GMC Consultation on Revalidation: The Way Ahead

1. I write with regard to the GMC consultation on Revalidation: The Way Ahead.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. It aims to encourage and maintain the highest standards of general medical practice and to act as the ‘voice’ of GPs on issues concerned with education, training, research, and clinical standards. Founded in 1952, the RCGP has over 38,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline.

3. The RCGP welcomes the opportunity to respond to this consultation. We are encouraged by the GMC’s efforts to engage with the medical profession and other stakeholders on this issue. We have received approximately 60 responses to this consultation from College members. We have previously consulted the GP profession and relevant organisations to produce the Guide to Revalidation for General Practitioners¹, which contains the RCGP’s proposals for the processes and standards for the revalidation of GPs.

Question 1a: Do you agree that revalidation should be based on a single set of processes for evaluating doctors’ performance in practice, rather than split into the separate elements of relicensing and recertification?

Yes

No

Not Sure

Question 1b: If you have any further comments please expand here

We agree that there would be no advantage in doctors providing separate supporting information for relicensing and recertification. There are a number of doctors, particularly those who have moved into a field away from their original area of training, who would be disadvantaged by such an arrangement. We support the concept of a “descriptive licence” – one which describes the role undertaken by that doctor – and agree that doctors should not be required to demonstrate continuing competence in a specialty which is no longer part of their practice. The fact that such doctors will remain on the register in which they qualified will be a source of reassurance to them. Employers and the public will have to be helped to recognise the centrality of the licence in understanding the competencies of a doctor.

Question 2: Do you agree that revalidation should be based on a continuing evaluation of doctors’ performance in the workplace?

Yes

Question 2b: If you have any further comments please expand here

Four respondents suggested that the use of annual appraisal and record keeping to demonstrate CPD would be overly time-consuming, expensive and inaccurate. One respondent suggested that ‘the most accurate and cheapest way to show if a GP is keeping up to date and is safe to continue working would be to have a knowledge assessment, for example by an MCQ test.’ However, the RCGP believes that a system of revalidation based around the appraisal process – encompassing both formative and summative elements of appraisal – will encourage self reflection and improvement, leading to improvements in quality of care. Our view is that examinations cannot demonstrate the ongoing delivery of quality patient care, and should only be used in exceptional circumstances.

It is also worth noting that four respondents believed that an inevitable consequence of revalidation would be the loss of older, experienced GPs, especially those close to retirement who may not wish to work full time. Whilst it was acknowledged that a small minority of these doctors would be those who choose not to engage with CPD, it was suggested that others would simply struggle with time to make the necessary credits, and give up on the process altogether. Although the RCGP proposes a minimum clinical commitment for revalidation to ensure a sufficient standard of patient care if a doctor proposes to submit a standard portfolio of supporting information, we feel that the GMC should take measures to ensure that revalidation does not lead to a drain of expertise.
Question 3a: Do you agree with the proposals for dealing with the most common situations where a Responsible Officer may not be in a position to make a positive recommendation?

Our proposal for Scenario A  Yes

No

Not Sure

Our proposal for Scenario B  Yes

No

Not Sure

Our proposal for Scenario C  Yes

No

Not Sure

Question 3b: If you have any further comments please expand here

Whilst we agree with the GMC’s approach, it should be noted that many GPs – including those who travel abroad to undertake charitable work, those who go on maternity leave and those with portfolio careers – have expressed concern that they will fall into the second category (Scenario B: the RO is unable to make a positive recommendation due to gaps in the provision of evidence). Sixteen respondents discussed problems for GPs with gaps in their service of one kind or another, or those with portfolio careers. Many of these felt that revalidation as a process was heading towards a homogenised general practice, in which those pursuing more individual career paths would be squeezed out, deliberately or by default, by the practical requirements of the process. Respondents made a number of specific points in this area.

a. One respondent spoke of returning to general practice after maternity leave far sooner than she had intended for fear that she would ‘burn her GP bridges if [she] stayed away too long.’

b. Another respondent suggested (and this has been echoed by others) that it is ‘important to be inclusive and to recognise that core Primary Care is home for a lot of bright thinkers who may have portfolio careers, be interested in integrated medicine and other aspects that are not obviously mainstream GP work, but which are vital for
the health of our society. If people like this are shut out... or the bar is too high, where else can they find a home?’

c. Some respondents argued that the GMC’s recommendation that GPs working abroad should let their licence lapse and renew it when they return was not adequate. One respondent, working in New Zealand at present said, ‘What will be the process for me... when I return to the UK and wish to work in General Practice again? And should I now leave the college, stop paying my fees, and lose the ability to use MRCGP after my name?’ Another respondent feared that ‘it would be extremely difficult to regain a licence without jumping through many expensive hoops.’

d. Seven respondents specifically argued that there should be a mechanism whereby experience or CPD gained abroad, or work meeting the requirements or the equivalent of revalidation in other countries, should count towards the achievement of revalidation in the UK. One respondent argued for ‘an acknowledgement of UK GPs who are residing overseas and working as GPs often complying with other standards at the same time. Whilst the old concept of reciprocity is not what it was, encouraging exposure to other primary care systems seems an asset and as such permitting a degree of acknowledgement within the revalidation process would be sensible’. Another respondent made a similar point. They explained that they were on the GMC full list and had a licence to practice, but that they live and work in the UAE where they have been running their own practice since 1974. They ask the question ‘How do people like me ever get to revalidate?’ A response sent on behalf of the RCGP Health Inequalities Standing Group (HISG) argued that it would be a sad waste if revalidation prevented British doctors from spending all or part of their career abroad, since this had enormous benefits in both directions. The group suggest that this would be a likely outcome of revalidation as it stands.

e. One respondent suggested that a partial solution to some of these issues, with a ‘split year’ approach as apparently practised in Australia: ‘This will help cover for episodes such as sabbatical, maternity/paternity leave... or it will simply allow a doctor to put in 100 credits in one year in order to get ahead and then enjoy the process of learning without documenting.’

With regards to Scenario C (the RO is unable to make a positive recommendation because there are concerns about a doctor’s practice), we agree that any issues with performance should be identified as soon as possible and not left to the end of the five year cycle. The RCGP is working closely with the Department of Health (England), through the Remediation Working Group, to establish a set of principles for the provision of and processes associated with remediation. The RCGP has identified the following three challenges relating to remediation in its Remediation for General Practitioners document:
- Clarity on the responsibilities of all the key stakeholders in remediation
- Consensus on the processes for tackling concerns and remediation, and the application of those processes consistently throughout the UK
- Sufficient resources to deliver a system of remediation that is value for money and effective in maintaining services while ensuring patient safety

Four respondents sought clarity on the following issues:

- How will remediation be funded? Will it be funded by the GP who requires support?
- What would the status of a doctor be whose revalidation is postponed while concerns are being investigated? Would they be permitted to practice, and if not, how should they be compensated if subsequently found blameless?

In addition, one respondent argued for legal safeguards for deaneries: ‘We are already subject to legal challenges as soon as we dare to say that a trainee is not progressing well. Revalidation will make the stakes even higher.’

The RCGP believes that, above all, the Responsible Officer (RO) role must be accountable and local systems must be robust. One of the weaknesses of this consultation, it has been pointed out, is that it is aimed almost entirely at individual doctors rather than employers. The RCGP would welcome reassurance that practice level data will be used appropriately by PCOs and ROs, and that local systems will be sufficiently quality assured.

It is absolutely essential that ROs make decisions consistently and fairly. One respondent highlighted the potential case of a doctor attempting to revalidate whilst in dispute with their employer/PCT, and argued that ‘there must be an option to gain revalidation in a way that is independent of the current employer.’ We believe that the risk of bias can be mitigated by the RCGP offering a service which involves advice from a senior trained doctor and a trained lay person on specific portfolios prior to the RO making their recommendation to the GMC. This model of quality assurance is explored in more detail in our response to Question 5b.

**Question 4: Do you agree that the Colleges and Faculties should not be involved in the recommendations made by the Responsible Officer to the GMC?**

Yes

**No**

Not Sure
Question 5: If so, what do you think the role should involve? Please tick all of the following that you think should apply:

*Setting standards and defining specialty information*

**YES**

*Advice and guidance for appraisers*

**YES**

*Advice and guidance for Responsible Officers*

**YES**

*Audit and quality assurance of the recommendation process*

**YES**

*Other*

**YES**

Question 5b: If you selected ‘Other’ or have any further comments, please expand here

The RCGP’s proposes to offer quality assurance of revalidation decisions at three interrelated levels. These are described below:

1. **Support and advice to Responsible Officers throughout the revalidation cycle**

The RCGP should be prepared to offer two distinct services to ROs. The first is advice on the supporting information for our speciality. Especially in the early years, there will be a need to support ROs in interpreting developing portfolios and identifying where the supporting evidence does or does not meet the College’s standards (as agreed by the GMC).

The second service is a rapid response and diagnostic service. When a Trust has identified a problem it may not have a clear idea of the nature of that problem and the correct way forward. Experience shows that deciding the severity of the problem and differentiating it into
the three dimensions of individual, team or environment can be difficult. (Indeed many problems are multidimensional.)

2. **Support and advice to the Responsible Officer prior to the revalidation recommendation**

The RCGP is clear that it is for the RO and the RO alone to make the revalidation recommendation to the GMC. However, the RCGP will offer a service which involves advice from a senior trained doctor and a trained lay person on specific portfolios prior to the RO making their recommendation to the GMC. The two advisers will offer two services which the RO can choose to take:

1. **Advice on portfolios that are not straight forward or which are possibly unacceptable for revalidation.** This advice will be restricted to insights from the advisers’ national training and their experience in other Trusts.

2. **Quality Assurance of portfolios that are intended to be recommended for revalidation.** This optional service will sample these portfolios, assuring the RO, the RCGP and the GMC on the quality of appraisals, the supporting information being submitted locally and the revalidation decision making in that Trust.

3. **Sampling of anonymised portfolios for quality assurance of decision making processes**

In order to ensure that decision making is equitable and correctly calibrated, the RCGP should review a sample of anonymised portfolios of supporting information from different geographic locations. They might review all portfolios not recommended for revalidation and all those that were the subject of intense discussion at the decision making meeting. They would sample a proportion of the others.

Since this quality assurance will post-date the revalidation recommendation by the RO it cannot influence that decision. It can however highlight any needs for policy development; any local training needs; and any action required to protect the integrity of the revalidation process. It will form the basis of the RCGP’s regular report to the GMC on the quality of revalidation decision making by ROs.

**Question 6a:** Do you agree that for trainees, successful progression through training should be the means of securing revalidation?
Question 7a: Do you agree with our proposals for the revalidation of doctors with no medical practice of any kind?

Yes

No

Not Sure

Question 7b: If you have any further comments please expand here

This is, on balance, a reasonable approach. However, we would welcome assurance that suitable processes will be put in place to manage GPs who want to re-enter clinical general practice after a long period of absence.

Question 8a: Do you agree that the list of registered and licensed medical practitioners should indicate the field of practice on the basis of which a doctor has secured revalidation?

Yes

No

Not Sure

Question 8b: If you have any further comments please expand here

The “descriptor” will be very important in terms of allowing doctors to demonstrate the required standards in the relevant field that they work. It will also reassure patients that they are receiving care from somebody who is suitably skilled to deliver it.

Question 9: Do you agree that, for the purposes of revalidation, the Good Medical Practice Framework is an appropriate basis for appraisal and assessment?

Yes

No
Question 10: Do you have any further comments on the proposed use of the *Good Medical Practice* Framework?

Four respondents commented on the use of *Good Medical Practice* as the framework for revalidation. Whilst they understood that it was useful to have a tangible and understood set of standards behind the process, it was felt by some that attempting to meet all the standards of GMP within the revalidation process would add to the level of bureaucracy. They felt that some of the standards were not as relevant or appropriate for revalidation as others.

Question 11a: Is the overall approach to the development of standards and supporting information for revalidation reasonable?

*Yes*

*No*

*Not Sure*

Question 11b: If not, what else is necessary?

*N/A*

Question 12a: Is the supporting information proposed by the Colleges and Faculties meaningful, practicable and proportionate for the majority of doctors in clinical practice?

Meaningful

*Yes*

*No*

*Not Sure*

Practicable

*Yes*

*No*

*Not Sure*

Proportionate

*Yes*
Question 12b: If not, or you have any further comments please expand here

The Academy has played a valuable and important role in terms of coordinating the development proposals from the Colleges and Faculties which make up its membership. We are encouraged the proposals have reached a level of convergence over time and have been guided by a set of common principles. There has, however, been some concern reported to us that the GP Framework and Checklist appears to be less comprehensive than that of the other professions set out in the document, thus giving the impression that less work was required from GPs to achieve Revalidation. We are keen to point out that this is not the case and we suggest that the components of the standards expected for GPs have not been broken down to the same extent as those of other specialties. We would be happy to advise on appropriate changes to achieve a more balanced presentation.

A very common theme in the responses that we have received is concern about additional workload and bureaucracy involved with revalidation. This was discussed directly in thirteen of the comments, and perhaps implied in many more. Respondents were not reassured by the GMC’s pledge in the Foreword that revalidation need not be ‘either bureaucratic or costly’. Several members argued that recording and reflecting in writing on their CPD was often more time-consuming than doing the CPD in the first place, and that revalidation was certain to lead to a greater diversion of GPs from their primary responsibilities. Our view is that the requirements for revalidation for GPs should not create additional workload.

Keeping up to date through CPD is a professional responsibility of all doctors and GPs should already be recording their CPD and undergoing annual appraisal. With suitable tools, including an effective Revalidation ePortfolio, and the provision of supportive information, we anticipate that GPs will be able to utilise their day-to-day activities for CPD, and ultimately, revalidation purposes. The RCGP’s Good CPD for GPs\(^2\) paper proposed the development of a nationally managed CPD scheme for GPs to support their educational and professional development within the context of revalidation. Since then, the RCGP has produced the Guide to the Credit-Based System\(^3\) for CPD, which is now in its second iteration. This

\(^2\) Good CPD for GPs (Professor Nigel Sparrow, 2007: http://www.rcgp.org.uk/docs/CPD%20Strategy%20Good%20GP\%20website2.doc)

guidance is designed to help GPs assess the credit value of the CPD activities which they record in their revalidation portfolios.

Six respondents referred specifically to issues for sessional and locum GPs and the difficulties they may experience when collecting evidence. It is important that the requirements for revalidation are suitable for all doctors, regardless of working pattern or setting, within each specialty. We anticipate that the results of the NHS Pathfinder pilots will provide valuable information on the collection of evidence for particular groups of doctors. However, the RCGP has commissioned its own pilots for ‘atypical’ groups of GPs, which include pilots for sessional GPs, remote rural GPs, GPs in secure environments and GPs in the Defence Medical Services and other hierarchical organisations. Through these pilots we hope to find out whether, for example, locum GPs experience problems related to specific supporting information areas, such as patient feedback, clinical audit and significant event analysis – activities which many GPs have argued require a stable practice base. It is our aim to produce alternative (but equivalent) methodologies for these groups of GPs, if it is deemed necessary. The GP profession has been very supportive in our search for solutions for particular groups of GPs. For example, a locum GP has recently informed us that they keep an outcome diary of all the patients who they refer in order to undertake ‘vital’ learning about their diagnostic and management skills. They suggest that an outcome log could be part of a locum’s supporting information if an audit proves to be impractical. We aim to incorporate this suggestion into the next version of the Revalidation Guide for General Practitioners.

It should be noted that five respondents felt that revalidation was essentially ‘a waste of time’, a costly and futile exercise, both in terms of the organisational costs of preparing, trialling and running the process, and the costs to individual practices of potentially paying for GPs to spend more time not treating patients. The following comment is fairly typical: ‘It is hard to see how a robust, fair, objective, fit for purpose and properly funded system of revalidation can be introduced at a time of recession… cuts in the health service and ever-worsening conditions in which doctors must struggle to provide quality healthcare.’

Question 13a: Do you agree that these are the appropriate principles to guide doctors’ Continuing Professional Development (CPD) activity in relation to revalidation?

Yes

No

Not Sure

Additional comment:
Three respondents argued that revalidation, contrary to purpose, would pose a serious threat to genuine CPD, as it would encourage a ‘box-ticking approach’ and appraisal for assessment rather than support. One respondent wrote: ‘I understand appraisal as a process involving encouragement, looking for the positives and enabling further development. Trying to discover the small number of bad or underperforming doctors requires other methods, I feel.’ One respondent, who was broadly against the whole process of revalidation, also felt that it would be a hindrance to genuine CPD. They argued instead for ‘much better planned education. A repeated, structured local programme that catches up with this year’s new issues and gives regular updates on the old. Much more pressure to have quality educational events… make them a priority.’

Another respondent criticised a failure to define ‘how good is good enough’ to be revalidated, and highlighted a need to address this issue.

However, six respondents expressed broad approval for revalidation as a process and argued that, so long as it avoided potential pitfalls of over-bureaucratisation, it would have significant benefits for the profession. The following comment is typical of this view: ‘it will help me on an individual level really focus on the “outcomes” of my learning rather than the task of learning itself. I have been engaged with the appraisal process for the last three years and have found it to be a formative process and I do not perceive the changes in expectation for revalidation to be too extensive.’

Five respondents praised the emphasis on appraisal within the consultation document, arguing that appraisal at present is patchy and efforts to formalise it will be beneficial. One suggestion was that the combination of appraisal with other methods may actually serve to protect GPs. Revalidation, they argue, will provide ongoing and regular stimulus for CPD, and provide evidence of long-term performance which can carry weight against short-term complaints.

Two respondents were concerned about the over-dependence of revalidation on electronic recording methods and e-learning (as being additionally time-consuming for those GPs who typically do their CPD longhand), and in particular the use of Microsoft-based systems that they felt were not sufficiently secure.

Conversely, two respondents complained about the paucity of e-learning within appraisal as planned. A GP in a small rural practice remarked that he found it ‘disingenuous and a bit self-serving of the university-based educationalists to try to limit the number of hours of CPD credits that can be achieved through e-learning to 10 or 20 per year. This may be OK for some but the model does not fit all.’ The RCGP, however, recognises the need for flexible learning which is based around the needs of the GP and does not prescribe where or how
learning credits should be gained, although guidance is provided on the number of credits which should be claimed for particular activities in the RCGP Guide to Learning Credits.

Four respondents expressed concern that the fairness of revalidation would be overwhelmingly dependent on the quality of appraisers. They suggest that unless robust quality assurance systems are put in place, there would be little confidence in revalidation amongst the profession and confidence in general practice per se would be undermined. One respondent envisaged ‘full time “revalidators”’ who, rather like professional politicians, might risk ‘losing touch with the real world of general practice.’ This respondent asked: ‘Could there be a time limit put on those who revalidate – perhaps 3-4 year stints once in their career… which will allow the system to refresh and stop it becoming stagnant.’

A small number of respondents highlighted the need for better electronic tools, which are ‘easy to feed data into’, in order to ‘capture relevant activities for appraisal and revalidation.’ A small number of GPs made technical comments about the forms and other mechanics of revalidation. For example, one respondent suggested that an appraisal toolkit would require a Form 4 PDP template to record what happened with regards to the previous year’s chosen PDP. Two respondents argued for the incorporation of PUNs and DENs into CPD.

**Question 14: Do you agree with our approach to patient and public involvement in revalidation? If not, what other arrangements would you suggest?**

*Involvement through questionnaire feedback to doctors*

_Yes._ We believe that patient feedback should be used in revalidation. Our view is that PSQ is a valid tool and it is one that the majority of GPs are now familiar with. The RCGP has commissioned an external non UK-based team to produce a report on the suitability of PSQ instruments, including those available, and those under development, for use in revalidation. We propose that GPs carry out two PSQs in the five year cycle, one in the first two years, and one in the last two years (with the option of completing a consultation review if the first PSQ demonstrates positive results). The rationale for carrying out two is that it gives the GP the opportunity to reflect, improve and record change.

However, nine respondents discussed the role of patient feedback in revalidation in their response and most felt that any form of patient feedback would be far too subjective to be useful: patients would be unable to understand the clinical and financial pressures behind the GP’s work. One respondent suggested that ‘the patient’s assessment of the consultation does not take into account ethical and cost-effective practicing.’ They expressed concern that the use of patient feedback for revalidation might actually encourage doctors to aim to please patients, rather than to do what was in their best interests.
We recognise that the collection of patient feedback may be problematic for particular groups of GPs including, for example, locum GPs. This is an issue which we are exploring in our pilots. One GP questioned how they would gain patient feedback while working abroad (in Kenya): ‘I think culturally we would struggle to get feedback from patients on what they thought of their doctor.’

No

Not Sure

*Involvement in the Responsible Officer’s recommendation and quality assurance*

Yes.

**No.** Please see answer to Question 4. We do not reject the GMC Affiliates model, but we would want reassurance that such an arrangement would be cost-effective. As previously stated, we believe that the option of a trained lay adviser present at the time of RO decision making should be made available.

Not Sure

*Involvement in the GMC decision making process where concerns are raised*

**Yes**

No

Not Sure

**Question 14b: If not, what others arrangements would you suggest?**

N/A

**Question 15a: Do you agree that GMC Principles, Criteria and Key Indicators for Colleague and Patient Questionnaires in Revalidation are appropriate for evaluating these types of questionnaires for revalidation?**

Colleague Questionnaires **Yes**

No

Not Sure
Question 15b: If you have any further comments please expand here

The requirement that PSQ and MSF should be achievable for doctors in all working patterns and settings should be added.

Question 16a: Do you agree that doctors should be required to participate in colleague and patient (where applicable) feedback at least once in each five year cycle?

Yes

No

Not Sure

Question 16b: If you have any further comments please expand here

Doctors should be required to carry out two MSFs and two PSQs in the five year cycle in order to reflect and demonstrate change in practice. (The RCGP proposes that GPs have the option of undertaking a consultation review if they have received positive results from their first PSQ.)

Question 17a: Do you think that there should be a mechanism for making sure that colleague and patient questionnaires comply with our criteria for revalidation?

Yes.

No

Not Sure

Question 17b: If you have any further comments please expand here

All tools must be fit for purpose and designed to a set of common principles. It is essential that the delivery of feedback to doctors is properly managed.
Question 18a: Do you agree that revalidation should be introduced initially in areas and organisations where local systems are developed and sufficiently robust to support the revalidation of their doctors?

Yes

No

Not Sure

Question 18b: If you have any further comments please expand here

Five respondents suggested that the Government / GMC should now ‘just get on with it’. One respondent suggested that revalidation has been hanging like a ‘millstone’ around GPs’ necks for far too long, and ‘fear of revalidation’ may in fact be hampering formative appraisal processes (i.e. current methods of appraisal are devalued because they do not contribute to revalidation, which everyone knows is coming.)

Question 19a: Do you agree with our proposed approach for the initial roll-out of revalidation?

Yes

No

Not Sure

Question 19b: If not, what alternatives do you suggest?

Question 19c: If you have any further comments please expand here

Question 20a: Do you agree that a deadline should be set for organisational readiness for revalidation?

Yes

No

Not Sure
Question 20b: If you have any further comments please expand here

There is a general sense amongst respondents that while revalidation should be trialled in lead areas first, its implementation elsewhere should not be delayed for too long.

4. We would like to express our gratitude to all our members who contributed their views to this response, as well as to the RCGP’s UK Revalidation Clinical Lead.

Yours sincerely

[Signature]

Professor Amanda Howe

Honorary Secretary of Council