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**The National Association of LINKs Members  
and  
National Voices**

**Revalidation of Doctors  
Briefing Note 1  
Public involvement in the appraisal of doctors**



**December 2011**



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## Introduction

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I attended on behalf of National Voices and NALM on November 23<sup>rd</sup> 2011. The ERDB has been set up to assess the state of readiness in England (including the NHS) for revalidation.

The registration and licensing of doctors is a UK wide issue which is delegated by the Secretary of State for Health to the GMC. However, health policy and delivery is a delegated power to the four constituent countries within the UK, who are responsible for delivering the revalidation activities within their own country. The UK Revalidation Programme Board (UKRPB) monitors UK wide responsibilities, (including the GMC), co-ordinates with the 4 country specific delivery boards, and reports back to the GMC Board, and advises the SoS on state of readiness for revalidation. The UKRPB is chaired by Sir Keith Pearson, and has members from the four countries' Department of Health, Royal Medical Colleges, and other stakeholders, including patients. We are represented on the UK Board by Stephen Fisher on behalf of National Voices.

The Revalidation process should be signed off in 2012-13 to David Nicholson, and the SoS will then decide based on the evidence from the ERDB in Summer 2012 whether the process can formally begin.

Malcolm Alexander, NALM/NV

Note:

- **An R.O. is a 'responsible officer'. Most are Medical Directors at the moment.**
- **R.S.T. is the NHS Revalidation Support Team - [http://www.revalidationsupport.nhs.uk/about\\_revalidation.php](http://www.revalidationsupport.nhs.uk/about_revalidation.php)**
- **ERDB = English Revalidation Delivery Board**
- **UKRPB = United Kingdom Revalidation Programme Board.**

## 1) What is revalidation?

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“The purpose of revalidation is to ensure that doctors remain up-to-date and continue to be fit to practise. It aims to support doctors in their professional development, to contribute to improving patient safety and quality of care, and to sustain and improve public confidence in the medical profession. It also seeks to facilitate the identification of the small number of doctors who are unable to remedy significant shortfalls in their standards of practice. To achieve these aims, the General Medical Council (GMC) will require assurance that local systems of medical appraisal and clinical governance function effectively and fairly in distinguishing between satisfactory and unsatisfactory performance, and that responsible officers are making correct and valid recommendations”.

The introduction of medical revalidation throughout the UK means doctors who wish to retain their license to practice in the UK, will need to demonstrate that they are up-to-date and fit to practice.

The General Medical Council (GMC) published two documents, [Good Medical Practice Framework for Appraisal and Revalidation](#) and [Supporting Information for Appraisal and Revalidation](#), which underpin the revalidation process. For more information, please visit the [GMC website](#).

## 2) Are all doctors required to be licensed and revalidated?

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Not all doctors are required to be licensed and, therefore, subject to revalidation. For most doctors, there is a statutory requirement to be licensed (either in primary or secondary legislation), and this will include GPs and hospital doctors. For some doctors, the requirement to be licensed is included in their contract of employment, but there will be other groups of doctors who are not currently required to be licensed and, therefore, are not required to take part in revalidation. Each doctor is responsible for knowing if they are required to be licensed, and ensure that they seek to revalidate. All doctors who write prescriptions and sign death certificates are required to be licensed.

## 3) What is the purpose of revalidation?

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The purpose of revalidation is to provide greater assurance to patients and the public, employers and other healthcare professionals, that licensed doctors are up-to-date and fit to practice.

#### **4) What is the process?**

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Doctors will be appraised annually by a colleague, who will be accountable to the Responsible Officer for the hospital/area. These appraisals should consider the professional practice of the doctor, and feed into the Revalidation process, which takes place every five years. Revalidation is essentially a process not an event, but it will culminate in a recommendation by the Responsible Officer to the GMC, that the doctor is revalidated or not. Revalidation will result in the extension of the doctor's license to practice for 5 years.

A new feature which revalidation will introduce to the doctor's appraisal, is patient and colleague feedback (also known as Multi Source Feedback – MSF). As patient representatives, we are concerned that the current GMC proposals and guidance for patient feedback are un-ambitious and limited. As patient representatives on the ERDB and UKRPB, we have pressed the GMC for an adequate response and met them on December 12<sup>th</sup> to discuss public involvement in this process.

At the meeting on December 12<sup>th</sup>, we discussed the GMCs draft patients' questionnaire and emphasised the need for the patients' voice to be representative and embedded throughout the appraisal and revalidation process. We made clear that we want the process of patient involvement to be real – not window dressing. We discussed methods for ensuring that all relevant information (complaints, incident and accidents reports and relevant outcomes from serious incident reports), becomes available during the appraisal process. We asked the GMC colleagues to provide support for a workshop to be run by NV on public involvement in revalidation.

ERDB = English Revalidation Delivery Board

UKRPB = United Kingdom Revalidation Programme Board.

#### **5) Guidance**

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The GMC is accountable to the Privy Council (and the Health Select Committee) for the development and operation of the revalidation process, and provides guidance to doctors, Responsible Officers, and others involved, including patients and colleagues. Revalidation will be every five years and assessment every year. The DH will be accountable for ensuring that the system is working.

#### **6) Public involvement in revalidation**

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At the ERDB on November 23<sup>rd</sup> 2011, (MA) emphasised the importance of patients and the public in the Programme, and that this should be highlighted in the Project/Milestones Plan. He asked for the important role of HealthWatch and ICAS to be acknowledged in raising concerns and issues about doctors during the process of revalidation.

At the moment, the GMC is leading on determining how the patient's view is determined, and providing guidance.

<http://www.gmc-uk.org/doctors/revalidation/9262.asp>

<http://www.gmc-uk.org/doctors/revalidation/9575.asp>

Patients are in the strong position to assess doctors because they collectively observe practice throughout the doctor's career. We believe systems are needed to enable patients to talk about their experiences and to support more effective evaluation.

LINKs can catalyse the process now by writing to local Trusts and asking for details about the progress of the local revalidation process.

MA has met Maree Barnett Head of **Revalidation** at Department of Health England to discuss this issue and will meet with Allan Coffey from the Revalidation Support Team to discuss the PPI issues in more detail.

## **7) Locum doctors**

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There will be difficult issues with the appraisal and revalidation of locum doctors and doctors who work exclusively in the private sector as lone practitioners. This issue will be especially problematic in London

## **8) National Quality Board (NQB)**

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A report on progress with revalidation went to the National Quality Board on December 15<sup>th</sup> 2011, where Sally Brearley (Healthlink/NALM), raised the issue of public involvement in revalidation. Quality Accounts will be used to as a local measure of progress towards revalidation. A report from the NQB will follow.

## **9) Shortages of Assessors**

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There is currently a shortage of assessors to carry out appraisals in some areas, and this may get worse because the assessors role can be onerous, especially if those being appraised are unco-operative. Work needs to be done to agree a process for dealing with doctors who will not submit to appraisal.

## **10) Readiness survey (ORSA)**

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This has shown that many Trusts are not sufficiently prepared. The Organisational Readiness Self Assessment (ORSA) exercise was designed by the NHS Revalidation Support Team (RST) to help designated bodies in England, as defined in The Medical Profession (Responsible

Officers) Regulations 2010, to develop their systems and processes in preparation for the implementation of revalidation.

The exercise is a two-stage process and was approved by the England Revalidation Delivery Board (ERDB) in February 2011.

- The first stage, completed by designated bodies in April/May 2011 (for the year ending 31 March 2011), has given an indication of the state of preparation for revalidation and helped to prioritise development needs.
- The second stage repeats the exercise in April/May 2012 (for the year ending 31 March 2012), to inform the Secretary of State’s decision regarding commencement of revalidation.
- More work needs to be done to develop objective criteria for appraisal and revalidation.

#### ORSA response rates

	Number of returns received	Number of known designated bodies	Percentage responses
East Midlands	27 (33)	37 (33)	73% (100%)
East of England	48 (45)	50 (45)	96% (100%)
London	115 (114)	167 (145)	69% (79%)
North East	28 (23)	29 (25)	97% (92%)
North West	76 (69)	76 (75)	100% (92%)
South Central	36 (41)	44 (41)	82% (100%)
South East Coast	50 (47)	55 (49)	91% (96%)
South West	47 (46)	64 (47)	73% (98%)
West Midlands	53 (48)	56 (50)	95% (96%)
Yorkshire and Humber	37 (41)	48 (52)	77% (79%)
<b>Total</b>	<b>517 (507)</b>	<b>626 (562)</b>	<b>83% (90%)</b>

## 11) Role of the CQC

The CQC has a crucial role to play in the preparation for revalidation, but progress is slow. The Board did not think it was appropriate to place the CQC’s lack of progress on the Risk Register. NALM will seek information from CQC about their progress.

## 12) Key organisations supporting revalidation

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Collaborative work between the Department of Health, GMC, CQC, NQB, Medical Directors, NPSA and Monitor, will be crucial in ensuring that appraisal and revalidation is effective. Monitor and CQC will be invited to join the English Delivery Board (ERDB).

## 13) Access to information for patients' groups

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MA proposed at the ERDB that patients should have access to information about the progress made by Trusts in the revalidation process, so that they can exercise choice about which doctor they wish to receive treatment from – e.g. has the doctor submitted to the process and are they required to take action to improve their performance. This proposal was not supported, but some data will be produced by Dr Fosters.

## 14) Volume of appraisals in NHS Trusts

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NHS Trusts may have up to 1500 doctors to appraise annually and must, therefore, appraise about 30 doctors each week.

## 15) Remediation

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This is the process to support doctors who have been identified as having performance problems, and need help and advice to improve their practice. A regional approach is being considered for doctors needing support.

## 16) National Clinical Assessment Service (NCAS)

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In the most serious cases of poor practice, the **NCAS** works with the doctor to determine if she or he will benefit from retraining, or should be removed from the GMC Register. NCAS (National Clinical Assessment Service), is currently housed with the NPSA and will move to NICE in 2012 for a year.

<http://www.ncas.npsa.nhs.uk/accessing-case-services/case-services-overview/>

<http://www.ncas.npsa.nhs.uk/>

End

Your comments and proposals welcome

Malcolm Alexander – NV/NALM  
Stephen Fisher – NV/ Repetitive Strain Injury (RSI) Action

## Appendix

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**From:** Steve Fisher [<mailto:steversi@talktalk.net>]  
**Sent:** Wednesday, October 05, 2011 07:30 PM  
**To:** Philip Finn (GMC)  
**Cc:** Jon Billings (GMC)  
**Subject:** RE: Patient information on GMC website

Dear Philip (and Jon)

I've now had an opportunity to look at the references on the GMC website, and I have to say that I'm not convinced that it is adequate. I don't know when the various pieces of information were placed on the GMC website, and whether this was before the Select Committee took evidence for the fourth report of the 2010-2011 session<sup>1</sup>, which was printed in February 2011. Reading the evidence submitted and the Committees views in paragraph 48 to 53, it seems to me that the references on the GMC website pre-date the select committee report. If that is the case can you advise what GMC has done in response to the select committee report?

The select committee report considered that patient feedback only once during a five-year cycle is un-ambitious and insufficient, and yet that is all that is required in Ref 5 (see below).

I would appreciate any further information that you can provide, but I can only conclude from the information seen thus far that much more work is required on patient feedback, in clearly identifying the principles of patient feedback, the frequency and manner of patient feedback, and guidance and further information for patients involved in doctor's revalidation.

**1 General GMC information for patients:**

[http://www.gmc-uk.org/information\\_for\\_you/patients\\_and\\_public.asp](http://www.gmc-uk.org/information_for_you/patients_and_public.asp)

N/a. Provides general information on the GMC, no mention of revalidation.

**2 Revalidation:**

<http://www.gmc-uk.org/doctors/revalidation/9571.asp>

Very top level purpose of revalidation, no specific information at all on patient feedback

**3 General FAQs:**

[http://www.gmc-uk.org/doctors/revalidation/faq\\_revalidation\\_p1.asp](http://www.gmc-uk.org/doctors/revalidation/faq_revalidation_p1.asp)

Lists 15 Q&A's, intended for doctors who will be revalidated, only question 9 is relevant to patients (see below), no details or principles.

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<sup>1</sup> HC557 [www.publications.parliament.uk/pa/cm201011/cmselect/cmhealth/557/557.pdf](http://www.publications.parliament.uk/pa/cm201011/cmselect/cmhealth/557/557.pdf)

**4 FAQs on patients:**

[http://www.gmc-uk.org/doctors/revalidation/faq\\_revalidation\\_p1.asp#q9](http://www.gmc-uk.org/doctors/revalidation/faq_revalidation_p1.asp#q9)

Written for the use of doctors, no details or principles

**5 FAQs on colleague and patient feedback:**

<http://www.gmc-uk.org/doctors/revalidation/8964.asp>

Written for the use of doctors or responsible officers, not patients. Provides no principles for details of what patient feedback should be, other than answer to Q1 states that patient feedback should be at least once per revalidation cycle (in report published in February 2011 the select committee indicated that this was un-ambitious and unacceptable)

**6 Colleague and patient feedback:**

<http://www.gmc-uk.org/doctors/revalidation/9575.asp>

Limited information on the web page. Provides links to the GMC draft patient questionnaire (6a) and the GMC draft colleague (6b) questionnaire. Also provides links to the guidance (6c) on colleague and patient questionnaires.

6a Very simplistic and superficial. Header instructs patient to the base answers only on the consultation you have had today, this seems restrictive and is not going to tell a real feedback on the surface that the doctor provides, which builds up over a period of time with multiple visits and multiple conditions. Compared to the colleague questionnaire, it is very simplistic and very time-limited. It also precludes including the name of the patient, contacting the patient again could be very important if further information is required.

6b Colleague questionnaire is much better than the patient questionnaire. It is not limited to a single consultation, it asks questions which will much better consider the doctors practice. Again concerned that it precludes including the name of the colleague, contacting the colleague could also be important if further information is required.

6c GMC guidance on colleague and patient questionnaires. There are only three criteria for developing questionnaires. The first is to reflect the values and principles set out in good medical practice, however there is no guidance as to what topics should be considered in the patient questionnaire, consequently it is a poor requirement to validate a questionnaire on. The second criterion is that patient questionnaires should be developed in consultation with those groups who will be included in completing the questionnaires. How has the GMC involved patients in developing the GMC draft patient questionnaire?