General Medical Council

Regulating doctors
Ensuring good medical practice

4b

To consider

Revalidation: Progress Report

Issue

1. A progress report on the revalidation work programme.

Recommendation

2. To consider the Progress Report (paragraph 7 and Annex A).

Further information

3. If you require further information about this paper, please contact us by email: gmc@gmc-uk.org or tel. 0161 923 6602

Background

4. Key Aim Three of the 2009 Business Plan is to ‘enhance assurance that licensed doctors are up to date and fit to practise by introducing licences to practise and preparing for revalidation’.

5. Underpinning Key Aim Three are objectives:

   a. To introduce the licence to practise.

   b. To establish the UK Revalidation Programme Board (UKRPB) to oversee the implementation of revalidation.

   c. To pilot and deliver the changes needed to support revalidation, working in conjunction with the Departments of Health in each of the four countries of the UK.

   d. To develop standards and evaluation method, working with the medical Royal Colleges and the Academy of Medical Royal Colleges.

   e. To develop and consult on guidance showing how revalidation will work.

6. In January 2009, Council agreed the Project Initiation Document (PID) for revalidation. This sets out the 12 work streams that form the building blocks for the implementation of revalidation.

Discussion

7. Key Aim Three is being taken forward through the work streams set out in the Revalidation PID. The report at Annex A sets out the progress against those work streams.

   Recommendation: To consider the Progress Report at Annex A.

Continued Practice Board

8. The Continued Practice Board met on 7 September 2009 and considered a number of papers about aspects of revalidation. Considerable progress was made in key areas. In particular, the Board:

   a. Agreed the establishment of a small working group to undertake initial evaluation of the medical Royal College and Faculty submissions on standards for recertification to be composed of members of the Continued Practice Board and GMC members drawn from the GMC/AoMRC Group. The Board also agreed the principles and requirements for evaluating the speciality standards for recertification.

b. Discussed issues concerning the use of Multi-Source Feedback as a component of revalidation. Among other matters, the Board identified the value of including feasibility/practicality among the principles and criteria governing the use of MSF on which the GMC will consult in 2010. The Board also underlined the importance of being able to demonstrate, through external assessment, that the GMC patient and colleague questionnaires satisfy our criteria and principles. This will reassure our key interests that at least one MSF tool will be available for use as revalidation is implemented.

c. Agreed that the role of Continuing Professional Development within revalidation, and the principles that should underpin it, should be part of the wider consultation on revalidation. The Board also agreed that work should be undertaken to re-draft the GMC's 2004 guidance on CPD for inclusion in the consultation in 2010.

d. Concluded that the role of the Colleges and Faculties in relation to revalidation recommendations will be to provide advice to Responsible Officers where Responsible Officers consider it appropriate to seek such advice. Responsible Officers will have the statutory responsibility for recommendations to the GMC about individual doctors.

f. Agreed that the appraisal and clinical governance criteria identified in the report of the Revalidation in General Practice in Wales project should inform the development of high level GMC standards that organisations will need to meet to support revalidation.

g. Agreed that the GMC's consultation exercise on revalidation should address key issues through a single consultation exercise. The issues to be covered include the revalidation model, the *Good Medical Practice* framework, criteria and principles for MSF as part of revalidation, the role of CPD in revalidation, remediation and proposals for implementing revalidation. The Board also agreed that the GMC should lead the consultation, while recognising the contributions of key interests, such as the four UK health departments, the Revalidation Support Team, the AoMRC and individual medical Royal Colleges.

UK Revalidation Programme Board

9. The UKRPB met on 14 October 2009. The items considered included:

a. Reports from each of the Delivery Boards about progress towards readiness based on the milestones and actions in the readiness plan.

b. A paper about current and future piloting activity including reports about the joint project to examine appraisal and clinical governance systems for GPs in Wales, a project with Buckinghamshire PCT to understand in more detail the type, quantity and quality of supporting information brought to appraisal by GPs, and a project with NHS Professionals involving locum doctors.

c. A paper intended to generate preliminary consideration of key factors that will need to be taken into account in planning the implementation of revalidation.

10. The UKRPB agreed that there should be a further, more detailed, paper about implementing revalidation for consideration at its next meeting on 8 December 2009, which we will prepare. We will report to Council on 9 December 2009 on the emerging direction of travel and we will update members orally on UKRPB's discussion the previous day.

Piloting activity

11. The UKRPB also received information about a significant ongoing programme of work by the NHS Revalidation Support Team to coordinate a series of multi-organisational pilots across England during 2010. The RST's intention is to cover in excess of 3,000 doctors in a variety of specialties and settings across England. The pilots – called 'pathfinder' pilots – will test key components of revalidation including:

a. Strengthened medical appraisal (incorporating the *Good Medical Practice* framework for appraisal and assessment).

b. The quality of information available to support a revalidation recommendation.

c. The role of the Responsible Officer.

d. The role of MSF as part of the appraisal framework.

e. Information flows within organisations – including the integration of clinical governance and appraisal data.

f. Information on time, costs and benefits.

g. Equality issues including effects on part-time medical staff and any issues affecting different minority groups.

h. Quality assurance and consistency of outcomes and recommendations.

12. On 30 September 2009 the RST held an information day for organisations considering participating in the piloting programme. More than 80 organisations attended and are now considering whether to submit formal bids. The summary timetable for the pathfinder phase is as follows

a. Quarter 1 2010: Begin pilots, including train appraisers, appraisees and pilot ROs.

b. Quarter 2 2010: Appraisals begin.

c. Quarter 3 2010: Appraisals are completed, and ROs make recommendations.

d. Quarter 4 2010: Feedback, analysis and external evaluation of pilots undertaken.

13. An evaluation report will be produced by January 2011, and RST intend to complete a final report on the outcome of the pathfinder programme in February 2011.

14. In the meantime, the UKRPB will consider a detailed paper on project and pilot strategy on 8 December 2009. The paper will discuss how to ensure that future activity is co-ordinated across all four UK countries to ensure that learning is shared, opportunities for joint work are optimised and that all areas of revalidation that require piloting or testing have been identified and that there are no gaps. The UKRPB will have a pivotal role in ensuring that there is a co-ordinated UK approach, and that learning is appropriately shared.

Communication and engagement

15. Keith Pearson has continued his series of meetings with senior officials in each of the four UK countries to discuss the progress that the four delivery boards are making. He will meet with Dr Michael McBride, Chief Medical Officer for Northern Ireland, on 6 November 2009.

16. Peter Rubin continues to meet with groups of doctors in various parts of the country to discuss a range of issues, including revalidation. Other Council members and staff have continued to speak at conferences and meetings about revalidation to a wide variety of public and professional audiences. On 21 October 2009 we will participate in a conference in Cardiff about revalidation along with a number of other organisations including the Welsh Assembly Government, the Wales Deanery for Postgraduate Medical and Dental Education, the Academy of medical Royal Colleges and the BMA. We will update members at the Council meeting on 22 October 2009 on the conference.

17. Looking ahead, we are contributing to a session at the NHS Employers conference on 4 November 2009, and Professor Malcolm Lewis is contributing to an interactive session on revalidation at the Medical Directors Conference on 27 November 2009.

18. Overall, since the summer there has been a marked increase in requests for us to provide speakers at revalidations events, no doubt reflecting increased awareness about revalidation, and a quickening of the pace around planning for it, among our key interests. We continue to respond positively to requests to provide speakers, wherever practicable.

Resource implications

19. None from this paper.

Equality

20. We will continue to work with the Equality and Diversity Reference Group to consider the implications at all stages. An initial discussion with the Group has underlined the need to prioritise equality implications in relation to the implementation of revalidation.

21. Paul Philip and Paul Buckley met the Co-Chair and officers of the BMA Equal Opportunities Committee on 14 September 2009 to discuss equality and diversity issues arising from revalidation. This was the second such meeting this year, and we have agreed that the discussions, which are proving to be useful and constructive, will continue on a regular basis.

22. In the meantime, and recognising that the implementation of revalidation is a responsibility shared with a number of other partners, we have agreed with DH(E) that we will contribute to work they are leading to develop a partial Impact Assessment which will include an Equality Impact Assessment. The EIA will need to capture how implementation could impact on all doctors, including doctors who work part-time, doctors taking career breaks and doctors working in particular settings or modes of practice in which black, minority and ethnic and/or international medical graduate doctors are particularly represented (including locums, single-handed GPs, Staff and Associate Specialist or speciality doctors. The partial IA will be included in the GMC's consultation in 2010. In the light of the consultation and piloting in 2010 DH(E) will complete a full IA (including a full EIA) by the end of 2010.