

## The General Medical Council response to the Health Select Committee Report 'Revalidation of Doctors'

5 April 2011

### Introduction

1. The General Medical Council (GMC) welcomes the Health Committee's report and its strong support for revalidation. It is clear that the Committee shares the joint commitment of the GMC and the four UK health departments to introduce revalidation by the end of 2012.

2. As we made clear in our evidence we also support the proposal for the GMC to be accountable to Parliament. In its Command Paper *Enabling Excellence* the government has also indicated its ambition to put this accountability on to a more formal footing for all the regulators of the health professions.

3. This memorandum sets out our response to the report's recommendations and the steps we are taking to ensure that we can deliver revalidation on time and in a way that is both practical and proportionate.

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

4. We welcome the opportunity to report directly to the Health Select Committee on all areas of our work, including revalidation. We have been calling for this for some time and we look forward to giving oral evidence to the Committee again later this year.

**Recommendation 2: Now that "late 2012" has been set as the date of implementation, we look to the GMC to ensure that there are no further delays and that the current target date is achieved. (Paragraph 20)**

5. We are confident that revalidation can begin in late 2012 but the successful implementation of revalidation does depend on the continuing co-operation,

commitment and hard work of all our partners in this endeavour - namely the four UK health departments, the NHS and other healthcare providers. We need to work together to ensure that all the elements to support the introduction of revalidation are in place and fit for purpose, including the legislation, good systems of appraisal and robust local clinical governance systems.

6. The shared nature of this responsibility was reflected in the Statement of Intent, published on 18 October 2010, which also emphasised the commitment of all our partners to delivering revalidation by the end of 2012. We have now moved revalidation from a development to an implementation phase, with a greater focus on readiness and roll out. The statement, which sets out the priorities for taking revalidation forward was agreed by the GMC, 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.

7. At the end of 2010, to reflect the fact that we have moved into the implementation phase, we put in place new arrangements for managing the programme. These included setting up a UK Revalidation Delivery Group, which met for the first time on 30 November 2010. The Delivery Group, which consists of the four health departments and the GMC, meets monthly to discuss progress, evaluate readiness and monitor risks and issues. We have updated the programme plan which sets out clear milestones and activities for implementation and how it will be delivered by the end of 2012.

8. We have continued to develop our own internal processes and governance arrangements to make sure that the GMC itself will be ready to accept recommendations and make revalidation decisions from the end of 2012.

9. We have begun to develop the necessary secondary legislation to support the implementation of revalidation. We are liaising with the Department of Health to ensure that they have enough time to review and to take the legislation through Parliament before sign off by the Privy Council in 2012.

10. We are working with our partners to make sure that the Secretary of State will have all of the information he needs to make an assessment of whether the system is ready to support revalidation in summer 2012. We have written to the four UK health departments to ask for further information on how they are assessing progress towards readiness. Their assessments should provide the assurance that the Secretary of State will need before he agrees to 'switch on' the relevant legislation in late 2012 to enable us to begin revalidating doctors.

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

11. The purpose of revalidation is to assure patients and the public, employers and other healthcare providers that licensed doctors are up to date and are practising to the appropriate professional standards. We agree that the vast majority of doctors are good doctors and that revalidation should support those doctors in their desire to maintain and improve their practice. In that sense, revalidation will be a positive affirmation that a doctor is up to date and fit to practise.

12. Of course, the proposals for revalidating doctors should not exist in isolation from other systems designed to assure the quality of care. It will focus on affirming good practice for the majority but will also complement other systems for detecting poor practice.

13. The appointment of Responsible Officers, together with appraisal and robust systems of clinical governance, should help identify poorly performing doctors earlier in the process. In such cases further training or remediation is more likely to be effective.

14. Revalidation is one of a number of measures we are taking which will create better links between the GMC and local systems for investigating and managing concerns about doctors.

15. In 2011 we are introducing a network of Employer Liaison Advisers. Their role will include developing good links with Responsible Officers to support a two-way exchange of information on poorly performing doctors. The employer liaison service should maximise the potential benefits of revalidation, encouraging earlier and meaningful intervention where concerns about doctors are identified.

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

16. We agree that the new arrangements must also focus on how the system should deal with doctors whose practice gives cause for concern. Our view is that in the first instance concerns are best dealt with locally, unless they are so significant that the GMC needs to intervene to place restrictions on a doctor's practice. Responsible Officers are now under a statutory duty to establish and implement procedures for investigating concerns about a doctor's fitness to practise and to refer to the GMC where appropriate.

17. We hope that our network of Employer Liaison Advisers, once established, will provide support to Responsible Officers in dealing with concerns about doctors, advising about our referral thresholds, and act as a link between local investigation and national regulation.

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

18. We agree that the primary purpose of both regulation and revalidation is the protection of patients. There will be instances therefore when remediation is not appropriate and action by the GMC is required to remove or restrict a doctor's right to practise. We recognise the importance of an effective interface between local systems of clinical governance and our fitness to practise procedures as well as the importance of early intervention by the GMC when it is required to protect patients.

19. The introduction of revalidation will not change the thresholds for referral to, and investigation by, the GMC. Significant concerns about a doctor's practice should be referred to the GMC as and when they arise and should not be delayed for any reason.

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

20. We are in the process of developing guidance for Responsible Officers and are working with the four health departments on the delivery of training to Responsible Officers in each of the four countries.

21. The guidance will include advice on the kinds of concerns that should be referred to the GMC. The guidance will build on existing advice developed for Medical Directors and other health professionals when responding to concerns about colleagues.

22. In terms of training, one of the modules in the training package is about dealing with doctors where there are performance concerns. We are contributing to the content of the training materials and will also be involved in the delivery of the training to Responsible Officers in each of the four countries.

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

23. We agree that consistent and effective appraisal systems across healthcare providers are critical to the introduction of revalidation and to the evaluation of the performance of doctors in the workplace. We have developed new standard guidance for appraisal and on the supporting information that doctors will need to demonstrate that they meet the standards in our core guidance *Good Medical Practice*. Both of these documents should help to encourage greater consistency in appraisal across all sectors.

24. We are working with our delivery partners in the four UK countries to assess the degree to which their respective appraisal systems are ready for the introduction of revalidation. We have written to the four UK health departments to ask for further information on how they are assessing progress towards readiness. Their assessments should provide the assurance that the Secretary of State will need before he agrees to 'switch on' the relevant legislation.

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

25. As part of the earlier work on this, each of the medical Royal Colleges and Faculties developed their own framework which set out the types of supporting information their specialists might include in appraisal. However, doctors responding to our consultation last year called for a simpler system to determine the types of supporting information doctors need to bring to appraisal.

26. We agreed that was the right approach and also that the focus should be on identifying information that could be readily collected using existing systems. At the same time we believe that, as systems become more developed, the type of supporting information available may well change. In light of all this we agreed to identify a set of supporting information that all doctors would need to provide at appraisal over the course of the revalidation cycle.

27. We have now completed this piece of work. We have agreed a core set of supporting information that all doctors will be able to collect to show they meet the standards set out in *Good Medical Practice*, regardless of their specialty, work environment or type of practice. The vast majority of this supporting information should be provided through existing systems and established practice such as clinical audit, significant event reviews, outcome data (where available) and reviews of complaints and concerns.

**Recommendation 9: The Committee supports the approach set out in the GMC's consultation review document aimed at making the process simpler and more flexible. In particular we agree that the different components of revalidation should be integrated into a single process, and that the**

**requirements of that process should be integrated into the appraisal and clinical governance systems operated by employers. (Paragraph 47)**

28. Following our consultation in 2010, our proposals for revalidation are now based on a single process. The guidance and other material that we are developing now reflect the move to a single process.

29. We agree that revalidation should be based on local systems of appraisal and clinical governance.

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

30. We are undertaking a literature review to evaluate the evidence base for appraisal and for each piece of supporting information that we are proposing that doctors collect for revalidation. This will include a review of existing research and literature on colleague and patient feedback.

31. We have also developed our own colleague and patient questionnaires based on the standards in *Good Medical Practice*. These are currently undergoing extensive research and piloting with hundreds of doctors across a range of practice settings.

32. Early research by Peninsula Medical School into the validity, reliability and practicality of these questionnaires has been encouraging. The results of the pilot study, conducted by Professor John Campbell, were published in the *Quality and Safety in Healthcare Journal* in June 2008.

33. We have commissioned Professor Campbell to undertake a more in-depth review across a larger number of doctors, patients and carers in different clinical settings and in different parts of the UK. This second report is due to be published shortly.

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

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

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

34. The Responsible Officer Regulations 2010 provide that designated organisations must appoint an additional Responsible Officer in cases where there is a conflict of interest or an appearance of bias. The Department of Health has also published guidance on how these conflicts should be managed.

35. The regulations also provide that Responsible Officers must be registered medical practitioners with a licence to practise. Responsible Officers will themselves be required to revalidate and be accountable for their practice, through appraisal and revalidation, to their own Responsible Officer.

36. The Responsible Officer does not make a decision on the revalidation of individual doctors. That decision is made by the GMC. The Responsible Officer simply makes a recommendation on the basis of the available evidence. Where a Responsible Officer cannot make a positive recommendation, then the underlying evidence must be submitted to the GMC. The doctor will have all his or her legal rights protected in these circumstances and can make representations, be legally represented and produce any evidence they wish to demonstrate that they remain up to date and fit to practise. Ultimately, doctors have a right to appeal any adverse decisions made by the GMC.

37. We are also looking at options for the quality assurance and auditing of recommendations made by Responsible Officers to ensure consistency.

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

38. We agree that it is essential that there should be clarity about where the Responsible Officers, who are currently based in PCTs, will be situated in future.

39. This is clearly the responsibility of the Department of Health (England) and we understand that the department will be consulting on this issue in the summer of this year.

40. We commented on the need for clarity on this issue in our response to the White Paper *Equity and Excellence – Liberating the NHS* and in our submission to the Public Bill Committee for the Health and Social Care Bill.

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

41. We remain committed to ensuring that our proposals for revalidation are proportionate and flexible for all practising doctors, including those in non-clinical and non-mainstream roles.

42. Following the consultation, we have streamlined and simplified the supporting information for appraisal so that all doctors regardless of their practice will collect a common set of core information.

43. Further piloting and testing in 2011 and 2012 should give us an opportunity to ensure that the process can work for doctors in non standard roles.

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

44. The Committee highlights the current problem that the GMC cannot check if doctors from the EEA are able to speak English so they can practise safely. We are determined to find a solution and are currently working closely and urgently with ministers and officials at the Department of Health to make sure patients are fully protected.

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

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

**Recommendation 19: We look forward to discussing these and other issues with the GMC at the first of these regular meetings later in the year. (Paragraph 71)**

45. We would welcome the opportunity to provide the Committee with any further information that it requires and to update them on our progress regarding revalidation.