

<b>Agenda item:</b>	<b>7</b>
<b>Report title:</b>	<b>Update on implementation of Taking Revalidation Forward recommendations</b>
<b>Report by:</b>	<b>Judith Chrystie</b> , Assistant Director, Registration and Revalidation Judith.Chrystie@gmc-uk.org, 0207 189 5459
<b>Action:</b>	<b>To note</b>

## **Executive summary**

Sir Keith Pearson's report on Taking Revalidation Forward (TRF) was published on 13 January 2017 together with the GMC's response, which welcomed the report and pledged to work with other stakeholders to implement the recommendations. We intend to begin this work immediately.

Addressing Sir Keith's recommendations will require a co-ordinated approach, both within and outside the GMC. We have set up a new internal TRF programme board to manage the actions needed by us. Separately, we intend to reconstitute the existing Revalidation Advisory Board (RAB) as a stakeholder oversight group for TRF.

By the end of March 2017 we will publish a high-level implementation plan setting out the key actions, timescales and responsibilities that have been agreed with stakeholders.

## **Recommendation**

The Strategy and Policy Board is asked to note the proposed approach to implementation of recommendations from Sir Keith Pearson's TRF report.

## Background to the Taking Revalidation Forward review

- 1 In March 2016, the GMC asked Sir Keith Pearson, the Chair of the GMC's Revalidation Advisory Board ('RAB')\*, to undertake an independent review of revalidation, commenting on its impact and making recommendations for improvement. The timing of the review coincided with the end of the first 'cycle' of revalidation, meaning that most licensed doctors had been through the process. It also occurred against a backdrop of concerns in the medical profession about the perceived burdens of appraisal and revalidation.
- 2 During his review, Sir Keith engaged personally with over 100 individuals from across the medical profession. These included chief medical officers, responsible officers, appraisers, doctors and patient groups, representatives from the royal colleges and faculties, the British Medical Association and the inspectorates. He also met with researchers from the UMBRELLA consortium who have been commissioned by the GMC to undertake a long-term evaluation of revalidation.
- 3 Sir Keith's report, [Taking revalidation forward: Improving the process of relicensing for doctors](#), was published on the GMC website on 13 January 2017. The report includes 15 recommendations, addressed to the GMC and other stakeholders. Although the GMC provided secretarial support to the review, Sir Keith led the drafting of the report and the recommendations are his own.

## Responses to the TRF report so far

- 4 The GMC published its response alongside Sir Keith's report. [Our response](#) [Annex A] welcomes Sir Keith's balanced and insightful report. We say we are reassured to hear that revalidation is beginning to have a positive impact, but we acknowledge the difficulties and challenges identified. We commit to pursuing all the recommendations and highlight five priority areas for action, which we explore in greater detail below.
- 5 Initial feedback from stakeholders obtained at the Revalidation Advisory Board on 10 January 2017 indicates widespread support for Sir Keith's findings. Many stakeholder organisations, including the Academy of Medical Royal Colleges, NHS Employers and the BMA, have issued press releases welcoming the report.
- 6 Media attention focused largely on concerns around locum doctors, including the danger to patients if locums are not subject to robust appraisal and revalidation processes. There was also some interest in the issue of improving patient feedback on doctors.

\* RAB was established in March 2013 to provide the GMC with advice from external stakeholders about how effectively revalidation is operating.

- 7** Feedback from individual doctors commenting on our website or through the media has been less positive. Their criticisms tend to focus on the cost, time demands and lack of demonstrable effectiveness of appraisal and revalidation.

## **Our priorities for action**

### *Making revalidation more accessible to patients and the public*

- 8** Sir Keith's report suggests that patients and the public believe doctors have regular and effective checks, yet they have limited understanding of how this process works or how they can feed into it. We will work with doctors and healthcare organisations to increase awareness of local assurance systems and to make it easier for patients to provide feedback on their care on an ongoing and 'real time' basis. We recognise that this will also require cultural changes within healthcare organisations.

### *Reducing unnecessary burdens and bureaucracy for doctors*

- 9** Some doctors find the appraisal process unnecessarily time consuming due to poor local IT systems or record keeping. Others experience appraisal as a 'tick box' exercise, focused on compliance with rules rather than professional development. We share Sir Keith's concerns about the conflation of revalidation criteria and local job-related requirements or training. We will support organisations to minimise administrative demands on doctors. And we will work with royal colleges to simplify our guidance and make clear what is – and isn't – required for revalidation.

### *Increasing oversight of, and support for, doctors in short-term locum positions*

- 10** We share Sir Keith's view that revalidation arrangements for locum doctors need to be strengthened. We will continue our work with NHS England and the Department of Health to ensure that locum agencies properly fulfil their obligations to doctors and that relevant information is transferred when locum doctors move between locations.

### *Extending the Responsible Officer model to all doctors who need a UK licence to practise*

- 11** Sir Keith's report highlights difficulties faced by doctors who need a licence to practise in the UK, but who do not have a Responsible Officer (RO). Whilst the GMC has put alternative provisions in place, we agree that an RO provides the most robust route to assuring a doctor's fitness to practise and their engagement with revalidation requirements. We will work with the four UK health departments to seek amendment of the Responsible Officer Regulations, to make sure all doctors who need a licence are linked with an RO.

*Measuring and evaluating the impact of revalidation*

- 12** We accept Sir Keith's recommendation that we should identify a range of measures by which to track the impact of revalidation on patient care and safety over time. Alongside the independent academic research we have commissioned (to be published in early 2018), we will work with ROs to better understand the impact of appraisal and revalidation at local level.

**Proposed approach to implementation**

- 13** Our approach to TRF implementation involves co-ordination across both internal and external stakeholders.

*Internal programme board*

- 14** We have established an internal TRF programme board to define and manage the work streams needed to deliver GMC actions. The resulting work programme will incorporate existing projects such as the review of guidance on supporting information for appraisal. The internal programme board includes representatives from Revalidation, Education, Strategy and Communications, Regional Liaison Service, Employer Liaison Service, Office of the Chair and Chief Executive and the devolved offices. It is supported by a dedicated project manager.

*Leadership and co-ordination of external stakeholders*

- 15** Our published response commits us to co-ordinating and supporting actions needed to deliver the improvements Sir Keith identifies. This will require ongoing collaboration with stakeholder organisations and a new oversight mechanism to replace RAB.
- 16** By the end of March we will publish a high-level implementation plan and outline monitoring arrangements. We have identified the steps needed to achieve this.
- The Chief Executive has written to stakeholder organisations asking them to tell us, by the end of January, how they intend to respond to the TRF recommendations.
  - We will collate responses and hold bilateral meetings with stakeholders during February and March to confirm their commitment and agree key milestones.
  - We will table a paper at the March RAB meeting proposing options to reconstitute the Board as an oversight mechanism for the implementation of TRF. We anticipate that the new board will have many members in common with RAB; but its terms of reference will be geared towards action rather than advice. A decision has not yet been taken on who will chair the new board.

**7 – Update on implementation of Taking Revalidation Forward recommendations**

**7 – Annex A**

**GMC response to Sir Keith Pearson's report on Taking Revalidation Forward**

**We welcome the report – it is well-evidenced and balanced**

Sir Keith has delivered a clear and incisive report and we are grateful to him for the quality of his review. It is evident that Sir Keith engaged extensively with stakeholders and they provided valuable and insightful evidence of the current impact of revalidation. We believe Sir Keith's review and his recommendations will make an important contribution to further developing revalidation to make sure it's fit for purpose and commands the confidence of all. We are determined to take forward all of Sir Keith's recommendations with vigour and we want other organisations to make the same commitment.

We are reassured to hear that revalidation is becoming embedded locally and beginning to impact on clinical practice, professional behaviour and patient safety. But revalidation is still a new process and we acknowledge the difficulties and challenges that Sir Keith identifies.

We are committed to working with others to make revalidation accessible and meaningful to patients and the public, while reducing unnecessary burdens and bureaucracy on individual doctors. We are determined to strengthen the systems of assurance around short term locum placements in secondary care and for those doctors who work outside mainstream practice. We will measure the impact of all aspects of revalidation to make sure that our requirements drive doctors' professional development and make a contribution to high quality and safe care for patients across the UK.

## The GMC has identified five priority areas for action

### **Making revalidation more accessible to patients and the public**

Patients and the public have an expectation that all doctors have regular and effective checks. Sir Keith's report suggests that patients and the public need to be provided with further assurance that this is happening. He also proposes that we

should simplify the terminology of revalidation so that it is more meaningful to patients. Sir Keith points out that some patient organisations suggest that the term 'relicensing' could be a better way to explain that the process is about checking that the doctor continues to be safe to treat patients. We agree. We will work with doctors and healthcare organisations to make sure that this system of assurance that we have put in place together is better understood and more meaningful to patients and the public.

Patients should also be more engaged in providing feedback to their doctors. We know that doctors find meaningful feedback from patients useful as it helps them to see their practice through the eyes of those that they treat. It's important that the mechanisms for collecting such feedback are effective and accessible to all patients and that there are more sophisticated means for providing feedback to doctors and the wider team responsible for their healthcare.

We will act on Sir Keith's recommendation to look at how a 'real time' approach could make this easier and provide doctors with a more representative and better quality picture of their practice. However, we will also need healthcare organisations to reflect and act on the broader changes to organisational culture that will be required if ongoing feedback from patients about their doctors and the wider healthcare team is to become the norm.

### **Reducing unnecessary burdens and bureaucracy for doctors**

Doctors are under increasing pressure. Some feel they have to spend too long preparing for appraisal (with frustrating and unwieldy IT systems) or are unhappy that their appraisal is too focused on compliance with revalidation requirements at the expense of professional development. Doctors must have access to good data and good IT in the organisations in which they work. We know that meaningful data about a doctor's practice and good quality appraisal can drive changes in practice which, in turn, has benefits for patients.

NHS boards and independent sector providers need to focus their attention on improving the data they provide to doctors about their practice. This may require investment in IT systems to help doctors access, and then reflect on, that data to make sure that appraisal can contribute to improvements in the care that doctors provide.

bodies in England, Wales, Scotland and Northern Ireland should support this approach by seeking evidence that these developments are underway across the healthcare sector in the UK. We will help employers and other designated bodies to deliver revalidation in a way that minimises administrative demands on doctors.

We are also concerned that there can be confusion between revalidation criteria and local job-related requirements, particularly around mandatory training. We do not consider it acceptable for employers to add management objectives to the evidence

required for revalidation. Everyone needs to be clear on what is required for revalidation – and what isn't. So, we will work with the Royal Colleges and others to clarify and simplify our guidance on the supporting information that doctors need to bring to appraisal, to minimise any confusion or uncertainty about what doctors need to do. We will communicate that clearly across all four countries. Royal Colleges should also review their guidance to make sure that they are not increasing burdens unnecessarily. Employers must be clear about any mandatory training requirements they are imposing locally and why – and they must not suggest that these are revalidation requirements when they are not.

### **Increasing oversight of, and support for, doctors in short-term locum positions**

We share Sir Keith's view that oversight of, and support for, locum doctors needs to be strengthened – particularly for those in secondary care – and are working with NHS England and the Department of Health already to address the issues the report identifies. There is significant variation in the resources and quality of the locum agencies that are currently tasked with evaluating the practice of over 8,000 secondary care locums working on short-term contracts in England, as well as uncertainty about the number of agencies deemed to have responsibility in law for the revalidation of locum doctors. We know that not all locum agencies are properly fulfilling their obligations to doctors and that relevant information is not always transferred when locum doctors move between locations. These challenges can make it difficult for locum doctors to engage meaningfully in appraisal and there is a potential patient safety issue.

We will continue the work we have started to make sure that only agencies who can demonstrate they have the resources and commitment to meet fully their obligations are deemed responsible for the revalidation of locum doctors – and that these agencies are readily-identifiable. We will begin discussions with the Government agency responsible for accrediting locum agencies in England to make sure that the quality assurance and audit arrangements that are in place reflect the significant additional responsibilities that these agencies now have for the doctors on their books.

Separately, we will work with Responsible Officers (ROs) in provider organisations to make sure that short-term locums are provided with the information they need to support their

appraisal following every placement and that any concerns about performance are raised directly with the doctor's own RO.

We will look across the four countries to make sure the challenges around short-term locums found in England are not also emerging elsewhere.

### **Extending the RO model to all doctors who need a UK licence to practise**

We agree with Sir Keith that doctors who need a licence to practise in the UK should have an RO to evaluate their fitness to practise on an ongoing basis and make recommendations to us about their revalidation. Although we have established alternative routes to allow doctors without an RO to revalidate and maintain their licence, we urge the four health departments across the UK to consider amending the Responsible Officer Regulations, to end the anomalies and make sure that all doctors who need a licence are linked with an RO.

### **Measuring and evaluating the impact of revalidation**

The GMC is committed to monitoring the impact of our revalidation requirements on doctors' professional development and the safety and quality of the care they provide. We have commissioned independent academic research – the results will be published in early 2018. We will work with ROs to better understand the impact of appraisal and revalidation at local level. In addition, we look forward to working with partners to identify a range of measures that will track the developing impact and value of revalidation to patient care and safety over time.

Sir Keith's report reflects the concerns that some doctors have with the fact that many ROs will also be the medical directors of their organisation. We agree that ROs with a dual role need to manage their responsibilities carefully - the RO Regulations envisaged that conflicts of interest might occur and provide for an alternative RO to be appointed if requested by the doctor. We agree that this issue would benefit from further consideration and that the ongoing evaluation of revalidation should explore the strengths and weaknesses of differing local approaches to the RO role.

## **What we will do to improve revalidation**

The GMC is committed to working with others to take forward Sir Keith's recommendations and to make the improvements he identifies as swiftly as possible. Whilst we will start work on this immediately, we recognise that we cannot achieve progress acting alone. The GMC will:

- **facilitate and support collaborative efforts**, especially those aimed at increasing the value of appraisal and reducing the administrative demands of revalidation

- **improve our published guidance** so that our revalidation requirements are clear and supported by practical examples that help doctors and appraisers;
- **increase our support to responsible officers** by promoting good practice approaches to revalidation support and decision-making;
- **develop a toolkit to help boards** understand and unlock the potential of revalidation data to support good clinical and corporate governance;
- **investigate the barriers to sharing of information** and work with others to seek improvements in local IT systems that support revalidation;
- **continue to share our data analysis and learning** from the independent evaluation we have commissioned, to allow stakeholders to understand the overall outcomes of revalidation as well as the experiences of doctors; and
- **continue our work with system regulators** to minimise duplication and reduce burdens, particularly for GPs.

## What others must do

Many of the areas for improvement identified in Sir Keith's report, including those that will most benefit doctors, require action from healthcare organisations other than the GMC. And some recommendations require legislative change. In addition to advocating for amendments to the legislative scheme from the relevant government departments across the four countries, we will encourage action – and sharing of good practice – by healthcare organisations, boards, system regulators and patient representative groups across the four countries to:

- **increase understanding of revalidation** amongst patients and the public;
- **improve local information systems** so that doctors can more easily access and collate the information they need to reflect upon at appraisal;
- **distinguish local initiatives and employment obligations from revalidation requirements in the appraisal process** so it is clear to doctors what is necessary for the purposes of revalidation and what is not;
- **make sure appraisal focuses on reflection and development** of the individual doctor, as well as compliance with revalidation requirements; and
- **make sure that appraisers have sufficient training and time** to prepare for and deliver high quality appraisals.

## Taking Revalidation Forward

Having a review of this quality offers a valuable insight into the impact of revalidation and how it is perceived since its introduction in December 2012. Sir Keith's work will be complemented by the independent evaluation being conducted by the UK-wide UMBRELLA consortium, whose final report will be available in early 2018.

Sir Keith's recommendations provide us – and all those who are involved in revalidation – with the foundations on which to build and refine current processes and systems. It took a number of organisations across the UK to work together to get revalidation off the ground in 2012 and to make sure, as Sir Keith has found, that revalidation has settled in well over the last four years. That commitment must continue as we take the changes that Keith has identified and develop them, in partnership with others.

We would like every doctor to benefit from a positive yet challenging appraisal that supports, rather than detracts from, the care they offer to patients. We would welcome patients being able to better understand and contribute to the assurance mechanism revalidation provides to the public. And we want all those involved in revalidation to feel that it is as effective and efficient as possible.

We will now start the work designed to implement Sir Keith's recommendations and achieve those aims as we take revalidation forward.