

Revalidation of Doctors

Briefing Note

August 18th 2012

The National Association of LINKs' Members

Patient and Public Involvement in Health and Social Care

NALM's Briefing Note

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THE AIMS OF NALM

The aims of NALM are to:

1. Provide a national voice for LINKS' members

2. Promote public involvement that leads to real change and the ability to influence key decisions about how care services are planned and run

3. Promote the capacity and effectiveness of LINKS' members to monitor and influence services at a local, regional and national level and to give people a genuine voice in their health and social care services

4. Support the capacity of communities to be involved and engage in consultations about changes to services, influence key decisions about health and social services and hold those services to account

5. Promote diversity and inclusion and support the involvement of people whose voices are not currently being heard

6. Promote open and transparent communication between communities across the country and the health service

7. Promote accountability in the NHS and social care to patients and the public

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On July 5th 2012 the English Revalidation Delivery Board signed off the revalidation process and sent their recommendation to the Secretary of State on July 12th

Regarding the House of Commons Health Select Committee Fourth Report of Session 2010-11 The Revalidation of Doctors

PART ONE

A) Key issues raised by the Health Committee with the GMC

- What happens in cases where the performance of an individual doctor gives rise to concern
- The operation of the appraisal system, and its consistent implementation across the country
- The administrative burden that appraisal and revalidation place on doctors
- The way in which patients and colleagues are involved in revalidation
- Where Responsible Officers who are currently based in PCTs will be sited in future
- The adequacy of the powers available to the GMC to ensure that doctors for whom English is a second language are able to communicate effectively with their patients.

<http://www.publications.parliament.uk/pa/cm201011/cmselect/cmhealth/557/55702.htm>

B) Our Comments on Some of the Health Committee's Recommendations

Rec 4. Doctors whose performance gives cause for concern

The Committee finds it unsatisfactory that so little attention has been given to the issue of how to deal with doctors whose practice gives cause for concern. We regard this as an important weakness in the current proposals that the GMC needs to address if the introduction of revalidation is to help sustain public confidence in the medical profession. (Paragraph 30)

The results from the March 2012 ORSA study show only 58.4% of doctors are covered by Designated Bodies where there is a policy for re-skilling, rehabilitation, remediation and targeted support for doctors whose performance gives cause for concern. Contributory factors to this problem are the difficulties in developing new policies or amending existing policies in NHS organisations without national agreements and guidance from relevant stakeholders (e.g. NHS Employers and the BMA). The DH recognises that this issue will require further planning and agreement to ensure the development

of effective local policies. The current reorganization of the NHS structure (primary care trusts and SHAs) exacerbates this problem and the development of appropriate policies in the short time remaining.

- Rec 5.** The Committee is concerned that instinctive use of the word "remediation" in cases where a doctor's performance gives cause for concern may have the effect of pre-judging the appropriate response to a particular set of circumstances. While it is important to ensure the rights and legitimate interests of individual doctors are safeguarded, the primary purpose of revalidation is to protect the interests of patients. (Paragraph 31)

Although, there is little that can be done to replace the term "remediation" at this stage, it is too obscure a term to be used in normal parlance. We would like to see patient assessable language used so that patients can understand what is happening in the case of a doctor that has for example provided inappropriate, inadequate or harmful care. Patients never know if a doctor is subject to a procedure for the improvement of his or her practice. They have a right to know, especially if they or their families have suffered direct harm and they have a right to accessible language and terminology.

- Rec 6.** The Committee, therefore, recommends that the GMC publishes clear guidance to Responsible Officers about how they should deal with the cases of doctors whose performance gives rise to concern. (Paragraph 32)

Guidance for Responsible Officers to help them understand and undertake their statutory duty to respond effectively to concerns about a doctor's practice was published in March 2012 (Supporting Doctors to Provide Safer Healthcare - Responding to concerns about a doctor's practice). It provides a model for establishing the level of concern, and lists the components of an organisational policy to support a consistent, equitable and fair process. The Royal Colleges are expected to have a role in providing expert advice around remediation and the return to work of doctors working in particular specialties. The ERDB believes that whilst there is still more work to be undertaken, particularly by the NHSCA, the necessary framework, guidance and high level principles are now in place to ensure that the approach to remediation can develop in a way that is "fair and consistent". The BMA has made a strong case for more resources to be provided for the Remediation process and this is the subject of discussions between the BMA and the DH

The Guidance on remediation does not consider the position of the patient in relation to remediation.

Rec 7. Appraisal

It is clearly unsatisfactory that there is such a degree of variation across the country in relation to appraisal, and unacceptable that some doctors are apparently not subject to appraisal at all. If an adequate appraisal system is not provided for all doctors, then revalidation, as currently envisaged, will not work. The GMC needs to satisfy itself that all organisations that employ doctors have satisfactory, robust and consistent systems of appraisal in place on a timescale that makes possible its objective of introducing revalidation in late 2012. (Paragraph 37)

The ORSA study published in March 2012 (next is due in October relating to September 2012)

- **73% of doctors had had an annual appraisal (consultants 73%, SAS doctors 53%, GPs 91%) SAS = Staff Grade, Associate Specialist and Specialty Doctors.**
- **86% of doctors are in designated bodies with sufficient numbers of appraisers**

Where locum doctors do not have a prescribed connection to a Designated Body because they work independently on a number of short-term assignments, they will not have a responsible officer and, consequently, would be outside the revalidation process. In June 2012, the GMC agreed proposals with the DH for a “suitable person” to take on the function of the responsible officer role in circumstances where a doctor does not have a prescribed connection. This will be reflected in the Revalidation Regulations and strict guidance will be in place defining the circumstances under which a “suitable person” is approved by the GMC. The RST is currently working with locums to produce short briefing notes to illustrate how information, particularly for quality improvement activity and colleague and patient feedback can be collected and used.

Rec 8. Requirements on Doctors

It is clearly undesirable that doctors should be required to provide an immense amount of documentation for their appraisals. We agree that much of what is required should already be in place, and that if institutions have effective systems for clinical governance then information that is required for that use will also be available for appraisal. (Paragraph 44)

Rec 9. The Committee supports the approach set out in the GMC's consultation review document aimed at making the process simpler and more flexible. In particular we agree that the different components of revalidation should be integrated into a single process, and that the requirements of that process should be integrated into the appraisal and clinical governance systems operated by employers. (Paragraph 47)

We believe it is necessary to ensure that MSF (multisource feedback) is a major part of revalidation for all doctors in practice. There also needs to be a process

of governance to ensure the appraiser and the RO have access to all appropriate elements of MSF and that these are included annually in the doctors portfolio; e.g. incidents, complaints, accidents, patients information and views and feedback from colleagues. Hospitals, clinics, the NHSCA and all other employers of doctors must develop the capacity to ensure that all recorded incidents, complaints etc involving a doctor are a major component of the annual appraisal portfolio of each doctor. This approach is essential to the effectiveness of appraisals in terms of improving performance.

Rec 10. Patient and Colleague Involvement

In its response to the consultation the GMC commits itself to further development of its proposals for colleague and patient feedback. We welcome this commitment; we hope the GMC will undertake a review of best practice in gathering the views of patients and colleagues and develop its proposals in the light of that review. (Paragraph 53)

This is probably the weakest element of the appraisal process.

Frequency of Patient Multi Source Feedback (MSF)

Main concerns

- GMC requires only one patient MSF in the 5 year revalidation cycle.
- The current tools only focus on “today’s” consultation; there is no opportunity for longitudinal patient response.
Scope of Patient Feedback Questionnaires (tools)
- The tools are limited to “to-days” consultation / visit (does not allow for longitudinal data)
- The questions are mainly concerned with interpersonal skills
- The tools do not consider if the doctor recognises the expertise of the patient, particularly important in long term conditions.
- The limited coverage of the GMP “Good Medical Practice” by patient MSF tools.
 - e.g. RCGP report on CSQ scores only 7/18 on GMC duties of a doctor, and 4/12 for attributes in the GMC’s Framework.
- The small numbers of patient responses recommended (RCGP report on CSQ advises that only 19 to 23 patient responses are required).

The RCGP’s recommend 5 Patient MSF tools:

1. General Medical Council Patient Questionnaire
2. Improving Practice Questionnaire (IPQ)
3. EDGECUMBE 360^o Version 2
4. Doctors’ Interpersonal Skills Questionnaire (DISQ)
5. Consultation Satisfaction Questionnaire (CSQ)

Many of the tools are only available if purchased, making it more difficult to assess them. The GMC tool is freely available, and the CSQ tool has been captured on screen.

The RCGP test data is also available for the CSQ. We have seen the GMC, the IPQ, the DISQ and CSQ tools. The GMC tool is freely available, CFEP provided him with a pdf of the DISQ (also used by IPQ). He has taken screen shots from the web to compile what he believes to believe to be the CSQ tool.

The dominant aspect of all these tools was interpersonal skills. Some give no attention to the patient evaluation of the doctor's skill and experience in their particular disease or condition. For many long-term conditions patients frequently have a high level of knowledge on their condition, and the patient should be able express their view of the doctor's competence in this area, and how well the doctor is able to work with the patient.

Consultation Satisfaction Questionnaire (CSQ)

The RCGP's report only gives 7 / 18 for coverage of GMC Duties of a Doctor, and 4 / 12 for coverage of domains and attributes in the GMC's Framework. The RCGP also report "that completion by only 19 patients would be good reliability for the questionnaire as a whole, and that completion by 23 patients would achieve reliability of 0.7 or above for all four scales".

Views of Sir Donald Irvine

In his memorandum of evidence to the Committee, the former President of the GMC, Sir Donald Irvine flagged up a number of issues with the proposed system of revalidation as it stands. He alleges that the bar used by the GMC to establish good or problematic practice (in the GMC document Good Medical Practice in the context of revalidation "is set too low to protect patients properly". In terms of revalidation, Sir Donald states that: In her final report [into the case of Harold Shipman] Dame Janet Smith said that "the reality of the 'remarkably low' standard above which doctors will be revalidated does not square with the claim that revalidation gives an assurance that the doctor is 'up to date and fit to practice'". Now, nearly eight years on, nothing seems to have changed. This is why urgent action is required.

The GMC's response to Sir Donald's criticisms:

The GMCs core guidance *Good Medical Practice (GMP)* sets out the standards that are required of a doctor. The GMC believe the 'bar' for good practice is clearly and appropriately set within *GMP*. Central to this, every doctor must know the boundaries of his or her competence and must act within those boundaries at all times. There is therefore no universal bar in the sense that a surgeon of twenty years' experience will be expected to perform at a different level than a doctor who has just left medical school.

The issue that Sir Donald Irvine raises is what happens when a doctor does not achieve those standards and in particular how far away from those standards does a doctor need to be before action - ultimately being struck off the register - is taken. Last year Sir Donald pointed to a number of panel decisions - in every one of which the GMC in its 'prosecution' role had called for the doctor to be erased - where he thought the panel had got it wrong by not striking the doctor off the register. Since then the GMC

have set up the MPTS (Medical Practitioners Tribunal Service) headed by a former High Court judge, who will run the panel system. The GMC are also pressing the government for the GMC to have a right of appeal against panel decisions we believe are too lenient.

The law is clear on what Panels can and cannot do: the GMC role and that of the Panels is to protect patients, not to punish doctors. As such, a Fitness to Practise Panel must consider whether the doctor's actions are remediable for example through re-training or supervision and whether the doctor has made attempts to remediate. Most importantly the panel must consider what the risk is of the doctor repeating that behaviour and therefore putting patients at risk in future. If there is no risk to patients the law is clear that the public interest is not served by barring that doctor from practise.

For revalidation, doctors will be required to undergo regular appraisals that are based on *Good Medical Practice*. As part of this, they must collect supporting information to show that they are continuing to meet the principles and values set out in GMP. This includes demonstrating attributes such as maintaining professional performance by taking part in professional development and communicating effectively with patients. As you know it also requires them to engage in multi-source feedback, including securing and reflecting on the views of their patients. The GMC believe that by encouraging reflection, revalidation will help doctors improve quality of care for patients, help identify poor practice and by ensuring doctors are supported in their practice, provide an opportunity for any concerns to be addressed earlier.

Recent assessments by the revalidation delivery boards in the four countries of the UK show that revalidation is already having a significant and beneficial effect even before it is introduced as organisations across the UK are strengthening their systems of appraisal and clinical governance as they prepare for revalidation...We are determined to get revalidation up and running and are confident... that it can start in early December 2012 subject to the Secretary of State's decision to commence the legislation. We have built on the findings of revalidation to make sure that revalidation is transparent for patients, meaningful for doctors and works for employers. Having said that, it will not be a perfect system and the GMC are committed to evaluating the effectiveness of revalidation, to keeping the process under review and explore how it can be developed in the future.

EXTRACT FROM: Medical revalidation: a statement of support from UK patient organisations - 16 July 2012

"We welcome the GMC's commitment to keep revalidation under review once it has been introduced and explore how it can be developed in the future. We also welcome the GMC's commitment that there will be active and constructive engagement with patient organisations in all aspects of ongoing and future revalidation developments. In response we will work with the GMC to ensure that the patient perspective plays a prominent and meaningful role in the development of future revalidation policy and practice, and to review the initial limitations of feedback in the model and identify opportunities for strengthening the involvement of patients in the various stages and levels of the revalidation process".

PART TWO

Information from the ERDB, UKPB and GMC

The Current State of Readiness

1) **Current state of readiness – as of July 5th 2012**

The English Revalidation Delivery Board decided on July 5th 2012 that the healthcare system in England is ready to implement medical revalidation in December 2012 (see table at end of the report).

The Secretary of State will now undertake an assessment starting in July 2012 and give his opinion on the state of readiness in September 2012.

2) **Implementing Revalidation across the UK – Background**

In October 2010 the GMC and health departments in England, Scotland, Wales and Northern Ireland published a joint statement indicating that the implementation of revalidation would commence in late 2012, subject to the achievement of six milestones (section 3) and Secretary of State's approval.

The SoS wrote to Professor Sir Peter Rubin, GMC chair, in June 2010 in response to the GMC's consultation on medical revalidation and set out his plan to extend the revalidation piloting period by a year in order to understand more about the costs, benefits and practicalities of implementation in relation to affordability, support for better care and effective use of doctors' time.

The SoS will undertake a formal assessment of readiness for England based on three strands of readiness (section 4)

3) **The Six Milestones**

i. **Responsible Officers are in place for all designated organisations**

ii. **All doctors are participating in an annual appraisal process**

The ERDB has decided that this milestone has been achieved to a sufficient level to enable revalidation to progress to implementation.

ii. **The Good Medical Practice (GMP) Framework is embedded in all appraisals**

iii. **There is an agreement about what constitutes the core information that doctors must bring to their appraisal**

v. **A process is in place for Responsible Officers to advise the GMC of their recommendations**

The GMC has developed practical guidance to support the process Responsible Officers will use to send their revalidation recommendations on to the GMC Registrar. The GMC Programme Board has declared they will be ready to accept revalidation recommendations from responsible officers from 3 December 2012.

vi. **Strategy agreed for remediation where performance concerns are identified**

View of the ERDB is that this milestone has been achieved to a sufficient level to enable revalidation to progress to implementation.

4) **Three Strands of Readiness**

In the Government's response to the Health Committee: Fourth Report of Session 2010-11: The Revalidation of Doctors (Department of Health, March 2011), the Secretary of State set out 3 strands of readiness for the implementation of medical revalidation in England:

A) Design readiness: medical revalidation is right for doctors and for patients and has been streamlined and made proportionate

B) Organisational readiness: health sector has systems in place to move to implementation (adequate numbers of Responsible Officers, effective appraisal and clinical governance systems)

C) Business case readiness (testing the components of revalidation) – clear evidence of what benefits revalidation will deliver and evidence that it can be implemented in a way that is cost effective and affordable.

Evidence of system readiness in relation to the three strands:

A) Design Readiness

Appraisal requires every doctor in practice to have an annual discussion with an appraiser and provide evidence to demonstrate the doctor's scope of work is in accordance with the GMC's Good Medical Practice. There has been a lack of clear guidance on what constituted an effective appraisal process for revalidation.

The current medical appraisal approach for revalidation has been piloted and guidance produced for doctors, appraisers, responsible officers and employers to describe how the appraisal process should operate on a practical level - the Medical Appraisal Guide (MAG). The MAG was approved by the Academy of Medical Royal Colleges, NHS Employers, GMC, Department of Health and the British Medical Association.

Responding to concerns / remediation

- Revalidation provides affirmation that licensed doctors are up to date and fit to practise
- The system should identify doctors who fall short of the required professional standards and whose practice gives cause for concern.
- The DH Remediation Steering Group published a report in Dec 2011 and highlighted three problems:
 - Funding for remediation
 - Placements for doctors needing supervised learning away from their practice
- c) Establishing consistent model for remediation across primary care through the NHS Commissioning Board Authority (NHS CA). The NHSCA is the designated body for primary care doctors and the designated body for all first level Responsible Officers.

Locum doctors

Locum doctors often work in less supervised environments. Some don't have a prescribed connection to a Designated Body because they work independently on short-term assignments, have no Responsible Officer and are outside the revalidation process. The GMC and the DH have agreed that a "suitable person" will take on the functions of the Responsible Officer. Briefing notes will be produced for locums to illustrate how to collect and use information for improvement and colleague and patient. The GMC campaign on Prescribed Connections is focussed on locum doctors. There is no regulatory difference between locums and other doctors – all must have annual appraisals. The GMC are targeting the 10% of doctors they know the least about – locums will be included. Responsible Officers (RO) must ensure that locums provide the same information as all other doctors.

Design readiness: Patients and the Public

A study by Ipsos MORI and the King's Fund found that patients, and members of the public surveyed, assumed that formal oversight of the doctors' clinical standards was already central to the systems of regulation.

Patients' organisations have attempted to influence the development of the revalidation process but have had little impact. These organisations include:

National Voices, Welsh CHCs, Patients Association, National Association of Patients Participation Groups, NALM and councils in Scotland and Northern Ireland.

NALM has written to SoS asking for the revalidation to produce evidence of increased effectiveness of medical practice as a result of patient and colleague inputs and for collaborative pilots between groups of patients and doctors to be established (**see below**).

B) Organisational Readiness

Before revalidation can begin the SoS must be assured that the health sector is prepared for implementation. The ERDB agreed to the use of the following indicators to assess the overall state of readiness at each Designated Body:

- Responsible Officer nominated or appointed in compliance with the regulations.
- Responsible Officer training has been undertaken.
- Number of trained medical appraisers is sufficient for the needs of the Designated Body
- Operational system for monitoring the fitness to practise of each doctor
- Process operative for investigation of any capability, conduct, health and 'fitness to practise' concerns
- A policy for re-skilling, rehabilitation, remediation and targeted support is in place

ERDB decided that to provide assurances to SoS that England has achieved a sufficient level of organisational readiness for revalidation to commence, that **at least 80% of all doctors in England should be covered by Designated Bodies which can demonstrate an overall (RAG) rating of Green or Amber/Green.**

The latest ORSA (Organisational Readiness Self Assessment) exercise was completed by designated bodies in May 2012 for the year ending 31 March 2012 shows:

- 95% response rate from known designated bodies - 100% in NHS
- 92% of doctors covered in this exercise are in designated bodies rated Green or Amber (estimated 180,000 doctors)
- Almost 100% of doctors have a Responsible Officer, 98% have a trained Responsible Officer

- 73% of doctors had an annual appraisal [**consultants 74%, SAS doctors 53%, GPs 90%**] (SAS=staff grade/speciality doctor)
- 86% of doctors are in designated bodies with sufficient numbers of appraisers
- 92% of doctors work for Designated Bodies which monitor their 'fitness to practise of doctors'
- **58% of doctors are in designated bodies with a policy for reskilling, rehabilitation and remediation**

C) **Business Case Readiness**

The business case explains the approach to implementing revalidation for doctors. It outlines the justification, practical viability and value for money of implementing the planned system. Within the DH, the business case has been cleared by the Director of Finance, the Chief Economist and the NHS Chief Executive. In addition, HM Treasury have assessed the case and confirmed their formal approval to proceed is not required.

The main points within the business case are:

- Revalidation will mandate an assessment of every doctor's practice to provide assurance that he or she remains fit to practise. Structured annual appraisal and strengthened clinical governance processes will underpin this assessment.
- Earlier identification of issues, through clinical governance information and regular appraisals, will mean earlier interventions for the minority of doctors whose medical practice falls below the standard required.
- Estimated annual cost of medical revalidation is just under £100 million per year on average. Of this, around £15 million is an actual financial cost and the remainder is an opportunity cost, where resources are diverted from elsewhere.
- When taking into account the harder-to-quantify benefits, such as estimates of improvements to the quality of care patients receive, and the qualitative benefits such as improved patient trust and assurance, revalidation is believed to deliver good value for money.

5) **Key Risks and Weaknesses**

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- The new NHS structure will have implications for implementation of medical revalidation as doctor's relationships with Designated Bodies will change; e.g. GPs accountability will be to the NHSCA
 - In primary care there will be competing demands on Responsible Officers as PCTs are abolished and are replaced by CCGs and local offices of the NHSCA...

- The annual ORSA survey, giving the position at 31 March 2012, shows **over a third of hospital doctors did not have an appraisal last year (including over 1 in 4 consultants); and over 40% of doctors work in designated bodies that are not yet covered by a policy for reskilling, rehabilitation and remediation which is compliant with the Responsible Officer Regulations**
- A three-year rollout may be too fast and will create peaks and troughs in workload in future years, which could be difficult to manage
- Non-engagement of the medical profession: Doctors may not fully engage with the revalidation process if they feel it is not fit for purpose.
- **The process for locums has some way to go**
- **Remediation process is weak in many parts of the country**
- **Appraisal rates for consultants and SAS (staff and associate specialist) doctors remain low in comparison to GPs**

6) **Current view within DH/NHS**

Comprehensive testing and piloting of the different elements of revalidation has shown that doctors, appraisers and responsible officers are confident that, with the appropriate training and support, they can successfully collaborate to make revalidation work.

There is more work to be done on remediation by the NHSCA and on how revalidation will work for locum doctors and doctors in training.

The SHA clusters will now review action plans and report back to the NHS Medical Director.

Challenged designated bodies will be supported to achieve readiness and appropriate action taken for those designated bodies, for example new locum agencies, which are yet to engage with revalidation.

7) **ACTION POINTS – Points needing action**

- DH needs to focus on the hospitals where the system for **reskilling is weak (58% of doctors are in designated bodies without a policy for reskilling, rehabilitation and remediation)**
- **Many Consultants are not actively being appraised- estimated at 1:4**
- **Locum doctors may easily slip through the net if they move quickly between health bodies and GP practices**

- **Patient feedback into appraisal system is minimal and rare – is a major area for development**
- **We must ensure that the patient feedback is prioritised in the development of future revalidation policy.**
- **Process for getting information about complaints, incidents and accidents into the appraisal system is vague and should be a major area of concern.**
- Further development of revalidation should enable patients to identify outcomes as a result of patient feedback, which demonstrate improvements to the effectiveness of medical practice.
- Production of outcome data that will assure patients that revalidation is an effective and meaningful system, leading to safer and more effective medical care.
- Support for pilots across the UK between doctors, patients' groups, LINKs/Healthwatch, and other statutory patient organisations is needed to develop local approaches to patient involvement in revalidation

8) NATIONAL CLINICAL ASSESSMENT SERVICE (NCAS)

NCAS helps resolve concerns about the professional practice of doctors, dentists and pharmacists in the UK and overseas. They provide expert advice and support, clinical assessment and training to the NHS and other healthcare partners. Most of the services are free to the NHS. NCAS' mission is to bring expertise to the resolution of concerns about professional practice and, in doing so, improve patient safety across the UK. They were founded in 2001 and have successfully assisted employers and contracting bodies in the management of 8,000 referrals across the UK. At any one time NCAS is working with over 50% of NHS organisations, and in any year about 75% make referrals to NCAS. On 1 April 2013 NCAS is changing. They will join the NHS Litigation Agency and will leave the National Institute for Health and Clinical Excellence.

Malcolm Alexander

Steve Fisher

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NATIONAL VOICES

WWW.NALM2012.ORG.UK

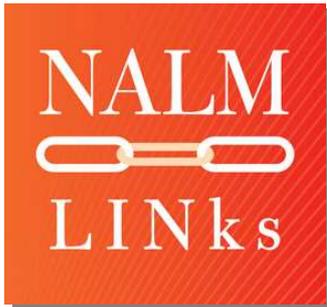
<http://www.nationalvoices.org.uk/>

07817505193 or 0208 809 6551

TIMETABLE FOR HANDLING THE READINESS ASSESSMENT

5 July	ERDB reviewed the case for readiness and agreed to submit to SoS
12 July	Submission to Secretary of State on readiness in England
12 July	Secretary of State considers the case over the summer recess and makes his recommendation for England in September 2012
12 September	ERDB informed of Secretary of State decision
13 September	ERDB submit readiness assessments to UKRPB meeting
20 September	UKRPB considers assessments from all four countries and GMC
27 September	GMC Council meeting receives report on UK readiness and recommendation on implementation from the UKRPB
28 September	Secretary of State receives recommendation on UK implementation from the GMC
End September / early October	Secretary of State announces decision on commencing legislation
3 December	Revalidation legislation commences and first doctors undertake process

- GMP Framework for appraisal and revalidation, sets out how the GMP framework should be embedded in appraisal
- Supporting information for appraisal and revalidation, describes the types of core information doctors should take to appraisal
- Medical Royal Colleges and Faculties have developed guidance for their members on the supporting information for appraisal:
www.aomrc.org.uk/revalidation/revalidation-publications-and-documents/speciality-guidance.html .



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National Association of LINKs Members

Andrew Lansley
Secretary of State for Health
Department of Health
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June 26th 2012

Dear Mr Lansley,

Revalidation of Doctors

We have been actively involved with the GMC, National Voices and other bodies, in development of the revalidation process for doctors, especially in relation to patient involvement Malcolm Alexander

Steve Fisher

VICE CHAIR, NALM

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07817505193 or 0208 809 6551

t in doctor's appraisals. We would now like to make a number of comments about the progress that has been achieved and our aspirations for the next stage of the process.

NALM believes that the revalidation of doctors will ensure that their skills are up to date, and that they are fit to practise. We recognise the valuable contribution that revalidation will make to the quality and safety of care that patients receive and value the additional assurances that this process will provide to patients. All patients want doctors to regularly go through a process that ensures they are practising safely and are up to date with their medical knowledge.

We welcome the commitment of the GMC to making patient's views and comments an integral element of revalidation. This approach will provide doctors with material they can use to improve their practise and enable them to follow the lead of the many doctors already collecting

feedback from patients for their annual appraisals. We hope all doctors will embrace this opportunity.

We recognise the GMC's responsibility as a regulator to support the development of a highly effective and trusted medical profession and believe that the development of effective patient input into revalidation is central to this aspiration. Equally, we understand the challenges and pressures faced by the profession and employers in preparing for revalidation.

We welcome the GMC's commitment to review revalidation once it has been introduced and we will work actively with the GMC to ensure that the patient perspective is included meaningfully in the development of future revalidation policy.

We hope you will confirm in the autumn that revalidation will go ahead, based on the progress already made towards strengthening local systems of appraisal and clinical governance.

We also ask you to support the further development of revalidation, in a way that enables patients to identify outcomes, which demonstrate improvements to the effectiveness of medical practice. This approach will fit well with local quality improvement initiatives, which Healthwatch, CCGs and local offices of the NHS Commissioning Board will actively lead and engage with.

We would particularly value your support for pilots across the UK between doctors, patients' groups, LINKs/Healthwatch, and other statutory patient organisations, to develop local approaches to patient involvement in revalidation, which include the production of outcome data that will assure all patients that revalidation is an effective and meaningful process, leading to safer and more effective medical care.

Yours sincerely

Malcolm Alexander
Chair

Ruth Marsden
Vice Chair

And on behalf of national NALM Steering Group:

John Martin, East Midlands
Barry Fippard, East Midland
Mary Ledgard, Eastern
Sally Brearley, London
Jack Firth, North West
Len Roberts, South East/Central
Anita Higham, South East/Central
John Langley, South West
Elli Pang, South West
Dag Saunders, West Midlands
Rob Rijckborst, West Midlands
Mike Smith, Yorkshire and Humberside

GLOSSARY

CHC	Community Health Council (Wales)
ERDB	English Revalidation Delivery Board
GMC	General Medical Council
GMP	Good Medical Practice
MAG	Medical Appraisal Guide
MSF	Multi Source Feedback
NHSCA	NHS Commissioning Agency
NHSCB	NHS Commissioning Board
NHSCBA	NHS Commissioning Board Agency
ORSA	Organisational Readiness Self-Assessment
Rec	Recommendation from the Health Committee
RO	Responsible Officer
RST	Revalidation Support Team
SAS	Staff Grade, Associate Specialist and Speciality Doctors
SoS	Secretary of State
UKPB	UK Programme Board

RATING AND DEFINITION

Rating	Definition
Green	Successful delivery of the project/programme appears highly likely and there are no major outstanding issues that at this stage appear to threaten delivery significantly
Green/Amber	Successful delivery appears likely. However, attention will be needed to ensure risks do not materialise into major issues threatening delivery
Amber	Successful delivery appears feasible but issues require management attention. The issues appear resolvable at this stage of the programme/project if addressed promptly
Amber/Red	Successful delivery of the project/programme is in doubt with major risks or issues apparent in a number of key areas. Urgent action is needed to ensure these are addressed
Red	Successful delivery of the project/programme appears to be unachievable. There are major issues on project/programme definition, schedule, budget, required quality or benefits delivery, which at this stage do not appear to be manageable or resolvable. The project/ programme may need re-base-lining and/or overall viability re-assessed