

7 March 2017

## Revalidation Advisory Board

### Minutes of the meeting on 10 January 2017\*

#### Members present

Sir Keith Pearson, Chair

Ian Finlay	Malcolm Lewis	Mark Porter
Norman Gibb	Yvonne Livesey	Mike Prentice
Mark Hope	Ian Mackay	Sally White
Chris Jones	Leslie Marr	Julia Whiteman
Sharon Lamont	Sol Mead	Paddy Woods
Gavin Larner	Val Millie	

#### Guests

Bill McMillan, NHS Employers  
Sarah Parsons, NHS Employers  
Stephen Barasi, Wales Revalidation Delivery Board

#### Others present

Charlie Massey, GMC Chief Executive	Colin Melville, Director, Education and Standards
Judith Chrystie, Assistant Director, Policy and Regulatory Development	Lindsey Westwood, Head of Revalidation
Clare Barton, Assistant Director, Revalidation	Helen Arrowsmith, Project Manager for Taking Revalidation Forward
Stephanie McNamara, Assistant Director, Communications	Chris Pratt, Board Secretary
Andy Lewis, Assistant Director, Employer Liaison Service	Sophie Holland, Executive Assistant to Una Lane

\* 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 The Chair welcomed members and guests.
- 2 The Chair explained that the written revalidation update papers had been circulated for information, but no time had been allocated to their discussion. This would free agenda time for presentation and discussion of his *Taking Revalidation Forward* review report to the GMC. The updates would be placed on the website in the usual way.
- 3 Apologies were noted from Una Lane and Claire Armstrong.

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

## Presentation and discussion of the *Taking Revalidation Forward* review

### Presentation of the report

- 5 The Board received a presentation from Sir Keith Pearson on his independent review of the impact of revalidation since its introduction in December 2012. Sir Keith emphasised that, having completed his review and submitted his report to the GMC, the final report is owned by the GMC and it will be for them to address the recommendations and issues raised.
- 6 Sir Keith's overall conclusion is that revalidation has settled well and is progressing as expected. Most now recognise it as a valuable means of assuring the public that doctors are keeping themselves up to date and safe to practise: no major overhaul is required. The review had considered how revalidation could become more effective in assuring the public through learning from the operation of revalidation processes over the four years since its introduction. Sir Keith's recommendations focus on improving some aspects of revalidation for the benefit of both doctors and patients.
- 7 The Board noted a number of key points about the review.
  - a Sir Keith had enjoyed unrestricted access to everyone engaged with revalidation, and had been especially impressed by the willingness of those with whom he spoke to give of their time and engage.
  - b The report reflects a spectrum of views about revalidation spanning enthusiasts to non-enthusiasts, and it was important to register that nobody had suggested revalidation should not continue.
  - c Sir Keith had been pleased to find a shared sense among those with whom he spoke that the timing of the review, after four years' experience, was opportune.

- 8** The Board noted Sir Keith's conclusions on the impact of revalidation:
- a** Medical revalidation is settling well and it is an achievement to have delivered such a complex intervention without major problems. We are where we anticipated we would be, and revalidation has been a success.
  - b** There is excellent commitment, ownership and personal leadership of revalidation by medical leaders and health departments in the four countries of the UK, and revalidation would not have worked without that.
  - c** The main impact of revalidation has been to embed whole practice appraisal and broaden doctors' reflective practice. There is clear evidence of stronger clinical governance arrangements in healthcare provider organisations and some evidence that revalidation is helping to identify and tackle poor doctor performance.
  - d** In general, doctors who do not support revalidation have concerns about the administrative burden or have not had a constructive appraisal experience.
- 9** Sir Keith summarised the areas of focus for improvement. These are discussed in detail in the [report](#):
- a** Public awareness of revalidation needs to increase if it is to fulfil its role in raising assurance. Sir Keith concludes the word 'revalidation' is not well understood among the public, and that we should in future talk about 'relicensing'.
  - b** Raising the quality and consistency of appraisal would both strengthen assurance and help secure buy-in from doctors. It is therefore a priority. Sir Keith had been encouraged to note that Responsible Officers and appraisers are increasingly focused on audit of appraisal for both consistency and lessons to be learned.
  - c** Revalidation can deliver further benefits if Boards of healthcare provider organisations take a more active role to challenge for learning and improvement. Boards should actively discuss appraisal and revalidation outcomes in the context of their local clinical governance activities and responsibilities.
  - d** Burdens for doctors can be reduced if organisations provide better support and improve information systems. This was a widely shared view across the countries of the UK.
  - e** Issues around the appraisal and revalidation of secondary care locums and doctors without a Responsible Officer constitute weak points in the system that need to be addressed.
- 10** Sir Keith sets out a number of recommendations to stakeholders in the report:
- a** The GMC should:

- clarify its revalidation guidance;
  - explore a broader definition of patient feedback;
  - support stronger local governance;
  - encourage better information sharing;
  - identify impact measures for revalidation; and
  - bring forward the revalidation dates for new entrants to the register.
- b** Government departments should:
- re-examine the Responsible Officer Regulations with a focus on locums and doctors without a Responsible Officer so that, as far as possible, all doctors who need a licence to practise in the UK have an Responsible Officer.
- c** Healthcare organisations should:
- continue work to drive up appraisal quality;
  - improve systems to support doctors;
  - share information; and
  - publicise the benefits of the 'relicensing' process, especially to the public.
- d** Boards of healthcare provider organisations should:
- challenge their organisations to demonstrate learning from revalidation; and
  - assure themselves of the quality and fairness of local appraisal and revalidation processes.

## The GMC response

- 11** The Chair invited the GMC's Chief Executive to outline the GMC's response to the *Taking Revalidation Forward* report.
- 12** Charlie Massey warmly welcomed the report as a well-evidenced, balanced and incisive analysis of the impact of revalidation. The review is reassuring about the embedding of revalidation and the positive impact it is beginning to have on clinical practice. The GMC believes the recommendations will contribute to the further development of revalidation to make sure it is fit for purpose and commands the confidence of all.

**13** The GMC is committed to taking forward all Sir Keith’s recommendations and would welcome similar commitment from other stakeholders involved. The GMC will prioritise work with those stakeholders to develop a plan of action that will take the recommendations forward and maintain momentum.

**14** The GMC has identified five priority areas for action. These are described in more detail in the GMC’s published [response](#) to the review. In summary:

**a** Making revalidation more accessible to patients and the public:

- Patients and the public expect all doctors to be subject to regular and effective checks. The GMC will work with doctors and healthcare organisations to ensure revalidation is better understood and more meaningful to patients and the public.
- The GMC agrees that patients should be more engaged in providing feedback to their doctors, and will work with others to look at how a ‘real time’ approach could make this easier and provide doctors with a better quality picture of their practice.

**b** Reducing unnecessary burdens and bureaucracy for doctors:

- The GMC agrees that doctors should have access to good data and good IT in their organisations, and believes NHS Boards and independent sector providers across the UK must move to focus attention on improving the data they provide to doctors about their practice.
- The GMC believes everyone needs to be clear what is required for revalidation, and what is not. The GMC will work with the Royal Colleges and others to clarify guidance on the GMC’s appraisal and revalidation requirements and how they relate to other related guidance and local governance-related requirements. GMC will endeavour to do this in a straightforward way which ensures the integrity of revalidation is maintained.

**c** Increasing oversight of, and support for, doctors in short term locum positions:

- The GMC will work with others with the aim of helping locum doctors engage meaningfully in appraisal for revalidation, for example by ensuring:
  - locum agencies have appropriate quality assurance and audit arrangements in place that allow them to fulfil their obligations to locum doctors; and
  - locum doctors are provided with the information they need to support their appraisal when they move between locations.

- d** Extending the RO model to all doctors who need a UK licence to practise:
  - The GMC agrees that, as far as possible, doctors who need a licence to practise in the UK should have a Responsible Officer to evaluate their fitness to practise and make recommendations about their revalidation. The GMC will work with the four health departments across the UK to consider amending the Responsible Officer Regulations to that end.
- e** Measuring and evaluating the impact of revalidation:
  - The GMC is committed to monitoring the impact of its revalidation requirements on doctors' professional development and the safety and quality of care they provide.
  - The GMC will draw on independent academic research and surveys of Responsible Officers to better understand the impact of appraisal and revalidation at the local level.
  - The GMC will also work with others to identify measures that will track the developing impact and value of revalidation to healthcare systems, as well as demonstrating to the public the professionalism of individual doctors.

### The views of Revalidation Advisory Board members

- 15** The Chair invited views from around the table.
- 16** Members welcomed the report and expressed universal praise for the thorough report and its proportionate recommendations. There was a general sense that the review means we can be more confident about the improvements needed going forward. There were no complaints or criticisms of the report and it was recognised that, as the report does not offer solutions on how to implement the recommendations, discussion would be needed. Board members expressed a strong intention that their organisations would work together to explore how to implement the recommendations.
- 17** Board members made a number of observations:
- a** The report captures the issues well, especially around burdens and patient engagement with revalidation, and is fair and balanced.
  - b** The recommendations are generally measured and realistic but the detail would need to be discussed.
  - c** There should be an incremental approach to improvements which is not burdensome.

- d** Whether doctors should have the ability to provide feedback on the process direct to the GMC, for example if they feel revalidation processes are being abused, is a point to consider.
- e** It is right to look at issues associated with locum doctors, including their revalidation and whether the Responsible Officer model can work. Some of the issues identified relate to the peripatetic nature and environment of locum doctors' practice, rather than locums' fitness to practise *per se*, so there is a need to proceed with caution. There will be substantial challenges in addressing issues in this area.
- f** Many locum doctors are recently out of training or between training posts which means that Deans will have an interest in the dynamics of information flows.
- g** Locum doctors are at risk themselves, especially those who only have locum practice and those new to the UK. It may help if NHS Employers' [locum guidance](#) were to be followed.
- h** There is already an identified need to refresh the Responsible Officer regulations to address some issues relating to locum doctors, but amending the regulations alone cannot resolve the locum doctor issues discussed in the report.
- i** When it comes to reviewing the Responsible Officer regulations, some saw a case to consider whether there is a conflict of interest where a Responsible Officer is also a Medical Director, while others saw benefit in one person undertaking both roles.
- j** We should consider how the Responsible Officer role should develop going forward, for example, with more emphasis on leadership and less on process.
- k** The word 'relicensing' may imply a doctor has lost their licence to practise and has to regain it, while revalidation is in fact the process through which licensed doctors maintain their licence. It may be that another word such as 'renew' would be more appropriate in the context of increasing public understanding of revalidation.
- l** Some aspects of the recommendations accord with work that is already in hand.
- m** In developing IT systems support for doctors' appraisal portfolios, it could be beneficial to co-operate to identify which are the best systems.
- n** Good support from HR departments is essential in helping Responsible Officers with appraisal, revalidation and local employment issues.
- o** Patients do not warm to the current patient feedback arrangements, so it will be good to revisit an approach which doesn't seem to be working. A feedback frequency of once in five years is inadequate from a patient perspective. The

results of the Academy of Medical Royal Colleges' project on patient feedback, due to report in a few months, may help inform the way forward.

- p** It may be difficult to stand on a principle of one patient feedback exercise in five years, but there needs to be careful thought about the impact of alternatives. For example, could 'real time' patient feedback be used with confidence, and what changes to organisational structure and culture would be needed to make this happen?
- q** Against the background that the level of complaints continues to rise, we should work with organisations to identify some real and basic questions for patients. For example, 'was there anything else you needed to know from the interaction with your doctor', and 'what did you learn from your interaction with your doctor today'?
- r** Preparing new doctors for revalidation is important and will not be helped by bureaucratic appraisal requirements.
- s** There is a contrast in patient feedback between doctors in training and those who are not. Doctors in training get regular, almost too much, instant patient feedback.
- t** It may be appropriate not to be too prescriptive when considering bringing forward the revalidation date for newly licensed doctors. For example, what would be the rationale and value for revalidating doctors at the end of foundation training (ie two years after doctors in training gain their licence to practise) and again after five years or at the point they receive their Certificate of Completion of Training? This would especially be so for doctors in training in the UK.
- u** Any new arrangements to revalidate doctors early may need to be different for different doctor groups.
- v** We should develop directions and key questions to help non-executive directors test and benchmark their Responsible Officers.
- w** We should consider how the principles of medical professionalism might be embedded in revalidation approaches.
- x** The clarification of guidance on revalidation and local employer requirements should recognise that there is no need for multiple appraisal conversations with doctors. A single conversation can have multiple outcomes.
- y** In simplifying and clarifying guidance it will be important to respect the interdependence between revalidation, which is fundamentally owned by the GMC, and appraisal, which is employer-owned.



- z** There is no real excuse for not being able to code clinical governance information to individual doctors.

### Concluding remarks from the Chair

- 18** The Chair expressed his appreciation for the highly supportive statements from Board members and for their willingness to work together to implement the review's recommendations. He urged members to consider whether their organisations could openly support the report and its recommendations in trade, national and social media.

### Next steps

- 19** The GMC requested Board members to share more detail on their thoughts on the recommendations and broadly how they plan to take action in response, by the end of January.
- 20** GMC would then coordinate responses and arrange meetings with stakeholders to agree an overall approach and timetable to explore and organise the implementation of Sir Keith's recommendations.

### Other business

- 21** There were no items of other business.

Confirmed:

A handwritten signature in black ink, appearing to be 'K Pearson', written over a horizontal line.

Sir Keith Pearson, Chair

7 March 2017