

Revalidation update

Chairman's introduction



As we move into 2010, it is a good time to take stock of where we are going with revalidation. Although some progress was made last year, there was a sense that more questions were arising than being answered. The introduction of the licence to practise was a success, and a testimony to the value

of close communication between the various stakeholders, as more than 213,000 doctors responded to the GMC's campaign. Despite some useful lessons being learnt from the early analyses of the various pilot projects, there is still a long way to go before we have a realistic idea of what revalidation will really mean for doctors.

The uncertainties over how revalidation will work in practice are a barrier to gaining the confidence of the profession – a confidence that is crucial for the success of any system that is introduced. Whilst chairing a conference on revalidation for several hundred GPs in Dover last week, I conducted a quick straw poll of the audience. It is telling that whilst a third of those present said they were supportive

of the introduction of revalidation, about a third said they were not, and the final third were unsure. This uncertainty is compounded by worries over the impact of the recession on the resources available, whether it be at trust level to free up time for those who will need to run the system, to underpin and support CPD and preparation time for individual doctors or to support remediation for those who require it.

The BMA will continue to have regular dialogue with the GMC, the colleges and the health departments in order to raise the concerns of our members, and to ensure that any system that is introduced is fair, transparent, properly resourced and avoids excessive bureaucracy.

Pilot news

The following sites have been announced as the 2nd stage pilots and are due to run until March 2011.

Pilot site	Sector
London Deanery	Primary care
South Central SHA	Multi-site all sectors
Northampton General Hospital	Secondary care
NHS Cornwall & Scilly Isles	Multi-site all sectors
University Hospitals Leicester NHS Trust	Secondary care
Mersey consortium	Multi-site secondary care
Yorkshire & Humber SHA	Multi-site all sectors
NHS Dorset	Primary care
Nottinghamshire Healthcare NHS Trust & Derbyshire Mental Health Services NHS Trust	Secondary care mental health
NHS West Midlands	Medical managers/responsible officers

Amongst other activities, each pilot will need to:

- Establish and test the role of the responsible officer
- Test the proposals for a strengthened form of medical appraisal
- Explore how the evidence of specialist standards are brought into the appraisal discussion
- Clarify the role of the Medical Royal Colleges or Faculties to support the process and the role of MSF as part of the appraisal framework.

The location of a number of smaller pilots has not yet been confirmed.

Revalidation: the next steps

It's a critical time for revalidation and those responsible have their work cut out; we look at the barriers that need to be overcome along with our outstanding concerns. For something that has been around for so long, much remains unclear:

Workload

It goes without saying that the process needs to be manageable. To us, the proposed appraisal framework feels too rigid and will prove time-consuming unless greater flexibility is developed. The current framework for England can be seen here:

http://www.revalidation.support.nhs.uk/Strengthened_Medical_Appraisal.asp

Our concerns have been backed up by some of the pilots where appraisals are taking far too long. Revalidation is meant to lead to a streamlining of appraisal and not take doctors away from frontline patient care. As it stands, this is a real risk particularly when the support that will help doctors through the process has not been clarified.

Remediation

The DH anticipates that there will be a 75% increase in the number of cases involving remediation. As such, it will have a significant role to play but we still do not have any firm information about remediation, who carries it out, how it is to be resourced and at what point GMC Fitness to Practise procedures come into play. It is difficult for us to have confidence in this figure, and the subsequent cost projections, with such a lack of detail. At the moment, we have particular concerns about what support will be available for sessional doctors and locums across the UK.

Costs

The process will be expensive and increasingly difficult to implement in full in the current financial climate. So far, the introduction of responsible officers and GMC affiliates in England are the only two component parts that have been costed. The former, based on 1000 ROs, would cost approximately £6.7M in start-up costs and £4.5M annually thereafter. The cost of scaling up the GMC affiliate model as piloted to a national level, is estimated to be between £4.1m and £7.4 to set up and

then between £4.4m and £4.5m to run each year. At this stage, it is not clear who will meet these costs and the GMC affiliate evaluation report suggests that alternative, cheaper models may need to be considered. The BMA is opposed to these costs being passed on to the profession. It also questions whether, as frontline NHS care starts to feel the financial pinch, this is the right time to be generating new pressures on scarce resources.

Responsible Officers

The role of overseeing revalidation is likely to fall to medical directors, but there are concerns that this could result in significant conflicts of interest. Is their main duty to support doctors through the process or to be accountable to the GMC and/or the employer? Surely doctors will be less likely to raise concerns if that could jeopardise that individual's revalidation process? Clearer and more robust ways of dealing with conflicts of interest are required. Another question is how medical directors will be supported in this additional workload. Whilst in England, the DH has suggested that each RO will oversee the revalidation of around 150 doctors, ROs in Wales look likely to be responsible for almost 10 times that number.

IT systems

Whilst doctors will be responsible for producing some of the supporting evidence, local systems will need to be strengthened to generate accurate and valid data in areas such as clinical audit, clinical monitoring and activity data, complaints and patient safety systems. A recent assessment by the team responsible for overseeing the new appraisal process in England suggests that the NHS is not in a position to provide such data yet. Without it, it will be impossible to introduce revalidation.

Equality

Revalidation needs to be a fair and open process with equivalent standards across each speciality and sector. This is not the case at the moment as some Colleges seem to be pushing ahead with more exacting standards than others. No one should be asked to produce more evidence than their peers, particularly since some doctors will find it much harder to collect evidence than others. For example, locums and those from smaller specialties may struggle to produce sufficient evidence. No doctors should be penalised by revalidation simply because they are unable to collect the evidence they need.

Pilots

This process needs to be thoroughly tested, involving doctors from each speciality and sector with independent evaluation. Where the pilots flag up clear concerns, as they have in the Mersey region, these should be publicised so that there can be an open and honest debate. Given the importance of learning from these projects, we feel that each pilot phase should be run independently until each phase has been fully evaluated. If there is no opportunity for lessons to be learnt and improvements made to the process, the end-product may not be fit for purpose. The revalidation project must not repeat the mistakes of the rushed and botched introduction of Modernising Medical Careers (MMC) in 2007.



Committee update – what the BMA's committees are doing for you

Central Consultants and Specialists Committee (CCSC)

The CCSC has continued to raise concerns about affordability and resource allocation in the course of various meetings with the GMC, DH and others. In December, it participated in a revalidation workshop with the DH to consider the benefits, costs and risks of revalidation. Our views, often challengingly sceptical, are likely to feed in to the DH business case in due course.

It also considered the conflicts of interest around the role of the responsible officer and the mechanisms required to deal with this. We hope that this will be clarified when the DH formally responds to its consultation in January.

The BMA now writes a blog on revalidation for hospital dr.

It can be found here:

<http://www.hospitaldr.co.uk/blogs/bma/where-is-the-revalidation-juggernaut-heading>

Equal Opportunities Committee (EOC)

The EOC has held further meetings with both the DH (England) and the GMC to discuss various concerns, particularly around the role of the responsible officer. The EOC pushed for the need for there to be a duty on designated organisations to co-operate with the monitoring arrangements that are put in place to scrutinise the decisions made by ROs. We hope that this will provide a degree of transparency and reinforce confidence in the process. The EOC believes that there should also be a requirement on designated organisations to monitor and publish data on appraisals, revalidation, and disciplinary action by type of doctor and in relation to the diversity strands. The importance of an appeal process was stressed, involving an external review undertaken by one or more ROs, outside the organisation and

unconnected with the organisation or with each other, who represent the diversity of the trust medical staff. The DH (England) indicated they were still in the initial stages of identifying key stakeholders and collating information to inform their Equality Impact Assessment. They will be holding an event to discuss progress on this, to which the EOC will be invited.

Following the DH consultation on ROs, it is encouraging that equality and diversity training will be a requirement for the role.

The full BMA response to the RO consultation can be found here:

http://www.bma.org.uk/employmentandcontracts/doctors_performance/professional_regulation/responsibleofficersconsultationresponse.jsp

General Practitioners Committee (GPC)

The GPC has continued to raise very strong concerns about the resource implications of revalidation for GPs during meetings with relevant stakeholders, including the DH. It wants to ensure that the system is properly funded, that it is professionally appropriate and proportionate, and that it is equitable for sessional GPs.

The RCGP has recently published three documents that are relevant to GP revalidation (links below). The GPC has been feeding back on these documents in their various forms, particularly in an attempt to ensure that the proposed CPD system is sufficiently flexible for GPs' different learning needs, and that resource implications for GPs are prioritised in discussions around remediation. RCGP Revalidation Guide Version 3: http://www.rcgp.org.uk/_revalidation/revalidation_guide.aspx

Guide to the credit based system for Continuing Professional Development:

http://www.rcgp.org.uk/practising_as_a_gp/professional_development/cpd_credits_scheme.aspx

Remediation for General Practitioners: http://www.rcgp.org.uk/_revalidation/revalidation_documents.aspx

Junior Doctors Committee (JDC)

Are you a junior doctor? Are you confused by how revalidation and in particular how relicensure will affect you? The Junior Doctors Committee is currently drafting information specifically for junior doctors. A fact sheet will be published on the BMA website soon. In the meantime, more general information can be found here: www.bma.org.uk/revalidation

Medical Academic Staff Committee (MASC)

Following meetings with the GMC, it has been agreed that academics will not be revalidated separately for their academic work; evidence that there had been an appraisal process that was Follett-compliant and took due account of such work would be sufficient.

The MASC had raised some concerns over the GMC's FAQ for the revalidation of medical academics and it was agreed that the FAQs would be amended in line with the discussions outlined above and that it would be considered a live document. The relevant FAQs for academics can be found here:

http://www.bma.org.uk/employmentandcontracts/doctors_performance/professional_regulation/academicrevalidationfaq.jsp

MASC has recently written to the DH reiterating that revalidation should not and need not be reliant on a separate assessment of academic activities and stressing the importance of the inclusion of medical academics within the pilot groups.

Staff and Associate Specialist Committee (SASC)

At the SAS Recognition and Development Conference in November, Peter Rubin outlined the challenges ahead with the implementation of revalidation. He explained that:

- The process should be as simple as possible, building on local systems to ensure that doctors were revalidated on what they currently did.
- The five year cycle for revalidation should mean that any concerns were flagged early in the five year cycle.
- Revalidation should be straightforward for most doctors.
- Whilst ROs would be responsible for making recommendations on revalidation, the final decision would remain with the GMC.

He concluded by stating that revalidation should be built around an effective and credible appraisal system and multi-source feedback for all doctors with early identification and remediation of any problems on a continuous basis.

If you would like to question the SASC Chairman on anything related to revalidation, please email info.sasc@bma.org.uk. He is due to be interviewed mid-February.

Devolved nations

NORTHERN IRELAND >>>



Whilst progress has been slow, work on revalidation continues to be monitored and taken forward through the BMA (NI) Council and its Branch of Practice (BoP) Committees. Locally, the BMA (NI) continues to be fully engaged with policy making bodies in revalidation.

We have recently developed a paper which was presented both locally and nationally outlining the conflict of interest issues

pertaining to Responsible Officers, and which will be used to inform discussions with the Department on NI statute modifications and the NI Responsible Officer consultation. The DHSSPS consultation on the Role of the Responsible Officer was launched on 4th December 2009 and will close on 5th February 2010. Work is ongoing to develop guidance for dealing with concerns as they arise and to establish principles for information sharing to support tackling concerns and linking into revalidation.

The workstreams of the DHSSPS Confidence in Care Programme continue to meet on a regular basis to discuss issues such as appraisal documentation and systems and tackling concerns locally. As part of this programme, a workshop took place to examine the potential impact on locum

agencies of some of the proposed changes to medical regulation. A further workshop has been organised for 1 March 2010 to examine more specifically the role of the responsible officer in relation to clinical and social care governance and tackling concerns.

GMC and Revalidation

Peter Rubin recently visited Belfast to speak at the BMA's Joint Divisional meeting. He outlined the various challenges facing the GMC as it implements revalidation and relicensing proposals and took questions on a range of topics such as the retired members' fee, who responsible officers should be, and the immense psychological pressures that doctors face when under investigation by the GMC.

SCOTLAND >>>



In Scotland employers, doctors and NHS Education for Scotland (NES) are working towards implementation of revalidation – noting developments south of the border – but with a pragmatic recognition that the process cannot be initiated until all the necessary elements are in place.

The Revalidation Delivery Board for Scotland is charged with coordinating delivery of revalidation. It has noted various documents from the (DH England) Revalidation Support Team and the Academy of Medical Royal Colleges and is carefully evaluating their relevance to the profession in Scotland. Various Scottish pilots are under way and clarity is being sought over the funding that will be necessary for both infrastructure and remediation.

It is clear that the timetable for the introduction of revalidation is challenging

but there is a determination in Scotland that when it is introduced it will be at an appropriate level, will not be inappropriately onerous on individuals and will not consume too many precious resources.

In the meantime Scottish doctors should continue to collect the evidence already prescribed by the existing system of appraisal and expect only developmental and incremental changes to what has gone before.



Since the last edition of this newsletter, BMA Cymru Wales has organised a very successful one-day revalidation conference in October in Cardiff. This joint conference with GMC Wales, the Wales Deanery for Postgraduate Medical & Dental Education, The Welsh Assembly Government and the Academy of Medical Royal Colleges in Wales was also very timely, as it coincided with relicensing going live. This was the first time in Wales, and possibly even in the UK, that all of the key players have appeared together in front of ordinary members of the medical profession who are directly affected by revalidation and its component processes. Although there were some 80 doctors present, the conference was oversubscribed, so we plan to hold another event in North Wales in spring 2010.

The morning session of the conference provided an opportunity for each of the partner organisations to explain how they are contributing to the implementation of medical revalidation in Wales, and a short presentation was given by each. The conference was filmed and it can still be viewed online at BMA Cymru TV (<http://uk.youtube.com/user/bmacymrutv>).

The afternoon session included an opportunity for doctors in Wales, including those not able to be present on the day, to put questions to the 'expert panel' representing each of the partner organisations. The conference ended with a closed meeting of BMA members, which gave them a chance to comment upon and influence BMA Welsh Council's policy on the implementation of medical revalidation in Wales. It is clear that members support Welsh Council's drive to ensure that revalidation processes are based on a 'light touch – positive affirmation – low bureaucracy' model and it is very encouraging that a clear consensus for this has emerged between all of the key stakeholders.

The previous Newsletter mentioned the now well-established, online GP appraisal system operated by the Wales Deanery for all GPs in Wales. At recent meetings of the Wales Revalidation Delivery Board, BMA Cymru Wales has lobbied hard for the wider adoption and adaptation of this model. It has many advantages, including being free at the point of access, it incorporates the relevant Royal College's standards (but isn't dependant on College membership), is securely accessible online and because it's operated by the Deanery is employer-independent and fully quality-assured. It also has the overwhelming confidence of GPs! Consequently, it is very encouraging to see that the appraisal model is now being piloted in secondary care settings (in Hywel Dda Local Health Board) to assess its suitability for use.

BMA Welsh Council is keen to hear individual doctors' views on revalidation and welcomes feedback through LNCs/LMCs, divisions, branch of practice committees, or directly to Welsh Council members.

Recent publications

Revalidation guidance for SAS grade doctors

http://www.bma.org.uk/employmentandcontracts/doctors_performance/professional_regulation/sasrevalidation.jsp

AQMAR interim findings

http://www.revalidation.support.nhs.uk/files/AQMAR_interim_findings_summary_report_Dec_09.pdf

GMC Affiliate pilots: final report of the KPMG evaluation

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109274

Explaining licensing to patients

<http://www.gmc-uk.org/news/5331.asp>

Recent BMA news stories

- Report questions who pays £7m for affiliates
- Recession sparks revalidation worries
- Revalidation equality for all, demands BMA
- Regulation study prompts BMA 'witch-hunt' warning
- Revalidation conflict of interest fears
- Revalidation pilots come in as take-off rears

Look out for the forthcoming GMC consultation

This consultation is due to be released in early-March. It will be wide-ranging and seek to finalise the following:

- Revalidation model
- Framework for appraisal and assessment
- Specialty standards
- Principles and criteria for multi-source feedback
- CPD principles
- Updating the medical register
- Roll-out of revalidation.

Further details will be made available on the GMC website in due course. We would urge all our members to respond.

If you have comments to make about this newsletter, about revalidation or about what the BMA is doing to support you, please contact: info.revalidation@bma.org.uk