Chairman’s introduction

As many of you will be aware, the BMA’s Annual Representative Meeting (ARM) took place recently. The ARM is our annual policy-making body and approximately 500 doctors from all branches of practice descended on Brighton to debate and vote on the major issues facing the profession and the health service.

Revalidation was the subject of several heated debates and, as always, it was invaluable to hear the views of doctors who work ‘at the coal face’. Doctors, rightly, feel strongly about revalidation and there remains much anxiety and confusion about how the system will work. I reiterated the BMA’s views that any system that is implemented must be fair, transparent and light on bureaucracy. I was also keen to draw attention to the fact that we are still very much in the planning, consultation and evaluation stages of this process, as demonstrated by Andrew Lansley’s recent announcement that the piloting period will be extended by a further year to ensure proper and thorough evaluation of the pilots. We welcome this announcement and further information about the Secretary of State’s decision and the pilots can be found below.

We are clear that while the BMA remains supportive of the principle of doctors demonstrating their continued fitness to practise, this must not be at the cost of time spent with patients or place an unnecessary burden on the profession or the health service. We have also made clear the minimum requirements we need to see delivered which, taken together, make up the BMA’s ‘line in the sand’ in terms of revalidation. We have responded robustly to the GMC’s consultation, and you will find more information about the BMA’s response below. We will continue to engage with the GMC, colleges and the departments of health in all four nations, in order to raise the profession’s concerns and push for a system that is fully thought-through, proportionate and properly resourced.

GMC consultation response

The consultation document, Revalidation – the way ahead, outlined the GMC’s proposals for revalidation and was based around 4 key themes: how revalidation will work, what doctors and employers will need to do, patient and public involvement and how and when revalidation will be introduced. In our response, we made clear that whilst the BMA supports the principles behind revalidation, we are concerned that the current proposals:

- Appear designed to describe excellence as a doctor rather than what is needed to maintain registration
- Bear disproportionately on individual doctors who may be unable to provide the level and extent of the detail required to revalidate
- Depend on the successful implementation of strengthened appraisal, when for many doctors ordinary appraisal has never been successfully implemented
- Appear designed to support an untested and unproven industry providing multi-source feedbacks
- Will prove expensive to implement and give rise to the possibility, in the current financial climate, that these costs will fall on individual doctors
- Have the potential to generate serious and multiple conflicts of interest in some designated organisations where the Responsible Officer is an executive director of the organisation
- Reinforce the view that revalidation is an all-or-nothing assessment of a doctor’s fitness to practice instead of a continual process of improvement in performance.

Following the close of the consultation, the GMC issued a press release to say that the proposals would be streamlined and simplified in light of the responses it had received. The press release can be found in full here: http://www.gmc-uk.org/news/7356.asp

Introduction of Responsible Officers

The draft RO regulations were laid in Parliament on 26 July and should come into force on 1 January 2011. Further details about the regulations, guidance and impact assessment can be found here: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117861
Revalidation pilot extension

Following the BMA’s response to the consultation, the Government echoed many of our concerns and extended the pilots by a further year. We have maintained that revalidation should only be introduced once the pilots have concluded, been fully-evaluated and the lessons learnt from them have been incorporated into plans for the national roll-out. We therefore welcome the extension and agree with the Secretary of State that it should enable us to develop a ‘clearer understanding of the costs, benefits and practicalities of implementation’. The Secretary of State’s letter to Peter Rubin underlines our view that the benefits need to be robust, achievable and cost-effective. As part of this, the specialist standards need to be proportionate.

The letter can be read in full here: www.bma.org.uk/revalidation

Stage 1 pilot reports
The reports from the five 1st stage pilots, involving primary and secondary care, along with the independent sector, have now been published.

Mersey pilot
This involved around 115 secondary care doctors and tested whether strengthened appraisal, based on the GMP Framework, could meet the demands of revalidation. It also explored the types of supporting information that could be used. The key findings include:

- 76% of appraisers felt that they would be confident to make a judgement as to whether the appraisal was ‘satisfactory’, as part of a five-year revalidation cycle.
- More guidance was required on the necessary quantity, quality and frequency of information for each attribute.
- 67% of appraisees and 60% of appraisers said that information gathering was not well supported by their Trust, and data was inaccurate, irrelevant or non-existent.
- The median time for appraisees to complete the process was 22 hours.
- 70% of appraisers, but only 40% of appraisees, felt that there would be an improvement in patient care as a result of the enhanced appraisal process.
- Participants expressed concerns during focus groups about the potential for Responsible Officers to have a conflict of interest, and thus to make a biased judgement against (or for) an individual.
- Concerns with the electronic appraisal toolkit tended to overshadow other aspects of the pilot project.

Sessional GP pilot
This study explored the potential problems locum, salaried and remote GPs may have with the proposed supporting information required for appraisal. In total, 53 sessional or remote GPs took part. The key findings include:

- Locums felt that they were perceived to have a lower status than other GPs, and that this translated in to a lack of engagement and support from practices in completing appraisal and revalidation activities.
- Locums, OOH, and remote GPs all reported that they would or did struggle to find enough doctors and other staff to nominate for MSF.
- Locums and Out of Hours GPs reported having the most difficulty in achieving an audit. This mainly focused on access, time and the ability to do something meaningful, and with their temporary and outsider status having access to necessary data.

The report suggests that the RCGP could improve engagement with these doctors by addressing:

- Issues of isolation and lack of support, by encouraging practices and PCOs to engage with all their GPs.
- The logistics of evidence collection and by providing guidelines and flexibility in evidence collection to allow evidence to be more easily and appropriately gathered.
- The purpose of supporting information. By looking at the intention behind the supporting information, alternative methods may be identified which are more suited to non-partner GPs’ ways of working.

Doctors working in special circumstances
This pilot involved locums, doctors working abroad, those on long-term leave along with those who had just returned to practice. Its aim was to explore issues and difficulties facing these groups of doctors, establish what supporting evidence could be used and to understand their perceptions of the revalidation proposals.

Locums felt that due to lack of time, lack of funding and isolation from practices and peers, they would not be able to collect a lot of the supporting information. The pilot identified that greater support was required, along with tailored MSF tools to enable this group of doctors to revalidate. It is evident that considerable support is required for overseas doctors. The majority of participants expected to encounter difficulties with the range of supporting evidence required, including CPD, MSF, review of complaints and significant event reviews. Greater flexibility, additional support and understanding on the specific circumstances of their work is necessary.

The supporting information suggested in the proposals could be collected by non-working doctors after a significant amount of time, as long as there were the correct resources in place. Examples from the group included the need for mentors, supervised practices, anonymous data for case reviews and significant events, all given as part of a returners course. The overall message from the returners group was a clear need for more information. A returners course was identified as a very helpful resource for the future proposals.

Further information about the independent sector pilot into strengthened medical appraisal, the primary care pilot looking at the feasibility of collecting supporting evidence and the full reports from each pilot can be found here:
http://www.revalidationsupport.nhs.uk/hot_topics.asp

http://www.bma.org.uk/revalidation
Central Consultants and Specialists Committee (CCSC)
The CCSC has recently become aware that some employers are promoting and seeking local agreement on new policies on strengthened appraisal. While strengthened appraisal will form the basis of revalidation, a number of pilots are considering what form it will take. In the meantime, employers should use the standard appraisal processes to ensure the integrity of the pilots and to avoid the chance that these local processes will not be sufficiently robust to support revalidation when it is introduced. We have raised this with the DH and RST and are exploring ways to ensure that non-pilot sites continue to use the standard appraisal process. If your trust is seeking to make changes to appraisal, please let us know:

info.revalidation@bma.org.uk

In March, we published a set of principles around which revalidation should be based. We are currently working with the DH to establish how each of these can be measured and achieved. These seven principles formed the basis of our response to the GMC consultation and can be found here:

http://www.bma.org.uk/employmentcontracts/doctors_performance/professional_regulation/revalidationstatement0708.jsp

Equality and Diversity Committee (EDC)
In February, the EDC attended a meeting with the GMC and DH (England) to discuss equality and diversity issues and the role of the responsible officer. The discussion focussed on the legislative framework that empowers the responsible officer and appropriate checks and balances on those powers. This was of particular concern in light of the research published by NCAS showing that non-white doctors who graduate outside the UK, older doctors and men are at greater risk of referral to NCAS. The EDC pushed for there to be a duty on the designated organisation to scrutinise the decisions made by ROs to increase transparency and reinforce confidence in the process. The role of the Board was discussed in reviewing the recommendations made by the RO and the GMC acknowledged they would need to be auditing the recommendations received from ROs and reflecting these back to organisations. The group agreed to meet again after the summer to discuss the results from the pilots and the GMC’s consultation.

General Practitioners Committee (GPC)
Laurence Buckman, the GPC chairman, has written to the RCGP to communicate the BMA’s seven principles for revalidation, particularly the need for there to be equality of opportunity to revalidate and a clear mechanism for dealing with conflicts of interest for responsible officers. The GPC has taken the opportunity to comment on the Revalidation Processes for Sessional GPs: A Feasibility Study to Pilot Current Proposals report to the RCGP. In this report there are a number of proposals for making the revalidation process more appropriate for sessional GPs that the GPC believes will need to be validated and evaluated. The GPC will fully review the recently published Version 4 of the RCGPs Guide for the Revalidation of General Practitioners. Version 4 of the Guide includes a revised Section 3 titled ‘Supporting Information required for the revalidation of GPs in special groups’.

Committee representatives have continued to raise GPC’s significant concerns about the resource implications of revalidation for GPs at meetings with relevant stakeholders. The representatives have also persisted in asking for progress on the development of remediation and emphasised that remediation must be fully funded. The GPC has representation on the pathfinder pilots being organised by the London Deanery and NHS Dorset and continues to be updated by BMA representatives on the progress of the eight other pathfinder pilots. The GPC representatives are monitoring the progress of the pilots and working to ensure that the proposals for revalidation are properly evaluated. Version 4 of the RCGPs Guide for the Revalidation of General Practitioners can be found here:


Junior Doctors Committee (JDC)
The JDC has been lobbying in meetings with the GMC for the ARCP to be entirely separate from the revalidation process. We have argued that successful progression through training can be the means for trainees of securing their revalidation, but the converse should not necessarily apply. Progression through training is about proceeding to the next stage in one’s career, whereas revalidation is about confirming someone’s fitness to practise at the level in which they are presently working (and with the same level of supervision) as shown by the process planned for GPs, consultants and SAS doctors. Although it is necessary to be fit to practise to progress in one’s training, the converse is not true. Many common scenarios bear this out, for example the trainee who is put into remedial training to allow them more time to pass an exam they have failed once. The annual reviews that all junior doctors undergo through ARCP/PRITA (and the academic equivalents) will provide evidence of fitness to practise at that level, and are an opportunity for concerns about conduct, etc., to be raised. Therefore any ARCP/PRITA panel meeting that does not result in formal investigation, a recommendation to the junior doctor’s RO to delay a positive revalidation recommendation, or referral to the GMC should be considered to be evidence of fitness to practise, even if the junior doctor has failed to progress or even been asked to leave the training programme.

Staff and Associate Specialists Committee (SASC)
The SAS Committee has been working on updating our guidance notes in light of the extension of the pilots and the publication of the reports of the first stage pilots. You will also find a podcast from the SASC Chair with updates on how the proposals will affect SAS doctors. Following the closure of the revalidation consultation the SASC Chair recently met with the GMC to discuss the involvement of SAS doctors in the pilots and future GMC plans to address BMA concerns. The SASC Chair raised the concerns regarding Responsible Officers, particularly given the possibly vulnerable nature of many SAS and BME doctors and agreed to work with the GMC to ensure checks and balances were robust.
In extending the pilots, the Secretary of State’s letter gave his commitment to ensuring that the necessary legislation to support revalidation will proceed and regulations establishing the Responsible Officer role in England, Scotland and Wales will be laid before Parliament. In light of this extension, the Chairman of the BMA (NI) Council Revalidation Subgroup called on the Department of Health, Social Services and Public Safety (DHSSPS) to delay the introduction of revalidation. The equivalent legislation in Northern Ireland ‘The Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010 was approved by the NI Assembly on 22 June 2010, with a view to having Responsible Officers in place in designated organisations by 1 October 2010.

The workstreams of the DHSSPS Confidence in Care Programme have recently undergone restructuring. The purpose of the revision of the Tackling Concerns and Revalidation workstream structures is to bring together the key stakeholders for revalidation and the implementation of the Responsible Officers and to use smaller working groups to share knowledge, best practice and learning from local and national pilots. The BMA (NI) representation on these workstreams will remain in place, with the possibility of additional representatives being called on to populate the subgroups.

The DHSSPS is continuing with its current testing of a minimum data set for appraisal and the Primary Care readiness review of appraisal and clinical governance systems. Work is also being undertaken in the 5 HSC Trusts, the Health and Social Care Board and NIMDTA on appraisal and preparation for revalidation and will continue to provide support to individual organisations as requested.

BMA Scotland has lobbied hard to ensure that the implementation of enhanced appraisal and revalidation in Scotland is realistic, proportionate, and avoids unnecessary bureaucracy and expense. Discussions with the SGHD indicate they understand our concerns and are willing to adopt a more pragmatic approach than they had, particularly with regard to secondary care appraisal, initially proposed. We are maintaining a constructive dialogue with the SGHD, but given the continuing uncertainty over revalidation, we are anxious not to rush to pre-empt any UK level developments at this time.

As expected, the recent GMC consultation dominated recent months and BMA Cymru Wales has encouraged individual doctors to comment upon it. After our successful joint revalidation day in South Wales in October 2009 (as reported in the January 2010 edition), we supported the GMC in holding two open events for doctors in North Wales. These meetings provided further opportunities for practising doctors from all branches of practice in North Wales to meet the GMC Chairman, Peter Rubin, to question him on the implications of revalidation, and to express their concerns. The structural reform of NHSS Wales, with the abandonment of the purchaser-provider split and creation of integrated Local Health Boards, has drawn employers’ attention to appraisal of employed doctors, in readiness for the introduction of revalidation. The WRDB has proposed a peer/professional model for appraisal of doctors in secondary care, based on the successful GP appraisal model that currently operates in Wales. This is being piloted in both Hywel Dda and Abertawe Bro Morgannwg LHBs and BMA Cymru Wales will be encouraging the Wales Deanery for Postgraduate Medical & Dental Education to hold open meetings for secondary care doctors to explain their model and how it works in practice.

Recent publications

BMA response to the GMC consultation

BMA statement of principles on revalidation
http://www.bma.org.uk/employmentandcontracts/doctors_performance/professional_regulation/revalidationstatement0708.jsp

1st stage pilot reports
http://www.revalidationsupport.nhs.uk/hot_topics.asp

GMC consultation documents
http://www.gmc-uk.org/doctors/licensing/5786.asp

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