

Revalidation Update August 2011

(Based on Specialist Societies Meeting 03 08 11 at RCP)

General

Regular appraisal will provide the basis for revalidation. Each year a portfolio of supporting information based on the GMP framework for appraisal and revalidation will be assessed and discussed, and an assessment made of the doctor's professional behaviour according to Good Medical Practice. This process will be supervised by a Responsible Officer. Every 5 years the Responsible Officer will make a recommendation to the GMC that the doctor is or is not suitable for revalidation by the GMC. The process should start in late 2012. It is still unclear what proportion of doctors will be involved in the first wave.

Guidance for Physicians on Supporting Information for Revalidation

Published by the RCP after consultation in August 2011. It amplifies the GMC's document on Supporting Information for Appraisal and Revalidation with suggestions for supporting information which recognise the range and diversity of physician practice. It does not contain any specific requirements for any speciality, including GUM.

The Medical Appraisal Guide (MAG)

The "core document" has been issued as a draft by the Revalidation Support Team. It gives a general description of appraisal as it relates to revalidation. Feedback is invited on www.revalidationsupport.nhs.uk/medicalappraisalguide/draftuserguide.asp The final guide will also include a User Guide and a Q&A section (neither yet available).

Support from Specialities

Input may be needed to help the decision making of the RO's or to support members who may have problems with the process. The mechanism is under discussion: would it be via the Regional Speciality Advisor? Would members initially consult their specialist association or their College? What training might be necessary to make sure that advice was consistent?

Remediation

Remediation should be the process by which areas of a doctor's practice that give cause for concern are addressed and rectified. It is as yet the least developed area of revalidation and the promised DH report is still awaited. A hierarchy of interventions is envisaged, analogous to those currently used for trainees. If a measure is put in place (re-training, supervision etc) it is not clear who or what body would be legally responsible for the decision as to whether it had been successful (and that patients were safe) or unsuccessful (and that the doctor should not return to an area of practice - which could lead to costly legal challenges). The RCP is to seek clarification from the GMC and RST. The House of Commons Select Committee has given its view here that the primary purpose of revalidation should be to protect the interests of patients, not doctors.

Quality Assurance of the RO decision making process

It had been assumed that the GMC would do QA, perhaps with input from the Colleges. Latterly the GMC has indicated that they would prefer to do it selectively, “risk-based”. The speciality representatives felt it would be safer to have a clear systematic process, particularly to guard against the repeatedly-stated concerns about conflict of interests for the RO’s.

Piloting of the Appraisal System

Piloting was done in 10 sites and involved 3,000 doctors. The organisations felt that the process would eventually lead to improved quality of care. Some doctors had considerable difficulty obtaining all the supporting clinical information they needed (in principle providing it is the responsibility of the employing organisation). Time to do appraisal varied widely, average 15 hours per appraisee, 5 per appraiser. Information on the pilots should be appearing on the RCP website.

Sum Up

“the GMC clearly has a considerable amount of work to undertake between now and the implementation of revalidation in 2012”.

House of Commons Select Committee on Health

Mark FitzGerald