

10 January 2017

Revalidation Advisory Board

Minutes of the meeting on 9 June 2016*

Members present

Sir Keith Pearson, Chair

Nick Clarke	Sol Mead
Duncan Empey	Val Millie
Ian Finlay	Mark Porter
Mark Hope	Ian Starke
Chris Jones	Julia Whiteman
Sharon Lamont	Michael Wright
Malcolm Lewis	Paddy Woods
Leslie Marr	

Guests

Marie Bryce, UMBRELLA
Kieran Walshe, Alliance Manchester Business School
Stephen Barasi, Wales Revalidation Delivery Board

Others present

Niall Dickson, Chief Executive	Lindsey Westwood, Head of Revalidation
Una Lane, Director of Registration and Revalidation	Helen Arrowsmith, Project Manager, Taking Revalidation Forward
Judith Chrystie, Assistant Director, Policy and Regulatory Development	John Gillibrand, Revalidation Operations Manager
Andy Lewis, Assistant Director, Employer Liaison Service	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 The Chair informed the Board that Norman Gibb had succeeded Frances Dow as public interest member for Scotland, and placed on record thanks to Frances for her past contributions to the Board's deliberations.
- 2 The Chair also informed the Board that the actions from the last meeting had been completed:
 - a The terms of reference for the review, *Taking Revalidation Forward*, were circulated to RAB members on 9 March; and
 - b The minor adjustments noted at the March Board meeting were made to the papers placed on the website.
- 3 The Chair explained that the written revalidation updates had been circulated for information, but no time had been allocated to their discussion. This would free agenda time for presentation and discussion of the revalidation research reports. The updates would be placed on the website in the usual way. The Chair noted that organisations which had not provided updates on this occasion had no revalidation developments to report since the March Board meeting.
- 4 Apologies were received from Norman Gibb, Julian Archer, Simon Bennett and Clare Barton.

***Taking Revalidation Forward* review**

- 5 The Chair informed the Board that his review of revalidation and how it could be developed for the future was under way. He had been especially pleased with the willingness of all to engage, and welcomed the time and effort everyone had taken to prepare. Contributions to the review from a wide range of interests had been thoughtful and hugely positive, and the engagement planned with individual doctors would further enrich the review. Contributions from any Board members would also be welcome, especially any able to provide anecdotes around individual practitioners' experience of revalidation.
- 6 The Chair would keep the Board informed, and expected to be in a position to feed back emerging themes at the Board's meeting on 15 September 2016.

Minutes of the meeting on 8 March 2016

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

Presentation and discussion of revalidation research projects

- 8** The Board received a presentation on each of two projects:
- a** Shaping the future of revalidation – interim report, from Dr Marie Bryce of UMbRELLA; and
 - b** Implementing medical revalidation – organisational changes and impact, from Professor Kieran Walshe of the Alliance Manchester Business School.
- 9** The Chair invited the Board to discuss the presentations, and to consider, in particular, whether the interim research findings reflected the experience of medical revalidation around the table. The Board was not requested to provide specific advice.
- 10** The Board warmly welcomed both research reports. A number of key points were made during the discussions and these would be considered further by the researchers and the review, *Taking Revalidation Forward*, as appropriate.

Shaping the future of revalidation

- 11** In support of her presentation, Dr Bryce additionally commented during discussions that:
- a** 16% of all doctors volunteered to respond to the survey, and this rate of response compares favourably with other similar surveys.
 - b** The overall appraisal rates shown are pushed down by doctors with no known connection to a designated body.
 - c** The research showed that collecting supporting information is easier when supported by systems, so the nature, accessibility and usability of systems impacts a doctor's experience of appraisal.
 - d** There is some evidence that reflection required for appraisal for revalidation does improve doctors' practice, for example, doctors are taking more time to explain diagnoses to patients, and those explanations are more detailed.
 - e** The free text contributions to the survey are still being analysed, but seem to be showing that doctors are reflecting more in practice than is indicated by some of the answers to the survey questions themselves.
- 12** Board members commented that:
- a** Revalidation is a by-product of appraisal, not vice versa. There may be an appraiser training issue around the relationship between the two.

- b** It is a positive sign that the research shows appraisal is now happening for the vast majority of doctors, when that was not the case prior to the introduction of revalidation. Appraisal provides more than just information for revalidation.
- c** Collecting information is more difficult where a doctor works in more than one organisation, and that this does lead to some repetition.
- d** The fact that appraisal is not consistently applied across the United Kingdom could be addressed by a fresh focus on appraisal quality.
- e** Revalidation itself must be seen to be the same for all doctors. There are justifiable differences in the nature of information collected to support individual doctors' appraisals for revalidation, but that is quite different from a multi-tiered approach to revalidation itself. It was noted that doctors in postgraduate training have the Annual Review of Competency Progression (ARCP) as the equivalent of the appraisal, and they were not included in the research.
- f** The Chair noted that the review, *Taking Revalidation Forward*, was hearing a more positive response to revalidation than was being shown by some of the research. Overall, Board members were optimistic about the research findings, and found it encouraging, for example, that one third of those responding to this survey had embraced revalidation, particularly as revalidation is still a relatively new process.
- g** The views of those doctors who feel revalidation has had a negative impact on appraisal should not be ignored. They provide a signal that there is room for improvement, which can be worked upon.
- h** A distinction should be drawn between hard data and perception; the research is showing that reality is currently better than perception. As an example of this it was noted that: 46.1% of doctors responding to the survey agreed that revalidation would fail to identify failing doctors, yet, 10.4% of appraisers responding to the survey had formally escalated a concern about at least one appraisee and 22.5% had identified concerns about at least one appraisee that they did not formally escalate. Non-escalated concerns were reported as principally being resolved within the appraisal.
- i** There was some suggestion that doctors may be handing out their own feedback questionnaires, which is not normal practice. The Chair indicated this is also a theme emerging from his review, along with some suggestions to address the matter.

Implementing medical revalidation – organisational changes and impact

- 13** In support of his presentation, Professor Walshe additionally commented during discussions that:

- a** 63% of Responsible Officers had completed the whole survey.
- b** Responses showed that revalidation has impacted organisational processes and pushed some thresholds. There are issues related to designated body size; large designated bodies generally benefit from economies of scale in developing and maintaining their systems.
- c** Revalidation has been a driver for improvements in appraisal and clinical governance.

14 Board members commented that:

- a** Well developed and managed systems are required for sound clinical governance, they are not a product of revalidation. Designated bodies, regardless of size, need to support their doctors.
- b** Revalidation has helped to integrate performance information that wasn't integrated before, and there is greater integration between employers and the systems regulators.
- c** It is important to use language clearly and consistently, for example in describing what revalidation is, and just as importantly, what it isn't. It is also important to avoid confusing 'revalidation' with 'appraisal' (or the ARCP for doctors in postgraduate training), which are separate but related processes. Revalidation reassures patients but is also beneficial to doctors by encouraging reflective practice and confirming fitness to practise. Appraisal is a reflective discussion.
- d** There is an increasing trend for doctors to move in and out of training which brings challenges for information sharing.
- e** Revalidation has strengthened communications between Responsible Officers.
- f** Several Board members were of the view that a differentiated model of revalidation would not be the preferred approach to addressing the challenges presented by the current model for certain doctor cohorts and designated bodies.

Other business

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

Confirmed:

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

Sir Keith Pearson, Chair

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