

9 June 2016

Revalidation Advisory Board

Minutes of the meeting on 8 March 2016*

Members present

Sir Keith Pearson, Chair

Duncan Empey
Anne Hanley
Mark Hope
Chris Jones
Sharon Lamont

Yvonne Livesey
Sol Mead
Sally White
Julia Whiteman
Michael Wright

Others present

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

Judith Hulf, Senior Medical Adviser and
Responsible Officer
Judith Chrystie, Assistant Director, Policy
and Regulatory Development
Lindsey Westwood, Head of Revalidation
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/about/council/21121.asp>

Chair's business

- 1** Apologies were noted from Frances Dow, Susan Goldsmith, Leslie Marr, Andy Lewis, Malcolm Lewis, Val Millie, Mark Porter, Ian Starke and Paddy Woods.

Minutes of the meeting on 8 December 2015

- 2** The Board approved the minutes as an accurate record, subject to deletion of the reference in the progress update report for Wales to electronic appraisals (paragraph 17b of the draft minutes).

Independent review on taking revalidation forward

- 3** Niall Dickson informed the Board that the GMC is commissioning an independent review of how revalidation has worked since it was introduced in December 2012. The review, to be led by Sir Keith Pearson, will begin immediately, and bring together and assess all available evidence on the operation and impact of revalidation. It will also involve meetings and discussions with stakeholders involved across the UK. The review will report by the end of 2016 on what is working well and what could be improved, and recommend any changes or improvements that could be made to benefit patient safety.
- 4** The terms of reference of the review would be announced shortly, and circulated to Board members.
- 5** Sir Keith Pearson reflected that it is timely to take stock now that most licensed doctors have been through revalidation, and will be familiar with the process. His firm intention is for the review to consider revalidation through the eyes of patients and the public, and assess whether it offers them confidence that doctors are up to date and fit to practise. Sir Keith emphasised the importance of obtaining patient views, and requested Board members to suggest individuals, organisations or groups with which the review should engage. Sir Keith also identified a specific role for the Revalidation Advisory Board in helping him to synthesise views emerging in the review.
- 6** The Board welcomed the announcement along with their intended involvement. The Board also emphasised the importance of engaging with all interests as the review progresses.

GMC progress report

- 7** The Board considered a report on the progress made with revalidation including the latest revalidation data provided in the Annexes.
- 8** The Board advised that:

- a** Consideration should be given to presenting the deferral rates for doctors in training separately from other doctors;
- b** Inclusion of some narrative around the reasons for deferring doctors in training would help set those rates in context.
- c** The revalidation data provided in Annex B meets their needs and is enough to begin to draw conclusions.

9 During the discussion, the Board noted:

- a** The vast majority of licensed doctors on the register at the time revalidation was introduced have now been revalidated. This means there will be far fewer doctors than is usual to be revalidated in the coming months.
- b** Deferral rates remain fairly consistent across the UK. The deferral rate for doctors in England is significantly skewed by the inclusion of doctors in training.
- c** The number of doctors without a designated body now finding a Suitable Person to make revalidation recommendations about them is increasing. This reduces the number of doctors needing to submit Annual Returns and sit the Revalidation Assessment in order to revalidate.
- d** Non-engagement levels remain low and most doctors begin to engage when they receive non-engagement or minded to withdraw licence communications from the GMC.
- e** The welcome approval of a new Suitable Person for crematorium referee doctors and the connection of small but significant groups of doctors to the Faculty of Medical Leadership and Management as their designated body.
- f** Most doctors have now provided their connection details, which clarifies how they will revalidate.
- g** There are over 11,000 doctors on GMC records who do not have a designated body or a Suitable Person. Of these, fewer than 6,500 doctors have told us they do not have a connection. The remaining doctors are part of a transient group for which we do not currently have connection details, several of which are new to the register and can be expected to make a connection when they find work.
- h** 11 doctors have booked to take the Revalidation Assessment.
- i** 2 doctors without a designated body have been revalidated on the basis of FRCS examination results and satisfactory appraisals.
- j** The interim evaluation report from UMBRELLA is due to be published shortly and would be shared with the Board before its next meeting.

- k** GMC continues to consider the questions of providing additional details about the reasons behind deferrals and how best to publish the outcomes of licence withdrawal appeals. A further update would be provided at the next Board meeting.
 - l** Doctors are increasingly, and encouragingly, relinquishing their licence when they are not working in the UK and applying to restore it when they intend to practise again in the UK.
 - m** The number of licence withdrawals remains small. Most of the 279 appeals for licence withdrawal have not gone to hearing because doctors either begin to engage with revalidation, or they decide to relinquish their licence.
- 10** The Chair advised that the Board meeting on 9 June will focus primarily on the revalidation research projects commissioned by the GMC and the Department of Health (England):
- Researchers for both projects would be invited to present and discuss their progress reports;
 - Less time would be available for revalidation updates, and so written country and other updates would be appreciated;
 - The Chair requested members to travel to London for the meeting if at all possible as this would facilitate and enrich the interactions.

Patient and Public Involvement project

- 11** The Board received a paper describing two GMC initiatives responding to feedback from a wide range of stakeholders that the requirements for collecting and reflecting on patient feedback for revalidation could be made clearer. The initiatives involved production of:
- A leaflet for patients about their role in giving feedback to their doctor;
 - A set of case studies showing how doctors can meet our patient feedback requirements in a range of roles and circumstances.
- 12** The Board congratulated the GMC on an important initiative and a fine piece of work which improves the GMC's guidance around patient involvement in revalidation.
- 13** The Board advised that:
- a** There are a number of issues, some of which could be substantial considerations in Sir Keith Pearson's revalidation review. These include:

- Whether patients do, or need to, understand the meaning of 'revalidation' in addition to having a general awareness about the importance of their role in feeding back to their doctor;
 - If there is shown to be a need to explain 'revalidation' to patients, then the explanation should be in readily understandable terms;
 - Emphasising the importance of patients giving feedback to their doctor needs to be reinforced whenever possible;
 - Whether the patient leaflet could be handed out with revalidation feedback forms;
 - Clarification of the difference between complaints and feedback and improving patient awareness of how their feedback will be used;
 - Examining examples of existing patient involvement initiatives with a view to guidance on best practice.
- b** Even more could be done to broadcast these resources to reinforce patient and doctor awareness and understanding.
- c** Revalidation Delivery Boards and Responsible Officer networks should consider these issues, and might also reflect on wider local dissemination for example via local radio or print media and groups, such as Community Health Councils and Healthwatch, where patients are actively engaged.
- d** Sir Keith's revalidation review should consider the frequency of patient and colleague feedback.

14 During discussion the Board noted:

- a** Patient feedback is a key part of revalidation.
- b** These new resources are being widely welcomed and very well received.
- c** The leaflets, in particular, are already being used by groups and organisations as well as the GMC to promote patient awareness across a wide range of fronts, for example to produce Healthwatch leaflets for patients. The Board also noted there are no constraints on the use of the GMC resources for such purposes.
- d** There are number of initiatives around the country actively involving patients more closely, for example;
 - Through participating in appraiser interview panels;

- Patients and medical professionals engaging to learn how to work better together;
 - Increasing patient awareness through access to Responsible Officer learning modules.
- e** Some patients appear unclear about the difference between complaints and feedback and how their feedback will be used.
- f** The leaflet and case studies are accompanied by a series of 'frequently asked questions' which also provide an important source of information for patients and doctors.
- g** Increasingly, because revalidation is not a point in time process, the independent sector is advocating patient and colleague feedback more than once in a doctor's revalidation period. The anecdotal feedback about this is good.

UK progress updates

15 The Chair thanked those who had provided written reports in advance, and invited verbal updates on key issues.

16 The key points noted were:

Scotland

- Appraisal rates at 93% had continued to improve and, encouragingly, the range (from 70% to 100% across organisations) had narrowed.
- Looking forward, Scotland will shortly undertake the 2015-2016 External Quality Assurance review. Evaluation panels will assess the submissions at the beginning of July 2016 and outcome reports will be presented to the Revalidation Delivery Board Scotland in November 2016.

Wales

- Appraisal rates have improved.
- Revalidation Quality Assurance visits to designated bodies are being piloted. Early indications are these have been beneficial to all. The visits are labour intensive, and their value for money will be considered by the Wales Revalidation Delivery Board (WRDB).
- The programme of High Level Responsible Officer visits to NHS organisations has been extended to non-NHS organisations. These visits intend to provide assurance that arrangements in organisations are sufficient to support revalidation or to identify areas where assistance may be required. An overview of the visits is to be presented to the WRDB on 19 March.

Northern Ireland

- It was noted that there is nothing new to report at this time.

England

- Now that appraisal rates are improved and the process is robust, there will be a focus for the coming year on leadership and appraisal quality. The aim will be for appraisal to be as good as it can be.
- A set of locum agency case studies to be shared soon will help Responsible Officers with locum revalidation issues.
- Work is under way to develop a framework and guidance around medical revalidation information flows between doctors and Responsible Officers.
- Proposed criteria for formal closure of the revalidation implementation phase will be agreed by the England Revalidation Implementation Board (ERIB). The Annual Organisation Audit exercise will take place in April. In the autumn ERIB will consider the criteria and what is expected to be a final Senior Responsible Owner's report, to inform the decision about moving to business as usual.

Independent sector

- The independent sector is increasingly asking doctors retiring from the NHS to reapply for practising privileges. The new privileges better reflect scope of practice and competencies in the independent sector, and are often significantly different from those previously held.

Health Education England

- HEE informed the Board of new initiatives relating to doctors in training. These are aimed at:
 - Underpinning consistency in dealing with significant incidents. This is to ensure they are consistently managed according to the Serious Incident Framework;
 - Increasing consistency in support for learners. Working with the GMC, this work intends to identify what is available and establish best practice;
 - Evaluating what is done to support the wellness and wellbeing of learners, including the availability of resources.

17 The Chair noted that a number of potential opportunities to engage with stakeholders for the revalidation review had been identified during the Board's discussions. These include meetings of programme and delivery boards and Community Health Councils. The Chair welcomed Board members' agreement to help facilitate these and other interactions during the review.

Confirmed:

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

Sir Keith Pearson, Chair

9 June 2016