1 June 2010

NHS Employers response to GMC consultation: Revalidation – The Way Ahead

I have pleasure in attaching NHS Employers’ response to the GMC’s consultation on medical revalidation. It is based upon a wide range of NHS service views, expressed through our Policy Board, the Medical Workforce Forum, various networking groups, and supported by an on-line survey based upon the GMC’s twenty questions.

It follows GMC presentations made to our Policy Board and Forum in recent weeks which highlighted the identified key issues for employers.

NHS organisations are keen to support revalidation. They recognise that the approach must be sufficiently rigorous to contribute to the future safety of patients and the quality of doctors.

However it is clearly essential that the approach does not over-burden employers financially or administratively. Current financial constraints in the NHS suggest that the time is right to review the ‘depth’ of data and process required for revalidation. That is why – as we emphasise at Question 1 - building revalidation upon existing systems is practical for employers and will contribute to avoiding excessive or unnecessary bureaucracy.

NHS Employers will continue to work with key partners on the implementation and benefits of revalidation through the pilot phase and beyond.

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NHS Employers
Section 1 – How revalidation will work

Q1. Do you agree that revalidation should be based on a single set of processes for evaluating doctors’ performance in practice, rather than split into the separate elements of re-licensing and recertification?

A1. Yes, the evidence on doctors’ performance and competences can support both re-licensing (meeting the minimum standard for fitness to practise) and recertification (meeting the specialist register standard).

The Policy Board of NHS Employers, representing employers in the NHS in England was strongly of the view that there should be a single set of processes for revalidation which are proportionate, affordable and cost-effective. These criteria will be best met if the processes are

• Simple
• Transparent
• Flexible
• Accessible
• Linked to existing clinical governance arrangements
• Linked to the employers’ organisational objectives.

The aim should be to have a straightforward, low-resource process that ensures that doctors are fit to carry out the roles required of them. The clear majority of respondents in our survey agreed with our Policy Board that it was essential to keep processes simple and remove any duplication of work; sample comment “why complicate the issue to gain a result of no significance?” One Chief Executive gave the example of multi-source feedback for consultants in his large trust which would be costly (for the consultants) and time consuming. He was concerned that an “industry” could be created around this which would put pressure on services and on medical staff themselves.

In general NHS organisations are keen to support revalidation as a single process and recognise that a sufficiently rigorous approach is needed for it to contribute to the future safety of patients and the quality of doctors.

Q2. Do you agree that revalidation should be based on a continuing evaluation of doctors’ performance in the workplace?

A2. NHS Employers Policy Board endorsed this position, and many individual doctors who responded to us were keen to make sure the system was unbiased, transparent and as fair as possible, particularly towards BME doctors. A properly “rounded” view was favoured, concentrating on overall performance and not resting solely on single incidents. Evaluation should concentrate on the improvement of knowledge over an assessment period.

The NHS Employers policy board and medical workforce forum have also said that they wanted a simple, fair and transparent system, which builds on existing systems, is
practical for employers, and avoids excessive or unnecessary bureaucracy and costs. This should be tied to the organisation’s own quality and safety monitoring systems and data. The fact that data will be used for both purposes will encourage clinicians to contribute data and record their clinical practice and outcomes accurately. The chief goal is that a more knowledgeable and safer doctor equals better patient outcomes.

There needs to be a clear distinction between medical revalidation and HR disciplinary processes, which remain a matter for the employer under employment law. While still being focused on improving performance, disciplinary processes are invoked for many reasons, including work performance, attitudinal and behavioural issues, and this will continue for some medical staff regardless of revalidation arrangements.

Q3. Do you agree with the proposals for dealing with the most common situations where a Responsible Officer may not be in a position to make a positive recommendation?

A3. NHS Employers believes that, whilst some individual doctors are uncertain about the level of independence that the trust medical director might bring to the process, the majority will recognise that the link between revalidation and local clinical governance is important.

The RO must remain responsible for ensuring a recommendation is reached, and is free to seek advice and assistance as required (e.g. GMC affiliates, Colleges and Faculties). However, the responsibility for any recommendation cannot be passed to someone else, other than to the GMC, where the decision to revalidate or not will be made.

Clear guidance for ROs, supported by training for the role, would help to clarify situations where a positive recommendation cannot be made. The expectation amongst employers is that situations leading to an RO not being able to affirm a recommendation should be relatively rare if the annual cycle of appraisals, supported by early remediation for doctors in difficulty, is properly followed. Quality assurance through continuing improvement remains important to employers and the doctors they employ.

Q4. Do you agree that the Colleges and Faculties should not be directly involved in the recommendations made by the Responsible Officer to the GMC?

A4. Yes. As above, NHS Employers notes that it was the strong view of most employing organisations who responded to us that the recommendation to GMC must come solely from the Responsible Officer, exercising their statutory responsibility. It would then be for GMC to investigate further with the relevant parties where a recommendation could not be made. Colleges and Faculties should not make the decision, even in cases where they may have been involved in providing advice and support to the RO.

Q5. If so, what do you think their role should involve?

A5. The role of colleges and faculties should be in standard setting for their specialties, providing advice and support to ROs and to appraisers in the consideration of clinical skills and other competences, and in supporting remediation where required for individual cases.
One employer felt that the colleges would be insufficiently aware of local circumstances and local processes for evidence gathering during the revalidation cycle. Others argued that colleges were already too heavily involved in local discussion and revalidation needed to cover performance as a trust employee as well as clinical knowledge. Employers were concerned that local resources would be stretched unduly if consultants had to be released for College involvement which went beyond what they felt was reasonable and practicable for revalidation purposes.

They also felt it important that recommendations on revalidation should come solely through the RO for the employing organisation and responsible for the evidence supporting that recommendation, and that it would then be for GMC (and not the Colleges) to audit the processes used and whether their standards were being properly met.

Q6. Do you agree that for trainees, successful progression through training should be the means of securing revalidation?

A6. Employers noted the intention to transfer RO powers to the respective deaneries responsible for trainees. This would be a practical step towards revalidation, as it would avoid duplication by reflecting the system already in place to track trainees’ progress and competence. The evidence gathering process would be made much easier and less bureaucratic if it were linked to existing ARCP assessments rather than operating across a range of organisations each with their own RO. Progression through training by acquiring additional competencies, and supported by exam success, should provide the necessary quality improvement and assurance which revalidation is designed to address, up to the point of CCT and prior to recertification as a specialist.

Q7. Do you agree with our proposals for the revalidation of doctors with no medical practice of any kind?

A7. Doctors with no medical practice of any kind at the time of revalidation should be encouraged to rescind their licence to practise, although they might wish to continue to hold GMC registration. If they are not performing activity that can be readily assessed through the evidence-gathering related to clinical competences, they cannot satisfy the standards for having a Licence, so why give them one? It seems to be a waste of time and money. Should their personal situation change, then GMC processes should allow for re-application and assessment for a Licence to Practise.

Other doctors should be revalidated on basic knowledge and on the field in which they are working rather than with medical practice in a specialty in which they may no longer be in touch. The assessment should be quality assured. We understand that discussions with medical managers are continuing so that the assessment properly reflects their range of skills and competences.

Q8. Do you agree that the list of registered and licensed medical practitioners should indicate the field of practice on the basis of which a doctor has secured revalidation?

A8. Yes. A clear majority of respondents to NHS Employers agreed with this. The list should also include the date of that revalidation.
Section 2: What doctors, employers and contractors of doctors’ services will need to do.

Q.9 Do you agree that, for the purposes of revalidation, the Good Medical Practice Framework is an appropriate basis for appraisal and assessment?

A9. Yes. Most of our respondents agreed that the Framework was comprehensive and the Core Domains and 12 attributes could be readily understood.

Q.10 Do you have any further comments on the proposed use of the Good Medical Practice Framework?

A10. Employers are awaiting the evidence from the pathfinder pilot centres on how workable the Framework will be in practice. There are some concerns about the evidence gathering process, including the sharing of information across organisations as doctors moved around the system, especially at junior level.

It is possible that the first revalidation exercise could expose trainees or others that are weak. There needs to be some clarity on how to deal with these struggling doctors. We have noted that doctors could be failing in a traditional educational sense, in relation to their skills and knowledge and the application of those, or failing to be revalidated simply because they cannot produce the correct documentation. There should be clear guidance on how these situations are dealt with.

NHS Employers has noted that the new Duty of Cooperation Regulations might provide a useful lever for improving the sharing of information, and areas of concern or apparent weakness, especially in gathering evidence across private practice and other non NHS settings. We have heard some anxieties expressed about doctors not consenting to the disclosure of information that could be important in the revalidation process. What should happen in such a situation should be clear.

Employers are concerned that a lengthy list of attributes and examples of evidence could lead to a simplistic “tick box” approach, and care would need to be taken to avoid a meaningless exercise. More should be done to identify core information requirements. Employers have experience of the danger of competence frameworks becoming over engineered and too prescriptive when a simpler more permissive approach could be more effective at identifying good practice and detecting poor performance and improving that in the future. There is a fear that, however good a process of this sort is, if it is over-complicated it will not be done, but simply be seen to be done.

NHS appraisers need to be trained or refresher-trained, to make sure that they can use the workforce tools effectively and in a fair and transparent way for all doctors. This has significant resource implications.
Q11. Is the overall approach to the development of standards and supporting information for revalidation reasonable? If not, what else is necessary?

Q12. Is the supporting information proposed by the Colleges and Faculties meaningful, practicable and proportionate for the majority of doctors in clinical practice?

A11/12. The common view is that high-level standards are helpful and necessary for quality assurance and a fair system, and employers’ representatives would wish to remain closely involved in the development and upholding of these standards.

Senior board members have expressed concern that College requirements, whilst understandable in the early developmental stages of revalidation, are disproportionate, potentially inconsistent across specialties, and could be too onerous and “Gold-plated”. Revalidation is not a re-assessment of CCT competences.

Employers felt that a core set of common standards across all the specialties would be helpful in reducing the burden on all parties. The “cottage industry” approach to revalidation was unwelcome, especially at a time of tightening financial arrangements within the NHS, so we would welcome a more streamlined and proportionate approach from the Colleges. There is a danger that an over-specific approach becomes too much of a box-ticking activity in too many areas; instead it should be focused more broadly on the doctor’s patient outcomes and a holistic approach to their medical practice. Multi-source feedback and audit activity is achievable and measurable but needs to be balanced carefully by the quality of the work as well as the totality of activity. This is a skill that appraisers and ROs are going to need to develop.

Q13. Do you agree that these (listed) are the appropriate principles to guide doctors’ Continuing Professional Development (CPD) activity in relation to revalidation? If not, what alternative approach is required?

A14. Yes. We agree that it is important that doctors take part in educational activities that maintain and further develop their competence and performance as outlined in the consultation paper. CPD is good for the doctor and for safe patient care, and it is important that this features strongly in revalidation as a tool for quality improvement. Some doctors have argued that the onus should not rest solely with the doctor, but more help will be required from the employer to support properly-directed CPD. Employers accept that such responsibility lies with them as part of the revalidation process.

Section 3: Patient and public involvement in revalidation

Q14. Do you agree with our approach to patient and public involvement in revalidation? If not, what other arrangements would you suggest?

A14. This area has not been fully tested amongst employers, and we accept it is hard to secure meaningful patient and public involvement, but the GMC’s efforts seem reasonable. The view of employers will be influenced by what emerges from the
pathfinder pilots, but we believe the onus should be on the doctor to show how they interact with patients and maintain a patient focus across their activities.

Employers accept that it is important that the public and patients feel a service is of high quality and safety-assured. Many trusts already use standard patient satisfaction questionnaires. The development of further guidance in this area, supported by common standards should be informed by current practice. One respondent suggested that the input should be at a high strategic level and for the chief input to be from patient feedback questionnaires.

Q15. Do you agree that GMC Principles, Criteria and Key Indicators for Colleague and Patient Questionnaires in Revalidation are appropriate for evaluating these types of questionnaires for revalidation?

A15. Again, these have not been fully tested with employers who will want to capture learning from the pilots. NHS Employers agrees in principle that questionnaires should be consistent and objective, and seek to encourage a clear role for patients and colleagues in determining how well the medical profession and its individual doctors are performing. Employers are worried about the costs and administrative burden of these processes. For example, one said, “I think the GMC's questionnaires should be made available free of charge, and trusts provided with guidance on how to undertake analysis themselves without a requirement to pay intermediaries (this is already a commercial bandwagon that feels out of control)”. Another raised the importance of training for staff in how to analyse responses form external feedback and internal peer group comment. Again employers would say, keep it simple, build on existing processes, and try to have a permissive rather than overly prescriptive approach.

Q16. Do you agree that doctors should be required to participate in colleague and patient (where applicable) feedback at least once in each five-year cycle?

A16. Yes. However there is much cynicism being expressed about how honest and unbiased the feedback might be, and a need to guard against the “vexatious” through good guidance and training in analysis. The “five year cycle” appears to be appropriate for such feedback.

Q17. Do you think that there should be a mechanism for making sure that colleague and patient questionnaires comply with our criteria for revalidation?

A17. Employers appear to want to await learning from the pilot studies before expressing strong views on this. Employers tend to incline to consistency through standard setting, but allowing for local flexibility in how evidence is acquired and evaluated prior to recommendations for revalidation.

Section 4: How and when revalidation will be introduced

Q.18 Do you agree that revalidation should be introduced initially in areas and organisations where local systems are developed and sufficiently robust to support the revalidation of their doctors?
A18. Yes, this is broadly supported by employers. We believe that utilising local systems is better than awaiting a system dependent on national IT systems, which may or may not be supported financially, nor prove “fit for local purpose”. Further work is needed however to help define what “being ready” looks like.

NHS Employers also advocates a rapid roll-out beyond the early adopters, otherwise pockets of weaker performance or poorer control over regulatory requirements may begin to “attract” the wrong sort of doctor.

It is important to employers that the momentum of revalidation is sustained, and this will need an ongoing strong and targeted communications strategy.

**Q19 Do you agree with our proposed approach for the initial roll-out of revalidation? If not, what alternatives do you suggest?**

A19. The evaluation of the learning from pathfinder pilots should inform this process. What is clear is that trusts are anxious to have a published high-level timetable which sets out key milestones so that they can measure their “state of readiness” more closely than hitherto, and not end up rushing at the last minute to meet target dates. There is a danger that the gradualist roll-out concentrates on those staff grades who are already highly supervised and where evidence of performance is already measured, i.e. trainees, rather than the more difficult areas, e.g. sole GP practices. Employers would want to see progress being sustained in all work areas.

**Q.20 Do you agree that a deadline should be set for organisational readiness for revalidation?**

A20. See Question 19 above. It is important that a clear definition of what it is that makes an organisation ready. Advice will be needed for employers to prepare and check their readiness for revalidation.

ENDS