

# **Royal College of General Practitioners**

**Revalidation Criteria, Standards and Evidence: outcome  
of consultation with stakeholders and the profession**



**April 2009**

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## Background to Revalidation

1. In 2009 the General Medical Council will introduce licensing. All doctors who are registered at the time that licensing is introduced will be entitled to a licence to practise. From its introduction next year, it will be the licence, rather than registration that signifies to patients that a doctor has the legal authority to write prescriptions, sign death certificates and exercise a wide range of other legal privileges. General practitioners will need a licence to practise if they work as a doctor, either in the NHS or in the independent sector on a permanent or locum basis. GPs will remain on both the general medical register and the GP register.
2. Only licensed doctors will be subject to revalidation. In common with all doctors, GPs will need to be relicensed and recertified (for the GP register) periodically. These two outcomes will be achieved through one process – revalidation – which will require evidence that they keep up to date and continue to be fit to practise.
3. The Royal College of General Practitioners (RCGP) has the responsibility, on behalf of members and non-members, to propose the standards and revalidation methods for the revalidation of general practitioners. The General Medical Council has to approve those standards and methods before introduction.
4. The first practical step towards defining the standards for revalidation was the publication by the General Medical Council of a Framework for Appraisal and Revalidation<sup>1</sup> based on Good Medical Practice. The criteria for the revalidation of all doctors are based on this document.
5. Next the RCGP published its revision of Good Medical Practice for General Practitioners<sup>2</sup> which sets out the expectations of an exemplary and an unacceptable general practitioner. The latter are the standards for revalidation.
6. Finally the RCGP has been describing the evidence required for most general practitioners and for those who will find the normal process challenging; and the process for revalidation.
7. The RCGP has been working with key partners – the General Medical Council, the General Practitioners Committee of the British Medical Association, the Academy of Medical Royal Colleges, the Departments of Health and bodies such as the Revalidation Support Team in England – to prepare for its roles. The consultation document took into account the views of these partners.

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<sup>1</sup> [http://www.gmc-uk.org/about/reform/gmp\\_framework.asp](http://www.gmc-uk.org/about/reform/gmp_framework.asp)

<sup>2</sup> RCGP and GPC. Good Medical Practice for General Practitioners: 2<sup>nd</sup> Edition. London: RCGP, 2008 [http://www.rcgp.org.uk/PDF/GMP\\_web.pdf](http://www.rcgp.org.uk/PDF/GMP_web.pdf)

## Consultation Process

8. The Royal College of General Practitioners (RCGP) launched the second phase of its consultation on the processes and the evidence required for revalidation on the week commencing 1<sup>st</sup> December 2008. Whilst in the first phase the College sought feedback from relevant stakeholder organisations, in the second phase the invitation to comment was extended to the entire profession. A letter was sent to all practices in the UK notifying them of the consultation, which was accessible on the RCGP website. The consultation also targeted key stakeholder groups. The consultation document, included here as an appendix, contained four elements:

SECTION 1: A description of the process that the Royal College of General Practitioners proposes for the majority of general practitioners who are in clinical practice.

SECTION 2: A description of how revalidation might occur for those general practitioners who need a non-standard route.

SECTION 3: The mapping of the RCGP criteria for revalidation to the General Medical Council's framework

SECTION 4: The criteria, standards and evidence that will be used in revalidation for general practitioners

9. The second phase of the consultation closed on the 9th January 2009. The College has received approximately 230 responses from Sessional, Principal, Retired and Portfolio GPs, as well as organisational responses, including those of the British Medical Association General Practice Committee (BMA GPC), the National Association of Sessional GPs (NASGP) and the NHS Revalidation Support Teams. We have also received responses from Local Medical Committees (LMCs) and PCT leads on appraisal. All countries of the UK, as well as the Republic of Ireland, are represented in the responses we have received. Additionally, the patient perspective has been voiced through the contributions of lay patient groups in the UK and Scotland. The College has also received feedback from doctors based overseas who have commented on the implications that revalidation might have for them. A full list of individuals, organisations and groups who responded to the consultation can be found in Appendix 2. This document summarises the main issues highlighted in the comments the College received. These are laid out under their relevant questions.
10. The College has given careful consideration to the comments received. In the section near the end of the document titled Overview and Next Steps, Professor Mike Pringle, the National Director for Revalidation, considers the feedback and outlines the action that the College will take to address any concerns raised.

## Introduction

11. There was a great deal of support for the College's proposals which, according to the NHS Revalidation Support Team, continue to "mark out the RCGP as being the revalidation vanguard". Several respondents recognised that the establishment of a 'robust structure' would be of great benefit to patients as a quality assurance process and the profession as useful developmental tool.
12. Several respondents considered the consultation document itself to be comprehensive, well considered and reflective of the hard work the RCGP has put into this area.
13. The fact that revalidation is part of an ongoing process that incorporates what GPs are already doing (i.e. appraisal, continuing professional development and audit) was welcomed. It was recognised that GPs were already familiar with annual appraisal and that this should make the transition to revalidation more straightforward.

## The suitability of the process to different types of GPs

14. Others were supportive, but wanted particular concerns to be addressed about the suitability of the process for particular types of GPs. For example, the BMA GPC welcomed the proposals, "providing that the process is not unnecessarily onerous for one group of GPs, such as locums." Several respondents voiced concerned that some of the areas of evidence, particularly Multi-Source Feedback (MSF), Patient Surveys, Significant Event Audits (SEAs) and Audits of Care would be particularly difficult for locums to carry out.
15. Furthermore, feedback was received from doctors who, nearing retirement, wanted to move from a position as a principal GP to a portfolio GP and felt that aspects of the proposed revalidation might be impractical for people not working long term in one venue. Several semi-retired GPs were concerned that they would be unable to maintain the minimal clinical commitment necessary for revalidation and that they would struggle to gather the evidence required for the process.
16. The National Association of Sessional GPs (NASGP) requested that infrastructure to support locum GPs is put in place, and that locums can "participate on revalidation on an equal footing" to principal GPs. Several respondents suggested that the RCGP support locums to achieve Multi-Source Feedback (MSF), audits and patient surveys.
17. However, one respondent warned against categorising sessional doctors in the same group, arguing that this 'heterogeneous' group range from the newly trained to the partially retired, the former may be regular or occasional employment whereas the latter are likely to work only occasionally. It was argued that each group has different priorities: young doctors need to consider professional development as their priority whereas the need of older doctors is to keep up to date. Furthermore, it is suggested that unless either group of doctor is in regular employment they will find it impossible to assimilate practice data from the varied work they undertake, and that this should not be expected of sessional doctors who only work on an occasional basis. Both groups, it is argued, would also struggle to identify the requisite number of clinical events for the evidence.

### Concerns about Revalidation

18. Revalidation was, on balance, generally welcomed by most respondents. There were, however, several concerns which it was asked that the College should address. A minority of respondents considered the proposals to be entirely idealistic – fine in principle but difficult to achieve in practice. Others feared that the process might become politicised, with one respondent supposing that the government might be able to have influence over which patients provide feedback for particular GPs. It was also suggested that the process does not have a firm enough evidence base, and that it might fall victim to ‘current fashions in medicine.’
19. There is no doubt that a few respondents considered Revalidation to be a threat to their careers, with one respondent observing that “there was no threat of losing you license to practise through annual appraisal.....a non-threatening constructive process...but this is a real threat through revalidation.”
20. Several respondents advised that the process should be “cost effective” and that a financial assessment should be included. Others highlighted the necessity of investing in appraisal, which was considered to be the cornerstone of revalidation. A typical response was that the process looks fine in principal, but the details need to be worked out.
21. Others highlighted the potential disruption that the process could cause to practices because of the additional preparation and personal development time doctors would require for completing the process. It was suggested that this could be a particular problem for small or rural practices, or generally those with a smaller workforce.

### Arguments against Revalidation

22. A very small minority of respondents were vehemently opposed to the introduction of Revalidation, with some reporting that they had no intention of ‘wasting their time’ by supplying evidence to justify their work when their patients were perfectly happy with the service they received. Others argued that revalidation would prove ineffective, with one or two respondents questioning whether revalidation could stop another “Shipman”. Revalidation was dismissed by some of those who shared this view as a ‘form filling’ exercise.
23. Others felt that revalidation was not appropriate for the GP profession. One respondent feared that the process would demoralise and demean the profession (in much the same way, they argue, that Ofsted has damaged the teaching profession.) Others spoke of the ‘demise of the caring GP’ and their replacement by a ‘target driven’ culture and suggested that the “new rules seem to have been designed by those with a more cynical view of the profession.”
24. It was suggested by another respondent that the process would not be able to capture all the aspects of being a GP, such as the challenges of using time and resources or how well GPs respond to difficult, demanding or emotionally needy patients.
25. Other respondents simply argued that revalidation would be too onerous and would significantly increase the workload of general practitioners. Two or three

respondents even felt that patient care could suffer because GPs would be distracted by the process. Linked to this was the argument that revalidation could potentially undermine existing appraisal processes and replace them with 'performance management systems'. It was suggested that unless considerably more time is allowed for appraisal meetings (which will have cost implications), the developmental, formative and supportive aspects of appraisal will suffer. A common misconception was that the current appraisal process would not be incorporated into the revalidation process and that GPs would have to duplicate much of their work. It was therefore suggested that the processes of appraisal and revalidation be combined.

26. A small minority of respondents believed that other forms of assessment would be more appropriate. One suggestion was that GPs should be shadowed or closely observed by a colleague for a week. Another suggestion was that the GP should spend a day in the appraiser's surgery to ensure that if there are any clinical difficulties they could be identified and dealt with.

#### The role of the RCGP

27. Several respondents commented on what they considered to be the appropriate role of the RCGP in the revalidation process. A few respondents argued that the College was "empire building" and that Revalidation was an imposition by "enthusiasts" and "educationalists". Others perceived that the RCGP was taking on the role of a "policeman" for the government and the GMC and were opposed to this.
28. Other respondents were supportive of the idea of a general practice body being a "standard setter" for the process, but advised against the RCGP being involved in recommendations to the GMC about whether an individual's portfolio meets minimum standards. This was a view held by the Principal Medical Director of NHS Nottinghamshire County.

#### Impact on NHS organisations

29. The potential impact of revalidation on NHS organisations was highlighted by NHS Highland, who, through RCGP Scotland, has volunteered to be part of an early project which aims to uncover the practical challenges that NHS organisations might face.
30. NHS Highland informed the College that NHS Boards already have to consider a large number of hospital doctors in time there would be a need for the existing systems system (the GMC and the Colleges) to expand to be able to cope with GPs also.
31. In addition to infrastructure requirements, it was also suggested that there would be a need to fund Responsible Officer activities, and a need to support those who fail in their Revalidation attempt; some of these will only require minor remedial support, others will require more intensive input. The loss of GPs who fail Revalidation will also impact on health systems.

32. However, it was also noted that many existing Clinical Governance Frameworks and structures within NHS organisations will lend themselves relatively easily to assisting in the administrative and process management of Revalidation.
33. It was also suggested that revalidation would result in an increased workload for PCTs in an English context.

#### General Practitioners with Special Interests (GPwSIs)

34. The Royal College of Anaesthetists (RCoA) urged the College to insert a recommendation in any guidance produced that GPs with a special interest consult the standards documentation of their special interest body, even though they may not be working at the level of a clinician on the specialist register. The RCoA also informed us that during 2009 the Academy Revalidation group will, with the GMC, be addressing the issue of clinicians practising in specialist areas of secondary and community care who are neither on the specialist register nor in training posts.

#### GPs in the Republic of Ireland (ROI)

35. The RCGP ROI faculty informed us that there were approximately one hundred doctors in the ROI, most of them members of the College, who have traditionally also held GMC registration, even though they principally live and work in the ROI. The new proposals for relicensing and revalidation, it was argued, would have a significant impact on these GPs, and it was suggested that there should be an appropriate pathway for revalidation for members in the ROI. These GPs, it was reported, already follow a competence assurance process which mirrors in some ways the proposals in the consultation document.

#### The consultation process

36. Finally, some respondents expressed disappointment at the length and timing of the consultation process. There did, in some cases, appear to be a delay in terms of the consultation documents filtering down to all who would wish to respond meaning that people were only made aware of the consultation some time after the College had sent it out. The deadline was extended for those who have had difficulty in responding by the original closing date.

## **SECTION 1: The standard process for the revalidation of general practitioners**

*Question 1: Have you any comments on the principles identified? Are any unclear, or are there any that have been missed?*

37. The principles were generally thought to be clear and acceptable.

38. It was argued that revalidation should be presented positively i.e. that its purpose is to allow the great majority of GPs to demonstrate to the public and profession their competence and fitness to practice, not to detect performance issues.

### On specific principles

- revalidation should act as confirmation that local processes have been effective
39. One respondent suggested that the line 'Local continuing clinical governance systems will detect and address performance issues' to 'Local continuing clinical governance systems should detect.....'
- revalidation should not be overly onerous for GPs, but should be sufficient to provide confidence to the public
40. Several respondents took issue with Principle Four, that "Revalidation should not be overly onerous on general practitioners". It was suggested that this might not be the case for locums, for whom it was suggested that some of the areas of evidence would be "onerous" to collect. It was however recognised that revalidation should be challenging enough to provide the public with confidence in the process and profession.
- evidence required and standards applied must take account of different working lives of GPs
41. See above point
- RCGP must judge that a general practitioner's evidence is suitable for recertification before it can recommend recertification to the GMC

*and*

- If RCGP is unable to make recommendation for recertification, GMC will consider the doctor's case – appeals process against any adverse decision by the GMC
42. There was some concern about Principle Six and Principle Seven which relate to the role of the RCGP in recommending the recertification of GPs to the General Medical Council. Several respondents felt that it was the role of the RCGP to Quality Assure, not to recommend recertification. The NHS Revalidation Support Team suggested that clarification is required on role of the RCGP in decision making as "(Principle 6) implies that the RCGP will actively make a recommendation on every GP for revalidation." A minority of respondents, especially those who are not RCGP

members, were adamant that the RCGP should not be allowed to judge their fitness to practice.

43. One suggestion was that it should be explicitly stated that it is not the RCGP that revalidates a doctor – or rather, that the ultimate decision to relicense is made by the GMC.

#### Other principles to add

44. These are listed as follows:

- “cost-effectiveness” should be built into revalidation
- that standards should be uniform across the country
- Appraisal systems should be objective, fair and equitable across the country and be open to independent review to ensure consistent standards between different PCTs
- the RCGP should not be responsible for poor provision of supportive information from local employers or host organisations
- local clinical governance processes should continue to occur.

#### EVIDENCE TO BE GATHERED

*Question 2: Have you any comments on the areas of evidence to be gathered? Are any of the areas particularly challenging to gather, and if so, how?*

#### General comments about the evidence to be gathered

45. Many respondents considered the evidence requirements to be sufficient and anticipated that they would be acceptable to all parties. It was suggested that there should be a mixture of learning experiences. If, for example, learning only took place online, it was argued that doctors would risk losing contact with colleagues outside their own environment, which was considered unhealthy.

Convergence between RCGP and NHS evidence requirements:

46. The NHS Revalidation Support Team (RST) reported that they were pleased with the level of convergence between the evidence that the College will expect, and that published by the RST (then the NHS Clinical Governance Support Team) in partnership with the National Association of Primary Care Educators in the 2007 Leicester Conference Statement on Essential Advice for Appraisal (The Leicester Statement). The RST pointed to discrepancies between their evidence requirements and those of the College, but suggested that “minor differences between NHS and College requirements can be accommodated.”

Impact on practices:

47. It was suggested that the evidence requirements of revalidation would impact on practices, particularly small practices, because they would have to provide doctors with time for learning and personal development, as well as preparation time to collect evidence.

#### Sessional GPs:

48. Several respondents highlighted the difficulties that sessional GPs might face in terms of collecting some of the areas of evidence, particularly SEAs, patient surveys and multi-source feedback. It was also suggested that sessional GPs often experience problems either finding time to attend courses or finding the resources to fund them.
49. A small number of respondents reported that they had retired as GPs, but carry out occasional locum work to, for example, cover a colleague on maternity leave in their old practice. Commonly, these respondents wished to 'contribute and keep a hand in general practice', but felt that, firstly, they would not be able to maintain the necessary number of sessions to be revalidated and, secondly, they would not be able to collect the required evidence, particularly the patient survey.

#### Overlap with appraisal:

50. Whilst there was agreement that much of the evidence was relevant, it was pointed out that much of this evidence is already discussed at appraisal, and it is therefore unclear why it should be provided again for revalidation. Instead, it was suggested that confirmation from the appraiser that these items had been discussed in appraisal would be sufficient.

#### Confidentiality:

51. It was suggested that any material that might identify a patient should be anonymised, as there are a number of people, other than the appraiser, who have access to the doctor's portfolio. It was also suggested that not all doctors might wish to record their information electronically, especially where sensitive information is recorded, and that the option to record evidence on paper should be retained.

#### Alternative forms of evidence:

52. Respondents suggested that other types of evidence could be used, including observed practice or exams.

#### Area of evidence: DESCRIPTION OF PROFESSIONAL ROLES

53. There were no comments on this area of evidence.

#### Area of evidence: EXCEPTIONAL CIRCUMSTANCES

54. Further clarification was sought as to what might constitute an Exceptional Circumstance.
55. One respondent highlighted the increasing feminisation of the general practice workforce, and suggested that allowance is made for women doctors taking maternity breaks, especially where there are complications of delivery or problems with the baby, such as serious congenital heart defects.

56. It was suggested that exceptional circumstances should also include the serious illness of a partner or spouse and parent or child, rather than simply personal illness.

Area of evidence: APPRAISAL:

57. Annual appraisal was described as the “cornerstone” for future arrangements for revalidation and recertification and it was noted that a well prepared and well undertaken appraisal is a valuable tool to improved performance. However, it was also noted that a great deal has to be done in terms of improving the present appraisal in General Practice, and that would require considerable financial investment.

58. It was suggested that the appraiser must be professional, well trained and independent, and believe in the system as a constructive means of assisting development. It was also suggested that the appraiser role should require an understanding of secondary care and care provided by non-NHS agencies.

59. Whilst several respondents agreed with the principle of annual appraisal, it was thought that five annual appraisals might be difficult to achieve in practice. One respondent suggested that there are sometimes more than 12 months between appraisals, and that if this happened several times during a cycle, a doctor would not be able to complete five appraisals during the revalidation cycle. Assurance was therefore sought, that if a GP was regularly receiving appraisals, but may be a few months overdue for an appraisal at the time of their revalidation, that this would be acceptable.

60. One suggestion was that there should be appraisals in four of the five cycles for a “full” portfolio and in three of five the cycles for a “partial” portfolio.

61. Reassurance was sought that the five annual appraisals would not all be carried out by the same doctor.

Area of evidence: PERSONAL DEVELOPMENT PLAN (PDP):

62. It was suggested that the method used by the GP to identify their learning needs should also be recorded.

Area of evidence: REVIEW OF PDP:

63. There were no comments on this area of evidence.

Area of evidence: LEARNING CREDITS:

64. Several respondents were supportive of learning credits and considered the concept and process to be clear enough, although several respondents suggested that the concept of learning credits would require further definition and suggested that GPs would want further explanation before they agree to accept this element of the proposals.

65. There were also opposing views on the actual number of credits that GPs would have to achieve. A few respondents felt that 250 credits would be too onerous for

GPs to achieve, while other thought that this was a low evidence requirement and suggested that it should be increased.

66. It was suggested by one respondent that learning credits should remain a voluntary assessment, as all GPs have different ways of keeping up to date.

Reliability:

67. One respondent suggested that this was a potentially unreliable area of evidence because of it would be “easy for individuals to over-inflate or underestimate their effort”. Other respondents were concerned that the GP alone would be the sole decision maker on how much credit can be claimed for each piece of work, though in actual fact this is not true because in the appraiser reviews and confirms a GP’s work. Clarification was sought with regards to who would check that credits were being claimed appropriately, and whether there would be a requirement to spread credits over a wide range of topics, or whether there would be a compulsory core.

68. It was suggested that a tool (or matrix) be developed for consideration of the evidence presented to avoid the risk of subjectivity by the self assessor and potential conflict at appraisal if challenged.

Effectiveness:

69. One GP was sceptical about the learning credits on the grounds that “general practice is a rich tapestry of care” and therefore “not all learning can or should be funnelled into the single outcome of measurable patient care.”

Impact on workload:

70. Although several respondents were happy with the process for collecting learning credits, others anticipated that the prospective collection and documentation (including being able to provide evidence and rationale for self-assessment) would be a relatively complex and onerous task, especially in the context of a working day. It was suggested that many GPs might resort to doing this as a retrospective exercise, which might not necessarily be very accurate, reliable or truly reflective of the day-to-day learning that GPs experience in practice.

71. A standard proforma for information to be logged and self-assessed was suggested by one respondent as a method to simplify the process.

Impact on other learning:

72. Others suggested that other areas of appraisal would suffer because learning credits would encourage doctors into an “easy to measure’ clinical routine”. There was a suggestion that learning credits might remove the emphasis from other areas of self-directed learning.

Sessional GPs:

73. The BMA GPC raised the concern that sessional GPs would be disadvantaged because the credit system is based on the ability of the doctor to affect change within their system – something which they felt it is harder for sessional GPs to do.

The Essential Knowledge Update:

74. The Essential Knowledge Update was considered very useful, providing that it did not become too prescriptive. However, one respondent felt that the Essential Knowledge Update was not reflective of a profession which draws its strength from a broad, holistic and dialectic approach to assimilation of knowledge skills and approaches and attitudes.

Area of Evidence: MULTISOURCE FEEDBACK (MSF)

75. Many considered MSF to be a very useful tool. Furthermore it was recognised the rationale behind the requirement for at least two MSFs in the five year cycle was to provide the opportunity to demonstrate change and improvement. However, others suggested that MSF could potentially be harmful and morale destroying if not carried out properly and a small minority of respondents were concerned by what they perceived to be the College's reliance on this 'unproven' tool to provide evidence in so many areas.

Reliability:

76. A common concern was that MSF is not always carried out objectively. One respondent said the following about MSF:

“It is too interlinked with the relationships between colleagues and there is a danger that feedback could be, for example, either so bland as to not ‘upset the apple cart’ or, in the case of a personality clash between colleagues, it might even be defamatory because of a personal grudge of dislike.”

77. Another respondent expressed concern that “the professional development of a doctor could be centred around the comments of a few people in his or her practice, with no proper facilitation and reflection.”

78. An additional consideration, as highlighted by one respondent, was that those completing MSF forms for a GP might have a financial interest in that GP progressing to revalidation as they might be employees, financial partners or close financial associates.

Appropriate areas for MSF:

79. A PCT based respondent stated that they did not consider Keeping up to date, Keeping good records, having indemnity and insurance, acting with probity and honesty and being fit and healthy to be appropriate for MSF.

#### Availability of persons to provide feedback:

80. Several respondents felt that there might be limitations on the availability of people to provide feedback, and that this would be a problem particularly for small or rural practices. One respondent suggested that in a practice with six GPs, potentially each GP might be requested to complete 10 MSF forms for colleagues over the five year cycle. This might not be achievable in all practices.
81. While it was recognised that feedback from the wider multidisciplinary team, including nursing and administration staff, would be valuable for the personal development of the doctor and the team overall, there was concern at the expectation that non-doctor staff would need to repeatedly participate in the process. It was envisaged that staff may become inundated with requests to complete forms, and their willingness to do so may dwindle, especially as this would not be a contractual requirement of them.
82. Clarification was sought as to whether it would be compulsory to have at least some MSF from other GPs. One respondent did not think that the document made this clear.

#### Anonymity and confidentiality:

83. A few respondents argued that the collation and feedback of the results would have to be handled confidentially and with sensitivity. There was concern that there might not be enough staff available to do this and anonymity, it was suggested, would be difficult to preserve in a small or rural practice where even typed and anonymous comments may be author-identifiable as a result of style and content.

#### Sessional GPs:

84. Several respondents felt that feedback from colleagues would be particularly difficult to organise for people who are not in long-term posts, and also for those in training posts. The BMA GPC stated that would be "unlikely that employed/salaried GPs would be involved in any management decisions that affect the practice. Further, if working part-time the salaried GP may not be able to attend practice meetings on a regular basis. These will impact on how colleagues within the practice view the management skills of these GPs".
85. A sessional respondent felt that staff would be less likely to respond to an MSF for a locum than for a partner, as they know the doctor less and are not paid a salary by them."

#### Areas for clarification:

86. One respondent sought clarification as to whether MSF would come solely from fellow doctors.

Suggestions for improvement:

87. The BMA GPC suggested that validated MSF tools be developed to support all GPs, including locums. Another suggestion was that an electronic format for MSF should be developed. MSF will become electronic through the e-portfolio.
88. The consultation feedback provided different views on how many MSFs GPs should be expected to undertake in the five year cycle. One respondent suggested that there should be a requirement for one of both the MSF and the patient survey in the five year cycle, with the option to repeat either one or both within the five year cycle as part of the action in response to a GP's self-reflection, if performance or outcome on either were less than desired. However, others believed that there should be two.

Area of evidence: PATIENT SURVEY

89. It was agreed that taking account of patient experience and feedback is very important and, as with MSF, there was recognition of the rationale for two patient surveys in the five year cycle – that is, to measure progress and improvement. However, not all were convinced by the efficacy of the patient survey. In addition to the suggestion that it might be a problematic source of evidence for sessional GPs (as outlined below), several respondents questioned their validity as a tool to assess fitness to practise, one respondent remarking that a patient survey would be unlikely to stop another “Shipman”.
90. One respondent suggested that there is a problem of ‘questionnaire fatigue’, highlighting the fact that patients are already presented with the QoF and annual access surveys. It was also suggested that in a practice where there are a number of GPs the patient questionnaire would create additional work for non-medical staff who would handle and distribute the forms as well as compound the sense of ‘fatigue’ from patients and staff.
91. However, it was also implied that ‘questionnaire fatigue’ could be minimised by good questionnaire design.

Sessional GPs:

92. There was concern for sessional GPs who might be exposed to a different ‘case base’ and not have the same degree of continuity with their patients. This was the view of the BMA GPC. A need was identified to adapt the survey to different working patterns.

Suggestions for improvement:

93. One respondent suggested that there should be a requirement for one of both the MSF and the patient survey in the five year cycle, with the option to repeat either one or both within the five year cycle as part of the action in response to a GP's self-reflection, if performance or outcome on either were less than desired.

#### Area of evidence: REVIEW OF COMPLAINTS

94. It was suggested that there should be further refinement of the meaning of “cause for concern”, and it might be better if the document specifically stated “cause for concern.....in relation to behaviour which could impact on ability to deliver appropriate care.” Respondents informed us that they would benefit from a tighter definition of a ‘formal’ complaint.

#### Sessional GPs:

95. Several respondents highlighted the fact that sessional GPs are very rarely involved in practice discussions about complaints made about them. It was suggested that this would have to change if sessional GPs were to submit this type of evidence.

#### Areas for clarification:

96. One respondent asked whether those undertaking the revalidation would be aware of complaints made against the GP, or whether the only information they would have would come from the GP.

97. Clarification was also sought with regards to where this information might come from. A PCT manager lead on appraisal and revalidation suggested that a GP trying to gather evidence from their registered PCT concerning an informal or formal investigation into them might face a number of difficulties in terms of accessing this information.

#### Area of evidence: SIGNIFICANT EVENT AUDIT (SEA)

98. A few respondents thought that five SEAs over a five year cycle would be too onerous and that the number should be reduced.

99. Others suggested that nationally approved templates should be used. There was one suggestion that Self Reflective Templates should be used instead, as outlined in the Leicester Statement.

#### Sessional GPs:

100. Several respondents highlighted problems that sessional GPs might experience collecting this evidence. It was argued that sessional GPs would find it particularly difficult to find the requisite number of SEAs without a permanent place of work. One respondent suggested that a locum doctor asking to discuss an SEA that involved another member of staff may not be well received by the practice. The situation, it was suggested, would be improved for sessional GPs if they were routinely involved in practice SEAs which, we were informed, at present they are not.

#### Area of evidence: AUDIT OF CARE

101. Several respondents were supportive of this proposal. Others suggested that the Quality and Outcomes Framework (QoF) is sufficient as it “inevitably encourages us to audit our performance in a wide variety of clinical and non-clinical areas”. One

respondent suggested that unless carried out properly, GPs could potentially replicate poor quality secondary care audits.

#### Practice wide audits:

102. Several respondents argued that practice wide audits are more beneficial. Arguing that positive change in practices is often achieved through extended teams, several respondents questioned the value of a personal audit of care, suggesting that practice-wide audits are of much greater value. One respondent remarked that “most of us work as part of a team and most audits that I do or have seen reflect the activity of the practice as a whole. I would hope that this would satisfy for evidence.”

103. It was suggested that practice audits should be considered as evidence if the doctor concerned has had input into the process, as long as this input and impact is explained and identified, and it is clear whether the audit was conducted personally or not.

#### Sessional GPs:

104. Many respondents suggested that the process of gathering the evidence for audit would be particularly problematic for sessional GPs. The BMA GPC argued that for a sessional GP to complete an audit on the outcomes of his/her referrals can be complicated - it requires the permission of the practice, the presence of the sessional GP in the practice outside of the usual contracted hours, and for the sessional GP to have access to the practice computer system.

#### Suggestions for improvement:

105. One respondent suggested that it would be helpful to have 5 or 6 worked examples of audits and how locums would perform them. It was also suggested that nationally approved templates should be used.

#### Area of evidence: STATEMENT OF PROBITY AND HEALTH

#### Confidentiality:

106. A few respondents were concerned about confidentiality and felt that a doctor's requirement to comment on their use of healthcare was overly intrusive. For example, there was concern that a doctor might have to comment on their use of emergency contraception or the termination of a pregnancy.

107. One respondent questioned why GPs should provide evidence of their Hepatitis B status, and considered this to be an invasion of their privacy. It was pointed out that a GP with Hepatitis could have a low transmission risk.

#### Practical issues:

108. A few respondents suggested that it would be impractical to register at another practice, especially if that practice was a long distance away. It was suggested that it would be far better to ensure that a colleague sees the GP initially for conditions

requiring prescription drugs, but that they should be prepared to be referred to another GP for specialist care if appropriate.

Suggestions for improvement:

109. It was suggested that the extended roles should include doctors in leadership or medical management positions.

#### THE SUBMISSION OF THE EVIDENCE

*Question 3: Have you any comments? Are there any particular areas that you think need to be considered when developing an electronic portfolio?*

Concept:

110. The electronic portfolio was thought to be an excellent idea, though a minority anticipated that it might cause problems for the computer illiterate.

111. It was suggested that if this was the only available tool and there is a charge there might be implications for fair competition.

Resource implications:

112. The RCGP was also urged to consider a range of options in the development of the e-portfolio and carefully consider its resource implications. The NHS Revalidation Team highlighted the potential complexity of such systems: "preliminary review suggests that the complexity of requirements of future IT systems to support revalidation are only now beginning to come to light." The College was advised to pilot the system first.

Practicality and accessibility:

113. Respondents sought reassurance that the portfolio would be practical and user-friendly. There was a suggestion that training should be provided either free of charge or at a reduced cost. One respondent suggested that Voice-activated software should be utilised to help visually impaired GPs. There were some concerns that the e-portfolio would not be as easily accessible to non-RCGP members as it would be for members.

114. One respondent highlighted the difficulties that sessional GPs might have in terms of collecting Prescribing Analysis and Cost Tabulation (PACT) data.

Flexibility:

115. Noting that electronic data tends to be in 'tick box' format, several respondents sought reassurance that they would be able to enter qualitative evidence and other additional evidence that would be relevant. The BMA GPC suggested that the portfolio should be "flexible enough to allow the possibility of off-line preparation of documents, information and responses for subsequent upload."

Security:

116. The majority of respondents sought reassurance that the portfolio would be secure and some were concerned that the system might be open to falsification.

Compatibility:

117. Many respondents were particularly keen that the e-portfolio would fit into existing systems so that they would not have to repeat work they have already undertaken. For example, it was argued that any e-portfolio developed should be easily linked to the NHS appraisal toolkit, which a number of GPs have already transferred information onto. It was suggested by a significant number of respondents that an easy link that would transfer material to the RCGP e-portfolio would be very helpful.
118. Furthermore, the NHS Revalidation Support Team advised the RCGP to take special care that any system developed allowed 'cross talk' with systems being developed by the Department of Health.

Suggestions:

119. Many respondents suggested that the portfolio be developed to have the capacity to accept additional evidence. It was also suggested that paper evidence should be considered along with electronic evidence, with one respondent reporting that some evidence e.g. PUNs and DENs are difficult to add electronically.

#### ASSESSMENT OF EVIDENCE FOR REVALIDATION

*Question 4: Have you any comments about the local arrangements described and those at the national level?*

120. Several respondents considered these arrangements to be sensible and the need for uniformity in arrangements across the UK as well as the need for standard guidelines was highlighted. It was suggested that statistics on the results of the process should be compared between different PCTs in order to detect whether there are any emerging patterns with regards to particular groups of GPs who are failing revalidation.
121. One suggestion was that there should be an 'early warning system' through appraisal in year 4 of the cycle to alert those who are potentially at risk of not being considered suitable for revalidation.
122. One respondent asked whether there could be a role for the Local Medical Committee (LMC) in the process as it is argued that the LMC is 'an elected peer group who should have the confidence of GPs.'

Duplication of process:

123. One respondent questioned why the Personal Development Plan (PDP), the review of the PDP, results from MSF, patient surveys, audits and statements about

probity and health would be required again for revalidation when it had already been presented and signed off by the appraiser during appraisal.

Confidentiality:

124. One respondent questioned how the appraisal content could remain confidential if almost all the evidence submitted at appraisal is to be included in the revalidation portfolio which can then be looked at by the Responsible Officer, any of his or her staff, and the local assessor group. Reassurance was sought that the security of the information could be guaranteed.
125. Clarification was also sought with regards to the responsibility of the PCT for ensuring security of portfolios. One respondent asked how long portfolios would be kept by the PCT after a revalidation cycle has been completed.

Administrative implications:

126. It was suggested that the PCT would not have the resources to deal with the added workflow.

Responsible officer:

127. Several respondents sought clarification as to what this role would involve, while others attempted to define the necessary leadership qualities of the Responsible Officer. It was felt by many, including the BMA GPC, that an essential pre-requisite of the Responsible Officer role is that they have an excellent understanding of general practice; many went as far to say that the Responsible Officer must be a GP, or at least a part time GP to maintain credibility in the process. Underlying this argument was an anxiety that the Responsible Officer might fail to understand the multiple constraints and challenges of general practice. RCGP Scotland suggested that the RO 'should appoint' rather than 'consider appointing' an appropriate general practitioner as their advisor if the RO is not on the GP register.
128. It was also suggested that the Responsible Officer should be experienced in areas of clinical governance and education and have a strong record in team and facilitative working.
129. Only one respondent, a medical director for a PCT, did not think that it was essential that the RO should be a GP. Describing themselves as a full time medical director (albeit with previous experience in practice) they argue that although they do not think they would be able to register on the GP register in future, they feel that they have the range of skills, experience and knowledge of primary care to make judgements in relation to fitness to practise, even if they do not apply their skills to patients.
130. The impartiality of the Responsible Officer was considered paramount, and one respondent highlighted the potential for conflict of interests if, for example, the Responsible Officer was both employed by a private provider and assessing portfolios of its employees. One respondent suggested that the Responsible Officer should not judge the revalidation portfolio of a colleague that he or she knows.

131. One respondent sought clarification as to who would be responsible for revalidating the responsible officer.

Lay assessor:

132. A few respondents were not convinced by the need for a lay assessor. It was suggested by this minority that the lay assessor was “appearance based” and are likely to be from the “vocal minority of the population” and are therefore “unlikely to aid the process.” Clarification was sought as to how the lay assessor would be appointed and to whom they would be accountable.

RCGP External Assessor:

133. Clarification was sought with regards to how the RCGP assessor would be appointed and to whom they would be accountable.

Decision making process:

134. Respondents identified a need to establish high standards of training for all three representatives and it was suggested by the Society for Academics in Primary Care that the RCGP should play a role in setting and maintaining standards.

135. Several respondents asked what safeguards would be present to ensure that the assessors will have the necessary experience and insights into the different environments of general practice. One respondent suggested that experience will be as important as training; as well as attributes of wisdom and discernment.

136. Respondents suggested that there could be problems if there was a delay in the decision making process. Furthermore, the possibility exists of a group facing a legal challenge from a doctor who has not been recommended for revalidation.

137. It was argued by a few respondents that cases for consideration should go to the GMC rather than the RCGP. The NHS Revalidation Support team highlighted quality assurance as the “means by which this new partnership between service and College will be made effective.”

138. There was some concern that sessional GPs might be discriminated against. One respondent reported that they had heard the suggestion that anyone not working in a managed environment would be automatically put into the “amber ‘needs discussion’ category”.

Criteria for assessment:

139. Respondents sought clarification as to how the Responsible Officer and the staff were going to assess the portfolios, and what criteria would be used to distinguish between a satisfactory portfolio and one requiring further discussion.

140. Furthermore, respondents asked whether the Responsible Officer and their staff would base their assessment on 3-5 appraisers involved over the five year period, or whether they would assess the portfolios in detail themselves. If the latter is the

case, it was questioned whether the criteria used would be different from that used by the appraisal process.

## QUALITY ASSURANCE

*Question 5: Have you any suggestions about how the RCGP should satisfy the GMC that the process is fair, equitable and objective?*

141. Several respondents argued that the process would require rigorous quality assurance systems. Furthermore, it was suggested that there should be standard guidelines for all and that the same criteria and process should be used for all doctors. One suggestion was that the use of standard criteria should be applied wherever possible, with clear guidance for non-standard cases.
142. A significant minority of respondents suggested that quality assurance systems should remain separate from the revalidation process (i.e. that the RCGP should only be involved in quality assurance). One respondent expressed concern that the GMC were effectively 'subcontracting' a task to a body that does not have all GPs as its members.
143. Other respondents used this question to argue that some of the types of evidence being used – particularly the MSFs and the patient surveys – do not have sufficient reliability. One respondent suggested an exam based process would be the only "fair repeatable and validated method" and that everything else would introduce "subjectivity and variation."

### Assessors:

144. Training for and ongoing assessment of the assessors was considered paramount by the majority of respondents. The BMA GPC suggested that training and standards of appraisers needs to be quality assured prior to the collection of evidence. Others suggested that Deaneries should support appraisers to carry out the process.
145. Several respondents felt strongly that the assessors should be GPs to maintain confidence in the process. Others argued that lay involvement and, more specifically, active patient involvement would safeguard the revalidation process.
146. It was argued that there would be a need to develop a national standard against which the quality of forms and PDPs can be assessed as part of the underpinning of the appraisal process. While this is being carried out locally, for fairness and consistency it these standards should be national. There would be a need to re-train all the current appraisers for this new approach in addition to those assessing the revalidation portfolios.

### Right of appeal:

147. Right of appeal was considered to be very important by respondents.

Further suggestions:

148. There were some suggestions of additional ways in which the RCGP help to ensure that the process remained fair, equitable and objective. These included spot checks, observation and GMC evolving the model and reciprocal visiting.

## **SECTION 2: Non-standard processes for the revalidation of general practitioners**

*Question 6: Are there any other areas that could be considered non-standard? If so, what are they and do they fall within the guidance defined in the paper?*

149. Several respondents felt that all guidance covered all areas. However, the BMA GPC advised flexibility and discretion on this matter, stating that it would be helpful "if the system could be sufficiently flexible so that discretion could be used so that well-trained and up-to-date doctors do not need to undergo a costly re-examination process."

150. One respondent was unclear as to whether the non-standard portfolio would be a freely available choice or whether a GP would have to be "approved" before taking up this option.

Sessional GPs:

151. A few respondents were concerned that sessional GPs would be pushed down the 'non-standard' route when they should instead, as a significant part of the GP workforce, be part of the mainstream process, and receive any necessary support. It was perceived by one respondent that the non-standard process was a 'second best' method and the non-standard process should be one of last resort for a small percentage of GPs.

Other non-standard areas:

152. Other non-standard areas identified included those on long-term maternity leave, semi-retired GPs who carry out occasional locum work, doctors returning from abroad, practising EU doctors, doctors working solely in Out-of-hours (OOH), doctors who carry out medical roles outside general practice (e.g. sporting events) and doctors who have been ill for a significant amount of time.

Areas for clarification:

153. One respondent sought clarification as to whether a doctor who had not been in clinical practice for five years (e.g. working exclusively in management) would be able to continue their role if not GMC recertified.

*a) The minimum clinical commitment required to establish eligibility for a recommendation for recertification*

*Question 7: Bearing in mind that the RCGP will need to consult on this in the future, do you feel that the example is about right?*

154. Several respondents considered the example to be realistic and sensible. However, one respondent highlighted the fact that quality of work and quality of time are entirely two different things. Others felt that there were GPs who work for less than the clinical commitment who should be considered for revalidation.

155. One respondent, an academic GP, reported that he had restricted his scope of practice to mirror the fact that he did relatively few sessions. He informed us that he

did not want to be in a situation where he did certain things too infrequently to maintain competence (e.g. surgery, antenatal care, IUCD fittings) and thought that revalidation and re-licensing should take account of this.

156. Another respondent suggested that while two sessions per week would keep their skills 'ticking over', it would not be enough to allow for professional and personal development at a clinical level.
157. Several respondents considered the example to be too general. One respondent suggested that there are differences between somebody who works two days per week taking two years out in years one and five of the cycle and someone in academic general practice doing one session per week in term time only.
158. Furthermore, it was suggested by one respondent that the example does not take account of different working patterns, such as Out-of-Hours (OOH), family planning or screening. One respondent suggested that some women opt to work in related areas to general practice such as family planning or child health (which can be more family friendly) around career breaks. They argued that this amounts to relevant clinical experience for general practice and should therefore be included.
159. Others suggested that the criteria for minimum clinical commitment might cause problems for those returning from abroad.

#### Suggestions:

160. One respondent suggested that the RCGP should be more robust in terms of what constitutes a day or a session. Several respondents suggested slightly different examples, including an average of two sessions per week over a five-year period, with those who have not been in clinical practice for two consecutive years to be considered in context.

#### Areas for clarification:

161. It was not clear to one respondent whether the 200 clinical half-day sessions in the five year cycle would need to be done regularly throughout the five years (as in the example given of one a week over a period of at least two years) or whether they could be spread out e.g. half a day a week for four years.
162. One respondent sought clarification as to whether Continuing Professional Development (CPD) would be included in the example for minimum clinical commitment. Others sought clarification as to where sick leave and maternity would fit in with the minimum clinical commitment.

#### *b) The acceptability of evidence from GPs not working in approved settings*

#### *Question 8: Do you feel this is the correct level for acceptability of evidence?*

163. Several respondents were in agreement with the correct level of acceptability of evidence. However, several respondents also felt strongly that individual cases should be considered on their own merit.

Doctors returning from abroad:

164. Several respondents highlighted the difficulties that doctors returning from abroad might face if evidence from outside the UK is not recognised and suggested that doctors might be penalised for carrying out charity work abroad. Using the example of doctors working for Non Governmental Organisations (NGOs) abroad, one respondent argued that while their environment is not likely to meet the criteria for revalidation, the experience of working in adverse environments is invaluable for professional development and will bring and will bring added value to their resuming practice on their return. It was suggested that there should not be any further barriers to doctors working abroad if they so choose.
165. One respondent, who ran a single-handed practice in Mustique, anticipated that he might experience significant problems if he tried to re-register in the UK, despite the fact that he informed us that his patients think they receive a good service and he has never had any complaint made against him.
166. Others anticipated that GPs working in such places as Australia and New Zealand would be able to easily prove that have kept their knowledge and skills up to date.
167. While many respondents suggested that appropriate evidence should be considered from abroad, further clarification was sought as to what would constitute an 'equivalent environment'. One overseas-based GP asked whether they would be required to spend time working in the UK to complete their appraisal.
168. One respondent suggested that entry onto the PCO's performance list should be the basic criteria to return to GP.

Categories of doctors to add:

169. Suggestions of other groups of doctors to add included medical journalists, A & E working GPs and non-clinical researchers with GP backgrounds.

*The extent to which GPs in active clinical practice can choose what evidence to provide*

*Question 9: Do you feel that this provision is flexible enough?*

170. Several respondents thought that the provision was flexible enough and even suggested that the non-standard portfolio might be a more attractive method of evidence gathering than the standard model. It was considered important that these choices are made available.
171. Others were concerned that sessional GPs would be pushed out of the mainstream process because some of the components would be difficult for them to achieve and argued that support should be available for them to gather the standard evidence. The BMA GPC argued that it "would be unfair if this group were forced to undertake an alternative means to revalidation."
172. However, others implied that sessional GPs would exploit the non-standard route. For example, one respondent expressed concern that an exam based

process would "perpetuate the current situation that some non-principals use their 'sessional' status as a defence against failing to complete SEAs, self-reflection on complaints etc". Similarly, one respondent highlighted the risk of 'cop out' for doctors not engaging in annual appraisal.

173. A small minority of respondents favoured 'objective' forms of assessment, and felt that these would have more benefits to patients. There was concern, however, that those who opt for the Applied Knowledge Test (AKT) / Clinical Skills Assessment (CSA) options would have to pay considerably to do so. It was argued by some that learning credits are not as beneficial and effective as a validated exam. Other respondents, however, argued that learning credits were too valuable to be replaced by an exam and that an exam based process would "inevitably lead to cramming of knowledge." It was suggested by one respondent that a better balance needed to be achieved between the two options.

Suggestions:

174. One respondent suggested that all GPs sit the MRCGP exam.

*d) The revalidation of GPs who return to clinical practice*

*Question 10: Have you any comments on the process put forward for those returning to general practice?*

175. Although several respondents thought that this was acceptable, one or two respondents highlighted a need to clarify why those returning to general practice had been absent in the first place. It was pointed out that if someone has been suspended, this is entirely different to a period of ill health or a secondment.
176. Funding was identified as an issue by several respondents. It was suggested by the BMA GPC that GPs who are required to undergo a re-entry programme should "receive a salary for the service they are providing."

Suggestions:

177. These are listed below:
- those returning to general practice should submit to formal assessment, which would include elements of the nMRCGP such as Clinical Skills Assessment (CSA) and Applied Knowledge Test (AKT)
  - the establishment of a mechanism of conditional certification for doctors on re-entry programmes, such as those who have taken extended career breaks for personal reasons
  - to ensure equity, support should be given to returning GPs through a National Returners Programme to ensure equity
  - returning GPs should undergo a hospital based component

*e) The revalidation of GPs working as doctors but not in clinical general practice*

*Question 11: Have you any comments (on the process put forward for those working as doctors but not in clinical general practice)?*

178. This was generally considered to be acceptable. However, one or two respondents suggested that the same process should apply to these doctors as others absent from general practice.

Suggestions:

179. The NHS Revalidation Support Team suggested that there should be a new category of College membership or association for non-clinically active members.

Categories of doctors to add:

180. Suggestions of other groups of doctors to add included medical journalists, A & E working GPs and non-clinical researchers with GP backgrounds.

*Question 12: Do you think that these definitions capture all the possible permutations?*

181. Many respondents thought that these definitions captured all possible permutations. The non-standard portfolio was welcomed by many respondents and one respondent suggested it should be open to all. Some respondents, however, felt that the portfolios required further definition.

182. It was recognised that a wide portfolio is essential for patient safety, a point made by the RCGP's Patient Participation Group.

183. It was suggested by some that elements of the non-standard portfolio would be hard to collate for part-time GPs.

### **SECTION 3 - APPENDIX 1: The map of the RCGP's Criteria to the Domains and Attributes in the General Medical Council's Framework**

*Question 13: Have you any comments about the mapping to the GMC's Framework shown in the table?*

184. The majority of those who commented on this question felt that the RCGP's criteria correlated well with the domains and attributes in the General Medical Council's Framework. We received the following quote from the NHS Revalidation Support Team:

"RST congratulates RCGP on this thorough work to map CSE to the GMP module. This has already significantly informed our own work in preparing appraisal paperwork which allows similar mapping of individual items as the appraisee accumulates them."

### **SECTION 4, APPENDIX 2: Criteria, Standards and Evidence for General Practitioners for Revalidation**

*Question 14: We would welcome your comments on the criteria, standards and evidence set out*

185. These were generally welcomed though several respondents, including the BMA GPC, were concerned that some GPs would have to resort to assessment tests and stressed the need for a "uniform revalidation process to be agreed which meets the needs of all GPs in active clinical practice."

186. A significant minority of respondents felt that there was too much emphasis on 'non-evidence' aspects such as MSF and patient surveys. One respondent suggested that "9 out of 10 RCGP criteria depend on colleague multi-source feedback. This is unbalanced and open to accusations of collusion." It was argued that there should be more research into the usefulness of MSF and the learning credits based system before such reliance is placed on this evidence for the revalidation process.

187. One respondent felt that there was not enough emphasis on practising good clinical medicine (e.g. diagnostic skills, choice of investigation, prescribing).

Other:

188. A respondent from a PCT suggested that recommendations would not be sufficient to enforce policies and the regulations would be required.

189. One respondent was confused by the RCGP's use of the terms "criterion" and "standard", which they argued had been used incorrectly.

## **OVERVIEW AND NEXT STEPS**

190. The Royal College of General Practitioners welcomes the large response to this consultation. The responders were, overall, supportive of the direction in which the College's proposals were going. This short paper responds to key findings from the consultation.

### **Sessional doctors**

191. The responses from the GPC of the BMA and from the NASGP focussed on the particular problems of locum general practitioners. Their concerns were echoed in other responses. The RCGP has recognised the special issues that need to be addressed for this group. A paper analysing the issues and offering ways forward has been drafted. We are holding a seminar at the RCGP on 26th February with representatives of the GPC and the NASGP, and with individual respondents, to try to arrive at a coherent set of recommendations which will be fed into the next stage of revalidation documents.

### **Doctors in hierarchical employment**

192. We have recognised groups of doctors, for example in the Defence Medical Services and the Prison Service, who will need careful consideration. Wing Commander Rich Withnall is working with me, leading this work with all the "non-standard" groups.

### **General Practitioners with Special Interests**

193. We note the response from the Royal College of Anaesthetists and have discussed it with them. Overall our current proposals seem proportionate and appropriate and have the support of the General Medical Council.

### **Understanding those who are negative**

194. There is a small but important minority whose views were negative and the RCGP needs to be sensitive to their concerns as it develops its proposals further. In particular several responders, probably but not certainly not RCGP members, questioned the role of the College in representing all general practitioners. We are very conscious of the need to be inclusive in our thinking and not to risk alienating any particular group such as those who are not currently RCGP members.

### **The process of recommending recertification to the GMC**

195. The warnings (paragraphs 41 to 43) are heard. The RCGP is considering how the RCGP National Adjudication panel should interface with the General Medical Council and it will publish proposals in time.

### **Learning Credits**

196. The responses reflect the inevitable uncertainty surrounding this system of CPD. Until the results of the pilots are made widely available and coherent guidance is issued, such responses are to be expected. However the CPD team will be studying the responses carefully.

### **Multi-source Feedback and Patient Surveys**

197. The comments are useful and will be taken into account as we develop our next stage proposals.

### **Other issues**

198. In general the other comments reflected the inevitable diversity of views that such a consultation will provoke with some good suggestions that will be carried forward. The positive and supportive tone of the vast majority of responders is welcome and lends support to the RCGP's developing work towards revalidation.

## **APPENDIX 1: List of Recipients**

### External Bodies

- Academy of Medical Royal Colleges (and devolved structures)
- Department of Health Lead on Recertification (and those in devolved countries)
- British International Doctors Association
- Family Doctors Association
- General Practitioners Committee of the BMA (and Committees in devolved countries)
- General Medical Council
- NHS Confederation
- National Association of Sessional GPs
- COPMED
- COGPED
- Society of Academic Primary Care

### RCGP Internal Groups

- Council
- Devolved Councils
- RCGP Faculties
- RCGP Patient Groups
- Postgraduate Training Board
- Professional Development Board
- Recertification Groups
- Committee on Medical Ethics
- Clinical Innovation and Research Centre (CIRC)

### **\*A consultation letter was sent to every GP practice in the United Kingdom**

\*A consultation letter was also sent to all PCTs / PCOs in the United Kingdom who were asked to bring it to the attention of all GPs on their performer's lists.

\*The consultation was advertised in RCGP news, on the RCGP website and in RCGP e-bulletin and 7-days

## APPENDIX 2: List of Respondents

Organisational responses were received from the following:

- RCGP Republic of Ireland
- RCGP Scotland
- NHS Nottinghamshire County
- The GP Centre, North Cheam
- The NHS Revalidation Support Team
- National Association of Sessional GPs
- The Royal College of Anaesthetists
- Eastern Health and Social Services Board
- NHS Dumfries and Galloway
- British Medical Association, General Practice Committee
- London Deanery, General Practice Department
- NHS Highland
- Lewisham PCT
- The GP Centre, North Cheam
- Aberfoyle Medical Practice
- Walsall LMC
- Lancashire and Cumbria Consortium of LMCs
- Avon LMC
- Norfolk LMC
- Gateshead and South Tyneside LMC
- Cambridge LMC

A full list of respondents can be found below:

GP? (Y/N), Other Job Title	Type of GP, as described (if applicable)
Y	Retired
Y	Not specified
Y	Sessional
Y	Principal
Y	Sessional/Trust Medical Advisor
Y	Other
Not specified	Not specified
Y	Sessional
Y	Locum, part time
Y	Sessional
Y	Principal
Employee of NHS Warrington and NHS Calderdale	N/A
Not specified	Not specified
Not specified	Not specified
Y	Principal/Trainer/Tutor
Not specified	Not specified
Y	Sessional
Y	Sessional
Y	Principal/Medical Director
Not specified	Not specified
Y	Trainer

Y	Principal
Y	Sessional
Y	Principal
Not specified	Not specified
Y	Sessional
Y	Principal
Y	Sessional
Y	Retired Principal, Appraiser, nMRCGP examiner
Y	Academic GP, one day a week in practice
Y	Sessional
Y	Sessional
Y	Principal
Y	Principal
Y	Not specified
Y	Sessional
Y	Principal
Y	Principal
Y	Sessional
Not specified	Not specified
Y	Principal/Trainer/Tutor/Appraiser
Y	Principal
Y	Part-time Principal
Y	Sessional
Y	Principle/Trainer/Postgrad Tutor/RCGP examiner
Y	Sessional
Y	Sessional/Chairman of LMC
Y	Principal
Y	Principal
Y	Locum, retired Principal
Y	Sessional
Chair of RCGP Patient Partnership Group	Not specified
Y	Other
Y	Principal/CG lead
Y	Principal
Y	Sessional
Y	Not specified
Y	Principal
Y	Private GP and company doctor
Y	Principal/Deanery AD/RCGP Advisor
Y	Principal
Y	Sessional/Appraiser/Clinical Lecturer
Y	Principal
Member of RCGP Thames Valley Faculty	Sessional/Appraiser
Y	Principal
Y	Appraiser
Y	Sessional
Y	Part-time sessional/Charity worker
Not specified	Not specified
Y	Principal
Y	Sessional/Trainer
Y	Principle
Y	Principal
Y	Principal/Appraiser
Y	Principal/Appraiser/Voluntary Doctor
Member of Beds & Herts LMC	Sessional

Y	Sessional
Y	Principal and GP trainer
Y	Sessional
Y	Principal/Trainer
Y	Principal
Y	Sessional
Y	Principal
Y	Sessional
Y	Principal
Not specified	Not specified
Y	Principal
Not specified	Principal
Y	Principal
Y	Principal
Y	Principal
Y	Principal
Y	Sessional
N	LMC Chief Exec
Y	Principal
Y	Sessional
Y	Academic GP
Y	Not specified
Y	Not specified
Y	Sessional
Y	Principal, Advisor on revalidation and appraisal
Y	Principal/Trainer
Y	Principal
Y	Principal
Y	Sessional
Y	Sessional
Y	Principal/Appraiser/Trainer/Deanery Tutor
Not specified	Not specified
Employee of Eastern Health and Social Services Board	Not specified
Y	Salaried
Not specified	Not specified
Member of Avon Local Medical Committee Limited	Not specified
Y	Salaried
Y	Principal
Not specified	Not specified
Employee of Croydon PCT	Not specified
Y	Not specified
Y	Sessional
Not specified	Not specified
Y	Sessional
Y	Principal
Y	Principal/Appraiser/Programme Director/Trainer
Member of City & East London LMC	Principal
Y	Principal
Y	Principal
Y	Principal
Y	Principal/Primary Care Educationalist
Y	Principal
Y	Principal
Y	Principal

Y	Sessional
Y	Principal
Employee of NHS Dumfries and Galloway	Not specified
Y	Sessional
Y	Principal & Appraiser
Y	Principal/Appraiser
Y	Principle
Y	Not specified
Y	Principal/Honorary (Deanery) GP Tutor
Y	Not specified
Y	Trainer
Y	Principal
Not specified	Not specified
Y	Principal
Y	Appraiser/Trainer
Y	Principal
Y	Sessional
Not specified	Not specified
Member of London Deanery, GP Department	Not specified
Y	Sessional
Y	Sessional
Not specified	Not specified
Y	Sessional
Y	Portfolio
Y	Not specified
Y	Sessional
Y	Not specified
Y	Sessional
Y	Other/Trainer/Appraiser
Y	GP Principal and Trainer
Y	Principal
Y	Principal/Appraiser
Y	Principal
Y	Sessional
Y	Principal/Trainer/Appraiser/Appraisal Lead
Y	Principal
Not specified	Not specified
Employee of Denbighshire Local Health Board	Not specified
Y	Sessional
Not specified	Not specified
Not specified	Not specified
Not specified	Not specified
Y	Sessional
N	Academic GP
Y	Principal/Trainer/Programme Director
Y	Principal
Y	Principal/Trainer
Y	Principal
Y	Principal
Y	Principal
Not specified	Not specified
Y	Principal
Y	Sessional
Y	Sessional
Y	Principal
Y	Not specified

Y	Principal
Y	Retired Principal/Undergrad. Teacher/Appraiser
Y	Principal
Y	Principal/Trainer/Appraiser/PBC Lead
Y	Principal
Y	Out-of-hours GP
Y	Sessional/Board Member in Jamaica
Not specified	Not specified
Y	Locum
Y	Sessional
Y	Sessional
Y	Other
Y	Retired GP Principal / Appraiser
Y	Sessional/Undergraduate Teacher
Y	Principal & Appraiser
Employee of NHS Lothian	Not specified
Y	GP Trainer
Y	Not specified
Not specified	Not specified
Not specified	Not specified
Y	Retired/Appraiser & Lecturer
Y	Sessional
Y	Sessional
Not specified	Not specified
Y	Sessional
Y	Principal
Y	Sessional
Y	Locum
Y	Sessional
Y	Not specified
Y	Salaried
Y	Principal
Not specified	Chief Executive, Cambridge LMC
Y	Principal
Y	Salaried
Y	Principal
Y	Principal
Not specified	Not specified
Y	Principal/Trainer
Y	Locum
Y	Sessional
Y	Not specified
Y	Other
Y	Medical Director and Clinical Tutor
Employee of Lewisham PCT	Not specified
Not specified	Not specified