To note

Report from the Revalidation Implementation Advisory Board

Issue
1. This paper reports the latest discussions at the Revalidation Implementation Advisory Board, noting particularly the issues considered at its meetings on 30 September and 17 December 2014.

Recommendation
2. The Strategy and Policy Board is asked to note the report and the latest discussions at the Revalidation Implementation Advisory Board meetings.
Report of the Revalidation Implementation Advisory Board

Issue

3 As outlined in its statement of purpose, the Revalidation Implementation Advisory Board (RIAB) was established ‘To provide advice to our Chief Executive during the implementation of revalidation, in order to support the GMC in fulfilling its regulatory objectives’. Its members are representatives from primary, secondary and independent healthcare across the four countries of the UK, as well patient organisations and the GMC. Sir Keith Pearson is RIAB’s independent chair.

4 RIAB has met twice since its last report to the Strategy and Policy Board. The minutes of the meeting on 30 September 2014 are at Annex A, and 17 December 2014 are at Annex B. RIAB approved the minutes of the September meeting when it met in December these were subsequently published on the website. RIAB will be asked to approve the minutes of the December meeting when it next meets on 4 March 2015.

Revalidation progress

5 At all RIAB meetings a progress report is presented which includes all the latest revalidation data. We now have two years of data, so analysing trends is becoming easier and more meaningful. RIAB continues to reflect on this data and advise as appropriate.

6 As well as this statistical information, in December RIAB heard from one of our Employer Liaison Advisers about how revalidation is working on the ground. RIAB was encouraged to hear that Responsible Officers (ROs) are reporting positively about the impact revalidation has had on clinical governance systems. RIAB noted that there was work to be done in other areas, such as to develop a proportionate system for the effective transfer of information between ROs.

Revalidation for doctors with no connection

7 At the December meeting, RIAB was invited to comment on our plans for the revalidation of doctors who do not have a connection to a designated body or suitable person. RIAB noted the need to develop robust arrangements for this group of doctors, particularly as they may not be working within governed systems, and the work in progress to develop an appropriate method of assessment.

Evaluating revalidation

8 In September 2014 RIAB received an update on the longitudinal evaluation of revalidation. RIAB expressed its support for this as a UK-wide project and enthusiasm for taking part.
In December 2014, Dr Julian Archer led an evaluation workshop with RIAB members. This followed his appointment to lead the project on behalf of the Collaboration for the Advancement of Medical Education Research and Assessment (CAMERA) and formed part of the early stages of the evaluation. Dr Archer gave RIAB an overview of the purpose, structure and schedule for the project and asked members to put forward their suggestions about how best to engage patients and the public, doctors, others in the healthcare team, employers and other stakeholders about the evaluation.

**Future meetings**

At its meeting on 17 December 2014, RIAB was asked to consider whether it felt there would be merit in extending its expected lifespan as an Advisory Board. Members agreed that RIAB should continue to meet on a quarterly basis in 2015.

The next meeting will take place on 4 March 2015, at which time RIAB will consider whether any changes to its name and duties might be appropriate, perhaps moving away from implementation as its sole focus given that revalidation has now been established for two years. Any changes to RIAB’s Statement of Purpose would be considered by the Strategy and Policy Board, and any related changes to the Governance Handbook would require Council approval.
Supporting information

How this issue relates to the corporate strategy and business plan

The work of the Revalidation Implementation Advisory Board supports Strategic aim 2 ‘Help raise standards in medical education and practice’, and strategic aim 5 ‘Work better together to improve our overall effectiveness, our responsiveness and the delivery of our regulatory functions’.

If you have any questions about this paper please contact: Una Lane, Director of Registration and Revalidation, ulane@gmc-uk.org, 020 7189 5164.
Minutes of the Meeting on 30 September 2014*

Members present

Sir Keith Pearson, Chair

Nick Clarke  Kate Rogers
Frances Dow  Ian Starke
Mark Hope  Sally Taber
Malcolm Lewis  Julia Whiteman
Sol Mead  Paddy Woods

Others present

Clare Barton, Assistant Director - Revalidation and Specialist Applications
Niall Dickson, Chief Executive
Catherine Evans, Board Secretary
Una Lane, Director, Registration and Revalidation

Juliet Oliver, Assistant Director - Policy and Regulatory Development
Rhian Rajaratnam, Revalidation Evaluation Project Manager
Simon Wood, Suitable person

*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.
Revalidation evaluation workshop

1 Due to unforeseen circumstances the revalidation evaluation workshop was postponed to a future meeting. Instead, Rhian Rajaratnam presented an overview of progress on the evaluation project and next steps. The Board noted that:

a Following a tender process in 2013, the GMC had appointed the Collaboration for the Advancement of Medical Education Research and Assessment (CAMERA), led by Dr Julian Archer, to develop an evaluation framework. This work was completed in October 2013.

b In 2014, the GMC ran a tender process to appoint a supplier to carry out the evaluation of revalidation, based on the framework. Dr Julian Archer was successful, with initial work on the substantive evaluation now beginning.

2 An evaluation team from across the UK had been established, bringing together a wealth of experience in appraisal and revalidation.

The Board welcomed the confirmation that this would be a UK-wide project and was pleased with the scope of the research. The Board also noted the need to work collaboratively with other programmes of research on revalidation, such as that being carried out by the Department of Health.

Chair’s business

3 Apologies were noted from Julian Archer, Mike Bewick, Ian Finlay, Judith Hulf, Chris Jones, Andy Lewis, Mark Porter, Wendy Reid, Jenny Simpson.

4 The Chair outlined the visits he was hoping to make to a variety of organisations across the UK in the coming months. He would report back at the next meeting.

Minutes of meeting on 18 June 2014

5 The Board approved the minutes as an accurate record.

6 At the meeting on 18 June 2014, the Board had suggested it would be useful to understand why the deferral rate among trainees in black, minority and ethnic groups is double that of white trainees. Following on from this, Julia Whiteman advised that there appeared to be inconsistencies in the approaches taken and percentages being reported by different Local Education and Training Boards (LETBs). The issue did not relate to the quality of trainees, but was likely to be linked to the administrative process. Health Education England was planning to begin reporting on LETB performance, including identifying issues that might need to be addressed.
Suitable persons

7 Clare Barton presented an overview of the suitable person (SP) role from the GMC perspective. The Board noted that the GMC would be developing an annual review of suitable persons over the coming months.

8 Dr Simon Wood, a suitable person for doctors who contract with the Care Quality Commission as Second Opinion Appointed Doctors (SOADs), presented an insight into his experience of the role to date, including the application and approval process, setting up the appropriate governance and systems, challenges and positive experiences.

9 The Board noted that:

a There must be a firmly established link between the SP and the doctor, but unlike Responsible officers (ROs), SPs are not obliged to take on all doctors who request a connection to them. Dr Woods will only take on doctors if he is satisfied that the majority of their work is as a SOAD.

b While there are not the same governance structures around SPs as ROs, there are similar structures and strong networks for SPs to draw on. SPs have access to governance systems of the organisations they are working with, which run in parallel to designated bodies. In this case, Dr Woods had strong links to the Care Quality Commission, for whom all his doctors work, even though the doctors are not directly employed by this organisation.

c The GMC had mechanisms in place to check for any conflicts of interest when doctors apply to be a SP.

GMC progress report

10 The Board considered a report giving an update on the GMC’s progress with implementing revalidation and publishing data. This included the latest information on SPs, revalidation for doctors who do not have a connection, GMC guidance on managing and responding to information about revalidation and a variety of revalidation data.

11 The Board noted that:

a The GMC had dealt with 287 annual returns from doctors with no connection between April and July 2014. Many indicated that they had not had appraisals that met GMC criteria and most doctors in this group were based overseas. With this in mind, the GMC would be revisiting its messaging about licence relinquishment.

b The GMC would be publishing its guidance on managing and responding to information about revalidation shortly.
There was a combination of factors likely to be contributing to the higher number of deferral recommendations coming from locum agencies. The high number of deferrals could also be looked upon positively, in that positive recommendations weren't being made by default.

The Board advised that:

a. It would be interesting to understand the reasons doctors choose to relinquish their licence, particularly how often revalidation or retirement are given as the primary reason.

b. Communications should be included as an item for discussion at the next meeting.

c. The GMC, Department of Health and NHS England should look at how the quality assurance mechanisms in the locum framework agreement are enforced.

Intelligence and advice from members

The Chair asked members to provide updates via email, including any comments on two points outlined in the minutes of the previous meeting:

a. Advice on specific cohorts of doctors who do not have a connection to a designated body and help in identifying potential Suitable persons

b. Examples of positive stories of doctors changing their practice as a result of patient feedback (or other elements of revalidation).

Any other business

There was no other business.

Confirmed:

Sir Keith Pearson, Chair 17 December 2014
Minutes of the Meeting on 17 December 2014*

Members present

Sir Keith Pearson, Chair

Mike Bewick  Sol Mead
Nick Clarke  Mark Porter
Frances Dow  Ian Starke
Chris Jones  Sally Taber
Malcolm Lewis  J an Warner
Yvonne Livesey  Julia Whiteman

Others present

Julian Archer, CAMERA  Sara Kovach Clark, Head of Policy and Regulatory Development
Clare Barton, Assistant Director  Colin Pollock, Employer Liaison Adviser
Mark Cohen, NHS England  Ben Whur, Assistant Director
Catherine Evans, Board secretary  Lindsey Westwood, Head of Revalidation
Susan Goldsmith, Chief Operating Officer  Sara Kovach Clark, Head of Policy and Regulatory Development

* As reviewed by the Chair. The Board will be asked to approve the minutes when it meets on 4 March 2015.
Revalidation evaluation workshop

1 Julian Archer, from the Collaboration for the Advancement of Medical Education Research and Assessment (CAMERA), introduced the workshop, setting out the main objectives for the session and then providing an overview of the seven work packages that form the evaluation. Members of the Revalidation Implementation Advisory Board (RIAB) considered a number of questions and put forward their suggestions about how best to engage patients and the public, doctors, others in the healthcare team, employers and other stakeholders about the revalidation.

Chair's business

2 Apologies were noted from Niall Dickson, Judith Hulf, Jenny Simpson, Paddy Woods and Michael Wright.

3 The Chair reflected on his recent visits to England and Wales, commenting particularly on the need for local transparency on deferral and appraisal rates. He recommended that trainees deferred because of changes to their Certificate of Completion of Training date should be separated from other deferrals and perhaps described in a way that makes clear the reason for their deferral. The Chair felt that this would bring the deferrals of other doctors into sharper focus, enabling greater transparency and scrutiny.

4 The Chair noted some concern that doctors were not viewing appraisal and revalidation as an ongoing process in which they need to continually be engaged and commented that he didn’t think revalidation had been successfully placed in the patient/public domain, with patient groups and institutions still needing to establish their role in revalidation. Support would be needed in this area and this should be part of the Board’s role in shaping the ambitions of revalidation going forward.

5 The Chair had been impressed with the systems underpinning revalidation in Scotland and Wales and also the knowledge of individuals within organisations across the UK about revalidation. Some of the above topics would be included in agendas for future RIAB meetings.

Minutes of meeting on 30 September 2014

6 The Board approved the minutes as an accurate record.

GMC progress report

7 The Board considered a report on the progress made with implementing revalidation, including the latest revalidation data. With revalidation having been implemented for two full years, the data emerging could now be more reliably used to analyse revalidation trends.
During the discussion, the Board noted:

a Designated bodies with no responsible officer (RO) are a concern and there are challenges around this given that, unless an organisation refuses to appoint a RO (in which case the Secretary of State has the power to appoint), there is no clear provision for who enforces or supports the requirement. Often the organisations with no RO are small and might be struggling to find someone to take on the role, or some have lost their previous RO and not been able to re-appoint.

b The GMC will not administratively remove doctors’ licences in situations where their designated body temporarily has no RO.

c Deferral rates remain fairly consistent. The GMC would look to work with NHS England to gain a better understanding of deferral rates in London, which seemed to distort the picture slightly. There is also work to do to understand the level of deferral amongst the group of doctors with a primary medical qualification from outside the UK.

The Board advised:

a Sharing ROs may be an option. In Scotland designated bodies below a certain size have been issued with a letter stating the requirement for them to enter into an agreement with a larger body for support with appraisal and the provision of a RO.

b At the next meeting there should be a more detailed look at appraisal and deferral rates, quality assurance and audit.

**Employer Liaison Service perspective on revalidation**

Colin Pollock, GMC Employer Liaison Adviser for Yorkshire and Humber, presented a view of revalidation based on the Employer Liaison Service’s (ELS) work with ROs. The ELS sits alongside the Regional Liaison Service and GMC devolved offices. It works across the four different health systems within the UK and therefore has to adapt the approach taken within each country.

In the discussion, the Board noted:

a Policies and processes around appraisal appear to be tighter and more consistent in NHS organisations than non-NHS organisations.

b ROs report that revalidation has had a positive impact on clinical governance systems.

c Area team ROs in England report that improvements are being made in the primary care system, but this is not as good as secondary care in terms of revalidation and appraisal systems.
There is a long way to go to develop a proportionate and appropriate system to allow effective information transfer between ROs when doctors move jobs and work across multiple portfolios.

12 The Board advised:

a At a future meeting the Board should consider any advice it could give about the level of turnover among ROs. It should also consider discussing and gaining further input from those involved in local systems.

Revalidation arrangements for doctors without a connection

13 The Board considered a paper outlining the arrangements being made by the GMC to allow doctors with no connection to revalidate.

14 In the discussion, the Board noted:

a Examples of doctors in this group include doctors based wholly outside the UK, doctors with no direct patient contact, crematorium referees, doctors doing medico-legal work, doctors performing procedures such as dental sedation.

b Although revalidation is a generic requirement that doctors show they are fit to practise, the use of a specialty-specific assessment for some doctors in this group would be appropriate to reflect the nature of their practice. It is important that the arrangements put in place by the GMC are robust and also that they encourage only those doctors who need a licence to maintain their licence to practise.

c The cost of any revalidation assessments will be borne by the individual doctor.

Any other business

15 Noting that the Board had agreed in December 2013 to review whether it should continue to meet in December 2014, members confirmed they saw merit in doing so. The lifespan of the Board would be reviewed again in 12 months’ time.