

ACADEMY OF MEDICAL ROYAL COLLEGES

Academy of Medical Royal Colleges response to the GMC Consultation: Revalidation: the way ahead

The Academy of Medical Royal Colleges (the Academy) welcomes the opportunity to respond to this consultation. It has provided a valuable opportunity to gather and put forward the current views of the medical Royal Colleges and Faculties, identifying those areas where agreement and clarity has been achieved, and those areas where further development is needed. The Academy looks forward to working with the GMC further on the issues of revalidation.

The Academy response is formed by the opinions of 11 of its members and the Academy Trainee Doctors' group (co-opted member). In general members were welcoming of the consultation and of the opportunity to give further views. While most tended to answer positively to the questions, it is important to acknowledge that caveats and concerns were also raised, even when agreeing (or disagreeing) overall with a question. These opinions are collated and summarised in what follows, question by question.

Question 1: 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 relicensing and recertification?

The Academy welcomes the simplification of the revalidation process and considers that it will bring greater clarity overall. Generally speaking, the Academy believes that revalidation should start as simply as possible and build incrementally, and that a single set of processes will help towards this goal.

However, there were a few caveats mainly regarding concerns over specialty related issues, for example:

'the current competencies of a doctor need to be fully reflected by a "descriptive licence"– so that it is clear that doctors who may no longer have continuing competence in a specialty do not need to demonstrate competency in areas which are no longer part of their practice. Employers and the public will have to be helped to recognise the centrality of the licence in understanding the competencies of a doctor.'

Question 2: Do you agree that revalidation should be based on a continuing evaluation of doctors' performance in the workplace?

All members of the Academy agreed with this point. Nevertheless, a number of concerns were raised. For example:

- The need for as simple a system as possible, avoiding excessive bureaucracy
- The need for sufficient resources and planning to support evaluation
- The need for whole practice appraisal for doctors with complex work patterns. There is uncertainty as to how this will be achieved
- The main thrust of the appraisal process should remain supportive, formative and developmental
- Paragraph 58 on page 14 [of the consultation document] states that annual appraisals will take place in the sector within which the doctor does most of his or her work. The proposal seems potentially in conflict with the Responsible Officer (RO) guidance, which states that if you are an NHS employee, your RO will be provided by your NHS employer. A doctor working more than half-time in independent practice would therefore have an RO from the NHS, even though NHS work is a minor component of practice.

Question 3: 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?

The vast majority of members agreed with these proposals. One College was unsure about Scenario A and one disagreed with both B and C. The concerns identified included:

- Deferrals for negative reasons – and how to manage this fairly and proportionately
- More than one request was made for clarity over the status of the doctor if revalidation is deferred – are they still able to practise?
- Deferrals due to return to practice after a period of absence – and how this would be managed. It must be done fairly and so as not to discriminate indirectly
- More clarity is sought over the Appeals process
- Possible conflicts of interest in the RO role, where other roles are held e.g. Medical Director
- The need for ROs to access specialty guidance/advice, especially if they are from a different specialty
- Concerns regarding commercial organisations or the Royal Society of Medicine taking on the RO role. For example, a College recommended that the regulations restrict which organisations can be designated for revalidation purposes to those with a clear focus on standards and quality
- From a Faculty whose members operate largely outside the NHS: *'We would not have access to NCAS so would refer to the GMC if and when it became necessary'*

- In the event of failure to revalidate, who will assess for retraining and who will fund the period of retraining?

Question 4: Do you agree that the Colleges and Faculties should not be involved in the recommendations made by the Responsible Officer to the GMC?

The Academy considers that this question is ambiguous because the meaning of the word ‘involved’ is not clearly defined. Based on the questions’ preceding text [in the consultation document], there is broad agreement that the final responsibility for the decision should be for the Responsible Officer alone, and the Colleges and Faculties should not be involved.

However, some Colleges and Faculties consider that they should be ‘involved’ in terms of giving support and advice to the Responsible Officer, and have also stressed the importance of their role in quality assurance of the revalidation recommendations. The Academy questions if these constitute involvement?

Several Colleges specifically stated that it should be made explicit that the GMC expects Responsible Officers to seek speciality specific advice and support from Colleges and Faculties. This is particularly important where there may be concerns about a doctor’s practice as the Colleges can offer support to address and remedy problems identified early in the process.

The RCGP has specific detailed proposals on this matter, which it has put forward in its own response to this consultation.

Question 5: If so, what do you think their role should involve?

Members were in agreement that they should be involved with:

- a. Setting standards and defining specialty information
- b. Providing advice and guidance for appraisers
- c. Providing advice and guidance for Responsible Officers.

However, d. audit and quality assurance of the recommendation process, only drew support from just over half of members responding to this question. The Academy considers that this is likely to be because of uncertainty (at the time of the response) around exactly what involvement in quality assurance might entail in practice.

It is worth noting that these views were received before the Academy’s meeting with the GMC around quality assurance on 18 May 2010. The views of the Colleges and Faculties were developed further at that meeting, with all those present being of the opinion that Colleges and Faculties should be involved with quality assurance of the system at some level. The most appropriate level and methods of this involvement will need to be developed further, and it is possible that different Colleges will wish to take different approaches.

The following illustrates the difficulty Colleges found in responding to this question:

‘Any borderline appraisal that requires collaboration or interpretation of the specialist component of practice must prompt reference to college or specialty associations. By virtue of

the fact that colleges and faculties have already defined the standards, they are best placed to make judgements on deviation from the standards and to assist the Responsible Officer without compromising the ultimate authority of that individual. By the same token, audit and sampling of all three elements of the assessment (Responsible Officer, appraiser, and colleges' standards assessment) should be the construct of the QA.'

'There is concern over the lack of defined legal status regarding Quality Assurance input.'

The Academy welcomes working in partnership with the GMC in order to take the work on Quality Assurance forward.

Question 6: Do you agree that for trainees, successful progression through training should be the means of securing revalidation?

In late 2009, the Academy stated its view that UK medical trainees are probably the most highly regulated and scrutinised group of professionals in the country, and so considered that it was not necessary to demand that a doctor revalidates while in a recognised training post. However, the Academy has been told that this opinion on this is not compatible with the legislation. Therefore, the current methods of monitoring trainees should be used and not duplicated. If necessary, this information should be augmented by confirmation from employers about patient safety/service issues.

Question 7: Do you agree with our proposals for the revalidation of doctors with no medical practice of any kind?

Only a quarter of Colleges and Faculties definitely agreed with this point, with over half being unsure, and two disagreeing altogether. This divergence of opinion seems to be driven, at least in part, by uncertainty as to exactly what 'medical practice of any kind' means.

A number of members identified issues regarding 'Return to Practice' which it is hoped will be addressed through our forthcoming working group on this topic, which will also involve the GMC.

Strongly held views were expressed. Some of these are reproduced below, in part to illustrate the lack of clarity in the question:

'The circumstances under which a doctor will be completely out of medical practice temporarily will vary considerably. It will not necessarily be planned or anticipated and it may be very difficult for a doctor to study for and sit the PLAB or similar skills tests whilst away from medical practice. The need for retraining will depend on the scope of medical practice undertaken before the break and the duration of the career break. We suggest that a better approach is to allow a licence to practise to be suspended during a career break with a graded approach to the requirements for resumption of practice depending on the length of the career break.'

'Some of these doctors may be responsible for standards setting in education, service configuration, government advice – and indeed may be extremely influential in their roles. It is therefore crucial that they are not excluded from an accountability process that relates to the rest of medicine.'

Question 8: 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?

The Academy agrees with this. The only doubt is how this would work in practice. The immense diversity of medical practice will not easily lend itself to a strict classification system unless that system is so complex that it ceases to be useful.

One possible solution to this problem could be a short free-text description of practice, agreed at each annual appraisal; but while such a description may be helpful for patients and employers it would not be computer-searchable, which would reduce its value.

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

Most of the Colleges and Faculties agreed with this. However, two members disagreed and one was unsure. Some of the uncertainty seemed to stem from members accepting that it was appropriate, but believing that it could nevertheless be improved. This is explored further in the responses to Question 10.

Comments included:

‘Providing comprehensive supporting information will be a challenge initially. Different versions of the framework for management, research and other non clinical roles will develop to allow these doctors to map their own practice against GMP.’

‘Yes. The GMC proposal is for the GMP framework and specialist frameworks for revalidation to be used by doctors to reflect on their practice, identify areas for practice improvement, and demonstrate accountability against the standards set by the profession and its regulator. We are confident that if the frameworks are used in this way, annual appraisal and five-yearly assessment will lead to desired outcomes such as quality improvement, strengthened professionalism and assurance for patients and others about the doctor’s competence and performance. The extent to which these benefits materialise as intended must be the focus of quality assurance ... the standards for those working in management or research still seem insufficient. The Academy of Medical Royal Colleges has done extensive work on this issue and has published relevant guidance (referred to in paragraphs 143-144).’

‘The Good Medical Practice Framework’s four domains are less clinically sensible than the seven headings of Good Medical Practice. There is insufficient evidence for the validity or reliability of the proposed system. In order for consistency between the Good Medical Practice (GMP) and appraisal, keeping to the current seven sections of GMP makes more sense to most doctors. The GMC should scrap the rather cumbersome four domains and 12 attributes.’

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

The majority of Colleges and Faculties chose to give further comments. A representative selection of key points follows:

A need to more thoroughly embed patient safety in revalidation – one College felt that *‘the checklists as outlined by most of the colleges do not address this.’*

Welcome for the GMC's confirmation that not every generic standard can be complied with by all doctors.

'The first phase of the Merseyside Pathfinder Pilot indicated several practical problems in using the Framework to demonstrate quality of practice. Trust information systems were insufficiently geared towards providing the required information for appraisals against the standards. The use of specialty specific supporting information within appraisal needs to be carefully piloted within the framework. Specialty-specific guidance will be needed to help doctors to gather the correct quantity and quality information within their specialist field.'

A concern that 'some attributes are inherently more difficult to assess objectively than others and therefore that supporting information in doctors' revalidation portfolios will tend to be weighted towards attributes which are easy to measure objectively.'

Question 11: Is the overall approach to the development of standards and supporting information for revalidation reasonable?

The Academy agrees that the approach is reasonable. The Academy wishes to applaud the way in which the GMC has worked with it on the development of standards and supporting information.

Question 12: Is the supporting information proposed by the Colleges and Faculties meaningful, practicable, and proportionate for majority of doctors in clinical practice?

Perhaps unsurprisingly all but one of the respondents felt that the supporting information was meaningful. Similarly, most agreed the supporting information was practicable and proportionate although two were unsure. There is nevertheless concern about the time, effort and resources that the revalidation process may consume, with consequent interest in the outcome of the cost-benefit analysis that is planned by the Revalidation Support team. There is concern that the standards should not be seen as the minimum and that doctors should aspire to excellence, and also to learn from the outcomes of the pathfinder pilots.

A representative selection of comments follows:

'Appraisal systems across the UK should be designed to support doctors to ensure they gather the required information over 5 year cycle - and signal early doctors experiencing difficulty, whether due to inadequate information systems, the nature of their practice, or real difficulties ... Appraisal (as part of revalidation) should aspire to support all doctors to improve their practice continuously - revalidation must not become a proxy for minimum standards.'

'If the question was widened to include the standards for non-clinical practice then our comment would be that the supporting information required by the GMC is too detailed and extensive to be practicable and proportionate.'

'The Academy has played a valuable and important role in terms of coordinating the development proposals from the Colleges and Faculties ... There has, however, been some concern reported to us that the GP Framework and Checklist appears to be less comprehensive than that of the other professions set out in the document, thus giving the impression that less work was required from GPs to achieve Revalidation. We are keen to point out that this is not the case and we suggest that the components of the standards expected for GPs have not been

broken down to the same extent as those of other specialties. We would be happy to advise on appropriate changes to achieve a more balanced presentation.'

Question 13: Do you agree that these are the appropriate principles to guide doctors' Continuing Professional Development (CPD) activity in relation to revalidation?

The Academy's Directors of CPD group (DoCPD) responded to this point. They are also sending in their own response – what follows below is a summary. They broadly agreed that these are in line with current thinking, but with the following comments or caveats:

The principles appear to have been developed in isolation and have not been discussed with DoCPD who have been coordinating the work of the Colleges to update CPD programmes for revalidation. Specifically, there is no mention of the Core Model for CPD Scheme Headings document, which was developed by DoCPD, accepted and approved by all the Colleges and Faculties and approved by the Academy Revalidation Development Group in June 2009.

Paragraphs 148-149: The Academy considers that there is a weakness in the wording of paragraphs 148 and 149, regarding the need to participate in a CPD scheme. Specifically, if Colleges/Faculties are setting the standards of professional practice, and CPD relates to the range of professional activities, it is logical that the Colleges should be setting the requirements for *what* CPD should be done rather than just *how much*. The GMC should support the idea that doctors should meet College requirements and adhere to College guidance in relation to their range of professional practice, even if they are not members of a specific College scheme.

Paragraph 150: There is general agreement that these principles reflect good practice in CPD, with the following suggestions:

- Clarify that CPD requirements for part-time doctors are broadly the same as for full-time doctors
- More detail is required about how compliance with these principles will be collected as supporting information
- The fourth principle (outcomes) advocates measurement by outcomes rather than an input/time based approach. It is agreed that this is the ideal scenario, but a successful system based on outcomes has yet to be demonstrated. The complexity of moving from an “input-based” method of evaluation of CPD to an “output-based” based method of evaluation should not be underestimated and this should be an evolutionary process.
- The sixth principle (appraisal and clinical governance) uses phraseology that is unclear. Issues arising through clinical governance will be dealt with initially outside the appraisal process, but some learning objectives may also be identified in this way. CPD must remain focused on quality issues rather than performance targets. In this regard, it is important that CPD is adequately supporting with SPA time.

Paragraphs 151-154: Regarding employers and contractors of doctors' services – there is no mention of the difficulties doctors have in trying to obtain study leave for CPD or obtaining funding for courses. Employers have a responsibility to ensure that these barriers to obtaining CPD are removed.

Question 14: Do you agree with our approach to patient and public involvement in revalidation?

This question marks the beginning of a number of questions which relate to patient involvement. It would seem sensible at this point to reflect that overall, many of the Colleges and Faculties felt that patient involvement will be a potentially challenging area that needs significant further development as part of the revalidation process. The Academy may be able to help develop this work further. That having been said, the Academy, Colleges and Faculties broadly agree with this approach.

- Ten Colleges and Faculties (who addressed this point) agreed with the approach in so far as 'Involvement through questionnaire feedback to doctors
- Eight members who responded to this point agreed with the approach to the 'Involvement in the Responsible Officer's recommendation and quality assurance', however two did not.
- All members who responded to this point agreed with the approach to 'Involvement in the GMC decision making process where concerns are raised'.

Comments included commitments to patient involvement, suggestions regarding different methods, and concerns regarding specific patient involvement tools.

There was a general view that while their input into the process is very important, the public must not have powers to influence the final revalidation recommendation in respect of individual doctors, as that should remain the role of the Responsible Officer alone.

There were differing views on the GMC affiliates model.

Question 15: 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?

The Academy agrees that this is an important aspect of revalidation, but there is concern about how well it will work. It needs to be developed carefully, with monitoring and refinement over time.

One comment addressed a concern regarding issues of conduct or probity, which it was felt have historically been the most common reasons for referral of doctors to the GMC (and that these are matters that will probably only be assessed directly in the revalidation portfolio in peer and patient feedback instruments). It was considered that this remains the single weakest link in the revalidation process.

Question 16: 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?

The Academy agrees with this. The two Colleges who disagreed indicated that more feedback is required rather than less, because one event does not facilitate improvement and re-assessment.

Solutions to this problem included a suggestion that two feedback events should be demanded in each five year cycle, or that the single event should be within the first three years, so that if a problem is identified there will be time for improvement and another feedback session as part of the PDP before revalidation is recommended.

Question 17: Do you think that there should be a mechanism for making sure that colleague and patient questionnaires comply with our criteria for revalidation?

The Academy agrees with this and all Colleges and Faculties agreed with this point, many very emphatically. This emphasises how important the criteria and guidance is, and the need to further develop the tools used.

However, there is some concern about how this will work in different specialties, and also in ensuring that this is a genuine learning exercise for doctors. The Academy would welcome further collaboration with the GMC in this area.

The Academy welcomes the GMC's broad statement about the principles of equality and diversity. It is important that all tools and methods should be assessed carefully for how they address equality issues such as ensuring patients with language, literacy and/or cognitive barriers will be able to complete them – as well as recommendations for supporting such patients with involvement. The voice of these patients may often not be heard, yet they may often face significant issues with health inequalities, both in terms of health status and in terms of access to healthcare.

Question 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?

The Academy agrees with this as a pragmatic approach. However, there are a number of reservations:

- This would not be a risk based approach to regulation. Those with the best systems will be first; those with the weaker systems, and therefore those likely to need closer monitoring, will be last.
- *'Whole practice appraisal is a fundamental part of revalidation. What happens if one of the doctor's workplaces is ready but the other is not? The GMC needs to be clear on the relative readiness of organisations across the country and the resources available.'*
- *'If a doctor works in a late adopter organisation and has not undergone revalidation, what happens if that doctor applies for a post in an early adopter organisation? Such individuals must not be penalised.'*

Question 19: Do you agree with our proposed approach for the initial roll-out of revalidation?

The Academy broadly agrees with the proposed approach, but there are concerns around the lack of clarity over timescales and resources.

Revalidation should start in the simplest way possible. Some components of the frameworks are aspirational and those involved in the process need to work incrementally towards a mature process as it becomes feasible to populate them over time, when data becomes more readily available.

The Academy is concerned that some elements of revalidation may prove somewhat onerous, and therefore are interested in the results of the cost-benefit analysis being planned by the Revalidation Support Team. There should be an opportunity to review the proposals for revalidation in the light of this and other aspects of feedback from the Pathfinder pilots. To permit this the Academy suggests that

there should be a break between the end of the pathfinder pilots and the start of the 'Early adopter' phase.

Question 20: Do you agree that a deadline should be set for organisational readiness for revalidation?

In general the Academy considers this to be a pragmatic approach (although two members were not sure). However, it raises issues that need further clarification, particularly regarding resources. A deadline implies the existence of a penalty for those organisations that fail to comply with the deadline. What will this be? Penalties should fall on the organisations that fail to implement revalidation, not on the doctors they employ.

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