

To consider

Translating *Good Medical Practice* into a Framework for Appraisal and Assessment

Issue

1. A review of Good Medical Practice to identify generic standards and map a framework for re-licensing and appraisal.

Recommendations

2.
 - a. To approve the four domains as the basis of the generic standards and framework for appraisal and assessment (paragraphs 7-13).
 - b. To approve the draft generic standards, which together with the domains, form the framework for appraisal and assessment of doctors, as a draft for discussion (paragraphs 14-23).
 - c. To agree that the framework should include examples of evidence to demonstrate compliance with standards; and that further consideration should be given to categorising and defining criteria for the robustness of the evidence that may be submitted in each category (paragraphs 24-26).
 - d. To agree that we should engage with key professional and patient groups to discuss the framework and generic standards, and seek views in writing from a wider group of organisations (paragraphs 27-33).

Further information

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Background

4. The White Paper assigns significant roles to the GMC for setting standards for revalidation: Chapter 2 (Revalidation: ensuring continuous fitness to practise) sets out two specific areas set out below (with emphasis added).

- a. 'This licence to practise will be subject to renewal every five years by undertaking revalidation successfully. **The re-licensing process will generally be based on agreed generic standards of practice set by the GMC**, a revised system of NHS appraisal for doctors and any concerns known to the doctor's medical director (or responsible officer) and the GMC Affiliate. The Department of Health will discuss with the GMC, and others how these generic standards might be adapted to address the skills and competencies required for career grade doctors who specialise in particular fields of practice.' (Paragraph 2.9.)
- b. 'Both re-licensure and re-certification depend on an objective assessment of doctors against clear standards. To support re-licensure, the Department will ask the GMC to consult with its key constituencies **to translate its recent update of *Good Medical Practice* into an effective framework against which individual doctor's practice can be appraised and objectively assessed.** In addition, in England, the Department will discuss with the profession, NHS employers and other stakeholders the best means of enshrining these standards in the contracts of those doctors who are directly employed and in the commissioning arrangements for those doctors who work within the terms of contracts with commissioners.' (Paragraph 2.21.)

5. The production of the generic standards and framework is part of the wider development of revalidation that will be taken forward in conjunction with the Joint GMC/Academy Steering Group and the DH Working Group on Revalidation. The drafting of generic standards and the framework will be an iterative process, taking into account development of other policy, and the views of key interest groups.

6. At workshops in April and May 2007, Council considered how the White Paper recommendations should be taken forward. In May 2007, the Council supported a proposal identifying four domains from *Good Medical Practice* which would cover key areas of doctors' practice. Those domains have been used as the basis for the generic standards and a draft framework: the detail of the generic standards will need further consideration as the project progresses.

Discussion

Domains, generic standards and a framework

7. The White Paper states that relicensing will be based on generic standards, appraisal and known concerns about a doctor. Although the White Paper does not specifically link the 'generic standards' with the framework for NHS appraisal, we have assumed that they must be linked. Using the generic standards in this way will ensure that successful completion of appraisal will also demonstrate compliance with the standards for relicensing. The framework and standards can also provide a guide

to those doctors seeking to relicense who work outside environments with formal appraisal systems.

Domains

8. In 1997 the Standards and Ethics Committee agreed to revise *Good Medical Practice* using seven headings identified as key domains for revalidation. A new edition of *Good Medical Practice* was published in 1998, and the ‘seven headings’ have been used in discussing revalidation and appraisal since then. For example, it is usual to hear that doctors’ will be assessed, appraised or revalidated against ‘the seven headings of *Good Medical Practice*’.

9. Nonetheless, the seven headings present some difficulties. They mix different kinds of guidance, covering points of principle, practical applications of principles and, occasionally, measurable standards. In the context of revalidation the more practical guidance might better be described as advice on evidence of compliance with a general principle. For example, the section on *Good clinical care* states that doctors must base treatment decisions on the best available evidence, while the section on *Maintaining good medical practice* says that doctors must be familiar with relevant guidelines that affect their work. The seven headings also involve some duplication, for example, many of the same skills will be used in communicating with patients, relatives, colleagues and managers. Finally, some of the headings deal with issues where satisfactory evidence of compliance would be difficult or impossible to obtain, or are not applicable to all doctors.

10. Identifying new ‘domains’, under which key elements from *Good Medical Practice* can be organised, will provide a solution to these problems. There are many possible ways of identifying ‘domains’; and we have reviewed work on standards setting by other organisations within and outside the UK. While the majority of bodies in the UK are setting standards for organisations, not individuals, they do provide some common themes.

	Competence /Expertise	Safety	Patient focus	Trust	Other
Standards for Better Health	Clinical and cost effectiveness	Safety	Patient focus; Accessible and responsive care	Governance	Public health; Care environment and amenities
NHS QIS	Safe and Effective Clinical Care	Assurance and accountability	Health and care experience		
Healthcare Standards for Wales	Clinical outcomes		The patient experience	Healthcare governance	Public health
NHSLA	Clinical care	Competent and capable workforce Safe Environment Learning from experience		Governance	
CanMeds	Medical expertise		Communicator		Health advocate Scholar, Manager Collaborator
LEAP framework Colleges of Australia & NZ	clinical expertise;	risk management		Professional values	
Medical Council of New Zealand	Medical care		Communication	Professionalism	Scholarship Management Collaboration

11. In reviewing *Good Medical Practice* to establish domains we also concluded that they should be inclusive, so that all doctors working in healthcare would be able to meet standards within each of the domains; and that they should provide some degree of read-across to the standards set by other UK bodies. We have, therefore, proposed the following domains:

- Knowledge, skills and performance
- Quality improvement and safety
- Communication, partnership and teamwork
- Maintaining trust

12. The domains have been developed from the version discussed by Council in May 2007. We have added 'Quality improvement' to the second domain, to ensure it has sufficient breadth and we have changed the third domain from 'Communication' to 'Communication, partnership and teamwork', to provide sufficient scope to deal with many aspects of doctors' relationships with patients and colleagues.

13. Each of the domains has been subdivided into three areas of practice, to demonstrate their scope (Annex A).

Recommendation: To approve the four domains as the basis of the generic standards and framework for appraisal and assessment (Annex A).

Generic standards and a framework – What do they mean?

14. The White Paper does not discuss what the 'effective framework' should comprise but, given that it may be adapted to be included in contracts, and should provide the basis for NHS (England) appraisal, we can assume that the framework and generic standards should be:

- a. Clear and simple.
- b. Comprehensive - covering all aspects of a doctor's work; and both clinical and non-clinical roles.
- c. Related to the professional behaviour of individual doctors and to activities for which they are personally responsible.
- d. Compatible with the standards and procedures used for the regulation of services and health care organisations.

Generic standards

15. The White Paper refers to 'generic standards' as one of the key elements of relicensing. The term 'standards' is used in normal speech to describe a range of different concepts, for example, as an adjective to mean average or normal 'a standard school'; to describe principles as in 'standards in public life'; or to define a general level of attainment 'a high standard of spoken French'.

16. A number of organisations responsible for setting standards have provided their own definitions. They vary, but usually encompass the idea of a level of performance, or the quality of services to be provided.

17. The term 'generic standards' suggests that the standards envisaged will fall between high level principles, and specific standards defining levels of quality or of attainment. Generic standards will need to be sufficiently broad to apply to doctors working in clinical practice, in management, research and other areas associated with health care. They must also avoid defining only those aspects of practice that can easily be measured, as they would be likely to side-line aspects of care, such as respect for patients' dignity, that are central to patients' experience of medical treatment.

18. The generic standards cannot themselves describe the level of attainment or quality needed, as they may vary between specialties. For example, while communication skills will be needed by all doctors, they may carry greater weight, or involve different skills, for doctors who routinely work with patients, and for those doctors whose communication is primarily with colleagues.

19. The draft generic standards in the Framework at Annex B are pitched between principles and specific standards, and are derived from the guidance in *Good Medical Practice*. Drafting the framework has raised a number of issues.

20. For the purpose of appraisal and revalidation, the standards must relate to aspects of practice for which it is possible to produce evidence of compliance, provided that the work involved in producing that evidence is not disproportionate to the benefits it would bring to an overall assessment that a doctor is up to date and fit to practise. *Good Medical Practice* itself, with its broader purposes, has no such constraints, and includes all the principles and values identified by Council as contributing to good practice. As a result, the generic standards cannot cover all the paragraphs of *Good Medical Practice*. Those that have been omitted cover:

- a. Values or very high-level principles, such as 'You must safeguard and protect the health and well-being of children and young people'.
- b. Issues where evidence will be disproportionately difficult to define or collect, such as 'respect the patient's right to seek a second opinion'.
- c. Issues where evidence would be unreliable as it would be seeking to demonstrate an absence of unacceptable behaviour, for example, 'you must

not use your professional position to establish or pursue a sexual or improper emotional relationship with a patient or someone close to them’.

21. At present, there is no direct link with the *Duties of Doctor*, and we may need to consider how the values and standards that form the *Duties* are assessed within the revalidation process.

22. The standards in the framework are currently split into ‘generic standards’ and ‘generic standards - clinical’, the former applying to all doctors, or doctors working in non-clinical roles, and the latter only to doctors working directly with patients. This split has been introduced to demonstrate that the generic standards are relevant to all doctors, and to reassure doctors who do not work with patients that they will be able to provide evidence of compliance with the GMC’s generic standards. However, many doctors will need to provide evidence of compliance with standards from both columns.

23. Clearly, it will not be possible for all doctors to produce evidence for all of the generic standards. In some cases the standards apply to specific areas of practice, and in others, producing evidence of compliance may depend on necessary circumstances arising, for example, reporting adverse incidents. While this has the advantage of flexibility, it lacks clarity about the requirements for successful revalidation. This issue will need further consideration.

Recommendation: To approve the draft generic standards, which together with the domains, form the framework for appraisal and assessment of doctors, as a draft for discussion.

Evidence

24. The framework currently includes a column indicating the type of evidence that could be produced to demonstrate compliance with the standards. This has been included only to show that some form of evidence is available, rather than as a comprehensive review of the many different forms of evidence that could be produced by doctors in all specialties.

25. The types of evidence listed vary in their robustness. Some evidence – such as mortality or complication rates for procedures – may be verifiable and wholly fact based. Other evidence, such as that produced by multi-source feedback, may reflect opinion about the quality of a doctor’s work or behaviour, but still be regarded as robust if the questions and results have been researched and tested, and the sample size is sufficiently large. Finally some ‘evidence’ may simply be self-reporting of incidents or events, and a doctor’s response to them. This evidence may not be verifiable, but may help to provide a more complete view of a doctor’s behaviour, attitudes and performance, as well as encouraging doctors to reflect on their practice as part of the revalidation process.

26. It may be helpful to indicate, within or alongside the framework, broad categories of evidence, and the attributes that would make evidence within a category acceptable, for example where results of MSF is relied upon, there could be a requirement that the MSF questions had been subject to successful testing or trials. However, at this stage in the consideration of the nature and type of evidence,

it may be preferable either to include only the current indication of the kinds of evidence that may be available, or to remove the column from the framework. The latter option, however, may lead to challenges about whether evidence can be produced to demonstrate compliance with standards.

Recommendation: To agree that the framework should include examples of evidence to demonstrate compliance with standards; and that further consideration should be given to categorising and defining criteria for the robustness of the evidence that may be submitted in each category.

Engagement

27. In *Good doctors, safer patients*, Sir Liam Donaldson recommended that the process of revalidation should have two components: relicensing that would determine a doctor's right to continue practising as a doctor, coupled with a system of recertification which would determine a doctor's right to remain on the Specialist or GP Registers (recommendation 26). Paragraph 2.18 of *Trust, Assurance and Safety* proposes that 'The second stage of revalidation for doctors will apply only to doctors who are on the specialist or general practice registers, requiring them to demonstrate that they continue to meet the particular standards that apply to their medical specialty, including general practice. Recertification, like relicensing, will be a positive affirmation of the doctor's entitlement to practise, not simply an absence of concerns.'

28. There is a clear need to minimise burdens, avoid duplication and reduce overlap. With this in mind, Council has acknowledged that, as a starting point, revalidation should be viewed as a single set of processes, with two potential outcomes – relicensing and, where applicable, recertification.

29. It is essential that the generic standards and the framework are supported by the Academy, Colleges and the UK Health Departments. In particular we will want to ensure that the joint GMC/Academy Working Group and the DH (E) Working Group on Medical Revalidation and Education and contribute to the framework.

30. It will be important to ensure that all our key interest groups, including patients and the public, have confidence in the standards as the basis for revalidation.

31. During the review of *Good Medical Practice* in 2005 and 2006 we engaged with a wide range of interest groups including professional organisations, patients and the public, employers and government departments. As well as a written consultation, we held open public meetings, round-table discussions and commissioned research. The published version of the guidance was well-received.

32. The 'translation of *Good Medical Practice*', both into generic standards and a framework for appraisal and assessment, should not seek to change the basic principles set out in *Good Medical Practice*. But the development of generic standards and framework involves choices about what is included and what is omitted. We will need to be satisfied that the documents are clear and comprehensible and that they fit with work being undertaken by other bodies. When we introduce revalidation, we will want to be satisfied that the underpinning

standards are seen to be (as well as being) applicable without cultural or other bias. Finally we will need to provide a means of communication outside the profession, to fulfil our obligation to involve patients and the public.

33. This indicates a need for engagement with our key interest groups. Meetings with individual organisations would provide a good opportunity to explain the context and answer questions, as well as receive views on the generic standards. An explanatory paper with the draft standards and framework could be sent in advance. Views in writing could also be sought from a wider group of organisations.

Recommendation: To agree that we should engage with key professional and patient groups to discuss the framework and generic standards, and seek views in writing from a wider group of organisations.

Resource implications

34. Costs of refining and developing the generic standards will principally relate to travel and meetings costs and associated expenses, which we would expect to amount to about £4,000.

Equality

35. We will undertake an equality impact assessment in line with our published procedure.