
— We remain concerned about certain aspects of the current proposals.
— We agree that the revalidation process should be simplified and streamlined.
— We consider that the differences between specialties should be acknowledged and supported within a common framework.
— High quality appraisal is central to the successful delivery of revalidation.
— Appraisal should remain a predominantly formative process.
— We consider that it would be simpler, and more broadly applicable, if specialty supporting information was categorised under three main headings rather than the 12 Attributes of the GMP Framework.
— The current proposals for Strengthened Medical Appraisal are over-detailed and should be simplified.
— Actual or potential conflicts of interest within the RO role should be addressed, and steps taken to manage these if they occur.
— Colleges and Faculties should continue to play a central role in the revalidation process, including setting of standards, supporting implementation, and in quality assurance.
— Specialist support and guidance should be provided by Colleges and Faculties to individual doctors, appraisers and Responsible Officers, both in routine revalidation processes and where remediation may be required.
— We wish to continue to work closely with the GMC, the Revalidation Support Team and other stakeholders to ensure that revalidation achieves its potential benefits in terms of improved quality of care for patients.

2. INTRODUCTION

2.1. The RCP is pleased to have the opportunity to support the work of this Parliamentary Inquiry. We believe that revalidation has the potential to yield important benefits to the public and to the medical profession in the form of improved healthcare quality and outcomes, and in terms of reinforcing public confidence in the profession.

2.2. However, significant uncertainties remain in relation to the planned process and its key components and we very much welcome the opportunity to contribute evidence to the Committee on behalf of our Fellows and Members

2.3. In October, the GMC published its analysis of the response to its public consultation “Revalidation: The Way Ahead”, to which the RCP had submitted a comprehensive response. We commend the GMC for conducting a thorough and comprehensive consultation in advance of the introduction of revalidation in the UK, and welcome the fact that the analysis of responses addressed a number of key concerns already raised by us and by other royal colleges. We also welcome the recognition of the need for further testing.

2.4. One of the main conclusions from the GMC’s report is that the process needs to be simplified and streamlined to provide a better fit with requirements and expectations. We acknowledge and support this conclusion.

2.5. We also believe that the essential differences between specialties should continue to be recognised, based within a common framework. In collaboration with the Academy of Medical Royal Colleges we are taking steps to streamline the components of the process that relate to the roles of this College and its Fellows and Members.

2.6. The Colleges are well placed to establish standards and to support implementation at local, as well as national, level. This support should include involvement in quality assurance of processes and outcomes, as well as the provision of advice and guidance to physicians, appraisers and Responsible Officers.
3. THE PURPOSE OF REVALIDATION

3.1. Throughout the development process, those organisations responsible (GMC, Department of Health, NHS and the Medical Royal Colleges and Faculties) must retain a strong focus on the purpose of revalidation. In their document “Revalidation: A Statement of Intent”, the GMC, the CMOs for England and Northern Ireland, the Deputy CMO for Scotland and the Medical Directors of the NHS in England have all agreed that “the purpose of revalidation is to assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and fit to practise”.

3.2. However, this document also acknowledges that revalidation “…..should be part of a range of measures to ensure high quality safe care”. The two other elements are appraisal and robust clinical governance. We believe that appraisal is the key to bringing the other two elements together “sensitively and effectively” (Secretary of State) and we support the view expressed in the CMOs report Medical Revalidation—Principles and Next Steps (2008) that appraisal “should remain a predominantly formative process”. A great deal of work has already been done to bring these processes together, but more is needed in order to avoid a conflict between the processes of clinical governance (quality control) and revalidation (quality improvement and regulatory assurance).

3.3. In its submission to the GMC consultation, the RCP emphasised the relative importance of quality improvement as the main benefit of revalidation. The public already has high confidence in the ability 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.

4. FRAMEWORKS AND SUPPORTING INFORMATION

4.1. It is clear that revalidation will depend on a number of systems and processes working efficiently together across the healthcare system. Although the GMC owns the last stage of the process (the point at which the doctor’s licence to practise is renewed for another five year period), a number of processes that lead up to that point are owned by other organisations (for example, by employers and the Medical Royal Colleges and Faculties).

4.2. The other area of the revalidation process of which the GMC has taken ownership is the underlying standards framework. This was adapted from the previous edition of the GMC’s code of practice “Good Medical Practice”. The Good Medical Practice (GMP) Framework consisted of four Domains, 12 Attributes and over 60 “Standards”, and provided a structure by means of which supporting information from the individual’s practice would enable doctors to demonstrate that they were up to date and fit to practise.

4.3. In 2008 the GMC approached the Academy of Medical Royal Colleges with a request that Colleges and Faculties should develop specialty-specific frameworks that would specify the supporting information that would enable each medical specialty (College or Faculty) to demonstrate that they were meeting the requirements of the twelve Attributes.

4.4. After much consultation each specialty provided a framework, many of which stipulated “core” and “optional” supporting information and an accompanying Checklist, since many elements of the supporting information were relevant to several Attributes. These specialty frameworks and checklists featured as an appendix to the GMC’s consultation document “Revalidation: The Way Ahead” (March to June 2010). The Colleges and Faculties anticipated that these “core” and “option” frameworks would need more work, and were continuing to review them on a regular basis.

4.5. The GMC’s analysis of the consultation response suggested that the Colleges and Faculties frameworks were over complicated. It had already been recognised by the Colleges and Faculties that the specialty proposals would require modification, and this work was taking place during the consultation period. The GMC has now stated that they wish to work with the Colleges to streamline the specialty-specific frameworks.

4.6. The GMC consultation response also indicated broad agreement with the proposal that relicensure and specialist recertification should be combined into one process of “revalidation”. While this makes sense from an administrative perspective we have concerns about its effect if the concept is combined with too much simplification and streamlining. This is because reduction of the required supporting information to a small number of generic elements will significantly limit the ability of doctors to revalidate according to the nature of their professional (hence specialist) practice.

4.7. Within the physician Colleges there are numerous sub-specialties, and therefore potential inconsistencies may arise. We have addressed this by allowing sub-specialties to maintain their own “take” on the core elements of the process, recognising that good practice in some sub-specialties will require, for example, greater technical or communication skills than others. This is where the specialist certification element of revalidation is important.

4.8. The Academy and its constituent Colleges and Faculties are working on a common core specialty framework that can be applied to all, while acknowledging essential specialty differences. This framework will achieve the streamlining that the GMC recommends, especially if it is structured under three main headings—Objective Evaluation, Perceptions and Maintenance of the quality of your work.
4.9. The RCP was closely involved in the first secondary care pilot in Mersey, and it was recognised through this pilot that Trust information systems needed upgrading, and that some of the GMP Attributes were more difficult to provide supporting information for than others. The proposed specialty frameworks were not available to test.

5. APPRAISAL

5.1. The appraisal process has, rightly in our view, been placed at the centre of proposals for revalidation. Appraisal is the process by which an individual doctor will be able to review the quality of his or her individual professional practice and will agree a plan for personal development. Dame Janet Smith considered that “appraisal is patchy and not fit for purpose” and recommended that it should be strengthened. We agree that there is wide-spread variation in the way appraisals are carried out in different organisations and therefore the current processes may not always be sufficiently robust to base revalidation upon them.

5.2. It is because of these challenges that a new format for appraisal, Strengthened Medical Appraisal (SMA), is being developed, within which doctors must demonstrate compliance with the GMP domains and attributes on an annual basis. SMA is currently being piloted within the “Pathfinder Pilots” in England.

5.3. The RCP recognises the importance of “Good Medical Practice” as a descriptor of the behaviour to which all doctors should aspire. Showing that doctors are achieving these attributes will require supporting information that may be more conveniently classified under the different headings suggested, so that specialty variations are more easily understood and acknowledged.

5.4. The process currently proposed for SMA is complex and detailed, perhaps because of the perceived need to make decisions based upon it legally defensible. Each item of supporting information is subject to scrutiny at a number of stages, and this has made the proposed process time consuming, and challenging to pilot effectively.

5.5. A number of electronic systems have been, and are being, developed in an attempt to streamline this process, but these have brought their own problems and have not always seemed helpful to their users. We believe that appropriate electronic systems should be available, but that they, like the process they are designed to support, should be flexible and streamlined.

5.6. Because of the relatively short (one year) timescales of the pilots, more work has had to be put in than may be required when revalidation is rolled out. This needs careful consideration, since to under-estimate the resource implications would be disastrous. It is important that doctors understand that although appraisal must happen every year, revalidation is a five-year process, and SMA needs to be based firmly on this premise.

6. DECISION-MAKING PROCESS

6.1. The Responsible Officer (RO) is the person who will have statutory responsibility for bringing together the outcomes of the annual appraisals and other information about the performance of a doctor, and making a positive recommendation to the GMC in favour of revalidation. The equivalent role within the NHS at present is that of Medical Director, and it has been recommended that the two roles should be carried out by the same person.

6.2. The competencies required of an RO have been set out in Guidance, and the ROs will themselves be subject to appraisal. However, some of the competency frameworks that have been suggested as a basis for this process appear over-complicated and aspirational.

6.3. The joining of the Medical Director role (clinical governance and performance management) with the Responsible Officer role (revalidation and quality improvement) may give rise to real or perceived conflict of interest, particularly where Trusts are under financial or target-related pressure. Proper mechanisms to support ROs, and to ensure that such conflicts of interest are avoided, must be developed.

6.4. This will form part of the quality assurance process that needs to be applied to revalidation, for the reassurance of doctors, and for the reassurance of the public. We believe that the Colleges and Faculties should be equal partners in this process with other key stakeholders. We have a responsibility not only to our members and Fellows to advise and support them, but also to our patients and the wider public to ensure that the doctors treating them are fairly judged.

6.5. Input from patients, carers and the lay public has been a central part of the way that we have approached the development of the recommendations for revalidation for physicians. The same is true for other Colleges and Faculties. Patient and carer participation and feedback should be obtained not only through patient questionnaires relating to individual doctors, but also through their continued involvement in the roll-out and quality assurance of the system.

6.6. The future role of GMC Affiliates (or the equivalent under new terminology) will need careful consideration. Even if, as “lay Affiliates”, they are not medically qualified, they will still be employees of the GMC. Thus while they will have an important role in ensuring consistency of decision making and engagement with relevant stakeholders they will not be best placed to provide the independent view normally associated with lay representatives.
7. ROLE OF THE MEDICAL ROYAL COLLEGES AND FACULTIES

7.1. The Medical Royal Colleges and their specialist organisations were tasked, in “Trust, Assurance and Safety” with developing the standards for specialist practice and developing the means to demonstrate that they were being met. The great majority of doctors are “specialists” (including General Practitioners) and therefore we believe that the Colleges and Faculties, and thus the Academy, must remain key contributors to a revalidation process that is designed to support doctors in demonstrating their professional competence within their specialist field.

7.2. We consider that the Colleges and Faculties are well-placed to train and advise appraisers and ROs on the requirements for revalidation in our specialties.

7.3. We consider that the Colleges should be involved in the quality assurance of revalidation. This will be important in order to provide an external perspective to that of the GMC, who would otherwise be solely responsible for the quality assurance of their own decision-making processes.

7.4. We recognise the central role of the Revalidation Support Team (England) (RST) in the development and implementation of revalidation. We have worked closely with the RST throughout the process so far, but are concerned that they may become linked mainly with NHS employers. This could create an excessively performance-managed approach to revalidation that risks polarisation and would not serve the process well. We consider that the RST, as representatives of the Department of Health, and the Colleges and Faculties, with the Academy, should work closely together to achieve a revalidation programme that meets all of the aspirations of all parties concerned.

7.5. We consider that, as specialist organisations, the Colleges and their specialist associations should be closely involved in the processes of remediation, where this is required. We are in a good position to provide advice to individual physicians and to their ROs regarding the skills and standards required. There will be individuals whose needs are relatively minor, when referral to a Clinical Advisory Service or the regulator will not be required. Adequate funding will need to be identified for the supportive remediation of these individuals, and Colleges will have an important role in its delivery.

7.6. WHAT WILL HAPPEN NEXT

7.7. The current Pathfinder “whole system” pilots are due to complete in March 2011. We agree with the GMC that the data gathered from these must (a) address the many key questions that are being asked and (b) be properly analysed and learned from prior to the roll-out of revalidation.

7.8. Additional pilot projects through 2011 should be targeted at any remaining critical areas. We consider that the revalidation of locum doctors and revalidation of those with “portfolio” job plans have not yet been adequately addressed.

7.9. The cost-benefit analysis, planned for the second quarter of 2011, must be realistic, honest and robust, and sources of funding to support revalidation must be identified and agreed by all. The GMC proposes to roll-out revalidation according to “organisation readiness”, and this implies, we think correctly, that there is uneven “readiness” across the UK. This being so, the cost analysis must address those organisations where appraisal and IT systems are currently poor as well as those where they are already excellent.

8. RECOMMENDATIONS

8.1. We recommend that there is continued close co-operation between the Academy of Medical Royal Colleges, individual Colleges and the GMC in the further planning and implementation of revalidation.

8.2. We recommend that the Colleges / Academy and the Revalidation Support Team (England) continue to work closely together in areas of mutual interest.

8.3. We recommend that all elements of the revalidation process should be streamlined, but at the same time that the process should continue to acknowledge that trained doctors practice in many different ways, and therefore the details of individual revalidation requirements will differ.

8.4. We recommend that the learning from the Pathfinder Pilots, and from the work in other areas that has already been carried out, is taken into account in the remaining time available before revalidation roll-out.

8.5. We recommend that the cost implications of revalidation are honestly and openly considered, and that proper and manageable arrangements are made to meet these costs.

November 2010
Written evidence from the Royal College of Surgeons of England Patient Liaison Group (REV 20)

The Patient Liaison Group (PLG) of the Royal College of Surgeons of England is an independent body, which reports regularly to the College’s Council. Comprising a majority of lay members (including its Chair), it provides a patient, carer, and public perspective across core College business. This submission represents the considered views of the PLG itself, and not necessarily those of the wider College or of its members.

Revalidation of Doctors

Revalidation of doctors is intended to improve medical practice, and to ensure that all doctors are up to date with new procedures and practising at the highest standard to equalise patient care and safety across the board.

— The PLG think that all doctors should undertake revalidation as soon as possible. Revalidation always seems to be two years away.
— The process of revalidation needs to be as straightforward as possible, including all doctors in the process, so that patient care is at the same level everywhere.
— Strengthening annual appraisals may be one way to accelerate the process. However, this needs to be carefully tailored to medicine revalidation, and not just a resort to speed up putting in place some kind of quality assurance.
— A register to ensure all doctors take part in an annual appraisal so no one who may be causing problems slips through the net.
— One way to introduce annual appraisals that are of a high enough standard to ensure that all doctors are being evaluated the same way would be to institute a fine for any Trust failing to produce an appraisal system that is up to the standard set.
— Another is to institute training of the annual appraisers to ensure that the standard is set at the same high level that patients have a right to expect.
— A plan needs to be in place of how to handle unsatisfactory appraisals and revalidation if they come to light.
— As appraisals are for patient safety, and security in the level of patient care, then the PLG feels that patients should be able to give more regular feedback about the care they receive, such as online or hospital feedback letters. This enables patients to interact with their doctors and their individual care.
— We endorse the use of objective relevant outcome data to be used in revalidation.

November 2010

Written evidence from The Health Foundation (REV 21)

1. About the Health Foundation

1.1. The Health Foundation is an independent charity working to continuously improve the quality of healthcare in the UK. We are here to inspire and create space for people to make lasting improvements to health services.

1.2. We want the UK to have healthcare systems of the highest possible quality—safe, effective, person-centred, timely, efficient and equitable. We believe that in order to achieve this, health services need to continually improve the way they work.

1.3. The Health Foundation has submitted evidence to previous Health Select Committee inquiries and would be glad to field a subject matter expert to provide oral evidence if this would be helpful.

2. Executive Summary

2.1. The Health Foundation supports revalidation of doctors on the assumption that it will improve the quality and safety of patient care. It is important that the process is robust but not onerous for participating doctors.

2.2. There is likely to be a link between revalidation and improving the quality of patient care but this has yet to be proven. Therefore the implementation and roll-out of revalidation must be strongly influenced by the developing evidence base through ongoing research, pilot evaluation and expert consultation.

2.3. Revalidation remains controversial amongst many doctors, in part because there is a lack of clarity about its purpose as well as concerns that the process as currently designed is disproportionate. If revalidation is make a positive contribution to the care that doctors give and patients receive, and not become another exercise in box ticking, it is vital that a clear consensus emerges on what it should achieve and how this should be achieved.

2.4. The Health Foundation is broadly supportive of the General Medical Council’s (GMC) response to their 2010 consultation on revalidation, particularly in the GMC’s commitment to building the evidence base for revalidation and its implementation.
2.5. As currently designed, there is a risk that revalidation does not meet the principles of modern effective regulation, most notably because it is insufficiently risk-based and overly centralised. The founding principle of revalidation should be the locally-based annual appraisal. This must have a summative component (“is this doctor safe?”) and a formative one (“is this doctor committed to continuous improvement and how should he or she go about delivering this?”).

3. What we know

Evidence on revalidation

3.1. Although revalidation is new to the UK, the idea is not a new one. “Relicensure”, a process in the USA similar to the UK’s revalidation, is well established.14 As are, to a lesser extent, similar processes in Australia and New Zealand.15

3.2. The health services of these three countries are however very different to that of the UK and there is an absence of focused research that evaluates the introduction of, or impact on professional development, quality improvement and patient safety of revalidation and similar processes.

3.3. Revalidation in the UK has had a controversial history since its conception.16 It has been conceptualised and designed in a very different environment from the one in which it will be implemented. In particular the fiscal crisis and the plans to design a more devolved and less centralised health service will impact on how revalidation is perceived and made operational.

3.4. The development of revalidation has been a lengthy process of consultation and compromise, led in large part by the Medical Royal Colleges. There are benefits to such a specialty-led process but there are also risks. Enthusiasts tend to design processes that are too resource intensive, too complicated, untargeted and insufficiently proportionate.

3.5. The Chief Medical Officer’s (CMO) 2008 report asserted that revalidation has three main aims relating to relicensure, recertification and further investigation or remediation.17

3.6. The CMO’s report appears to include secondary aims, which include generating “further focus and energy to doctors’ desire to keep up to date and improve their practice through continuous professional development and reflective practice, [which] is one of several mechanisms for improving the quality and reducing the risks of patient care”.18 The extent to which revalidation can achieve all of these aims is unclear.

3.7. This weakness of evidence means that the implementation and roll-out of revalidation must be strongly influenced by the developing evidence base through ongoing research, pilot evaluation and expert consultation.

Developing the evidence base

3.8. The Health Foundation is currently funding independent primary research into revalidation.19 This research seeks to explore policy and decision makers’ views of the origins, definitions, and potential purpose of revalidation. It will also address how revalidation relates to concerns about assuring and promoting patient safety and quality of care. It is led by Dr Julian Archer at Peninsula College of Medicine & Dentistry, Universities of Exeter and Plymouth and will be published in 2011.

3.9. Our research is only part of the story. Public perceptions and clinical experience are also highly relevant in this context. The Health Foundation plans to support a second project that will assess the impact on clinicians and clinical practice within the pilot sites, including exploration of the extent to which revalidation might help to deliver a new model of professionalism (see paragraphs 3.12 to 3.15 below).

3.10. The evaluation of pilot processes across the four countries of the UK needs to be thorough and feed formatively into the implementation and roll-out of revalidation. Our understanding is that independent evaluations are currently being commissioned by the GMC, which is essential for this process of revalidation to be successful.

3.11. The international evidence base is essential for guiding the development of revalidation, and the Health Foundation is pleased that the GMC plans to “conduct a large-scale literature review looking at clinical governance and appraisal, clinical audit, patient and public involvement in the delivery of healthcare and the evaluation of health professionals’ practice… [and] learn from the experiences and research of international and industry experts. The latter will be informed by an international symposium to be held in early December.

18 Ibid.
19 What is revalidation? http://www.health.org.uk/areas-of-work/research/what-is-revalidation/
Learning from this symposium, sponsored and co-designed by the Health Foundation, must influence implementation.

The role of “New Professionalism”

3.12. The Health Foundation intends to launch a programme working with healthcare professionals and professional bodies to explore a new model of professionalism which we believe is required to respond to the context and challenges of medical professionalism in a changing health landscape and society.

3.13. The need for a new model of professionalism has been recognised in academic literature, in the work of leading professional organisations and within policy circles. For example the Royal College of Physicians has undertaken work that redefines what it means to be a doctor in the 21st century and this and other work has been summarised by Stanton and Lemer.

3.14. We believe that the new model of professionalism has a number of components. It places a stronger emphasis on accountability, recognises the benefits of creating a different dynamic between patients and professionals, assumes a stronger sense of responsibility for how the wider health system works and for all dimensions of quality. It promotes a constant drive to improve what clinicians do and accepts change as a virtue rather than a threat. It commits to using a range of different approaches to develop and mobilise knowledge about how to improve care and build the formal evidence base underpinning improvement. Finally, it emphasises the importance of clinicians working as part of multi-disciplinary teams and across professional and organisational boundaries.

3.15. We are interested in understanding the role that revalidation may play in encouraging doctors to think differently about their role in the health system. Revalidation presents a valuable opportunity to embed the beliefs and qualities of the new model of professionalism in what it means to practice medicine in a modern context and for the next generation of clinicians.

4. CONCLUSIONS AND RECOMMENDATIONS

4.1. The process must be proportionate and based on local appraisal. The process must be robust without being onerous. It must be informed by principles of modern regulation.

4.2. Revalidation must be influenced by high quality research and evaluation. It would be sensible to ensure that learning from the pilot programmes and the Health Foundation research is thoroughly considered during roll-out.

4.3. Revalidation should be a vehicle for engagement in the principles of continuous improvement and professionalism, not just clinical skills. Revalidation is an opportunity to ensure that doctors are engaging with the evolution of their profession, rather than keeping their narrow clinical skills updated. While technical competence is of great importance it is not, in and of itself, sufficient. Revalidation should support the development of medical professionalism in a modern health system.

Written evidence from the Royal College of General Practitioners (Scotland) (REV 22)

The Royal College of General Practitioners (Scotland) welcomes the opportunity to provide written evidence to the Select Committee on the Revalidation of Doctors which aims to provide a safeguard policy of proactively ensuring that general practitioners who are registered in practice are still safe and competent to do so.

The Royal College of General Practitioners (RCGP) is the academic organisation in the UK for general practitioners. Its aim is to encourage and maintain the highest standards of general medical practice and act as the “voice” of general practitioners on education, training and issues around standards of care for patients.

The College in Scotland came into existence in 1953 (one year after the UK College), when a Scottish Practitioners was created to take forward the College’s interests within the Scottish Health Service. We currently represent over 4500 GP members and Associates in Training throughout Scotland. In addition to a base in Edinburgh, the College in Scotland is represented through five regional faculty offices in Edinburgh, Aberdeen, Inverness, Dundee and Glasgow.

20 GMC response to revalidation consultation, October 2010, p9.
http://www.rcplondon.ac.uk/pubs/books/docinsoc/
http://www.kingsfund.org.uk/publications/understanding_docs.html
The Chair of the Royal College of General Practitioners (Scotland) supports the views provided by Professor Amanda Howe, Honorary Secretary of Council in written evidence, submitted on behalf of RCGP, and the following is a summary of the points contained within that document:

1. The Royal College of General Practitioners strongly supports the introduction of revalidation for doctors. Revalidation will offer the public, health professionals, managers, employers and the state reassurance that every doctor is keeping up to date and remains fit to practice. In addition it will encourage doctors to reflect on their standards of care, strive for improvement; and identify any underperformance at an early stage when intervention is most likely to be effective and feasible.

2. In supporting revalidation, we recognise some significant challenges exist. Revalidation for doctors must be fit for the purpose; fair and equitable to all doctors; achievable with minimal disruption to the delivery of healthcare; and applicable to all doctors whatever their chosen career pathway.

3. Revalidation must be as simple and explicable as possible, while still achieving its stated objectives. For this reason we wish to achieve:
   - A common definition of the supporting information normally required from all doctors regardless of their specialty.
   - The simplification of mapping of the supporting information for revalidation and the appraiser sign off.
   - The processes and tools for Colleague Surveys and Patient Surveys should be clarified.

4. Annual appraisal is evolving, but it must become a more robust assessment of information on a doctor’s performance, using a common set of supporting information.

5. Local clinical governance must be an effective system that responds appropriately to concerns raised through appraisals or through other routes.

6. There are a number of unresolved issues arising from Equity and Excellence: Liberating the NHS that threaten the overall integrity of revalidation including the location and organisation of:
   - The maintenance of the Performers List (the local register of GPs).
   - Clinical Governance and patient safety.
   - The Responsible Officer.
   - Processes for addressing concerns about the performance of individual doctors or teams, including a definition of the nature of the problem and the actions to address it, support/remediation and reintegration.

In addition to the above, RCGP Scotland would also like to offer the following views for consideration when concluding the policy on revalidation.

(a) At present, still in the early stages of revalidation tools development, Colleges, NHS agencies and Academies are endeavouring to meet the criteria as set out by the Select Committee. Collaboration and communication between these agencies regarding the development and access to their revalidation tools system could afford great merit in ensuring the interoperability of tools, both existing and for future design. Standardised and compatible access process and input procedure could result in a more powerful and accessible tool for all users.

(b) Finally, RCGP Scotland welcomes the Secretary of State’s announcement to extend the piloting of revalidation by a year meaning that it will not now be fully implemented until 2012 at the earliest and we strongly feel that taking the time to ensure the system is relevant, accessible and user-friendly will pay dividends for the general practitioners and patients alike.

We hope you find these comments useful.

November 2010

Written evidence from NHS Employers (REV 23)

1. NHS Employers represents employing organisations in the NHS in England on workforce issues and helps employers to ensure the NHS is a place where people want to work. NHS Employers is part of the NHS Confederation.

2. Our role is to help employers understand and contribute to changes in the recruitment, training and career structure of the medical workforce in order to improve the quality of patient healthcare. This includes providing general advice and guidance on good practice, as well as representing NHS organisations to policy makers. Further information on our role is provided in the appendix.

3. We are fully behind the drive for successful implementation of revalidation for doctors and we welcome the Health Select Committee’s involvement at this critical stage. We are pleased to have the opportunity to submit evidence to this inquiry.
Executive Summary

— NHS Employers is at the heart of the discussions on medical revalidation in England because employers are central to the design, preparation and delivery of medical revalidation.

— We support the GMC’s current plans for taking revalidation forward as summarised in the GMC and the UK health departments’ statement of intent.

— We support the establishing of the Responsible Officer (RO) role from 1 January 2011 through the measures set out in The Medical Profession (Responsible Officers) Regulations 2010.

— The appointment of ROs is an essential step in testing and preparing for revalidation. It should not be delayed until the whole system is ready. It is over three and a half years since the concept and underlying principles of revalidation were set out in the UK Government’s White Paper on professional regulations, Trust Assurance and Safety—The Regulation of Health Professionals in the 21st Century. There has been enough delay.

— We are conscious that the public expects employers to assure themselves that their doctors are competent.

— Strengthened medical appraisal and robust clinical governance systems must be achieved in any event.

— Barriers to successful strengthened medical appraisal must be identified and addressed.

Our Interest in the Revalidation of Doctors

4. Medical revalidation is about reassuring government and the public that doctors are competent to do what they are employed or commissioned to do. Employers carry the vicarious liability for the competence of their staff, including doctors, and so are central to the design, preparation and delivery of medical revalidation. We represent those employers in relation to medical revalidation.

5. We have summarised our interest and activities in relation to medical revalidation in an appendix to this evidence.

The Way in which the GMC Proposes to Establish Revalidation

6. We agree fully with the General Medical Council (GMC) statement that the purpose of revalidation is to assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and fit to practise.

7. We believe that revalidation should be designed to build on existing arrangements in an effective, proportionate and affordable manner.

8. Employers already accept that they have a responsibility to assure themselves that their doctors are competent. They believe that strengthened annual appraisal, continued professional development and robust clinical governance are necessary to ensure that assurance can be given to patients and the public at large. We think the public expect that assurance and indeed may be surprised that such a process does not already exist. These processes build on existing good practices in preparation for revalidation.

9. The GMC’s response of 18 October to their major revalidation consultation takes on board our key concerns about keeping the system streamlined and straightforward, and building on existing systems and clinical evidence rather than inventing wholly new assessment methodologies. We do not want to overburden employers or the doctors themselves. We believe that effective appraisal is key to revalidation, and this should be linked to organisational and business objectives to ensure that its introduction is both affordable and cost-effective.

10. Our views on the GMC’s response to their consultation can be read in full at http://www.nhsemployers.org/PressReleases/2010/Pages/NHSEmployersRespondsToGMCConsultationRevalidation%E2%80%93TheWayAhead.aspx.

11. We welcome the commitment that the GMC has made to streamline the process of revalidation, particularly in the current climate. We want revalidation to be effective and cost effective. The promise of support from the GMC, the four health departments and other organisations to help employers to get ready is very helpful. The challenge that employers now have is to ensure their systems of medical appraisal and clinical governance are ready and robust enough to support revalidation. That will require the appointment of
Responsible Officers to proceed as soon as possible. Responsible Officers will take responsibility at Board level for implementing the requirements demanded of Trusts in supporting medical revalidation.23

12. Revalidation should be seen by employers as contributing to and stimulating their efforts to achieve organisational excellence and high quality care, rather than as a separate priority that they need to deliver. Our earlier written submission to the GMC consultation can be read in full at http://www.nhseo.org/SiteCollectionDocuments/NHSE%20response%20to%20the%20GMC%20Revalidation%20-%20The%20Way%20Ahead.pdf.

THE RESPONSES TO THE CONSULTATION AND THE GMC AND UK HEALTH DEPARTMENTS’ STATEMENT OF INTENT ISSUED ON 18 OCTOBER

13. Employing organisations have told us that they want timetable and milestones published. The statement of intent does this and sets out the steps employers need to take to assess their own readiness. After many years of preparation they are keen to move from the design phase to the implementation phase. Target dates will help Responsible Officers begin the local task of ensuring a smooth pathway to revalidation. Indeed the Responsible Officer role is vital, regardless of the legislative requirements of revalidation, to make sure that organisations adhere to strong clinical governance and strengthened medical appraisal.

14. We intend to test the statement of intent with employers at our forthcoming NHS Employers’ conference (16–18 November 2010) and at the Medical Directors’ conference (25 November) to identify any barriers to successful implementation and what further support can be provided by the key partners.

THE EXPERIENCES OF THOSE WHO ARE INVOLVED IN THE PILOTS IN LONDON AND WEST YORKSHIRE

15. The pilot exercise is far wider than the exercises in London and West Yorkshire, which were simply about the proposed role of the GMC affiliates, a role which employers have supported as a useful independent addition to the process of recommending for revalidation or otherwise. We are a key stakeholder in the Pathfinder Pilot Strategic Oversight Group (PPSSOG) tasked with evaluating the progress of the pilots and whether the processes are right, affordable and deliverable for wider revalidation. We are particularly keen to be sure that any barriers to successful strengthened medical appraisal are identified and addressed.

THE SECRETARY OF STATE’S DECISION IN JUNE TO EXTEND THE PILOTING OF REVALIDATION BY A YEAR, MEANING THAT IT WILL NOT NOW BE FULLY IMPLEMENTED UNTIL 2012 AT THE EARLIEST

16. Fortunately many employers already have clinical governance and appraisal systems in place which provide a practical platform upon which to implement revalidation. However, the Secretary of State’s decision to extend the piloting period for a further year will provide a welcome opportunity to ensure that, when a decision is made to move to full implementation, the system will be practical and effective. We believe this is critical to ensure that the revalidation process is effective, proportionate, affordable and good value.

17. We believe it is also necessary during this extension period to look in further detail at non-NHS clinical responsibilities such as duties performed in the independent sector and the quality assurance of agency medical locums. In both these areas the sharing of evidence across career pathways and the early identification of shortcomings and proposed remedial action will be vital to the overall success of the scheme.

AFFORDABILITY

18. We will play our part as partners in revalidation to provide sufficient evidence to government for them to make their decision in late 2012 on whether revalidation is effective and cost effective.

19. However, employers in both the NHS and the independent sector would welcome, sooner rather than later, a realistic estimate of the anticipated costs of revalidation based on the simplified approach which is now preferred, and taking into account the new organisational structures and lines of accountability proposed for the NHS, particularly within primary care.

23 RESPONSIBLE OFFICER (England).

Subject to parliamentary approval of The Medical Profession (Responsible Officers) Regulations 2010, on 1 January 2011 it is intended that all designated healthcare organisations (Trusts) will have appointed a Responsible Officer (RO) who will often, though not necessarily, be the medical director. All doctors working for the Trust (secondary care) or who are included on its performers list (PCO’s) will come under the RO’s remit and all working doctors will be required by the GMC to relate to a specific RO. Advice on finding an RO will be available. The ultimate function of the RO will be to help doctors prepare for Revalidation and make a recommendation to the GMC once every five years, through a recommendation to the Trust Board, about an individual doctor’s readiness for Revalidation.

In order to be able to make and justify a recommendation, the RO will need to have robust systems in place within their Trust. The RO will take responsibility at Board level for implementing the requirements demanded of Trusts in supporting medical Revalidation. They will be responsible for the systems needed to support it and will be accountable for the recommendations that are ultimately made to the GMC about an individual doctor’s readiness for Revalidation.

They will need to ensure that, over the five year Revalidation cycle, that an annual appraisal is carried out to a sufficiently high standard and that the appraisal system links adequately with other Trust systems, ensuring clinical governance data is available to support a review of a practitioners work and inform service development.

They will work with doctors in addressing any shortfalls identified—including offering support in addressing the underlying causes whether educational, performance or health related, ensure any concerns or complaints have been addressed, and collate this information to support a recommendation on revalidation of individual doctors to the GMC.
20. 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.

21. It will be challenging to identify “cost-effectiveness” arising from revalidation in isolation from other measures designed to improve quality patient care and productivity through the current QIPP arrangements. This will also have to be set alongside the less-quantifiable gains in public protection and confidence in the profession though a robust revalidation process.

TIMING OF THE RESPONSIBLE OFFICER (RO) REGULATIONS

22. We have noted that the British Medical Association, the trade union representing the majority of UK doctors, have lobbied the House of Lords Scrutiny Committee about The Medical Profession (Responsible Officers) Regulations 2010. Their submission was a repeat of their submission to the GMC’s consultation The Way Forward. This consultation was responded to by the GMC on 18 October 2010 and we were pleased to see the GMC accept most of the points made by ourselves and by the BMA, for example about the need to make the processes more straightforward and proportionate and to reduce the burden on employers and on doctors.

23. We differ from those in the medical profession who support revalidation in principle but would have us delay implementation of the RO regulations until we have a “perfect” system. It is an iterative process; we have to start somewhere in beginning the revalidation cycle to learn by sharing good practice and supporting ROs in their local work. We welcome the GMC’s announcement of the formation of a regionalised network of support for ROs in their work.

24. Some may argue that an RO recommendation not to revalidate is in some ways career limiting. We believe this can be mitigated by having an open, fair, collaborative process based on mutual trust where it is in the interest of both the employer or commissioning body and the doctor to satisfy themselves that they can both provide the best possible care to patients. If there is a dispute then there should be the means to resolve this through the constituent parts of the process (e.g. dispute resolution in appraisal) before the RO makes a recommendation.

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APPENDIX

NHS Employers’ Interest and Involvement in the Revalidation of Doctors

(a) Employers recruit, deploy, train, motivate and reward doctors in the NHS. They provide opportunities for training to the doctors of the future, from medical student placements through postgraduate training to the employment of specialty practitioners in the hospital sector, and the contracting of General Practitioners in primary care.

(b) They aim to do this in a supportive learning environment which provides quality assurance to patients through robust clinical governance systems, backed by regular appraisal and continued professional development of the doctors themselves.

(c) From the outset of the policy decision to introduce a licence to practise in the UK supported by a system of regular revalidation, employers have sought and delivered engagement in the design of the system and helping employers to prepare for implementation.

(d) We have provided evidence to the GMC’s consultation exercise and were very pleased to see that their 18 October response broadly agrees with that evidence on the question of streamlining and proportionality, and the centrality of the employers in making the process work effectively.

(e) We believe it is now time to move from “design” to “doing” and we have therefore communicated with employing organisations in the NHS by:

— Producing a briefing paper (June 2009) for employers on what revalidation means
— Having regular input into the GMC’s revalidation communications strategy by making sure that messages are targeted toward employers and clearly understood by them
— Maintaining up-to-date web-based information for employers on revalidation: see http://www.nhsemployers.org/PlanningYourWorkforce/MedicalWorkforce/Medical-regulation/MedicalRevalidation/Pages/Medical-revalidation.aspx.
— Supporting regional workshops on revalidation, notably in London, Yorkshire and the Humber, and in the North East
— Worked hand in hand with the NHS Revalidation Support Team (established by the Department of Health) to provide ongoing evaluation of the pathfinder pilot projects
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— Holding well-attended sessions on revalidation at the NHS Employers’ annual conference in 2008 and 2009. Another such session is scheduled for 17 November 2010.

(f) We have represented the voice of employers through the various workstrands established to support revalidation, including the UK Revalidation Programme Board, its Executive Board, its workstream on remediation, through to the Department of Health Professional Standards Board, the England Delivery Board and the Pathfinder Pilot Oversight Group (PPSSOG).

Written evidence from the British Society for Rheumatology (REV 24)

EXECUTIVE SUMMARY

— BSR is a medical specialty society promoting excellence in the treatment of people with arthritis and musculoskeletal conditions, and supports those delivering it. BSR has a 25 year history of promoting high quality standards of care, and providing education, training and support to those working in rheumatology. With more than 1,500 members including rheumatologists, scientists, trainees, allied health professionals and others from the UK and overseas, BSR also has close links with a number of patient groups, including Arthritis Care, National Rheumatoid Arthritis Society (NRAS) and Arthritis and Musculoskeletal Alliance (ARMA).

— BSR generally support the suggested mechanisms and approaches of revalidation put forward by the General Medical Council (GMC).

— A substantial formative element must be included at appraisal. Constructive the interaction between appraiser and appraisee is key to the success of the process.

— High quality rheumatology practice includes working with a multi-disciplinary team to benefit patients. Therefore, gaining outcome measures to reflect only an individual rheumatologist is very difficult.

— Team outcomes which are directly relevant to patient care are important to consider in relation to appraisal and revalidation for rheumatologists.

— Quality assurance of the appraisal process is key to the success of revalidation.

— Further detailed assessment is needed to identify appraisers.

— More than one appraiser should be involved in the five year cycle of appraisals.

FULL RESPONSE

1. BSR welcomes the opportunity to comment to the Health Select Committee on the current proposals for revalidation of doctors. The comments are relevant particularly in relation to consultant rheumatologists.

2. In general BSR supports the increasing emphasis that the GMC is placing on developing practical, workable and relevant mechanisms for an individual doctor to demonstrate that they are practising to the appropriate standard.

3. The workload involved in revalidation must be proportionate to the benefit of the revalidation process. In this context it is appropriate to focus on development of workplace based assessments.

4. BSR also supports the approach now being proposed to combine the two previous processes of relicensure and recertification, as many of the aspects of supporting information overlap between them.

5. BSR supports and has had input into the response to the GMC consultation provided by the Royal College of Physicians (RCP). In particular BSR would endorse the important potential role of revalidation in raising the standards of care provided by all physicians and its role in strengthening professionalism. In this context its value for the great majority of physicians who are already practising to a high standard must include a substantial formative element at appraisal and the success of the process depends to a large extent on constructive interaction between appraiser and appraisee.

6. Rheumatology is a sub-specialty of medicine and BSR, as a Specialist Society, has worked closely with the RCP to develop the proposed framework of supporting information, as detailed in annex 2 of the consultation. BSR would like to emphasise that for our specialty, team working is of paramount importance and over recent years have promoted the value of working with other health professionals particularly specialist nurses, physiotherapists and occupational therapists for the benefit of our patients who have complex multi-system physical diseases and management plans. Indeed this multi-disciplinary approach to patient management in now endorsed in national guidelines such as those produced for Rheumatoid Arthritis by NICE. In this context, development of outcome measures which are a reflection of an individual rheumatologist’s quality of practice are very difficult or impossible to identify.

7. BSR has developed as a specialty a Peer Review scheme which assesses all aspects of care from the rheumatology team and multi-centre audits both regionally and nationally which also look at benchmarking aspects of the quality of team working. BSR feels that measures of team outcomes which are directly relevant to patient care are important to consider in relation to appraisal and revalidation for rheumatologists. At
appraisal the individual rheumatologist can indicate how he/she has been involved personally in facilitating an area of excellence or if necessary what he/she is doing to address issues where overall practice needed to be improved. Clearly issues more related to an individual’s practice might be identified by other mechanisms such as peer or patient multisource feedback and through other information available to the Medical Director/Responsible Officer.

8. BSR supports the development of strengthened appraisal as the cornerstone of revalidation. Quality assurance of the appraisal process is therefore key to the success of revalidation.

9. BSR has concerns regarding potential conflicts of interest of appraisers and Responsible Officers. Doctors who are also local Trust Managers have a remit to ensure performance management of individual consultants and this may potentially conflict with the quality of care issues being addressed through appraisal. The recommendations on who the appraisers should be require further detailed assessment. For this reason it is important that more than one appraiser is employed in an individual doctor’s five year cycle of annual appraisals for revalidation.

10. BSR also has concerns regarding the relationship between the Specialist Societies, Royal Colleges and Responsible Officers. The role of BSR in conjunction with the RCP should be in the development of appropriate standards for assessment of rheumatologists, and not to become involved in discussion of individual cases.

November 2010

Written evidence from The Patients Association (REV 25)

The Patients Association welcomes the opportunity to submit its views to this important inquiry.

1. The Patients Association strongly supports revalidation as a vital mechanism for improving the safety of patients and ensuring individual accountability for clinical care. We are very disappointed that plans for the implementation of revalidation for doctors have been delayed for a further year.

2. We are disappointed with the GMC consultation response, particularly the lack of detail in responding to our suggestions to collect patient experience in a systematic and comparable way.

3. There is substantial evidence that patients and the public support regular assessment of the competence of their doctors. Notably the 2005 Department of Health public opinion research that found:
   (a) Almost half assume that regular assessments already take place, with over one in five thinking they already happen on an annual basis.
   (b) Over 90% agree that it is important that all doctors’ competence is checked every few years.
   (c) Nearly half the public think these assessments should be done on an annual basis

4. A 2008 review of NHS safety and quality by the Joint Commission International concluded “There is limited oversight of individual practitioner performance” and “Information on individual practitioner performance is virtually non-existent.”

5. We welcome the emphasis of the current White Paper to introduce much more measurement of outcomes and patient experience across the NHS.

6. If individual clinicians were required to collect evidence of the quality of care their patients receive this would act as a powerful driver for the system to drive up standards of care across the NHS and potentially prevent widespread failings as developed at Stafford.

7. 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 license is accurately reflected by the recommendations made by the Responsible Officer.

8. 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 five years is un-ambitious. 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 five yearly basis the collection of patient experience data should be spread across this period with a mechanism for bringing forward revalidation should concerns arise.

9. Standardisation of at least parts of questionnaires used to collect patient evaluation data should be introduced. Whilst we accept that during the introduction of revalidation understanding and comparing patient evaluation data may be of limited value, we would expect that over time the standardisation and benchmarking of patient evaluation results should become incorporated into the revalidation process. This will only be feasible if there are standardised elements to the questionnaire and so we would recommend beginning with this approach to provide the best possible foundation for developing the use of patient evaluation data. There are a

number of options to consider. Standardisation could include questions/ratings common to all hospital doctors or GPs or to doctors from the same speciality for example.

10. There should be standardisation of collection methods to ensure particular aspects of this process are always present (e.g. random selection of patients, selection from across the doctors areas of practice, clear and credible assurances about the anonymity of the participant).

11. We recognise that collection of patient evaluation will not apply to all registrants. However, adjustments should be made and barriers overcome to maintain a focus on patient feedback as a centrepiece of evaluation, and ensuring that collection methods are robust and the results comparable. In particular, ensuring patient evaluation data is included in the revalidation process for locum doctors is critical to ensuring the safety of patients.

12. We also feel that the development of a robust framework for evidencing both the knowledge of and outcomes achieved by healthcare professionals as part of the revalidation process is also important for the same reasons as highlighted above. As evidenced by the aforementioned research patients expect this to be a part of the appraisal of doctors, ranking evidence that a doctor is keeping up to date with medical developments as their key priority.

13. We recognise implementation of this is more difficult, hence the need for a focus on patient experience in the short term to prevent further delays to implementation of the revalidation process.

Written evidence from the National Clinical Assessment Service (REV 26)

Executive Summary

1. The National Clinical Assessment Service (NCAS) is committed to supporting the introduction of medical revalidation as a process of clinical and professional governance.

2. The role of the responsible officer is pivotal in the implementation of revalidation.

3. NCAS’ role in revalidation focuses on the situation where there are concerns about the performance of a practitioner that may lead to a failure to revalidate, and is to support the responsible officer at a local level to deal with this.

4. This submission describes the support that NCAS will provide during the implementation of revalidation, in particular to responsible officers.

NCAS’ Role in Supporting Medical Revalidation

5. The National Clinical Assessment Service (NCAS) is now in its tenth year of bringing independent expertise to the resolution of concerns about the practice of individual doctors. The service was established in April 2001, following recommendations published in the reports of the Chief Medical Officer for England, entitled Supporting Doctors, Protecting Patients (November 1999), and Assuring the Quality of Medical Practice: Implementing Supporting Doctors, Protecting Patients (January 2001).

6. Following the recommendations in the review of Arm’s Length Bodies it is anticipated that NCAS will move, over the next few years, to be a self funded service. Currently NCAS receives more than 1,000 new referrals per year across three health professions (dentists and pharmacists, in addition to doctors). To date, about 90% of referrals have been about doctors and whilst not anticipating a significant increase in this number as a result of the introduction of medical revalidation, NCAS believes that support for early intervention (including if appropriate remediation) will be an important component in ensuring successful revalidation for doctors where concerns have been raised about their practice.

7. NCAS is committed to supporting the introduction of medical revalidation as it believes that this is appropriate to enhance patient safety, and to provide public protection and assurance as part of clinical and professional governance. We believe the focus of activity in professional governance should be at the front line of services as far as possible, providing specialist expertise to support local activity and involving national organisations only where absolutely necessary. This carries two clear benefits:

7.1. development of greater local expertise in predicting, preventing, identifying and handling performance concerns.

7.2. ensuring a proper balance of priorities in the use of resources—skills, staff and financial.

8. NCAS will take a tiered approach in the support available by providing a variety of interventions based on different levels of input in handling concerns about practitioner performance (and/or the revalidation process) and by using our experience to advise on the most appropriate intervention. The tiers consist of:
Advice and support

9. NCAS will provide advice and support to responsible officers (ROs) as they develop their role and are faced with concerns that are identified about a practitioner which emerge through local governance systems, following appraisal, or during the process of considering an individual for recommendation for revalidation. Advice on handling performance concerns is currently a core area of work for NCAS. We expect that the introduction of ROs and revalidation will enable identification of concerns about performance at an earlier stage.

Local review

10. NCAS is designing two methods for use in local review—a review of clinical records and a structured interview with the practitioner to explore issues arising from the record review. We will recruit and train a panel of reviewers who will be available to ROs wishing to undertake a review using local resources.

11. The local review will provide information about a practitioner’s performance to enable the RO to decide whether there is a problem that needs further investigation or assessment.

12. When an RO considers a local review is required, NCAS expects that they will contact members of the panel and contract with them directly. The RO will organise and fund the review locally, to a timetable which suits the local situation. The local review should expedite the process and, in our opinion, will be useful in identifying concerns at an earlier stage, ensuring that doctors can be supported as necessary.

13. We will establish a transparent process for the recruitment and selection of reviewers. We intend to develop and test the methods over the next six months and should have the first members of the panel (GPs, psychiatrists and paediatricians) trained by June 2011.

Support for remediation

14. Remediation may be appropriate where there are performance concerns and NCAS will use its experience to contribute to local remediation at all levels. NCAS experience suggests that the focus of remediation needs to be local and workplace-based so ownership is maximised by both the practitioner and their organisation. NCAS will continue to support the planning of further training programmes and will work alongside the providers of interventions (including Deaneries and Royal Colleges) to ensure a robust and practicable process. In addition we intend to share this way of working and our experience through certified training and web based tools and other resources.

Education

15. NCAS is currently developing a portfolio of initial training and ongoing professional development in areas of NCAS’ expertise and experience which will be available to ROs. Areas to be covered will include:

15.1. handling performance concerns, including statutory obligations and record keeping.
15.2. undertaking investigations.
15.3. handling concerns about a practitioner’s health.
15.4. handling concerns about a practitioner’s behaviour.

16. This training is being developed in conjunction with the Revalidation Support Team (RST) and the GMC.

17. This training will also be available to others who deal at first-hand with performance concerns, to support the development of effective local governance arrangements more widely within NHS organisations.

Conclusion and Recommendations

18. Revalidation will be central to providing public assurance of good professional governance of doctors, and the role of the responsible officer is pivotal. The revalidation process requires an effective response where concerns emerge as a result of enhanced clinical governance systems. The services described above will, we believe, significantly contribute to supporting ROs in discharging their statutory obligations and, as it develops, the successful implementation of professional revalidation. This approach will enable the development of maximum expertise at the front-line and ensure a flexible and cost-effective approach.

19. The Select Committee is asked to note NCAS’ role in supporting the effective introduction of medical revalidation in those cases where there may be concerns about an individual’s ability to revalidate.

November 2010
Executive Summary

This is a submission from the Chartered Management Institute (CMI), the only Chartered professional body dedicated to raising standards of management and leadership across all regions and sectors of the UK. We work closely with many different employers in the NHS to raise their teams’ management and leadership skills, resulting in better performance for staff and better care for patients.

Our focus in responding is how the Government can take this opportunity, in reforming the NHS, to champion and improve management and leadership skills throughout the health service, in order to achieve its stated aim of better health outcomes, centred on the patient rather than the process.

While instances of poor leadership and management practices in the NHS are relatively rare, bad managers and leaders can lead to serious incidents and, in the worst cases, cost lives. We have evidence from some of our members that a lack of national, quality assured management and leadership training in the NHS leads to inconsistent management performance, resulting in time and money wasted as problems are investigated and resolved. The recent events at the Mid-Staffordshire NHS Trust are a dramatic example of what can happen when poor management goes unaddressed.

It is therefore essential that the Government puts the conditions in place for the NHS to improve leadership and management skills, starting with senior leaders and managers but eventually helping all managers within the NHS—after all, today’s middle manager may well be tomorrow’s leader.

Some good work is already being done in some areas of the NHS to improve leadership and management. For example, the NHS Institute for Innovation and Improvement (NHSIII) has developed and implemented its Leadership Qualities Framework (LQF) which describes the qualities expected of existing and aspiring leaders. But we urge Government to take this development work much further. We believe that all managers should be accredited to a national, professional management and leadership framework. In time we would like to see all senior NHS managers (i.e. board level) holding a management and leadership qualification. In this way, NHS managers would become professionally qualified to practice, just as clinical staff must be medically qualified.

In our response we have set out our proposals for implementing a national accreditation framework, based on the recommendations made in the Department of Health’s report, Assuring the quality of senior NHS managers (February 2010), and outline how we can help to deliver higher management and leadership skills for NHS managers, which will in turn contribute to better health outcomes for patients. We have also commented on how our proposals tie into the new structure and goals being proposed by Government in the consultation document.

1. Overview of CMI

1.1 The Chartered Management Institute (CMI) is the only chartered professional body dedicated to management and leadership, with some 88,000 individual members across the UK. Our members are employed at all levels of management within business and public sector organisations. We are well represented in the health sector, with over 3,000 members employed in the NHS and associated organisations (including military medical managers), and almost 100 holding our prestigious Chartered Manager award.

1.2 We have helped many NHS employers around the country to improve the management and leadership skills of their employees over the years. Some examples of our work with the NHS are included in section 6 of this report. Our health sector members agree that in using a professional body with years of experience of improving management and leadership skills at all levels, they benefit from our skills and knowledge of management as a profession, which are tailored to meet the particular needs of the public health sector.

2. Putting Management and Leadership Skills at the Heart of NHS Reform—The Business Case

2.1 The CMI welcomes the Government’s ambition to put patients at the heart of the National Health System, and to ensure that the focus is on patient outcome, rather than the treatment process. We do not wish to comment on the structural and clinical changes which are proposed in the consultation document, as this is outside the scope of our expertise. However, we believe that, far from viewing managers as an expensive burden on the NHS, managers and their teams must be viewed as the drivers of change. If the Government is to achieve its stated aim of bringing about a “change in the culture and focus of the NHS, driven by staff who are empowered, engaged and well supported” (p 3), it must ensure that all NHS managers, whether clinical or administrative, high level or junior, are offered the opportunity to become accredited to professional, nationally recognised management and leadership standards.

2.2 At a time when there are multiple demands on resources, and public expenditure must be wisely spent, the business case for improving management and leadership skills in the NHS is clear. Indeed, the Department of Health itself acknowledges the importance of the link between management and leadership skills and
improving the quality of care in its recent report, Assuring the quality of senior NHS managers. It states: “Studies such as West and Johnson (2002) and Jiang et al (2009) have shown that good management and board practices can reduce mortality rates in hospitals by improving the interactions between all the members of the community that comprise a hospital.” (p 10).

2.3 It is therefore disappointing that both the White Paper and the consultation document fail to recognise the importance of leadership and management skills in improving patient outcomes. It is surprising that the consultation document makes no reference to the findings of previous Government reports on improving the performance of the NHS, for example Lord Darzi’s report, High Quality Care for all, NHS Next Stage Review. This report notes that a small number of managers are deemed to have significant performance issues, and makes recommendations for improving staff performance across the NHS. The Francis Inquiry into problems at the Mid-Staffordshire NHS Trust hospital also underlined fundamental problems with leadership and management, which resulted in 400 avoidable deaths at the hospital. Both these reports highlight a key theme—that management and leadership skills in the NHS are essential to improving patient outcomes.

2.4 We also know from our members working in the NHS, some of whom are senior managers and leaders, that a lack of systematic, national, quality-assured management and leadership training for all NHS managers leads to performance problems which sometimes take a great deal of resources to resolve. One of our Trustees reports that good clinical staff are often promoted to management without receiving management training, which leaves them to develop their management and leadership skills based on their own experience, rather than professional standards. He describes a case he has been involved in which has lasted seven years, which resulted from poor leadership skills by one head of department, and a consequent lack of timely remedial action. These cases take up valuable time and resources which should be directed towards patient care, rather than administration costs. Where staff do receive training, it is sometimes unaccredited and there is no quality assurance scheme to ensure that training is effective.

3. A NATIONAL, PROFESSIONAL ACCREDITATION FRAMEWORK FOR HEALTH MANAGERS

3.1 We therefore urge Government to introduce measures to help improve the management and leadership skills of managers at all levels of the NHS, as part of its commitment to making the health service more patient-centred.

3.2 As a first step, we urge the Department to act on the recommendations made by the Advisory Group on Assuring the Quality of Senior NHS Managers in its recent report. The report made a recommendation that, in order to strengthen the performance of individual hospital Trusts and to ensure that senior staff with performance issues do not simply leave and join NHS organisations elsewhere, the National Leadership Council introduces a professional accreditation scheme for all senior managers. It recommends that the scheme is developed and administered by an independent organisation with expertise in setting and accrediting standards of professional managerial practice, overseen by a board reporting to the National Leadership Council. The Chartered Management Institute is uniquely placed to implement such a scheme and we are discussing this with the National Leadership Council.

3.3 However, we believe it is essential that the Department also acts on another recommendation from the Advisory Committee, to raise the skills level of all NHS managers, not just those at the very top. There is a pressing need to ensure that all managers receive the same high standard of skills training, particularly since under the new structure more and more decisions will be taken at local and sub-regional level. The Advisory Committee report states: “It [is] recognised that the principles that apply to senior managers should apply equally to managers and leaders at every level in the NHS...The National Leadership Council, in due course, will want to consider how the principles that the group wants to apply to senior leaders should extend to the leaders of tomorrow in more junior (but still important) managerial roles within the NHS.” (p 15)

3.4 CMI therefore urges Government to introduce a nationally-accredited management and leadership skills training system for all NHS managers, concentrating on senior managers first. By using national accreditation services, all NHS employers will ensure that the training they purchase has been quality-assured and sets a national standard for managers. In this way the Government can ensure that management and leadership skills are professionally and nationally benchmarked and form the basis of the customer-focused standards set out in the White Paper.

3.5 In order to achieve parity between clinicians and non-clinician managers, in time we would like to see all senior managers to have professional accreditation, which would give them a license to manage in the NHS, similar to their clinical colleagues’ medical license to practice. This would give patients and their families reassurance that those who are in charge of overseeing NHS services within their area are fully equipped to do so, using professionally recognised management and leadership skills.

26 Ibid.
27 Ibid.
4. **HOW TO DELIVER THE ACCREDITATION FRAMEWORK**

4.1 There are many different routes by which a national accreditation framework for management and leadership could be introduced into the NHS throughout England—through NHS employers becoming approved centres; by direct delivery of accredited qualification programmes, and via direct delivery by recognised partners and quality assured providers. Employers may choose to have their in-house management and leadership programmes validated, which would not lead to a qualification but would be mapped to the framework and would assure them that national standards are being met. In this way, employers would be offered a flexible system which caters to their needs and budgets, but nevertheless ensures that national standards are met.

5. **HOW BETTER MANAGEMENT AND LEADERSHIP SKILLS CAN HELP DELIVER THE GOVERNMENT’S AGENDA FOR CHANGE IN THE NHS**

5.1 We would like to comment on how improving management and leadership skills are essential to the proposed reforms in the consultation document. The consultation paper proposes an outcomes framework which is made up of a set of goals. The Chartered Management Institute believes that a set of national, professionally accredited management and leadership standards, delivered using accredited training, will help achieve these goals in all five domains set out in the consultation document. However, we believe that management and leadership skills have a particularly important role to play in delivering the goals set out in domains 4 and 5:

**Domain 4: ensuring people have a positive experience of care**

5.2 This section, together with domain 5, is most dependent on the quality of management and leadership in the NHS. As the consultation document states, “quality of care includes the quality of caring” (p 30). The domain emphasises the importance of the patient experience, and capturing how patients feel about the care they receive. Good management and leadership are essential to improving patient feedback. Mistakes and poor care are often the subject of patient complaints, and incidents such as the case of the Mid-Staffordshire NHS Foundation Trust are an example of how poor management, low morale and a disengagement between clinicians and management staff result in tragic outcomes for patients.

5.3 We are aware that the NHSIII has developed the Leadership Qualities Framework to promote world-class leadership qualities and identify how NHS leaders can improve their skills. This is a very valuable tool and is widely recognised in the NHS. However, more needs to be done to develop and implement a national, quality assurance framework which will all NHS managers, not just those at the top, can use. This is why we recommend the alignment of the Leadership Qualities Framework with the National Occupational Standards, which can then map clear progression routes across the frameworks. This work could be done relatively quickly and cost-effectively.

5.4 The CMI’s quality assurance framework for management and leadership is based on the National Occupational Standards (NOS) for Management and Leadership, which have been developed in consultation with a wide range of practising managers, as well as academic and policy experts. The Standards set out constructive ways in which managers can improve their performance in six areas: managing self and personal skills, providing direction, facilitating change, working with people, using resources and achieving results. In following the NOS, employers can ensure that managers are trained to high standards which are nationally recognised as being proven benchmarks of best practice.

**Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm**

5.5 Again, the quality of management and leadership in the NHS is central to achieving the goals in this domain. The three underlying principles of Domain 5, protecting people from further harm; an open and honest culture; and learning from mistakes, are all dependent on factors such as communication, team work, positive leadership and helping staff address problems with their performance. The Francis Inquiry into the Mid-Staffordshire NHS Foundation Trust found that problems in the hospital included bullying, low staff morale, disengagement by consultants from management, an uncaring attitude by staff, and frequent changes in management, which led to a sense of lack of leadership and support. All these problems, which ultimately resulted in 400 avoidable deaths, could have been solved by better management and leadership by hospital staff, and the report made a specific recommendation that a system of “professional accreditation” should be introduced for senior NHS managers.

6. **EVIDENCE THAT CMI CAN DELIVER IN THE NHS**

6.1 CMI has developed numerous case studies showing how NHS clients have used our products and services to achieve their development aims. Three such examples are set out briefly below:

**Kingston Hospital**

6.2 Kingston Hospital is a district general hospital which supports approximately 320,000 residents. It has recently appointed a new Chief Executive who has implemented a number of organisational changes. With

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these changes going on, and given the more challenging financial operating environment, it is important that Kingston hospital’s managers are well equipped to handle change and to disseminate information to staff where and when appropriate. Members of the management team have varying levels of experience and qualifications.

6.3 A key aim of the hospital’s training strategy is to equip managers with the skills and knowledge to manage all the changes taking place effectively. The hospital works with Kingston College, a local FE establishment, to provide a choice of four CMI courses for its staff, including the Introductory Certificate in Management and the Introductory Diploma in Team Leading. To date more than 40 staff, predominantly at the junior level, have taken up the courses. As a result, the hospital has witnessed an improvement in the skills level of its staff, and some have been promoted as a direct result of the training.

6.4 Kingston Hospital Training Manager Marie Mackenzie says: “The type of skills we need our staff to have include good communication, a well rounded understanding of the organisation and its goals, the ability to form strong relationships with fellow team members and an understanding of the importance of trust and transparency when managing change. We have seen a definite improvement in all these areas following CMI course participation...Our belief is that if you have good managers, who manage their teams effectively, this translates into better service provision and improved customer satisfaction as a result.”

Nottingham NHS University Hospital

6.5 Nottingham University Hospitals NHS Trust (NUH) is one of the largest acute teaching trusts in the country, providing acute and specialist services to 2.5 million people within the Nottingham area. NUH employs over 13,000 staff, making it one of the city’s largest employers. During 2009–10 the Trust cared for around 100,000 people. It has set itself ambitious targets for the future; by 2016 it aims to become the best acute teaching Trust in the country. Following the publication of two NHS reports which highlighted the importance of strong leadership (“Inspiring Leaders of the Future” and “High Quality of Care for All”) the Trust decided to embark on a management development programme that would play an integral part in achieving its ambitious goal.

6.6 Fitting training into managers’ daily workload was always going to be a challenge in itself, and the Trust wanted a programme that would ensure managers received real value for time spent, with learning they use immediately and pro-actively within their different teams, ranging from finance to physiotherapy. It was also important that NUH design and deliver the programme themselves whilst allowing the accreditation to come from a credible external organisation. Responding to the needs of the Trust, CMI took NUH’s learning requirements and proposed a bespoke management development programme for Level 7 managers. Extremely flexible, the course could be segmented into weekly chunks to make it easier for as many managers as possible to devote time to attend. The training was called “Building Essential Leadership Skills” (BELS) and launched in 2009 and that year was delivered to 132 managers, the highest voluntary attendance rate achieved at NUH.

6.7 Having received the training, managers reported that they feel more empowered to make a difference to the patient experience and, according to the training team, staff appear more satisfied in their jobs. The programme has given managers more confidence to make decisions, and has challenged the way they approach situations. The course is really helping support the application of the elements needed to achieve our Trust’s vision and is helping the Trust re-define its leadership roles. Things are continually changing, so it’s important to keep it fresh for the fourth tranche. Managers’ needs don’t stay the same and neither will the course—but the CMI’s input into the BELS programme allows us to adapt it as we grow and move the Trust forward towards the future.”

Royal Free Hospital NHS Trust

6.8 The Royal Free is a large hospital and medical school employing approximately 5,000 staff across multiple sites and disciplines. Its Staff Education and Development Centre provides a wide variety of course programmes for all staff, at all levels. In April 1996 the senior management of the Trust recognised the need to have programmes in management approved by an external organisation. As a result, the Centre was given approval in 1997 to deliver various CMI qualifications and training. The Hospital’s management board developed a “management by objective” strategy, in partnership with CMI’s External Verifiers. Staff were offered the most appropriate level training according to their needs, including at Level 3, Level 5 and Level 7.

Staff Education & Development Centre Manager, Joe Serra, believes that the variety offered was key to its long-term success. He said: “To have a true impact, the development programme had to be made available to staff at all levels. Anything less would have diluted buy-in, created a two-tier system of staff development and would not have had the desired effect on the Trust’s performance. The application of management theory to practice was also critical, as all relevant management knowledge needed to be applied by participants within their respective clinical areas.” Following the training, surveys showed that satisfaction amongst patients increased as a result of the training programme and the Trust earned a five star rating for excellence—the highest that could be awarded. Some staff then went on to study for Chartered Manager award, and staff from other external organisations have also received management training at the hospital under the scheme, enabling the hospital to become a de facto centre of excellence for leadership and management training.
Ev w54  Health Committee: Evidence

7. Conclusion

7.1 The Chartered Management Institute is strongly placed to help deliver the Government’s desire to improve patient outcomes by creating a more patient-centred approach within the NHS. To achieve this outcome, the Government needs to build on the numerous reports into specific performance issues within the NHS, and to implement recommendations to improve management and leadership skills at all levels. In this way managers will be better equipped to reach the standards set by the consultation document, resulting in better performance for staff and better care for patients.

October 2010

Written evidence from Lifeblood: The Thrombosis Charity (REV 28)

Summary

— Lifeblood recognises and fully supports the General Medical Council’s (GMC) prioritisation of revalidation.
— Doctors should be able to demonstrate at revalidation adherence to best practice standards of safe and effective care and that their patients are receiving a positive patient experience.
— Lifeblood recommends that any core revalidation criteria match national priorities for the NHS as well as knowledge on conditions which are recognised as having a significant health and economic impact on the NHS.
— VTE Prevention, as a national priority has the capacity to save thousands of lives and hundreds of millions of pounds of NHS spending each year, but has low awareness among health professionals.
— As such, knowledge of and adherence to nationally accepted minimum standards of VTE prevention should form a core criteria of professional revalidation.
— Lifeblood supports the recommendation of the Academy of Medical Royal Colleges in calling for this inclusion.

Submission

1. Lifeblood: The Thrombosis Charity (Lifeblood) is delighted to submit evidence for the Health Select Committee’s Inquiry into the revalidation of doctors.

2. Lifeblood will respond to the most relevant issues. This submission will focus on the Statement of Intent published in October 2010, as agreed by the General Medical Council, 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. This submission will also draw on the GMC response to the revalidation consultation, also published in October 2010.

3. Lifeblood recognises and fully supports the GMC’s prioritisation of revalidation. We fully agree that the revalidation system must support high quality and safe care in the organisations and practice settings where care is delivered.

4. In confirming the timetables and milestones for NHS employers and other healthcare providers to have the local systems in place to support the revalidation of their doctors, Lifeblood recognises that there is core information that will be required by doctors who will be leading the appraisal. Lifeblood recommends that there are clear criteria to determining this core information.

5. Lifeblood recommends that any core criteria match national priorities for the NHS as well as knowledge on conditions which are recognised as having a significant health and economic impact on the NHS. An effective appraisal process must include awareness and up-to-date understanding of the medical protocols around such health and prevention priorities.

6. In developing a streamlined process which reflects these national priorities, Lifeblood supports the role of the Academy of Medical Royal Colleges’ Faculties and Members to review their speciality and general practice frameworks. Any separation of information which is “expected” and which is “optional” must mirror national healthcare priorities if it is to be significant, relevant and useful.

7. It is essential that in developing what “expected” standards look like, the Faculties draw on the expertise of organisations dedicated to the relevant area.

8. The prevention of venous thromboembolism (VTE)—manifested as deep vein thrombosis (DVT) or pulmonary embolism (PE)—is a condition which the Health Select Committee in 2005 recognised as the greatest avoidable cause of hospital mortality. Although PE are known to be under-diagnosed and often missed, in 2008–09 alone, there were 62,066 recorded cases of DVT and 56,029 recorded PEs (Hansard, 1 November 2010: Column 658W) and in 2008 over 19,000 recorded deaths in England due to PE.

9. It is recognised by leading clinicians, the Department of Health, and the Academy of Medical Royal Colleges, that significant progress can be made in reducing avoidable deaths and long term morbidity from VTE, through simple and effective risk assessment and prophylaxis in hospital, as two thirds of all cases of
VTE occur following hospital admission (“hospital acquired VTE”). The rate of death due to hospital acquired VTE result in it being the number one patient safety issue in hospital care. It is therefore essential that the principles underlying the revalidation of doctors recognise the importance of bestowing professional responsibility on clinicians to ensure their clinical knowledge is intrinsically linked to delivering patient safety, by demonstrating the understanding of these core components to a competent authority.

10. VTE has historically been classified by the Chief Medical Officer as a Cinderella issue, due in part to low levels of professional awareness about the causes and preventative steps that should be taken to prevent avoidable incidence of VTE in hospital patients.

11. Lifeblood supports the Academy of Medical Royal Colleges’ five point plan to cutting the numbers of deaths from VTE, specifically the commitment by Colleges and Faculties to ensure Fellows and Members participate in regular audit of the percentage of patients risk-assessed for VTE, which in some specialties, “is suitable for becoming a mandatory standard for revalidation”.

12. VTE prevention needs to become an embedded standard of care in the NHS, so that the scale of this preventable condition can be tackled, and clinicians can be adequately protected from the risks of medico legal challenge, which are now prevalent in confirmed diagnoses of hospital acquired VTE, due to the requirement for root cause analysis, to identify where national guidance was not followed.

13. Education has a part to play by ensuring the next generation of doctors are properly educated at the undergraduate level, by ensuring a consistent level of inclusion in medical school curricula. However, part of the solution for protecting the patients of today rest with qualified doctors.

14. VTE prevention knowledge is therefore central to enabling doctors to undertake their daily duties in a safe and effective manner. Therefore, adherence to nationally agreed prevention protocols should be demonstrated during professional revalidation.

November 2010

Written evidence from the Hospital Consultants and Specialists Association (REV 29)

INTRODUCTION

The Hospital Consultants and Specialists Association (HCSA) is a Professional Association and non-political Trade Union affiliated to the TUC. It is the only Trade Union that exists solely to represent the views and interests of senior hospital doctors.

However, in addition it takes seriously the wider agenda of healthcare delivery in the UK. The membership is drawn from a wide range of specialities in the NHS and individual members are currently involved in many innovations and quality programmes aimed at improving the functioning of the service.

The organisation has been following closely the discussions concerning Revalidation and was pleased to be able to respond to the recent GMC consultation document, “Revalidation: The Way Ahead”.

As professionals, clearly we take very seriously the importance of continually improving patient safety, and will continue to support all legitimate methods of achieving this.

SUMMARY

— Despite a large amount of effort and resource since 2005, no doctor has yet been revalidated.
— There is no consensus on how best to approach this.
— The proposed basis of revalidation is Strengthened Medical Appraisal (SMA).
— To appraise 37,000 NHS Consultants (England) in this way would be likely to cost the NHS approximately £74,000,000 per annum.
— There is no evidence base for the value of SMA in rooting out poorly performing doctors.
— Strengthening existing Clinical Governance systems for specialities rather than individual doctors would be a better and cheaper way of protecting patients.

DISCUSSION

1. Consultant appraisal was first introduced in 2001. Although it has been subject to some criticism in that it could be done in a superficial way, nevertheless, the HCSA believes that it has significant value when done properly and carefully. It is clearly beneficial for senior staff to spend time, with an appraiser, reflecting on their practice, reviewing outcomes and achievements, and setting professional objectives.

31 Hospital Consultants and Specialists Association: www.hcsa.com

2. Since the publication of Dame Janet Smith’s Fifth Shipman Report\footnote{Shipman Inquiry, 5th Report Strengthening NHS Medical Appraisal to Support Revalidation in England \url{http://www.revalidationsupport.nhs.uk/files/Strengthening%20Medical%20Appraisal%20to%20Support%20Revalidation%20in%20England.pdf}} and the DoH response to this, the concept of revalidation of Consultants has been proposed and discussed extensively. However, no real consensus has been reached on how this should be done in a meaningful way.

3. The GMC undertook an extensive consultation on Revalidation, and its response was published in October 2010. The HCSA was one among many organisations which responded to this consultation.

4. Many of the same themes and concerns were raised by all the bodies, and in this response the HCSA does not see any value in merely reiterating them. We wish to concentrate on one particular aspect which, in our view, has been addressed only in very general terms.

5. At the heart of the proposal for revalidation is the concept of Strengthened Medical Appraisal, SMA which would include a requirement to provide positive proof against the four domains and twelve attributes defined by the GMC. But all the responses to the GMC consultation have indicated that, despite its worthy intentions, the process is grossly over-complicated and the Revalidation Pilot Toolkit a deeply “user-unfriendly” piece of software.

6. The HCSA fully agrees with these concerns, and in addition have attempted to estimate the financial costs involved.

7. An SMA will inevitably take considerably more time than conventional appraisal, both for the appraiser and the appraisee. It should be noted that appraisals are now being used as part of the legal process, and some appraisers have already been summoned by the courts and cross-examined over appraisals which they have performed. This adds to the necessity for the preparation of the appraiser to be as meticulous as that of the appraisee, and it is deemed essential that appraisers are thoroughly trained, and also have regular “time out” for supervision, as recommended.

8. There are approximately 37,000 Consultants in England. To appraise each of these would require approximately 5,000 Consultant appraisers, each performing an average of eight appraisals per year.

9. Using rather crude figures the appraisee would require a minimum of six programmed activities (PAs) to prepare, undergo and complete the appraisal documentation, which approximates to 222,000 PAs per year. This is probably a conservative figure for some specialities. (A PA equates to four hours of Consultant time).

10. At a notional rate of about £175.00 per PA this equates to a total cost of £38,850,000 per annum.

11. 5,000 appraisers performing eight appraisals per year, and utilising five PAs per appraisal equates to 200,000 PAs. Again at a notional rate of £175 per PA this equates to £35,000,000. This figure does not take into account the cost of training and training time required, and the time out for supervision.

12. While the HCSA accepts that these figures are rather crude, nevertheless, we feel that they give a reasonably accurate reflection of the costs involved, and it totals a staggering £73,850,000 per annum. It must be emphasised that this is only for the Strengthened Appraisal of NHS Consultants in England. It does not include General Practitioners.

13. These calculations do not take into account Consultants being taken away from direct patient care, and the associated but hidden costs of delayed patient management.

14. Despite the good intentions the fact remains that SMA, as suggested, lacks any substantial evidence base that it is any better at identifying poorly performing doctors than the existing mechanisms based on the GMC “Good Medical Practice” Guidelines and good Clinical Governance Systems.

15. Doctors are already the most regulated profession in the UK (and possibly the world). Since the horrors of Shipman et al the evidence is that strengthening of existing systems of regulation has served to identify problem doctors at a much earlier stage. Lack of care and harm to patients is now generally related to systems failure rather than individual doctors (e.g. Mid Staffordshire NHS Trust).

16. It is the view of the HCSA that, rather than committing large resources to revalidation of individual doctors, time and money would be better spent on reviewing the performance of clinical specialities and Trusts. Such work is already being led by the Care Quality Commission.

17. There is no “new money” to fund SMA (or revalidation). The costs must be found from within existing NHS budgets. Trusts are being asked to improve efficiency and make huge savings. SMA is not consistent with these aims and without evidence, does not represent good use of senior hospital doctors’ time.

Conclusions

— It is the considered view of the HCSA that Strengthened Medical Appraisal as the basis for Revalidation lacks a credible evidence base and would prove hugely costly to implement.

— Conventional appraisal has some merit and should be continued but it needs to be strengthened.
— A better approach would be to enhance overall Clinical Governance procedures for clinical specialties rather than focusing on individual doctors. This would be a better and cheaper way of improving patient safety.

November 2010

Written evidence from the Academy of Medical Sciences (REV 30)

The Academy of Medical Sciences welcomes the opportunity to respond to the Health Select Committee’s inquiry on revalidation. In September 2009 we published a position paper on revalidation, and in addition to responding to specific consultations on revalidation, we have engaged closely with the Department of Health, General Medical Council (GMC) and the Academy of Medical Royal Colleges, as well as a range of medical constituencies across the university, industry and healthcare sectors.

The UK benefits from a first-class medical workforce, with clinicians undertaking diverse roles across a range of settings that contribute to the development and delivery of clinical service. It is important that any new reforms serve to protect and further promote the UK’s ability to achieve excellence and do not bring unintended consequences.

The proposed revalidation proposals are a culmination of work undertaken by a number of organisations. The Academy views this an opportune time to carefully review the objectives of revalidation and ensure that the proposed processes and supporting documents are proportionate, workable for front line clinical service, and meet public expectation in a cost effective manner. We therefore welcome the GMC’s response to their consultation “Revalidation: the way ahead” published on 18 October 2010.

It is essential that sufficient time is allocated to reviewing and refining the proposed revalidation processes prior to implementation and therefore we welcome the Secretary of State’s decision to extend the current pilots. We support a careful, incremental approach; the pilots should not just focus on clinicians in mainstream NHS posts but include those working in other settings. The pilots must be robustly evaluated and the findings shared with the medical community, prior to full implementation of revalidation.

The Academy’s position paper, sets out a number of principles of revalidation, however we would like to emphasise the following:

Aims of Revalidation

The Academy endorses the GMC’s principle that revalidation should focus on instilling robust local governance across all areas of medical practice. There are numerous examples of localities with excellent governance; extending good practice will reap rewards in strengthening medical workforce management and providing world-class healthcare. A simple, flexible system that strengthens and empowers local governance with national support from the GMC is highly favourable.

Implementation of Revalidation

The Academy strongly urges the GMC to adopt a simple, pragmatic and cost-effective approach to revalidation. A streamlined process is essential to avoid both unnecessary financial and opportunity costs.

Competency Based Assessment

As set out in our response to the Academy of Medical Royal Colleges’ consultation on specialist standard frameworks, it is imperative that revalidation focuses on the competency of a clinician to deliver their defined and agreed job plan. We have reviewed the Specialty and General Practice Frameworks and whilst the proposed standards and attributes for each assessment domain are uncontroversial, we strongly question the effectiveness of introducing so many criteria, and the requirement for collecting vast amounts of detailed supporting information. Clarity is needed on how some of the information will help to assess whether an individual doctor is safe and qualified to undertake specialist practice. Care must be taken to ensure that perceived quality is not confused with competence.

The frameworks require evidence of participation in a wide range of clinical activities. This approach could disadvantage individuals who do not undertake full-time clinical service, including, but not limited to, those who undertake other roles, for example: clinical academics and individuals working in the pharmaceutical industry and public administration. Focusing upon a smaller number of core domains, each allowing a range of supporting evidence would help these individuals to demonstrate their commitment.

It would be timely to consider alternative models of how the current proposals might be incorporated into existing local assessment mechanisms in a manageable way that brings real value to both the doctor and their area of practice.
SUPPORTING CLINICIANS WHO PURSUE A VARIETY OF ROLES

The Government’s decision to protect investment in health and medical research in the recent spending review means that the UK can continue to translate extraordinary advances in medical science into benefits for patients and society. To support this translational science agenda, it is vital that the contribution of clinicians whose work involves a significant component, or a preponderance, of research, teaching and other academic work is greatly valued. University Medical Schools and their NHS partners have well-established mechanisms for jointly agreeing and appraising the clinical service and research contribution made by clinical academic staff, and it’s important that these relationships are not compromised by the proposals for revalidation. Careful consideration must be given to clinicians who are currently working outside the NHS or established medical centres; individuals working in other settings must be revalidated equitably.

In developing appropriate mechanisms to revalidate clinical academics, it is imperative that appraisals adhere to the Follett principles. It is also essential to define the boundaries of revalidation; there must be recognition that many of the “non-clinical” activities undertaken by a clinician might not be relevant to their professional status. Revalidation should only consider those aspects of a clinician’s activities for which it is a requirement to be a doctor. Other activities should only be relevant if they raise concerns about honesty and integrity, for example, research fraud.

OVERSIGHT OF REVALIDATION

The GMC must provide national oversight of the revalidation process in its entirety. The Royal Colleges and Faculties provide an essential national role in maintaining the standards for the knowledge base within specialties, by setting the training curriculum etc. The Colleges and Faculties have an important advisory role, but involving them directly in the evaluation and revalidation of individual doctors would be unwieldy and almost certainly inappropriate. However, we support the proposal for Colleges and Faculties providing appraisal and Responsible Officer facilities to specialists who work outside of managed healthcare environments.

November 2010

Written evidence from Medical Defence Union (REV 31)

1. The Medical Defence Union (MDU) is the oldest and largest of the UK’s medical defence organisations (MDOs). We are a non-profit making mutual membership organisation with members in the UK and Ireland. In the UK we provide a wide range of medico-legal benefits to our members who are over 50% of doctors in hospital and primary care. Among the benefits of membership, the MDU’s medical members receive advice and assistance with matters such as complaints procedures, investigations by the General Medical Council, disciplinary investigations by their employer or contracting body, inquests, public inquiries and many other matters arising from their treatment of their patients.

2. We expect members will seek our assistance with medico-legal problems arising from the introduction of Responsible Officers (ROs) from 1 January 2010 in England, Scotland and Wales (and 1 October 2010 in Northern Ireland), and revalidation when it is introduced throughout the UK. On behalf of members we have taken part in working groups set up by the Department of Health to consider the key proposals and plans arising out of the 2007 White Paper Trust Assurance and Safety, and more recently we have responded to consultations on draft legislation for ROs and on proposals for revalidation.

3. Our submission to the Health Committee covers the main points we raised in the GMC’s recent consultation on its plans and proposals for revalidation. Since we submitted comments in June 2010, the GMC has responded to that consultation and we were pleased to see that its response document quotes from the MDU’s response and takes up key themes we raised on behalf of members. We expect to continue to discuss the GMC’s proposals for revalidation as they emerge and to represent our members’ interests in this process. The areas we believe need particular consideration are:

EXECUTIVE SUMMARY

Role of Responsible Officers

4. The MDU believes that one of the most difficult aspects of revalidation will be the role of the Responsible Officer (RO). We realise that ROs are outside the GMC’s control, but they will be crucial to the success of revalidation. Their relationship with the doctors for whom they are responsible will need to work smoothly and without problems. However, the MDU has misgivings about a number of aspects of the role of the ROs as set out in the Department of Health’s recent consultation on ROs and the draft regulations (which are currently before Parliament). In short, we do not believe that the proposed role for ROs provides enough safeguards for a robust procedure when the ability of a doctor to revalidate and to remain licensed to practise is at stake. Our main concerns relate particularly but not exclusively to robustness and fairness (or otherwise) of the procedures to investigate concerns, and the potential for conflicts of interest between ROs and doctors for whom they are responsible.
5. The GMC referred to the MDU’s concerns in its consultation response and has pledged to consider how it will best support ROs in future to “manage concerns about the practice of individual doctors early and effectively”. This will be crucial to the eventual success of revalidation.

**Specialty Frameworks and Information Required from Doctors**

6. In the interests of fairness and consistency the revalidation requirements must be, as far as is possible, equally demanding upon all doctors. The MDU believes the emphasis must be on greater consistency of requirements between specialties, possibly by standardisation of requirements in core areas of practice and moving even towards a more unified framework for a number of related specialties. We also understand that some of the frameworks require the setting up of procedures or collecting of information that is not routinely collected, even in a well-managed environment. It would seem appropriate therefore, for the frameworks to concentrate on collection and collation of information that is currently available within that specialty, and in other specialties, than to require new procedures and processes to be set up in order to provide material necessary. Some types of information will be easier to collect and collate for revalidation if they are the same data sets that the employer or contractor has to provide for another purpose, for example to a healthcare regulator.

7. The GMC referred to the MDU’s concerns in its consultation response and has agreed that the specialty frameworks need to be streamlined to make them more straightforward, proportionate and realistic. It further agrees that the focus should be on identifying the information that can be readily collected using existing systems. It will be important to get this right if revalidation is to succeed.

**Fairness to Doctors and Consistency of Process**

8. 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.

**MDU Submission**

**Responsible Officers**

9. The MDU believes that one of the most difficult aspects of revalidation will be the role of the Responsible Officer (RO). We realise that ROs are outside the GMC’s control, but they will be crucial to the success of revalidation. Their relationship with the doctors for whom they are responsible will need to work smoothly and without problems. However, the MDU has misgivings about a number of aspects of the role of the ROs as set out in the Department of Health’s recent consultation on ROs and the draft regulations (currently laid before Parliament). In short, we do not believe that the proposed role for ROs provides enough safeguards for a robust procedure when the ability of a doctor to revalidate and to remain licensed to practise is at stake. Our main concerns relate particularly but not exclusively to robustness and fairness (or otherwise) of the procedures to investigate concerns, and the potential for conflicts of interest between ROs and doctors for whom they are responsible.

10. If the concerns that the MDU outlined in our RO consultation response are not resolved by the time ROs are introduced there is the potential for considerable practical difficulties that may inhibit revalidation and that will need to be resolved before doctors can revalidate. While it will be in the interests of doctors, and a GMC requirement, to ensure they revalidate successfully, this must be balanced against their rights to a fair procedure that takes proper account of their rights during a process that could ultimately lead to their being removed from the register. The MDU will do what we can to assist members in the hope that the procedure may run smoothly, but we point out our concerns as the role of ROs may be a significant obstacle to successful revalidation for some doctors.

11. To give an example of the potential for conflict between the doctor and the RO: there may be a difference of opinion between the two as to whether the doctor has provided sufficient information for a decision in favour of revalidation. The doctor may consider that he or she has, and the RO may take a different view. It is not clear in such a circumstance how such a difference of opinion will be resolved. Will it be for the RO appeals process (which is designed to challenge the appointment of the RO rather than any decision the RO makes), or a matter for the GMC to decide on the basis of the evidence that the doctor believes is adequate because it meets the revalidation requirements that are clearly set out?

12. To ensure there is complete consistency of decision making on behalf of ROs, there must be no room for doubt. There will need to be clear guidance right from the start to make it clear, for example, what standards are expected of doctors. The same standards must be applied to all doctors and, while there must be flexibility to allow for different types of practice within the same specialty, doctors must not be penalised because their RO has a more prescriptive interpretation of the standards than an RO in a neighbouring trust or PCT.
Ev w60 Health Committee: Evidence

Information required from doctors

13. We discussed the proposed specialty frameworks in the GMC consultation document with our Council members who are senior clinicians in most major specialties and primary care to seek their views as practising clinicians. Their view was that most of the frameworks as provided would require disproportionate effort from clinicians who are already working to capacity and that the frameworks needed more work. The requirements set out differed considerably between specialties and some of the frameworks would appear to require far greater effort from clinicians in certain specialties than is required of those in other specialties.

14. This is not the MDU’s area of expertise as the decisions on standards must be clinical, but in the interests of fairness and consistency the revalidation requirements must be, as far as is possible, equally demanding upon all doctors. We believe the emphasis must be on greater consistency of requirements between specialties, possibly by standardisation of requirements in core areas of practice and moving even towards a more unified framework for a number of related specialties. We noted that the GMC highlighted this concern of ours in its revalidation consultation response as a matter for consideration and we believe the development of a clear and realistic set of specialty frameworks is central to the success of revalidation.

15. We understood that some of the frameworks required the setting up of procedures or collecting of information that is not routinely collected, even in a well-managed environment. It would seem appropriate therefore, for the frameworks to concentrate on collection and collation of information that is currently available within that specialty, and in other specialties, than to require new procedures and processes to be set up in order to provide material necessary. Some types of information will be easier to collect and collate for revalidation if they are the same data sets that the employer or contractor has to provide for another purpose, for example to a healthcare regulator.

Fairness to doctors

16. 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.

17. The introduction of revalidation must be fair for all doctors and at present it is clear there are many areas where local systems are not sufficiently developed and robust enough to support revalidation. While we understand the argument for making a start with revalidation by introducing it in some areas rather than others, given the potential severity of the outcome for doctors who fail to revalidate, they must not be put at a disadvantage because of their location or specialty and the requirements should apply to all equally. No doctor should be required to revalidate if the local systems and procedures are not in place, not least because most doctors are not in a position to influence such changes. In the first instance it may be fairer to set a date for all organisations to have appropriate systems and procedures in place to check that they are robust. Thereafter revalidation could be phased in by whatever means is considered fairest—presumably after further consultation.

18. This is particularly important because our concerns about ROs (whose role will be fundamental to the success of revalidation) relate to uncertainties about the role of ROs themselves, and not their location or specialty or similar factors. Any problems that may occur with ROs would be as likely to happen in healthcare organisations that already have robust systems and procedures in place in respect of revalidation as in those that don’t. Thus it cannot be assumed that because an organisation has appraisals and other procedures in place, the doctors who work there will necessarily be ready to begin to revalidate.

19. It is a little too early yet, but the deadlines for revalidation need to be announced as early as possible to allow organisations and individual doctors to prepare. The deadlines need to be clear as does the course of action to be followed by organisations that do not make these deadlines. The MDU’s concern is that most doctors, who may be keen to revalidate, may not be in a position to influence the readiness or otherwise of their organisation to provide information that these doctors need to meet a revalidation deadline. These doctors should not be penalised because their organisation fails to provide information they need to rely on. Consideration needs to be given to alternative arrangements for doctors who are in this position.

Protecting doctors’ rights

20. It must be very clear that details of an individual doctor’s revalidation will be confined only to the doctor, his or her appraiser and the RO (and his or her support team). Information from the appraisal process must not be shared with others unless necessary—for example, with the employer or bodies with defined roles such as the GMC or NCAS. There is no role for anyone else as the process is a private matter and all information about the doctor must be treated as confidential. We see no role for GMC affiliates to get involved in individual cases or to be given information relating to individual doctors, indeed it would be inappropriate for them to do so. For example, it would be appropriate for a GMC affiliate to advise an RO on the threshold for Fitness to Practise referrals, but that person must not be given details of identifiable individuals. Similarly RMRSTIs must not be provided with information about individual doctors and should confine discussions only to principles.
21. Just because certain bodies or individuals think they should be given information about an individual doctor’s revalidation does not mean they have any right to such information. It must be very clear in any guidance that doctors have a right to confidentiality. A fair process will ensure information about them is shared only with those who have a right to see it.

22. In summary, the MDU believes that revalidation should be based as closely as possible on existing information and processes to minimise the need to introduce additional administrative burdens for doctors and for employers/contracting bodies supplying the information. We will work with the appropriate organisations to try to achieve this on behalf of our members.


November 2010

Written evidence from the Recruitment and Employment Confederation Medical Sector Group (REV 32)

1. INTRODUCTION

1.1. This Submission is in response to the House of Commons Health Committee call for evidence on the Revalidation of Doctors.

1.2. This response outlines the role of the REC and REC Medical, the interaction between our members, Locum Doctors and the impact of the revalidation process.

2. ABOUT THE REC AND REC MEDICAL

2.1. The REC represents around 8,000 recruitment company branches, estimated to constitute half of all Recruitment agency branches but a higher proportion by turnover.

2.2. Over 85% of the industry is made up of small businesses. In 2008–09 the recruitment industry generated turnover in excess of £22 billion and placed 1 million people in temporary jobs every week in every sector in the labour market.

2.3. REC Medical is one of 20 specialist groups, covering the entire Recruitment industry run by the REC. REC Medical represents agencies who deal primarily with the placement of Locum Doctors, Nurses and Emergency support staff. The group comprises of over 3,500 Recruitment Agencies across the UK.

2.4. The REC supports members with their responsibilities through the provision of free legal services, model contracts and advice and guidance on setting up and agency. Correct and ethical recruitment is the prime concern of the REC and all our members’ sign up to a code of professional practice and are subject to random inspections.

3. SUMMARY

3.1. REC Medical fully supports all measures to enhance safe and ethical recruitment. The general principles behind the revalidation of doctors are sound. However, the practical implementation of revalidation procedures raises specific concerns for locum doctors working on a number of different sites and often through several different agencies.

3.2. The REC Medical Sector Group is committed to finding workable solutions and is already working with the General Medical Council (GMC) and the Department of Health (DoH) on these issues.

4. FEEDBACK FROM REC MEMBERS

4.1. Feedback from REC Members has identified a series of concerns that would need to be addressed in order to make the system workable.

4.2. Concerns about Responsible officers; It is estimated that the total cost of employing a qualified doctor is in the range of £125,000 to £200,000 on-cost figures. Whilst the net cost will be lower—the doctors in question will be able to practice medicine whilst acting as the responsible officer—this will ensure increased costs to Recruitment Agencies.

4.3. These increased costs have a particular impact on smaller firms who cannot afford to absorb these costs. Out of the 53 Locum agencies operating within the NHS framework 94% are small or micro size (less than 50 and 10 employees respectively) and 6% are of medium size (50 or more employees).

4.4. The onus cannot be put solely on agencies. For instance, it is unrealistic to expect all agencies to have responsible officers in place within their organisation. While larger agencies might be able to have built-in solutions, smaller agencies would find it impossible to have responsible officers in their organisation.
Ev w62 Health Committee: Evidence

5. RECOMMENDATIONS

Whilst the REC welcomes moves towards enhanced standards, ensuring that the quality of medical practitioners is improved, they are concerned that special considerations need to be made as regards to the costs of implementing these changes.

5.1. Need to understand the nature of the locum market; career locum doctors would have very different requirements to locums who are operating on a temporary basis. Where a locum works for one agency there must be an effective method of sharing that information.

5.2. It is crucial for the GMC to take the lead in developing regional lists of Responsible officers ensuring that they are readily available. REC members have highlighted the cost and difficulty of reaching a responsible officer, primarily due to the lack of availability of Consultants. It is also important that there is an established system whereby Recruitment agencies would be able to pool Responsible officers to minimise costs without compromising on quality.

5.3. There needs to be extensive clarification as to the responsibilities, skills and qualifications of responsible officers. Their clinical effectiveness and quality must undergo constant inspection, ensuring that the necessary standards are maintained.

5.4. For locums in PCTs, the assessment could be done through the existing performance register. For locums in secondary care, the appraisal could be done through a PCT in the area in which they live. It was also suggested that a mechanism could see Foundation Trusts get involved in assessing the locums for a fee.

5.5. Registration of Responsible officers needs to be portable to ensure that there are not unnecessary delays to the process of hiring locum doctors. This problem is particularly acute given existing concerns about the working time regulation and the effect that this is having on the effective supply of Doctors to the NHS.

5.6. Assessing non-UK doctors. Questions remain over the way in which non-UK doctors could be fully assessed. As a result of some of the staff shortages highlighted above it is likely that we will continue to see more doctors coming in from overseas even on short term assignments from other EEA countries.

November 2010

Written evidence from Care Quality Commission (REV 33)

INTRODUCTION

1.1 The Care Quality Commission (CQC) welcomes the opportunity to provide commentary to the Health Select Committee on the revalidation of doctors. CQC responded to the General Medical Council (GMC) consultation on revalidation earlier in the year and would be happy to supply this to the Committee.

1.2 It should also be noted that revalidation is being considered for other professions and similar issues identified below will apply. There is currently a consultation on revalidation of dentists and we are aware that the Nursing and Midwifery Council is considering options for revalidation of nurses and midwives. We believe the Health Select Committee should consider the impact that their recommendations may have on other future revalidation schemes.

THE ROLE OF CQC

2.1 CQC is the statutory regulator of health and adult social care providers in England. All providers must be registered with us; it is the legal entity (whether this is an individual, partnership or organisation, such as an acute trust) that provides the regulated activity to patients that must register, and once registered we will monitor their compliance on an ongoing basis. To be registered providers must meet essential standards of quality and safety. These have been developed by CQC as a result of legislation set out in the Health and Social Care Act 2008 and CQC’s (registration) Regulations 2009.

2.2 We have developed and use a risk-based approach to monitor compliance and we are able to use a wide range of enforcement powers to make sure that swift action is taken where services are failing to meet these requirements. All NHS trusts, adult social care, independent hospitals and clinics (which fall within the rules) should now be registered with us. Primary dental care providers will come into registration from 1 April 2011 and primary medical care providers from 1 April 2012.

OVERARCHING PRINCIPLE

3.1 It is vital that the systems of regulation for doctors and for healthcare providers must be aligned, while their unique contribution to protecting public well-being are recognised and maintained. There are several key issues that need further development and consideration as revalidation is introduced to ensure that alignment is as effective as possible.
3.2 CQC and the GMC have a good working relationship. We recognise that we have a responsibility to work together, and with other professional regulators, to share information appropriately in order to safeguard the well-being of the public and minimise the burden of regulation.

3.3 There will inevitably be some areas of overlap and issues of mutual interest between the two types of regulation. Where these overlaps occur the regulators must work together to share relevant information and articulate the similarities and differences in order that doctors and/or providers are clear about both sets of requirements. We recognise that those doctors that work on their own or in a very small provider and will need support to understand how they can use information as evidence toward revalidation as well as ongoing compliance with CQC registration requirements.

3.4 Clarity regarding these regulatory systems is essential to ensure that poor practitioners do not fall through the regulatory net, that patients are effectively safeguarded from poor quality care. The public can have confidence in the quality of care offered both by individual doctors and by organisations providing care. This will also ensure that the profession is clear about where regulatory responsibility lies; reducing confusion and enabling doctors to focus on providing high quality patient care.

**How CQC and the GMC Work Together**

4.1 We have a close working relationship with the GMC and in May 2010 signed a memorandum of understanding (MoU). The MoU details how we will work together to share information in order to safeguard the well-being of the public. In particular we will share:

- Information about an individual’s fitness to practice.
- Concerns about GMC approved practice settings.
- Information that may call into question an organisation’s suitability as a learning environment, and
- Information about the robustness of appraisal and clinical governance systems.

4.2 The MoU will be supported by a specific information sharing agreement.

4.3 The MoU currently recognises the need for cooperation between the GMC and CQC in developing the system of revalidation of doctors. There are a number of key issues that need to be taken into account as revalidation is implemented, and the MoU will be amended accordingly.

**The Relationship between Registration and Revalidation**

5.1 When the Health Select Committee is considering the implementation of revalidation we believe it is important to recognise the different roles of registration and revalidation. Registration provides assurance that an organisation delivering services meets essential standards of quality and safety. However, it does not provide assurance that every individual doctor delivering those services is clinically and professionally competent to undertake their specific role. This is the role of professional regulation, and thus revalidation.

5.2 It is not CQC’s role to assess the competence of individual doctors. However, it may be more likely that concerns about individual competence will not be addressed in an organisation where governance arrangements are poor or where staff are not adequately supported. These organisations may also be at risk of not implementing appropriate appraisal and revalidation systems and processes. Our compliance monitoring should identify organisations where these risks exist. For this reason, information about an organisation’s registration will be of interest to the GMC. For example, registered providers must meet essential standards about ensuring that:

- staff have the right qualifications, skills and experience and are fit to do their job;
- staff receive appropriate support, supervision and training, and
- the quality and safety of services is monitored, learning is taken on board and improvements are made.

5.3 As revalidation is implemented we will look at the systems and processes that organisations have in place to support revalidation in relation to the essential standards identified above. We will need to work with the GMC and responsible officers to share information about concerns that may either: impact on a provider’s compliance with essential standards; or vice versa, that may affect the quality of appraisal and revalidation decisions.

5.4 As well as systems to support doctors, and other staff, there are others ways in which the registration essential standards and the standards that must be met by individual doctors for revalidation cover similar issues. For example, in order to comply with essential standards a registered provider is required to ensure that care delivered follows evidence based guidelines. Similarly, appraisers and responsible officers, as part of the revalidation process, will want to be assured that an individual doctor’s practice is evidence-based.

5.5 Given that there is some overlap between the expectations of registration and the content of professional standards it is important that both organisations are able to clearly articulate the benefits of each system.

5.6 We recognise that doctors that work independently, or within a very small provider, may feel that the process of revalidation and registration together will be burdensome. We are committed to supporting these
doctors to use the evidence they have for both purposes where overlap exists. We also hope that effective partnership working between ourselves and the GMC will, where concerns are identified, allow us jointly to take decisions about the appropriate response.

5.7 We are aware that the Department of Health is reviewing the scope of registration for some private doctor’s services. We expect that the role of revalidation will be considered as part of this review. We will work with the Department and the GMC to ensure that an appropriate and proportionate solution can be found.

CONCLUDING REMARKS

6.1 The complementary regulatory systems delivered by CQC and the GMC will offer patients and the public greater assurance about both the professional standards of the doctor and the quality of care of the provider they visit. Patients will, in future, be cared for by registered providers, where registration means the organisation is meeting essential standards and safety; and by revalidated doctors, where revalidation means that the doctor is competent to undertake their role.

6.2 We hope that the Health Select Committee is assured that the two regulatory bodies will continue to work closely to share information appropriately, both to safeguard patients and reduce burden on providers and doctors, as registration develops and revalidation is implemented.

November 2010

Written evidence from The Royal College of General Practitioners (REV 34)

SUMMARY

(a) The Royal College of General Practitioners supports the principle of the introduction of revalidation for doctors. Revalidation can offer the public, health professionals, managers, employers and the state reassurance that every doctor is keeping up to date and remains fit to practise; encourage doctors to reflect on their standards of care and to strive for improvement; and identify any underperformance at an early stage when intervention is most likely to be effective and feasible.

(b) In supporting revalidation, we recognise some significant challenges. Revalidation for doctors must be fit for the purpose; fair and equitable to all doctors; achievable with minimal disruption to the delivery of healthcare; and applicable to all doctors whatever their chosen career pathway.

(c) Revalidation must be as simple and explicable as possible, while still achieving its stated objectives. For this reason we wish to achieve:
   — A common definition of the supporting information normally required from all doctors regardless of their speciality.
   — The simplification of mapping of the supporting information for revalidation and the appraiser sign off.
   — The processes and tools for Colleague Surveys and Patient Surveys should be clarified.

(d) Annual appraisal is evolving, but it must become a more robust assessment of information on a doctor’s performance, using a common set of supporting information.

(e) Local clinical governance must be an effective system that responds appropriately to concerns raised through appraisals or through other routes.

(f) There are a number of unresolved issues arising from Equity and Excellence: Liberating the NHS that could threaten the overall integrity of revalidation. Detail is lacking on many facets, including the location and organisation of:
   — The maintenance of the Performers List (the local register of GPs)
   — data collection and analysis for clinical governance to support patient safety
   — The Responsible Officer
   — Processes for addressing concerns about the performance of individual doctors or teams, including a definition of the nature of the problem and the actions to address it, support/remediation and reintegration

BODY OF EVIDENCE

1. The Royal College of General Practitioners (RCGP) is the largest membership organisation in the United Kingdom solely for GPs. It aims to encourage and maintain the highest standards of general medical practice and to act as the “voice” of GPs on issues concerned with education, training, research, and clinical standards. Founded in 1952, the RCGP has over 38,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline.

2. The RCGP welcomes the opportunity to provide written evidence to the Select Committee on the Revalidation of Doctors. The RCGP has been a leading organisation within the movement to revalidation for over a decade and we continue to offer leadership both to the half of the profession in general practice and,
through our membership of the Academy of Medical Royal Colleges, to the profession generally. We have previously consulted the GP profession and relevant organisations to produce the Guide to Revalidation for General Practitioners, which contains the RCGP’s proposals for the processes and standards for the revalidation of GPs.

3. The RCGP supports the introduction of revalidation. We do so because we believe that patients, the public, health professionals, managers, employers and the state expect and deserve reassurance that every doctor is keeping up to date and remains fit to practise; all doctors should be encouraged to reflect on their standards of care and be encouraged to strive for improvement; and that we should identify any underperformance at an early stage when intervention is most likely to be effective and feasible.

4. In supporting revalidation, we recognise some significant challenges. Revalidation for doctors must be fit for the purpose described in paragraph 3; it must be fair and equitable to all doctors; it must be achievable with minimal disruption to the delivery of healthcare; and it must be applicable to all doctors whatever their chosen career pathway. In the latter case, general practice especially provides a plethora of career choices (such as working as a peripatetic locum or out of hours; in secure environments or the defence medical services; providing extended clinical services; in medical management; teaching; undertaking research) which must be accommodated within proposals for revalidation. We do not want to inhibit good doctors from providing innovative, high quality services but we do wish to see all doctors demonstrate that such services are safe and of high quality.

5. The RCGP does therefore recognise that revalidation, when introduced, must be as simple and explicable as possible, while still achieving its stated objectives. For this reason we are supportive of the GMC’s aim, as one outcome of its consultation, to streamline proposals for revalidation. We wish to achieve:

   — A common definition of the supporting information normally required from all doctors regardless of their speciality. This portfolio of information will need to be varied for exceptional cases and augmented in some specialities (for example surgical outcomes for the surgical specialities). This will mean that all doctors are being expected to provide similar information promoting cross-discipline equity; all doctors can be clearer about the information required; doctors moving speciality will not be disadvantaged; and Responsible Officers will be presented with similar information regardless of the speciality of the doctor.

   — The mapping of the supporting information for revalidation needs to be simplified (and in many instances removed) and the appraiser sign off should be clearer.

   — The processes and tools for Colleague Surveys and Patient Surveys should be clarified. We believe it should be the responsibility of the Colleges to assess available tools for their appropriateness within their working environment (most good tools can be applied in most settings); and for the GMC to oversee the organisations that administer and analyse the results in order to ensure confidentiality, appropriate feedback to the doctors and involvement of the clinical governance processes when there is cause for concern.

6. At the centre of revalidation for doctors lie two key systems: annual appraisal and clinical governance. Annual appraisal is evolving, but it must become a more robust assessment of information on a doctor’s performance, using a common set of supporting information as described above. The RCGP does not wish to disable the formative element of an effective appraisal, and for most good doctors the checking of supporting information to ensure it is “fit for revalidation” should take only a small proportion of the time available. However, in those cases where the supporting information cannot give the appraiser the assurances they seek, the focus of the appraisal will need to be on that information.

7. The second key system is local clinical governance. There will be a requirement for an effective system that responds appropriately to concerns raised through appraisals or through other routes.

8. While the RCGP has welcomed the overall thrust of the Coalition Government’s White Paper Equity and Excellence: Liberating the NHS, there are still a number of unresolved issues that could threaten the overall integrity of revalidation, especially in general practice. It is not yet clear to us where the following functions will sit, the priority and resources that will be available to them and the quality assurance regimen that will be applied:

   — The maintenance of the Performers List (the local register of GPs).

   — Data collation and analysis for clinical governance and patient safety.

   — The Responsible Officer.

   — Processes for addressing concerns about the performance of individual doctors or teams, including a definition of the nature of the problem and the actions to address it, support/remediation and reintegration.

9. This evidence will now respond to the specific requests for information from the Select Committee.

The Way in which the GMC Proposes to Establish Revalidation

10. With the caveats above, the RCGP believes that the current proposals are proportionate and appropriate. We support both the direction of travel and the broad means towards achievement being proposed by the GMC. The RCGP has been conducting pilots to assess the feasibility of current proposals (see Appendix) and is broadly satisfied with the outcomes.

The Responses to the Consultation and the GMC and UK Health Departments’ Statement of Intent Issued on 18 October

11. The RCGP strongly welcomes both the GMC’s summary of the responses to its consultation and the joint statement of intent. In particular the latter provides considerable reassurance of political intent to carry the revalidation project through to a successful conclusion.

The Experiences of those Involved in the Pilots in London and West Yorkshire

12. The RCGP assumes that these are references to two of the Pathfinder Pilots being conducted by the Revalidation Support Team in England. The RCGP is not involved in the Pathfinder Pilot in West Yorkshire but it does have a representative on the steering group for the London Pathfinder Pilot. The latter is progressing satisfactorily, although the numbers of completed “revalidation ready” appraisals is behind schedule. One recurrent theme concerns the use of the Pathfinders Revalidation Toolkit which seems to be challenging to use. This pilot should provide useful information for the continuing refinement of the both the supporting information and the processes for revalidation.

The Secretary of State’s Decision in June to Extend the Piloting of Revalidation by a Year, Meaning that it will Not now be Fully Implemented until 2012 at the Earliest

13. The RCGP welcomed and continues to welcome this announcement. Although it believed that the proposals for supporting information would have been ready in time for the original launch date of April 2011, it was clear that NHS processes (in both primary care and hospital settings) would not have been sufficiently developed. The processes in non-NHS settings will remain a concern even in 2012. We urge all departments of health to use the extra time to ensure that local systems are in place and effective as soon as possible in order to achieve the go-ahead in the summer of 2012 with the phased introduction of revalidation in all sectors following that decision.

November 2010

Appendix

Summary of the Outcome of the RCGP Revalidation Pilots

The RCGP has the responsibility, on behalf of all GPs, to propose the standards and methods for the revalidation of GPs. To ensure that its proposals are realistic, proportionate and achievable for all GPs, the RCGP has commissioned a number of pilots. As well as testing its proposals on mainstream GPs, the RCGP has tested its proposals on specific groups, including sessional and remote rural GPs. A summary of the findings of the completed Warwick, Sessional, Tayside and Prescribing Indicators pilots can be found below. Two further pilots are currently underway—one for doctors working in the Defence Medical Services (i.e. outside the NHS) and one for doctors who work in Secure Environments, such as prisons, custody suites and immigration removal centres.

Learning from these pilots is incorporated into the RCGP Guide to Revalidation on an ongoing basis.

Warwick Pilot

The objectives of this pilot were as follows:

- To assess the feasibility of a representative sample of English and Welsh general practitioners (principal and sessional GPs, full-time and part-time) collecting supporting information as required for the RCGP’s proposed revalidation portfolio.
- To compare the rating of the contents of the RCGP’s proposed revalidation portfolio with an alternative source of evidence for revalidation (an applied knowledge test).
- To explore the feasibility of GP appraisers and Responsible Officers rating the contents of the RCGP’s proposed revalidation portfolio.
- To identify GP and GP appraisers’ views on revalidation and the RCGP’s proposed GP revalidation portfolio and to gather their suggestions on how the process might be improved.

The methodology used was as follows:

- A sample of GPs from three Primary Care Organisations (two in England & one in Wales) collected 12 month’s of supporting information in a project portfolio guided by criteria and standards as detailed in the RCGP Revalidation Guide.
— Participants mapped their supporting information against the GMC *Good Medical Practice* four domains & 12 attributes.
— A reflective issues log, an on-line questionnaire and focus groups were used to obtain participants’ views on the proposed revalidation process and the associated logistics.
— A group of these GPs was recruited to sit an nMRCGP Applied Knowledge Test (AKT) assessment and the results were correlated with the contents of their portfolios.
— Project assessors rated the contents of participants’ portfolios.
— Assessors were interviewed and focus groups were arranged to gather their feedback.

Main findings:

— 50 GP principals, 18 sessional GPs and one GP registrar submitted project portfolios. (520 GPs were invited to participate in the project, 118 consented to participate—*Numbers of portfolios submitted may have been affected by the swine flu epidemic coinciding with the project recruitment period and the temporary withdrawal of the NHS Appraisal Toolkit in the last month of the data collection period*).
— Just over two-thirds (68%) of the portfolios submitted by the GPs contained evidence of sufficient quantity and quality to meet the proposed RCGP revalidation standard for at least four out of the eight to ten supporting information areas.
— The study suggested that the principal factors that affected a GP’s ability to submit quality supporting information were a lack of automatic access to practice data (i.e. access to practice files and invitations to practice meetings) plus lack of colleague and patient continuity.
— Salaried GPs scored comparably in all supporting information areas with the GP principals. GP locums, however, compared less favourably with GP principals and salaried GPs on SEA, colleague MSF survey, and the full-cycle clinical audit supporting information areas.
— For seven of the 10 supporting information areas required for the project GP portfolio, more than three-quarters of the respondents reported that this was appropriate evidence for assessing their performance as a GP. The GPs were less convinced that the extended roles (59%) and colleague MSF and PSQ questionnaires (57%, and 55% respectively) were appropriate supporting evidence to assess a GP’s performance.
— More than three-quarters of the respondents reported that they could collect supporting information for seven out of the 10 evidence areas in a five-yearly cycle. These respondents were most concerned about providing supporting information for extended practice, learning credits and patient satisfaction questionnaires.
— There was considerable variation in the time taken by GPs to produce portfolios—the four sections that the GPs found most demanding time-wise to produce, reflect and write up were the learning credits, PSQ, clinical audits and colleague MSF.
— The vast majority of problems reported by the GPs centred on the new types of supporting information areas of learning credits and colleague MSF surveys.
— Three out of the ten doctors passed the AKT test; seven out of the nine GPs who submitted portfolios were marked satisfactory and five out were marked satisfactory for their portfolio learning credit evidence. The numbers were too small to be of statistical significance for correlation with the ratings of their portfolio contents.
— The time taken by the GP appraisers to rate a paper-based GP portfolio with the evidence sorted into the eight to ten supporting information areas ranged from 10–75 minutes with an average time of 21 minutes. There was variation between scores when “double marked” suggesting that benchmarking is very important.
— The project ROs were impressed with the quantity of information that the GPs had been able to submit over a relatively short period of time. However, they considered that the quality of the evidence could be improved. The absence of self-reflection was notable in some cases.

**Conclusions/Main Recommendations:**

— Participants’ portfolios contained quality supporting information that with training and support should develop into evidence that could be recommended for the proposed RCGP revalidation.
— There should be a gradual introduction of revalidation process to allow GPs, other colleagues and organisations involved to fully understand the process.
— GPs require clear, practical guidance on how to collect areas of supporting information.
— GPs require access to a user-friendly electronic portfolio.
— Appraisers will require initial face-to-face training.
— Alternate revalidation methods and support networks need to be explored for sessional GPs who experience reduced access to practice data.
— Colleague and patient feedback should be performed out of house to increase the objectivity of the process.
— High quality training is required for Responsible Officers and appraisers to promote the standardisation of the rating of GP portfolios.
— GP assessors’ rating of portfolios must be quality assured to ensure consistency.

 SESSIONAL AND LOCUM DOCTORS PILOT

Objectives and methodology:
— This study set out to explore the experience of locum, salaried and remote GPs in collecting supporting information in the proposed RCGP revalidation portfolio.
— 53 sessional or remote GPs took part in focus groups or interviews and attempted to collect items of supporting information—clinical audit, significant event analysis, colleague and patient feedback—over a three month period.

Key findings:
— The sessional GPs in this study who felt most able to collect the RCGP’s proposed supporting information were mainly those with a fixed practice base for at least one session a week over a period of time. GPs who experienced the most difficulty tended to be peripatetic locums and Out of Hours (OOH) GPs with no permanent practice base.
— Remote rural GPs in small practices highlighted issues relating to the limited practice list size for clinical and significant event audit and having insufficient colleagues to elicit colleague feedback.
— Locums felt that they were perceived to have a lower status than other GPs and that this translated into a lack of engagement and support from practices for appraisal and revalidation activities.
— OOH and remote GPs also experienced isolation and felt relatively unsupported.
— The availability of a peer group of supportive colleagues would help the completion of supporting information requirements by providing the opportunity for reflective discussion.
— Remote rural GPs were generally able to complete clinical and significant event audit, although there were concerns about small sample sizes for both SEAs and some audits.

Conclusions/Main Recommendations
— Revalidation would require a culture change: sessional GPs to be supported in their professional development by both practices and Primary Care Organisations.
— OOH organisations should provide their regular GPs with specific systems to carry out clinical audit; identify and discuss SEAs and elicit colleague and patient feedback, as well as offering some educational updates.
— A number solutions were identified for areas of supporting information which proved to be problematic—these are incorporated into the RCGP Guide to Revalidation.

TAYSIDE

Objectives and methodology:
— 60 Tayside GPs were recruited into a revalidation study which aimed to explore the value of a prescribed portfolio of feedback information about the doctor’s individual practice and information from the environment in which the doctor worked (i.e. the GP practice).
— The prescribed portfolio contained both personal and practice based feedback information. Personal feedback information was provided from Multi-Source Feedback (MSF), Patient Survey Questionnaire (PSQ), analysis of written complaints and a self assessed open book knowledge test (RCGP Scotland PEP).
— Practice feedback information was provided from QOF plus data and data on 12 potentially dangerous co-prescriptions.
— In order to assess whether the prescribed feedback information covered the four GMC domains and 12 attributes, the pilot team carried out a mapping exercise using feedback formats which were mapped to the four domains and 12 attributes.
— At the start of the project participants were asked to map the feedback formats based on how they thought they would map to the GMC framework. As most would have had no previous expertise of using these feedback formats, this was a measure of their perceptions.
— At completion of the study participants were asked to complete the mapping exercise a second time—on this occasion their responses would be based on their experience of the feedback formats (which involved receiving the feedback, reflecting on the feedback and using the feedback at their appraisal discussion).
Key findings:

— A high level of agreement by participants over how the feedback formats mapped to the GMC framework.
— MSF as a feedback format was thought most likely to test most of the GMC framework.
— Following experience of using the feedback formats—the only significant changes from their initial perceptions were that knowledge testing and patient surveys tested more of the GMC framework than they had thought using their perceptions alone.
— The open book knowledge test was valued by participants.
— The open book knowledge test seems to act as a catalyst for further reading and learning.
— MSF and PSQ feedback was particularly valued if it included comments about the doctor.
— Provision of the 12 potentially dangerous co-prescriptions was valued by most participants and this data was used as a source of further exploration into the practice prescribing.

Conclusions/Main Recommendations:

— The feedback tools used demonstrated that MSF, PSQ and open book knowledge testing were perceived by participants to map best to the GMC revalidation framework. The open book knowledge test was valued and can be a catalyst to promote further learning.

Prescribing Indicators

Objectives and methodology:

— To develop and test a set of indicators of prescribing and medicines management that could be used for the purposes of quality improvement in General Practice and feed into Revalidation processes.
— A list of potential prescribing safety indicators were identified through a literary search and a series of consensus panel meetings.
— The indicators which were deemed appropriate were tested to see if they could be turned into computer queries.
— Those which could be turned into computer queries were tested on two types of clinical system

Key findings:

— The process demonstrated that it was possible to develop a mechanism for data extraction, indicator encoding and data assessment based on those indicators. It also showed that there is inter-practice variation in prescribing.

Conclusions/Main Recommendations

— Electronic prescribing currently only exists in general practice and it is the combination of that and the clinical record which made this project possible. If electronic records (clinical and prescribing) develop in other sites, such as hospitals, there may be scope for such information gathering for revalidation by other disciplines.
— Individual prescribing numbers should be introduced for GPs—this would be essential to enable the use of prescribing indicators as supporting information for revalidation.
— Any such data generated from prescribing indicators would need to be interpreted in an appropriate way.

Written evidence from Dr Foster Intelligence (REV 35)

1. Background on Dr Foster Intelligence

Dr Foster Intelligence is joint-venture company half-owned by the Department of Health. Dr Foster provides clinical benchmarking services to hospitals and commissioners. It also publishes information about outcomes achieved by different healthcare providers in the UK. Dr Foster is committed to achieving a more patient-centred and transparent health service and consequently operates to a high level of transparency and accountability itself. Oversight of the company is provided by an independent ethics committee.

2. DR FOSTER AND REVALIDATION

2.1 Dr Foster Intelligence supports the introduction of revalidation and believes that it is an important step in ensuring high quality healthcare.

2.2 We understand the reasons for delay in the introduction of revalidation and agree that the system must be proportionate, cost effective and supported by clinicians if it is to work. That said, we are concerned at the length of time it is taking to implement a system of revalidation.

2.3 We have recommendations in relations to revalidation in two areas:
2.3.1 We believe if it is to be cost effective, revalidation must be looked at in the broader context of initiatives to improve the quality of health services through monitoring of standards. If done in a way that complements these broader initiatives it will prove cost effective. Quality improvement initiatives are often specific to the devolved administrations within the United Kingdom. However, there is sufficient commonality of approach to be able to take useful steps to ensure that revalidation is developed in line the broader objectives of quality improvement and regulation.

2.3.2. We believe that a large part of the cost of revalidation is collection of data in the areas of patient feedback and clinical outcomes. However we believe that by using existing data resources more effectively the costs can be managed.

3. REVALIDATION AND OTHER INITIATIVES DESIGNED TO ENSURE QUALITY HEALTHCARE

3.1 There are a number of policies and initiatives currently to monitor and improve quality in the NHS. These include:

3.1.1 The outcomes framework and transparency (England only)
This outcomes framework a proposed set of outcome metrics and supporting measures defined by the National Institute of Clinical Excellence that will be used to judge the overall quality of the NHS. Another proposed policy aligned with this, is a plan to encourage greater transparency around outcomes. This is intended to ensure accountability not just to national government but also to local populations and individual patients.

3.1.2 Regulation (CQC in England, the Healthcare Inspectorate in Wales etc.)
The healthcare regulators monitor a wide range of data and have responsibility for ensuring quality of healthcare providers.

3.1.3 National clinical audit (can be UK wide but participation is voluntary)
These are a range of specialty specific audits (data collections, databases and benchmark reports) designed to track measures of quality for secondary care specialists and allow comparison of outcomes between clinicians.

3.2 There are some clear principles that underpinning all of these initiatives as well as revalidation. These principles are:
— Clinicians should be auditing and comparing measures of clinical efficacy and safety including both outcome and process measures.
— Clinicians should have access to data about what patient think about the services they provide and understand where there expectations are not being met.
— Data should be shared with colleagues and clinicians should receive feedback from colleagues about their practice.
— Appropriate comparative measures of performance derived from these data should be published.

There remains different views as to the appropriate level of transparency in health systems but where transparency is regarded as important, revalidation can play an important role in supporting it.

3.3 RECOMMENDATIONS

1. Where clinical audit already exists and specialty associations have recommended outcomes for monitoring, it should be mandatory to review this evidence as part of NHS appraisal. This could be introduced now.

2. Where there are no relevant national audit standards and outcome measures, such standards should be developed. The use of local audit—as for example, proposed for GP revalidation—is of limited benefit. We would like to see a timetable for establishing national standards for audit that include an element of outcome measures for all doctors.

4. GETTING THE MOST FROM EXISTING DATA RESOURCES

In the areas of clinical outcomes and patient safety the key data resources are:
— Primary care clinical data.
— Routinely collected hospital data (HES, PEDW, HIS, ISD).
— National clinical audit data.

4.1 There are a number of ways in which these data are not well suited to revalidation. The key issue are:

4.1.1. Primary care clinical data

There are no requirements on GPs to systematically record any data on their clinical systems. These systems exist for the benefit of the GP to support the administration of their practice and the management of patients. However, these data provide the most extensive source of information with which to understand the clinical quality of practice.
A requirement on GPs to meet minimum data recording standards is also increasingly recognised as vital to underpin the broader management and quality monitoring of the health system. Revalidation provides an important mechanism through which it will be possible to develop consistent and accurate records of primary care.

4.1.2 Routinely collected hospital data

Routinely collected hospital data is being proposed as a source of data for revalidation by some specialty associations. A number have put forward clinical indicators that can be derived from these data. However there are a number of aspects of the data that mean it is not as effective as it might be in supporting either revalidation or, more broadly, monitoring of quality. In particular:

— There is no accurate record of the doctor or anaesthetist performing any procedure.
— There is no “present on admission” flag to distinguish the diagnoses with which the patient presented at hospital from those which may have resulted from treatment.
— There are inadequate rules around the coding of complications such as Deep Vein Thrombosis.

Modest investment in the development of routine data sources could greatly reduce the costs of ensuring doctors have the data they need to support revalidation.

A related issue with routine data is lack of clinician involvement in the recording of these data which can result in inaccuracy and mistrust of the data. Secondary care providers need to take steps to ensure clinicians take an active role in ensuring information is recorded correctly.

4.1.3. National Clinical Audit

The key problem with National Clinical Audit data is the cost of completing the data, the consequent lack of completeness of many records and the lack of independent checks to identify where data is incomplete.

Stronger requirements on clinicians to participate in audit would help. We would also like to see routine comparisons between the hospital’s routine records and the clinical audit record to ensure completeness and accuracy.

4.2 Recommendations

1. Minimum standards for data recording on clinical systems are established for GPs

2. A review of routine hospital data is implemented and the data set is adapted to enable it to best support revalidation.

3. National Clinical Audits are required to regularly compare themselves with official records of activity to identify where data is not being recorded

November 2010

Written evidence from the Faculty of Pharmaceutical Medicine (REV 36)

Introduction

1. The Faculty of Pharmaceutical Medicine (FPM) is a registered charity with approximately 1,400 members who are practising or retired pharmaceutical physicians or those with a professional interest in the specialty.

2. The FPM’s mission is to advance the science and practice of pharmaceutical medicine by working to develop and maintain competence, ethics and integrity and the highest professional standards in the specialty for the benefit of the public.

3. As the standard setting body for pharmaceutical physicians and a Faculty of the Royal Colleges of Physicians of the UK, the FPM has been actively involved in developing the framework and machinery required for revalidation, both through the Academy of Medical Royal Colleges (AoMRC) and directly with the GMC and the DH.

4. Physicians working in the specialty of pharmaceutical medicine are concerned with the discovery, development, evaluation, licensing and monitoring of medicines and the medical aspects of their marketing. Most of their work is undertaken outside the NHS—predominantly in private pharmaceutical companies, the regulatory agencies or as private contractors.

5. The majority of pharmaceutical physicians’ work does not involve direct patient contact however their work does have an impact on the health of populations of patients and the public. The FPM has recommended that all pharmaceutical physicians in active practice maintain a Licence to Practise.

6. The process of revalidation for pharmaceutical physicians will need to take a different course to that of clinical doctors in certain aspects and this has required us to take a different approach when proposing appropriate mechanisms for revalidation. We are particularly keen to see that the revalidation of pharmaceutical
physicians is carried out in a manner which is as objective, transparent and robust as possible, so as to avoid all possible conflicts of interest, and we will ensure this.

7. Doctors normally spend a number of years working in the NHS before joining the pharmaceutical industry or related organisation and they take this expertise with them. It is important that the revalidation process enables the movement of doctors between industry, the NHS and academia. This occurs in different directions and often a number of times during an individual’s medical career.

8. The Faculty is committed to ensuring that there is a process for revalidation for pharmaceutical physicians wherever their place of work, whatever their role and we are making good progress with developing proposed processes for this. It is intended that these processes will be available to all pharmaceutical physicians, whether they are members of the FPM or not (as many practicing pharmaceutical physicians are not currently members of the FPM). We have also been consulting with our members and others to refine our thinking as the strategy for revalidation develops.

9. We have prepared detailed proposals as to how the various proposed components of revalidation could operate in pharmaceutical medicine. For example, the Faculty is proposing to provide an appraisal service for pharmaceutical physicians who are either self-employed or who are employed in settings that are too small to facilitate medical appraisal.

10. The Faculty has been designated within the Responsible Officer (RO) legislation as having a duty to provide RO functions for those of its members that are not able to relate to a local RO. This will apply to those who are self-employed or those who are employed in settings that are not appropriate for designation due to their small size. We are aware that larger pharmaceutical companies have not yet been designated within legislation and would recommend that this is addressed at the earliest opportunity. The FPM is also concerned that there remains insufficient clarity on the role of RO’s in the independent sector.

11. The FPM is not directly involved in the initial raft of ten “Pathfinder” pilot schemes run by the NHS Revalidation Support Team to test the strengths and frailties of proposed systems for revalidation. The Faculty of Public Health and the Faculty of Occupational Medicine are in a similar position to the FPM, in that their members either work outside the NHS or do not have direct patient contact. In light of this the FPM has been working in partnership on a “tri-faculty” project to set up a pilot revalidation project to mirror those that are taking place within the NHS. The tri-faculty steering group is aiming to have its pilots up and running by February 2011, with appraisals taking place over a period of 6 months. Participants will be drawn from the spectrum of pharmaceutical medical practice. A detailed analysis of the outcomes of the pilot will be carried out and the findings will be reported to the Academy of Medical Royal Colleges (AoMRC), who awarded the funding for the pilots, and the NHS Revalidation Support Team.

FPM Response to the GMC Consultation Revalidation: The Way Ahead

12. Earlier this year, the FPM independently submitted a response to the GMC’s consultation Revalidation: The Way Ahead. We stated that although we are generally satisfied with the manner in which the GMC is handling the revalidation process to date, there are several issues that we felt needed further attention and compelled the GMC to ensure that the revalidation process remains “pragmatic, rather than bureaucratic”. The FPM is seriously concerned that the process could become far too complex and time-consuming.

13. The GMC recently released a document outlining their reaction to the responses received from all parties. We feel that the GMC has in general responded positively to the comments which we ourselves made. However, there are still several areas where we feel the GMC response has not fully addressed our concerns.

We would like to draw your attention to the following points which are of particular relevance to the specialty of pharmaceutical medicine. The questions quoted below were posed by the GMC as part of its consultation and are included here for reference purposes.

14. (Q5) What role should Colleges and Faculties have in the revalidation process?

The FPM is not yet sure if Colleges and Faculties should have responsibility for audit and quality assurance of the recommendation process. We feel that this would present a potential conflict of interest for Colleges and Faculties that are designated bodies within the RO legislation. The FPM is therefore pleased to note that the GMC are now intending to review this and develop different options relating to quality assurance and a possible GMC programme of sampling and audit.

15. (Q7) Do you agree with our proposals for the revalidation of doctors with no medical practice of any kind?

The FPM would encourage the GMC’s commitment to ensure that the revalidation process is applicable for doctors in non-mainstream roles and its continued dialogue with relevant organisations such as the FPM.
16 (Q8) Do you agree that the List of Registered Medical Practitioners should indicate the field of practice on the basis of which a doctor has secured revalidation?

The FPM is pleased to see that the GMC has planned to develop more detailed proposals around this issue and is supportive of the concept. The level of detail which would be given within the GMC register would require consideration and is of particular interest to the FPM.

17. (Q14) Do you agree with our approach to patient and public involvement in revalidation?

Although the FPM approved of all three of the patient and public feedback options, we expressed concerns that lay involvement, especially within pharmaceutical medicine, in RO involvement and GMC decision making must be unbiased and preferably have some understanding of the specialty. The GMC has clearly taken on board our comments and will further consider whether there is a role for patients and public in the GMC decision making process. The GMC are also to commission a literature review to examine the evidence base for patient and public engagement.

November 2010

Written evidence from the Association of Anaesthetists of Great Britain and Ireland (REV 37)

1. The AAGBI welcomes the opportunity to submit written evidence to the House of Commons Health Select Committee inquiry into the revalidation of doctors. The AAGBI is a voluntary, professional, representative organisation founded in 1932. It has in excess of 10,000 members; more than 85% of NHS consultant anaesthetists are members. It also represents the majority of NHS Intensive Care and Pain Medicine consultants. The two primary objectives of the AAGBI and its charitable arm, the AAGBI Foundation, are to “advance and improve patient care and safety in the field of anaesthesia and disciplines allied to anaesthesia” and to “promote and support education and research in anaesthesia, medical specialties allied to anaesthesia and science relevant to anaesthesia”.

2. The AAGBI’s principle concerns about revalidation are:

   (a) The real purpose of revalidation.

   (b) Resources (time and funding) for effective appraisal including 360 degree appraisal relevant to anaesthesia.

   (c) Revalidation relevant to individual practitioners.

   (d) The role and competing interests of the Medical Royal Colleges.

   (e) The role and competing interests of Responsible Officers.

   (f) The lack of evaluation of current pilot schemes.

   (g) The timing of introduction of the final scheme for revalidation.

   (h) The need for continuing evaluation and modification.

   (i) The need for an effective and transparent remediation process.

3. The AAGBI remains uncertain of the aims of revalidation. If it is to be a positive affirmation of the ability of doctors safely to care for patients, then the current proposals, based on a rigorous appraisal process will be adequate. However if the intention is to detect “rogue” doctors such as Shipman and Ledward, it is unlikely to succeed. The AAGBI has seen little evidence for the detection of “rogues”, most of whom come to light after critical incidents, complaints or criminal investigations. There must be honesty as to the true purpose of revalidation lest politicians and the public receive false re-assurance.

4. For revalidation to be effective the underlying process of appraisal must be rigorous and not, as may happen for many at present, a simple “tick box” exercise. This is particularly important at a time when public spending is facing justifiable review. Doctors must be given the time to achieve their personal Continuing Professional Development (CPD) needs, and adequate funding. Medical CPD of quality is not cheap, and study leave budgets provided by employers are often insufficient. At a time when health employers wish to meet financial challenges, any reduction in the opportunity and funding of CPD will make meaningful revalidation impossible. 360 degree multi-source feedback must be validated and relevant to the practice of the individual, rather than simply an “off the shelf” commercial package.

5. Revalidation must be relevant to the work any individual doctor does (although there are core skills and knowledge pertinent to all medical practitioners which would allow relicensure). Most AAGBI members will be Fellows of the Royal College of Anaesthetists (FRCA) (or equivalent) but may then pursue very different careers within Anaesthesia, Intensive Care or Pain Medicine, or combinations of these. Many anaesthetists go on to careers in senior medical management. The AAGBI is concerned that the CPD requirements are relevant to the individual’s job plan; much of the syllabus of the FRCA may be irrelevant to, say, a Consultant in Chronic Pain; too broad a requirement may mean that limited CPD resources are effectively wasted.

6. At present Royal Colleges advise the General Medical Council (GMC) of the specialty requirements for CPD for revalidation. Those Colleges may also validate the educational content of meetings and material of
other providers against the CPD requirements (and may charge a fee for this). The same Colleges may also be providers of CPD, which they self-validate. There is the distinct possibility of a clear competing interest.

7. The AAGBI agrees with its close partner the British Medical Association (BMA), whose evidence it has seen through representation on BMA’s Central Consultants and Specialists Committee Anaesthetic Sub-Committee that there are concerns about the roles, responsibilities and appointment of Responsible Officers (ROs). Medical Directors are already busy individuals; it is difficult to see that any could take on the additional time and responsibility of the RO role. As Board Members of employers they would have clear conflicting interests, and duties of confidentiality, in the support and management of individual doctors through revalidation, particularly doctors who may be experiencing difficulties. Although of less relevance to members of the AAGBI, other current government proposals for Strategic Health Authorities and Primary Care Trusts will make the appointment of ROs for doctors employed directly or indirectly by these organisations extremely difficult.

8. The AAGBI would support the current extension of the pilot schemes for revalidation, even though this will defer implementation of the final scheme. The poor experience of the “big bang” introduction of radical changes in medical employment such as Modernising Medical Careers and the Medical Training Application Scheme should serve as examples of how not bring about reform. The current government has vowed to stop “top-down” changes. If revalidation is to be successful, it must have the support of doctors. This means careful evaluation, and if necessary re-evaluation of resultant changes, to produce a system that is workable and achieves what was intended. It is surely better that revalidation works than its implementation by any specific, and arbitrary date? Once introduced revalidation must the subject of continual re-assessment, re-evaluation and modification; it is unlikely that any scheme will be perfect from the start.

9. For most doctors appraisal and revalidation will be a straightforward process. However it is thought that about 1% to 1.5% of doctors will have concerns raised about their performance. These individuals will need some participation in remedial activity to revalidate. The AAGBI is concerned that a robust process for remediation is not available. The AAGBI is concerned about the role of the Royal Colleges in this process. There is a possibility that the existing relationship between the Colleges and their Members/Fellows members may change and a formal role in remediation would lead to the Colleges assuming a more regulatory function. It is vital that adequate remediation support is in place before the introduction of revalidation. This process will need to be monitored robustly.

10. The AAGBI would be happy to present oral evidence if this would assist the Committee’s enquiry.

November 2010