

8 March 2016

**Revalidation Advisory Board**

2

*As approved by the Revalidation Advisory Board on 8<sup>th</sup> March 2016*

**Minutes of the Meeting on 8 December 2015\***

**Members present**

Sir Keith Pearson, Chair

Simon Bennett  
Nick Clarke  
Frances Dow  
Duncan Empey  
Anne Hanley  
Mark Hope  
Ros Hynes  
Chris Jones

Malcolm Lewis  
Sol Mead  
Val Millie  
Sally White  
Julia Whiteman  
Paddy Woods  
Michael Wright

**Others present**

Niall Dickson, Chief Executive  
Una Lane, Director of Registration and  
Revalidation  
Clare Barton, Assistant Director,  
Revalidation

Lindsey Westwood, Head of Revalidation  
Sara Kovach-Clark, Head of Policy and  
Regulatory Development  
Chris Pratt, Board Secretary

\* These Minutes should be read in conjunction with the Board papers for this meeting, which are available on our website at <http://www.gmc-uk.org>

## Chair's business

- 1 Apologies were noted from Ian Starke, Ian Finley, Dave McLeod, Judith Hulf, Mark Porter and Wendy Reid.
- 2 The Chair thanked Jan Warner, who had recently retired, for her contribution to the work of the Board, and noted that a formal nomination for her successor had not yet been made.

## Minutes of the meeting on 1 September 2015

- 3 The Board approved the minutes as an accurate record.

## Matters arising: third anniversary of the introduction of revalidation

- 4 Niall Dickson reflected briefly on the excellent response to revalidation, and applauded the substantial progress in bringing doctors into a regulated environment. Revalidation continued to evolve and there was room to improve, but the marked increase in doctor appraisal rates across all disciplines and throughout the UK is a strong sign of how well doctors, organisations and Responsible Officers have engaged and taken their responsibilities seriously. Looking to the future, learning and review will help us refine procedures to further benefit patient safety.
- 5 During the discussion, the Board considered it important to continue to build on the narrative around achievements, and to reflect on its own role going forward.

## GMC Progress Report

- 6 The Board considered a report on the progress made with revalidation, including the latest revalidation data.
- 7 The Board advised that:
  - a The trends in above average deferral rate statistics should be kept under review.
  - b In the interests of avoiding information overload, any additional information about deferral rates provided in future Board updates should have a clearly identified use and value.
  - c The GMC's reflections about the future approach to releasing additional deferral information should include consideration of whether such information should come to the Board only if it identified a concern on which the Board would be asked for advice.

- d** Where 'insufficient information' is the reason for a deferral recommendation, it would be useful to understand more about the specific nature of the missing information. This may increase understanding, for example, of whether doctors are providing supporting information covering their whole scope of practice.
- 8** NHS England agreed to the Chair's request to share their conclusions about the deferral rate for secondary care locums.
- 9** During the discussion, the Board noted:

  - a** That the GMC continues to engage with a range of stakeholders to increase the pool of Suitable Persons. Board members were invited to send any suggestions to the secretariat about organisations that might be approached, particularly in relation to crematorium and S12 (of the Mental Health Act) doctors.
  - b** That the interim evaluation report from UMbRELLA would help shape the future of revalidation, notably in relation to supporting information. The Board also noted the intention, time permitting, to share the interim report with members in advance of publication.
  - c** That the UMbRELLA work to survey patients' revalidation experiences and views was progressing well and would conclude at the end of January 2016.
  - d** That the majority of doctors, except those in training, have a scheduled revalidation date between December 2012 and March 2016.
  - e** That deferrals continue at the rate of 7 – 11% (excluding doctors in training) across the UK. The average deferral period remains consistent at about 240 days. The Board also noted that deferral is a neutral act. Deferred doctors remain in the process and are working towards revalidation. The vast majority of doctors whose submission date is deferred once, go on to be revalidated.
  - f** The above average deferral rate statistics relating to ethnicity and place of primary medical qualification.
  - g** That the above average deferral rate for secondary care locums working for a Framework Agency would be looked into by NHS England.
  - h** That Annex C focuses on deferral information which the GMC already holds, and which could possibly be included in future RAB Reports.
  - i** That the GMC is separately considering whether there is additional information that should be collected to help establish a more detailed picture of the reasons behind deferral recommendations. This would require systems development to

deliver. The Board further noted that the GMC is awaiting specialist and legal advice on a number of data protection and equality and diversity issues associated with any release of additional deferral information.

- j** The GMC would reflect on the expert advice in relation to both deferral work streams and revert to the Board during 2016.

### **Licence to practise appeals**

**10** The Board received a brief description of the licence withdrawal process and reviewed six examples of redacted appeal decisions. The Board considered how information about appeal case outcomes might be shared to best advantage.

**11** The Board advised that:

- a** The GMC should publish statistics about appeals, making it clear that none to date has been successful.
- b** The GMC should explore further how best to put the details of appeal outcomes into the public domain and revert to the Board for further advice next year.

**12** During the discussion, the Board noted:

- a** 238 doctors had exercised their right of appeal following a decision to withdraw their licence, and that to date there had been no successful appeals.
- b** The percentage of doctors who appeal is higher for doctors with a prescribed connection than for those without.
- c** Publishing information about appeals would:
  - i** Be consistent with the fundamental principle of transparency.
  - ii** Provide insight for doctors considering an appeal.
  - iii** Give assurance, particularly to the public and Responsible Officers, that revalidation is working and the GMC is making sound revalidation decisions.
- d** That appeal outcome information could be published as full redacted text; alternatively, a shorter narrative of the essential points may allow a sharper focus.

### **Assurance on appraisals for doctors without a connection**

**13** The Board received a paper considering how the GMC currently obtains assurance that appraisals of doctors without a connection meet our requirements. The paper

also outlined improvements made recently, and identified options for future improvement.

**14** The Board advised that:

- a** It is important to maintain the integrity of the system so that revalidation is fair and equitable across the board.
- b** One option to add assurance might be to require appraisers of doctors without a connection to be undertaking appraisals for a designated body. In this way they would be required to engage with networks which support and underpin appraisal consistency.
- c** There is no particular minimum or maximum number of appraisals that should be conducted annually to remain competent as an appraiser. The Board considered that establishing a minimum would seem reasonable, but indicated there might be issues for smaller organisations to take into account.
- d** A list of 'approved' appraisers would be difficult to maintain and inferences would be drawn if an individual were not on the list. An option might be to consider directing doctors without a connection who find it difficult to find an appraiser to Responsible Officers or designated bodies for advice.

**15** During the discussion, the Board noted that:

- a** Every doctor who has told us they don't have a connection has an annual return date within the next 12 months.
- b** This population may well reduce if such doctors decide they do not wish to sit the revalidation assessment due to be introduced early in 2016.
- c** Of the 2,200 annual returns made last year by doctors without a connection, the GMC had accepted only 662.
- d** The GMC needs to have sufficient assurance about appraisals for this cohort of doctors, as well as a robust challenge to the quality of supporting information.
- e** Doctors practising overseas may find it difficult to find a suitable appraiser.
- f** It is the appraisee doctor's responsibility to ensure their appraisal meets GMC requirements and their appraiser meets our criteria.
- g** Some organisations set a minimum and/or maximum number of appraisals to be conducted in order to remain accepted as an appraiser. The numbers differ between organisations.

- h** The GMC will be strengthening its appraisal requirements and appraiser criteria, for example to emphasise that appraisers of doctors without a connection must be engaged in revalidation themselves, and reflect during their own appraisal on how they keep up to date and remain fit to undertake appraisals for revalidation.

## **UK progress updates**

**16** The Board received updates on key appraisal and revalidation issues from each UK country, members were reminded that written notes provided before Board meetings give members the chance to read and reflect on the information provided in advance.

**17** The key points noted were:

### *Scotland*

- a** The fourth External Quality Assurance report on Medical Revalidation in Scotland for 2015/15 had been published in October. The annual appraisal rate continues to rise and for 2014/15 stood at 93%, compared with 87% in 2012/13. To date, 93% of doctors in Scotland had a recommendation to revalidate, and 7% had a recommendation to defer, made about their revalidation.
- b** Noted achievements include that over half of all organisations now provide an annual revalidation report to their governing body, and that organisations are moving beyond compliance with process towards aligning revalidation with quality improvement and patient safety.
- c** The report identified future challenges and made a number of recommendations in the areas of information sharing, making best use of trained appraisers, gathering patient feedback and supporting smaller/non-NHS organisations.

### *Wales*

- a** There has been a significant improvement in appraisal rates, particularly for SAS doctors. 90% of all hospital doctors are appraised.
- b** The revalidation process is working well, and further improvements, for example to develop electronic appraisals, were anticipated.
- c** There is a developing programme of visits to designated bodies to gain a wider picture, and to engage with their governance boards. Patient representatives are involved and it was reported that revalidation had gained significantly in status – ‘doctors are no longer saying it is a waste of time’.
- d** Increasing links with Community Health Councils were also making a positive contribution, for example in relation to patient involvement.

### *Northern Ireland*

- a** The independent regulator will review implementation in the spring and report next summer.
- b** All Trusts now include a section on revalidation in their Quality Reports.
- c** Engagement with revalidation remains largely unchanged, and is good. The appraisal rate is 100% for GPs and for two of the five Trusts.

### *England*

- a** The England Medical Revalidation Programme update and Senior Responsible Owner's Report to Ministers 2014/15 had been published in October.
- b** A generally improving picture of compliance with the Responsible Officer Regulations in England was reported.
- c** The overall appraisal rate had increased to 86% from 84 % a year earlier. The appraisal rate for NHS England is 93%.
- d** The overall unapproved and missed appraisal rate is 6%. Within NHS England this rate is 1%. More work was required, especially among small designated bodies, to ensure that reasons for missed appraisals can be provided and understood.
- e** A Secondary Care Locums Task and Finish Group had worked with key stakeholders to address a number of perceived issues around the employment of secondary care locums. This work, which extends wider than revalidation and Responsible Officers, is due to be completed by March 2016.

### *Independent sector*

- a** The appraisal rate had been increasing. It currently stood at 60%, and further improvements were expected.
- b** The appraisal rate situation is exacerbated by the turnover rate – about one third of doctors change connection annually. This gives rise to issues and concerns among independent sector Responsible Officers about the need to rely substantially on information provided from elsewhere.

### **18** The Board advised that:

- a** It should keep a careful watch on its own relevance and role.

- b** There should be an increased focus on ways to bring greater consistency to revalidation across the four countries.

**19** During the discussion, the Board noted:

- a** The significant improvement in appraisal rates across the board.
- b** That NHS Greater Glasgow and Clyde (NHSGGC) are developing an information sharing template. Healthcare Improvement Scotland would arrange to put NHSGGC in contact with NHS England as information sharing presents a challenge more widely.
- c** That a number of the country updates indicated a growing sense that the revalidation implementation phase is, or is very nearly, complete.
- d** That when revalidation is fully embedded and operating, its own advisory role may no longer be valid. This may be relatively soon.
- e** It was currently difficult to see what successor arrangements might be needed when the Board has fulfilled its present remit. There were benefits realisation exercises under way locally, and these would help inform further deliberations.
- f** That any changes in revalidation process or policy following review and evaluation would need implementing and coordinating across the UK. A successor group to the Revalidation Advisory Board may have a contribution to make in relation to achieving consistency.
- g** That the approach to supporting revalidation into the future may need to be different in the countries of the UK to reflect local situations.
- h** The ongoing interest among certain stakeholders in aspects impacting on revalidation such as burdens and bureaucracy, patient involvement, the role of Responsible Officers and data improvements and sharing. These will be relevant in the development of future revalidation policy.

**20** The Chair asked members to reflect and bring their thoughts to the next meeting for discussion. Members should feel free to contact the Chair with any further or additional views in the interim.

### **Any other business**

**21** None.

Confirmed:

A handwritten signature in black ink, appearing to read 'K Pearson', with a horizontal line underneath.

Sir Keith Pearson, Chair

8 March 2016