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To consider

Revalidation: Policy and Implementation

Issue

1. The development of recertification, our plans in relation to multi-source feedback and the establishment of the UK Programme Board for the implementation of revalidation.

Recommendations

2.

a. To agree that three recertification process models should be worked up for discussion through workshops, in preparation for piloting (paragraphs 15-28).

b. To endorse our proposed approach to the establishment of the governance structure for the implementation of revalidation (paragraphs 29-37).

Further information

3.	Richard Marchant	020 7189 5024	rmarchant@gmc-uk.org
	Una Lane	020 7189 5164	ulane@gmc-uk.org
	Paul Buckley	020 7189 5022	pbuckley@gmc-uk.org

Background

Recertification: GMC and Academy of Medical Royal Colleges Group

4. On 2 July 2007, Council agreed the establishment of a joint GMC and Academy Group to advise on, and promote, a coordinated approach to, and make recommendations on, the development of recertification. The membership and terms of reference are at Annex A.

5. The work of the Group is underpinned by the propositions on recertification agreed by Council in September 2007 (Annex B). The work is also informed by Council's decision, on 5 December 2007, that we should work with the Academy on the relationship between relicensing and recertification, with a view to ensuring that recommendations and decisions are based, as far as practicable, on performance.

6. The GMC and Academy Group has met three times.

UK Programme Board

7. *Medical Revalidation – Principles and Next Steps: The Report of the Chief Medical Officer for England's Working Group (MRPNS)*, published in July 2008, charted the way forward for the introduction of revalidation. Council endorsed the report, noting that it was consistent with the GMC's position on many key issues, and provided affirmation of the approach we have been developing over a number of years.

8. In particular, the report:

a. Places at the heart of revalidation both enhanced appraisal, built around our framework for appraisal and assessment, and effective clinical governance.

b. Acknowledges the need to approach relicensing and recertification as one set of processes with two potential outcomes, rather than as separate streams of activity.

c. Recognises that relicensing and recertification need to be rooted in the evidence of doctors' day to day performance.

d. Recognises the need to work closely with the administrations in each of the four countries of the UK, to ensure that the delivery model reflects local circumstances.

e. Recognises that the implementation of revalidation is a shared responsibility across a number of organisations.

9. Building on the notion of revalidation as a shared responsibility, which needed participation from all four countries of the UK, the report proposed the establishment of a UK Programme Board to oversee implementation.

Multi-source feedback and revalidation

10. Both the White Paper and MRPNS address the role of multi-source feedback within revalidation. We had already initiated work through the research into questionnaires being undertaken by Peninsula Medical School. MRPNS acknowledges that work and proposes that we now develop criteria and principles that all MSF tools must meet.

Discussion

Recertification

Recertification: roles, responsibilities and processes

11. The purpose of recertification is to enable 'doctors on the specialist register and GP register to confirm that they meet the standards appropriate for their specialty' (MRPNS paragraph 1.5).

12. Discussion within the GMC and Academy Group has reaffirmed key principles:

- a. That it is for the medical Royal Colleges and Faculties to set the standards and competencies for recertification and design appropriate assessment tools.
- b. That it is for the GMC to approve the standards and competencies developed by the medical Royal Colleges and Faculties.
- c. That, for doctors in active medical practice in the UK, both clinical and non-clinical, the principal evidence for recertification should be derived from actual medical practice, generated from within the workplace and brought together locally through appraisal.
- d. That, for most doctors, relicensing and recertification would draw upon largely the same evidence.
- e. That separate objective assessment tools would need to be made available, principally for doctors who are unable to draw upon adequate evidence of performance in the workplace.
- f. That the decision making process for recertification must be capable of delivering to the GMC a single recommendation on a doctor's revalidation which encompasses both relicensing and recertification.
- g. That responsibility for the decision about whether a doctor should be recertified will rest with the GMC.

13. The recertification decision will be for the GMC. The aim of College or Faculty involvement, in supporting that decision, is to provide:

- a. Confidence that the standards for recertification set by the Colleges and Faculties are being robustly applied and met.
- b. Assurance for specialists that the Colleges and Faculties are exercising appropriate oversight.
- c. Assurance that the evaluation of specialist practice is fair, objective, transparent and free from unfair discrimination.

14. The means of delivering recertification must be simple, effective and efficient in its use of resources; minimise burdens and avoid duplication; ensure consistency across specialties in all circumstances; and be fair, objective, transparent and free from unfair discrimination.

Decision making models

15. The agreed principles, set out above, are wholly consistent with the conclusions in MRPNS. They have led the Group to identify three potential models for recertification:

- a. College or Faculty quality assurance of the local processes leading to the recommendation by the responsible officer.
- b. College or Faculty involvement in the sign-off of individual recertification recommendations at local level through the regional advisor, clinical tutor or other appropriate college officer.
- c. Referral of each recertification recommendation for central sign-off through the relevant College or Faculty.

16. The three models are outlined in Annex C. They are not mutually exclusive. They will need to be fleshed out in greater detail before any decisions could be made about viability. We have asked the Colleges and Faculties to help with this.

Quality assurance

17. Model 1 envisages a role for the Colleges and Faculties that includes agreeing the standards of evidence for specialist practice; developing and quality assuring the methods used to evaluate performance; training and approving appraisers; quality assuring the local recertification process; and providing a review of, and support for, doctors where there were emerging signs of poor performance.

18. Some members of the Group wished to go further by building direct College or Faculty involvement into every recertification decision. Model 2 reflects this approach by giving the Colleges and Faculties a role at local level, working in tandem with the responsible officer to review appraisals and evidence throughout the five year revalidation cycle.

19. The potential attraction of Model 2 is that it provides the Colleges and Faculties with confidence that standards are being met through their involvement, not just with assuring the quality of the process overall, but with the revalidation recommendation for each doctor being recertified. It would be for the Colleges and Faculties to decide the most appropriate person to fulfil the local role. The disadvantages of Model 2 are the potential resource implications for the College and Faculty local representatives, and the complexity for responsible officers who would need to liaise with College and Faculty representatives across a wide range of specialties.

20. Model 3 takes College or Faculty involvement in decision making one stage further. It would involve not only College and Faculty engagement with the responsible officer at local level, but separate College and Faculty sign-off of all revalidation recommendations.

21. The main argument advanced for having a final, central, sign-off by the College or Faculty is to ensure confidence in the responsible officer's decision making. However, aside from the potential resource implications, the force of this argument is diminished if there is involvement of College and Faculty representatives at local level. Unless a College or Faculty was expecting to have additional evidence, which was not available locally, the proposed central sign-off would amount to checking that local processes had arrived at the correct recommendation. There would be significant resource implications. The RCGP, for example, would need to examine around 60,000 recertification recommendations.

22. A variation on Model 3 would be for the College or Faculty to review each doctor's specialist portfolio and provide a report that would inform the local appraisal process. It was suggested that this might have merit for small, technical, specialties, but would have practical and resource implications for other, larger specialties.

23. The Group was clear that, were Model 3 to be adopted, it would be important to be able to articulate the value added by reviewing every case in this way, as opposed to quality assurance of the processes and auditing a sample of recommendations. It was not obvious that Model 3 would satisfy the tests of efficiency, minimising burdens and avoiding duplication.

24. A more practical option might be for direct College or Faculty involvement in individual recertification recommendations to be limited to cases where the responsible officer needed to take specialty advice or where doctors were unable to draw upon adequate evidence of performance in the workplace.

Lay involvement in recertification decisions

25. The Group has highlighted the importance of lay involvement in recertification. This would be delivered through involvement in College and Faculty standard setting processes; through contributions to multi-source feedback on doctors' performance; through the design of quality assurance processes; and through involvement in the sampling and audit of recertification recommendations. Whether there was added value in having direct lay involvement in every recertification recommendation was likely to depend on the recertification model selected.

Piloting

26. MRPNS emphasised the need for careful testing of concepts and piloting of processes. The views of the NHS and the independent sector, in all four countries, will be crucial to decisions on different options.

27. We are working up the three models in further detail for discussion at a series of workshops involving NHS and independent sector representatives in each of the four countries. We aim to hold the workshops later this year or early in 2009. The outcomes will be used to inform proper piloting of the processes and of the interface between the bodies involved.

28. Among the issues the workshops will need to explore are:

- a. Providing assurance for patients and the public on robustness of processes.
- b. Effectiveness and efficiency in the use of resources.
- c. Regulatory burdens and avoiding duplication.
- d. The costs for doctors.
- e. The case for consistency of approach across all specialties versus a mixed economy approach.
- f. Compatibility with the wider quality assurance framework.

Recommendation: To agree that three recertification process models should be worked up for discussion through workshops, in preparation for piloting.

UK Programme Board and four country implementation

29. MRPNS proposes that we establish a Programme Board to oversee the delivery of revalidation. The Board would encompass 'the four UK administrations, the medical Royal Colleges, employers, commissioners, the BMA, patient representatives, and the system regulators for the four countries' (paragraph 14.11).

30. Initial discussion with officials in each of the four countries has indicated that there would be merit in a variation of that proposal, based on the fact that there are two distinct tasks.

31. First, each of the four countries has indicated a need for the equivalent of a delivery board that can secure implementation of revalidation in a way that is consistent with the common elements of the UK model, but reflective of local circumstances. It would be for the government in each of the four countries to determine the composition of its implementation group. The implementation groups would be represented on, and report into, the UK Programme Board. Preliminary discussions with officials in the devolved administrations suggest that they would welcome this approach.

32. Second, we need a UK Programme (or Coordinating) Board to take responsibility for the core principles of the model including, for example, the central place of our framework for appraisal and assessment as part of updated appraisal arrangements capable of delivering evidence for the judgements required. The Programme Board would oversee implementation of the common elements of revalidation that will apply across all four countries. An important role for the UK coordinating board would be to command the confidence and support of key interests. The UK Programme Board would be accountable to the GMC; and the independent Chair would be appointed by the GMC.

33. Given that there would be separate delivery boards, we have reviewed the proposed composition of the UK Programme Board. The composition would need to be such that the Board could command the confidence of key interest groups without duplicating the role or make up of the delivery boards.

34. One option would be to invite a representative from each of the delivery boards together with medical and lay representation from the GMC, and a member of the GMC senior executive.

35. An alternative would be a more fully inclusive Board encompassing the four UK administrations in the form of, say, the delivery board chairs, together with representatives put forward by invited UK wide bodies such as the Academy and the BMA, patient organisations, the NHS and other healthcare providers, GMC, and an independent chair. This should achieve an appropriate spread of stakeholder expertise without the Board becoming so large that it cannot function effectively.

36. The independent chair of the UK Programme Board will need to be a person of standing, preferably with significant knowledge and experience of the NHS and excellent interpersonal skills, who commands the confidence of stakeholders across the four countries, and has practical experience of overseeing the successful delivery of major projects. We are currently trying to identify a short list of potential candidates who might be approached. Members are invited to put forward the names of suitable candidates to the President.

37. Our preferred option, therefore, would be to establish a UK Programme Board that would oversee and co-ordinate the implementation of revalidation by the four delivery boards. The Programme Board would be constituted along the lines set out in paragraphs 35-36 above. Subject to Council's agreement, we will work with the administrations in each of the four countries, and with key interest groups, to put the necessary structures in place.

Recommendation: To endorse our proposed approach to the establishment of the governance structure for the implementation of revalidation.

38. If the overall approach is agreed, we will initiate contacts with a potential chair and with stakeholder organisations about membership of the Programme Board. We will also draw up terms of reference for agreement by Council with a view to holding the first meeting towards the end of 2008.

Multi-source feedback

39. One of the key recommendations in MRPNS is to incorporate MSF into the revalidation process. It states:

‘the GMC will develop principles and criteria for these [MSF] tools. They will seek expert advice on this and will consult widely before they are adopted. Although the GMC will wish to establish and approve the overall criteria and principles that any such tool will need to meet, in order to be acceptable for revalidation purposes, they will not approve individual questionnaires (paragraph 2.15)’.

40. The Academy has a Working Group on MSF. The purpose of the Group is to develop principles and criteria for MSF in recertification. The Group has suggested the possibility of developing joint principles and criteria for MSF in revalidation with the GMC. This would ensure a broad-based and consistent approach to MSF. We will be discussing this possible way forward at the next meeting of the Group on 15 October 2008.

41. We plan to test our thinking on the principles and criteria for MSF with key interest groups (including individuals with particular MSF expertise). It will be important that we continue to work closely with the Academy on this. We plan to bring proposals to Council in November 2008.

Resource implications

42. The regulatory impact and resource implications of the three recertification models will need to be assessed more fully as we flesh out the different models through the proposed workshops and early piloting. Much of the burden of the models is likely to fall upon the responsible officers within local healthcare organisations and medical Royal college/faculty processes rather than directly upon the GMC. Their input into the evaluation of the models will therefore be key.

Equality

43. We will undertake an equality impact assessment as part of our development of the possible recertification models.