Health Select Committee Inquiry: Revalidation of Doctors  
Evidence from NHS Employers, November 2010

Deadline: Noon 9 November 2010

1. NHS Employers represents employing organisations in the NHS in England on workforce issues and helps employers to ensure the NHS is a place where people want to work. NHS Employers is part of the NHS Confederation.

2. Our role is to help employers understand and contribute to changes in the recruitment, training and career structure of the medical workforce in order to improve the quality of patient healthcare. This includes providing general advice and guidance on good practice, as well as representing NHS organisations to policy makers. Further information on our role is provided in the appendix.

3. We are fully behind the drive for successful implementation of revalidation for doctors and we welcome the Health Select Committee’s involvement at this critical stage. We are pleased to have the opportunity to submit evidence to this inquiry.

Executive Summary

- NHS Employers is at the heart of the discussions on medical revalidation in England because employers are central to the design, preparation and delivery of medical revalidation.
- We support the GMC’s current plans for taking revalidation forward as summarised in the GMC and the UK health departments’ statement of intent.
- We support the establishing of the Responsible Officer (RO) role from 1 January 2011 through the measures set out in The Medical Profession (Responsible Officers) Regulations 2010.
- The appointment of ROs is an essential step in testing and preparing for revalidation. It should not be delayed until the whole system is ready. It is over three and a half years since the concept and underlying principles of revalidation were set out in the UK Government’s White Paper on professional regulations, Trust Assurance and Safety – The Regulation of Health Professionals in the 21st Century. There has been enough delay.
- We are conscious that the public expects employers to assure themselves that their doctors are competent.
- Strengthened medical appraisal and robust clinical governance systems must be achieved in any event.
- Barriers to successful strengthened medical appraisal must be identified and addressed.
Our interest in the revalidation of doctors

4. Medical revalidation is about reassuring government and the public that doctors are competent to do what they are employed or commissioned to do. Employers carry the vicarious liability for the competence of their staff, including doctors, and so are central to the design, preparation and delivery of medical revalidation. We represent those employers in relation to medical revalidation.

5. We have summarised our interest and activities in relation to medical revalidation in an appendix to this evidence.

The way in which the GMC proposes to establish revalidation

6. We agree fully with the General Medical Council (GMC) statement that the purpose of revalidation is to assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and fit to practise.

7. We believe that revalidation should be designed to build on existing arrangements in an effective, proportionate and affordable manner.

8. Employers already accept that they have a responsibility to assure themselves that their doctors are competent. They believe that strengthened annual appraisal, continued professional development and robust clinical governance are necessary to ensure that assurance can be given to patients and the public at large. We think the public expect that assurance and indeed may be surprised that such a process does not already exist. These processes build on existing good practices in preparation for revalidation.

9. The GMC’s response of 18 October to their major revalidation consultation takes on board our key concerns about keeping the system streamlined and straightforward, and building on existing systems and clinical evidence rather than inventing wholly new assessment methodologies. We do not want to overburden employers or the doctors themselves. We believe that effective appraisal is key to revalidation, and this should be linked to organisational and business objectives to ensure that its introduction is both affordable and cost-effective.

10. Our views on the GMC’s response to their consultation can be read in full at http://www.nhsemployers.org/PressReleases/2010/Pages/NHSEmployersRespondsToGMCConsultationRevalidation%E2%80%93TheWayAhead.aspx.

11. We welcome the commitment that the GMC has made to streamline the process of revalidation, particularly in the current climate. We want revalidation to be effective and cost effective. The promise of support from the GMC, the four health departments and other organisations to help employers to get ready is very helpful. The challenge that employers now have is to ensure their systems of medical appraisal and clinical governance are ready and robust enough to support revalidation. That will require the appointment of Responsible Officers to proceed as soon as possible. Responsible Officers will take responsibility at
Board level for implementing the requirements demanded of Trusts in supporting medical revalidation.¹

12. Revalidation should be seen by employers as contributing to and stimulating their efforts to achieve organisational excellence and high quality care, rather than as a separate priority that they need to deliver. Our earlier written submission to the GMC consultation can be read in full at


The responses to the consultation and the GMC and UK health departments’ statement of intent issued on 18 October

13. Employing organisations have told us that they want timetable and milestones published. The statement of intent does this and sets out the steps employers need to take to assess their own readiness. After many years of preparation they are keen to move from the design phase to the implementation phase. Target dates will help Responsible Officers begin the local task of ensuring a smooth pathway to revalidation. Indeed the Responsible Officer role is vital, regardless of the legislative requirements of revalidation, to make sure that organisations adhere to strong clinical governance and strengthened medical appraisal.

14. We intend to test the statement of intent with employers at our forthcoming NHS Employers’ conference (16-18 November 2010) and at the Medical Directors’ conference (25 November) to identify any barriers to successful implementation and what further support can be provided by the key partners.

¹ RESPONSIBLE OFFICER (England)
Subject to parliamentary approval of The Medical Profession (Responsible Officers) Regulations 2010, on 1 January 2011 it is intended that all designated healthcare organisations (Trusts) will have appointed a Responsible Officer (RO) who will often, though not necessarily, be the medical director. All doctors working for the Trust (secondary care) or who are included on its performers list (PCO’s) will come under the RO’s remit and all working doctors will be required by the GMC to relate to a specific RO. Advice on finding an RO will be available. The ultimate function of the RO will be to help doctors prepare for Revalidation and make a recommendation to the GMC once every 5 years, through a recommendation to the Trust Board, about an individual doctor’s readiness for Revalidation. In order to be able to make and justify a recommendation, the RO will need to have robust systems in place within their Trust. The RO will take responsibility at Board level for implementing the requirements demanded of Trusts in supporting medical Revalidation. They will be responsible for the systems needed to support it and will be accountable for the recommendations that are ultimately made to the GMC, about an individual doctor’s readiness for Revalidation. They will need to ensure that, over the 5 year Revalidation cycle, that an annual appraisal is carried out to a sufficiently high standard and that the appraisal system links adequately with other Trust systems, ensuring clinical governance data is available to support a review of a practitioners work and inform service development. They will work with doctors in addressing any shortfalls identified – including offering support in addressing the underlying causes whether educational, performance or health related, ensure any concerns or complaints have been addressed, and collate this information to support a recommendation on revalidation of individual doctors to the GMC.
The experiences of those who are involved in the pilots in London and West Yorkshire

15. The pilot exercise is far wider than the exercises in London and West Yorkshire, which were simply about the proposed role of the GMC affiliates, a role which employers have supported as a useful independent addition to the process of recommending for revalidation or otherwise. We are a key stakeholder in the Pathfinder Pilot Strategic Oversight Group (PPSSOG) tasked with evaluating the progress of the pilots and whether the processes are right, affordable and deliverable for wider revalidation. We are particularly keen to be sure that any barriers to successful strengthened medical appraisal are identified and addressed.

The Secretary of State’s decision in June to extend the piloting of revalidation by a year, meaning that it will not now be fully implemented until 2012 at the earliest

16. Fortunately many employers already have clinical governance and appraisal systems in place which provide a practical platform upon which to implement revalidation. However, the Secretary of State’s decision to extend the piloting period for a further year will provide a welcome opportunity to ensure that, when a decision is made to move to full implementation, the system will be practical and effective. We believe this is critical to ensure that the revalidation process is effective, proportionate, affordable and good value.

17. We believe it is also necessary during this extension period to look in further detail at non-NHS clinical responsibilities such as duties performed in the independent sector and the quality assurance of agency medical locums. In both these areas the sharing of evidence across career pathways and the early identification of shortcomings and proposed remedial action will be vital to the overall success of the scheme.

Affordability

18. We will play our part as partners in revalidation to provide sufficient evidence to government for them to make their decision in late 2012 on whether revalidation is effective and cost effective.

19. However, employers in both the NHS and the independent sector would welcome, sooner rather than later, a realistic estimate of the anticipated costs of revalidation based on the simplified approach which is now preferred, and taking into account the new organisational structures and lines of accountability proposed for the NHS, particularly within primary care.

20. While we support a proportionate approach to revalidation based on existing processes, there will nevertheless be both immediate and ongoing costs to be met, including the training and re-training of appraisers, identified remediation
costs where doctors in difficulty are identified across the five year cycle, and supporting quality multi-source feedback. Employers need to be able to plan for those costs now in order to meet the significant challenges they face over the coming years to deploy available resources to meet increasing demand. The current revalidation model assumes an employer-led, management-based process when the future may be less structured.

21. It will be challenging to identify ‘cost-effectiveness’ arising from revalidation in isolation from other measures designed to improve quality patient care and productivity through the current QIPP arrangements. This will also have to be set alongside the less-quantifiable gains in public protection and confidence in the profession though a robust revalidation process.

**Timing of the Responsible Officer (RO) Regulations**

22. We have noted that the British Medical Association, the trade union representing the majority of UK doctors, have lobbied the House of Lords Scrutiny Committee about The Medical Profession (Responsible Officers) Regulations 2010. Their submission was a repeat of their submission to the GMC’s consultation *The Way Forward*. This consultation was responded to by the GMC on 18 October 2010 and we were pleased to see the GMC accept most of the points made by ourselves and by the BMA, for example about the need to make the processes more straightforward and proportionate and to reduce the burden on employers and on doctors.

23. We differ from those in the medical profession who support revalidation in principle but would have us delay implementation of the RO regulations until we have a “perfect” system. It is an iterative process; we have to start somewhere in beginning the revalidation cycle to learn by sharing good practice and supporting ROs in their local work. We welcome the GMC’s announcement of the formation of a regionalised network of support for ROs in their work.

24. Some may argue that an RO recommendation not to revalidate is in some ways career limiting. We believe this can be mitigated by having an open, fair, collaborative process based on mutual trust where it is in the interest of both the employer or commissioning body and the doctor to satisfy themselves that they can both provide the best possible care to patients. If there is a dispute then there should be the means to resolve this through the constituent parts of the process (e.g. dispute resolution in appraisal) before the RO makes a recommendation.

**Gill Bellord**  
**Director for Core Services - NHS Employers**  
**8 November 2010**
Appendix

**NHS Employers’ interest and involvement in the revalidation of doctors**

a) Employers recruit, deploy, train, motivate and reward doctors in the NHS. They provide opportunities for training to the doctors of the future, from medical student placements through postgraduate training to the employment of specialty practitioners in the hospital sector, and the contracting of General Practitioners in primary care.

b) They aim to do this in a supportive learning environment which provides quality assurance to patients through robust clinical governance systems, backed by regular appraisal and continued professional development of the doctors themselves.

c) From the outset of the policy decision to introduce a licence to practise in the UK supported by a system of regular revalidation, employers have sought and delivered engagement in the design of the system and helping employers to prepare for implementation.

d) We have provided evidence to the GMC’s consultation exercise and were very pleased to see that their 18 October response broadly agrees with that evidence on the question of streamlining and proportionality, and the centrality of the employers in making the process work effectively.

e) We believe it is now time to move from “design” to “doing” and we have therefore communicated with employing organisations in the NHS by:

- Producing a briefing paper (June 2009) for employers on what revalidation means
- Having regular input into the GMC’s revalidation communications strategy by making sure that messages are targeted toward employers and clearly understood by them
- Maintaining up-to-date web-based information for employers on revalidation: see [http://www.nhsemployers.org/PlanningYourWorkforce/MedicalWorkforce/Medical-regulation/MedicalRevalidation/Pages/Medical-revalidation.aspx](http://www.nhsemployers.org/PlanningYourWorkforce/MedicalWorkforce/Medical-regulation/MedicalRevalidation/Pages/Medical-revalidation.aspx)
- Supporting regional workshops on revalidation, notably in London, Yorkshire and the Humber, and in the North East
- Worked hand in hand with the NHS Revalidation Support Team (established by the Department of Health) to provide ongoing evaluation of the pathfinder pilot projects
- Holding well-attended sessions on revalidation at the NHS Employers’ annual conference in 2008 and 2009. Another such session is scheduled for 17 November 2010.

f) We have represented the voice of employers through the various workstrands established to support revalidation, including the UK Revalidation Programme Board, its Executive Board, its workstream on remediation, through to the Department of Health Professional Standards Board, the England Delivery Board and the Pathfinder Pilot Oversight Group (PPSSOG).