Progress of patients input into Revalidation in the UK

Meeting 4th April 2012

Meeting with Una Lane (GMC lead for Revalidation), Jon Billings, Sarah Kovach-Clark

Stephen Fisher- National Voices, Malcolm Alexander-National Voices/NALM

The meeting was held to discuss the response of the UKRDB and GMC to Stephen Fisher's letter of January 10th 2012 (attached).

In the limited time available we discussed the following issues raised in the letter:

- The need for a definitive requirement document for patient MSF tools (to enable tool and process compliance to be checked).
- Our involvement in the development of patient aspects of revalidation, and the opportunity to comment on relevant documentation before publication. The GMC welcomed our involvement from the early stages of future development.
- To broaden the scope of patient MSF to cover all aspects of good medical practice (GMP), current patient feedback is limited to interpersonal skills. The GMC recognised the current limited nature of the patient MSF, and the scope to include the other aspects of GMP.
- The inadequacy of limiting patient MSF to one batch of 25 patient questionnaires in five years. The GMC considered that although the current provision is limited, it does establish patient feedback as a key part of revalidation, has now become accepted by the medical profession. The GMC recognised the need to further develop this provision.

We agreed:

1) The GMC will respond formally to Steve Fisher's letter of Jan 10th 2012.

2) The parties to this meeting will continue to meet regularly to progress their shared objectives, and that meetings will continue post SoS sign-off.

3) Steve Fisher and Malcolm Alexander will prepare a paper for the UK Revalidation Program Board to: a) identify those issues raised in our letter 10 January 2012 which we understand will be implemented in the initial revalidation rollout, and those which we ask the GMC / UKRPB to consider resolving by further development of revalidation after the initial rollout; b) to propose possible development paths towards the most effective means for patients to contribute of patients input into MSF.

4) The current scope and content of patient feedback in the MSF component of revalidation is minimal.

5) We will work jointly with the GMC to improve the effectiveness of the GMC public webpage on patient involvement in revalidation.

6) That the GMC would involve us in all stages of future development of patient involvement in revalidation and patient MSF. Documents pertaining to MSF will be shared with SF, MA and SL in advance of publication for our comment and input.

7) MA will activate contacts in Scotland, N.Ireland and Wales to achieve consistency in approach across patient's representatives across the UK.

8) That the GMC will ask the Chair of the four country boards to ensure that patients input into MSF is prioritised.

9) That pro-active, ad hoc and deliberative comments would be a welcome addition to more structured independent surveys of patients' and both will be used for MSF, and that positive messages about this component will be included in guidance.

10) That doctors should be pro-active in seeking comments from patients and colleagues and that the approach should be more sophisticated and ambitious, the GMC have removed all references to "patient feedback where applicable".

11) The emphasis has moved towards the general position being that patient input will be provided for all doctors, bar exceptional circumstances.

12) Doctors would need to find an approach that enables patients input even where they operate in a specialised and/or unique area of practice. Whilst the GMC has moved their position on the initial rollout as above, this aspect may take further development of revalidation to achieve.

13) Case studies and scenarios would be available to support the guidance on patient input into MSF.

14) Is it essential to maintain the energy levels and appropriate processes required post-SoS sign off of Revalidation, to ensure the continuing development of increasing and meaningful involvement of patients input into revalidation.

15) A form of word is needed to jointly move us forward. i.e. to achieve our aspirations for a process, with milestones and parameters, in which patient input into appraisal and revalidation will have increasing importance and recognition, as a key factor in improving the performance of doctors through a process of reflection on clinical practice, interpersonal relationships and shared decision making

We aspire to:

1) Milestones to ensure that the process of increasing involvement of patients in revalidation follows an agreed pathway.

2) In the short term to a minimum of two recorded episodes of objective patient input into MSF – at the beginning and end, to demonstrate how patients views have

changed during the five year revalidation period in relation to the doctors reflection on practice over that period.

3) A process of checking compliance with the requirement for effective patient input into MSF

4) Ensuring that the names of ROs are in the public domain.

We questioned the use of the term: "conventional patients"

Noted that:

1) Sign off for Revalidation during 2102 is critical for the GMC and the Delivery Boards.

2) Patient input into MSF is only one part of a portfolio to inform discussion during appraisals en route to revalidation.

3) The onus is on doctors is to bring critical information to their appraisal.

4) The appraised and appraiser will determine what is and is not appropriate for inclusion in the appraisal.

5) In relation to particular patient conditions/illnesses, the patient may be more knowledgeable that the doctor.

6) The GMC accept that their questionnaire for patients input is limited to gathering information about interpersonal skills.

7) Research by Professor Campbell, Peninsula College of Medicine, included comments from 42,000 people.

8) The Fitness to Practice programme is under review (http://www.gmc-uk.org/guidance/10900.asp).

9) Good Medical Practice will be republished this year.

10) The duties of Responsible Officers (ROs) are set out in Regulations. ROs are responsible to ROs. http://www.legislation.gov.uk/uksi/2010/2841/made

End