



Government Response to the
House of Commons Health Select Committee:
Fourth Report of Session 2010-11:
The Revalidation of Doctors

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
March 2011



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Any enquiries regarding this publication should be sent to:
Department of Health
Customer Service Centre
Richmond House
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SW1A 2NS

This publication is also available on <http://www.official-documents.gov.uk>

ISBN: 9780101802826

Printed in the UK by The Stationery Office Limited
on behalf of the Controller of Her Majesty's Stationery Office

ID P00 2418870 03/11 10527 19585

Printed on paper containing 75% recycled fibre content minimum.

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1. Foreword

1. On 8 February 2011 the House of Commons Health Committee published 'Revalidation of Doctors': Fourth Report of Session 2010-11. The report followed an inquiry by the Health Select Committee, which sought evidence from the General Medical Council (GMC), The Academy of Medical Royal Colleges (AoMRC) and the British Medical Association (BMA). Whilst the Department of Health issued a memorandum to the inquiry, Ministers were not called to give oral evidence.
2. We welcome the publication of this report and have carefully considered the Health Select Committee's recommendations and the issues it raises. Patients and the public have the right to expect that the doctors who care for them are up to date and fit to practise. The Government will work with the GMC and other delivery partners to design and properly test a proportionate and streamlined system for revalidation during 2011-12. The intention is to undergo a final assessment of readiness in late 2012, to ensure that revalidation meets the needs of the profession, employers, patients and the public and can be implemented in a way that is effective, cost-effective and affordable.

1.1 Background

3. The GMC consulted on its plans and proposals for how revalidation would work in practice between 1 March and 4 June 2010. They received over 940 written responses, 700 of these from individuals.
4. In June 2010, the Secretary of State for Health wrote to the GMC in response to the GMC consultation. In his letter, he stated his intention to extend the piloting period for a further 12 months to develop a clearer understanding of the costs, benefits and practicalities of implementation so that it can be paced in a way that is affordable, supports high quality care and makes effective use of doctors' time.
5. On 18 October 2010, the GMC published its response to its consultation.

Five key themes emerged from the consultation:

- ensuring that revalidation is straightforward and proportionate;
- ensuring the revalidation model is flexible;
- ensuring that revalidation is affordable for both individuals and organisations;
- the need for further detail; and

- the need for further testing and evaluation.
6. This was supported by a joint *Statement of Intent*¹ from the four administrations and the GMC. The Statement of Intent sets out a timetable for assessing readiness for the introduction of revalidation.
 7. On 15 December 2010, the Department of Health published the NHS Operating Framework 2011/12. The Operating Framework sets out what needs to happen over the transition year 2011/12. All parts of the health service are required to work across organisational boundaries to respond positively to the reform set out in *Equity and excellence: Liberating the NHS*², whilst ensuring that service quality and financial performance are maintained and improved at a time of change. The following line on revalidation can be found in the *NHS Operating Framework*³, page 21, para 2.43:

“NHS organisations will need to ensure they have in place the key components to underpin medical revalidation, in advance of an assessment of readiness in early 2012/13 to help doctors remain up to date and fit to practise throughout their career”
 8. In his letter to the GMC in June 2010, the Secretary of State announced his intention to press ahead with regulations on responsible officers. The role of the Responsible Officer is essential to ensuring that the health sector is ready for revalidation. The Responsible Officer Regulations came into force on 1 October 2010 in Northern Ireland and on 1 January 2011 in England, Wales and Scotland.

2. Introduction

2.1 Introduction

Recommendation 1: The current legislation makes the GMC accountable to the Privy Council; in the absence of a mechanism which makes this accountability effective we intend to exercise this function ourselves, on behalf of Parliament. (Paragraph 7).

9. The Government welcomes the Health Select Committee's intention to exercise the accountability function held by the Privy Council on behalf of Parliament (para 7).
10. The Government also welcomes the Health Select Committee's suggestion of inviting the GMC to give oral evidence against its annual report each year (paragraph 70).
11. The Coalition Government recently published '*Enabling Excellence, Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers*'⁴. The Command Paper sets out the Government's proposals for how the system for regulating healthcare workers across the UK and social workers in England should be reformed. It announced that we have asked the Law Commission to undertake a simplification review of the existing legislative framework for all the professional regulators covering health professions and social workers in England. We will alert the Law Commission to the Health Select Committee's recommendation.

3. History of Revalidation

Recommendation 2: Now that “late 2012” has been set as the date of implementation, we look to the GMC to ensure that there are no further delays and that the current target date is achieved. (Paragraph 20).

12. The overall responsibility for leading the work to introduce the revalidation of the medical register rests with the General Medical Council (GMC), but the Department of Health, its delivery arm the NHS Revalidation Support Team (RST) and its partners have a critical role to play in contributing to the design of the system and enabling its implementation within England. We will work with the GMC and other partners to achieve our planned timetable, as set out in the *Statement of Intent*¹, published in October 2010.
13. The Department of Health is responsible for bringing the legislation for revalidation into force and ensuring that the system is proportionate and does not place an undue burden on doctors themselves or on those who employ or contract with doctors in England in the public and private sectors.
14. The England Revalidation Delivery Board (ERDB) was established in late 2010 to provide assurance that England is progressing towards readiness for revalidation in 2012.
15. The ERDB is overseeing the plans for the extended year of testing in line with the Secretary of State for Health’s letter to the GMC in response to its consultation, with the intention of ensuring that, by the time Ministers consider the evidence from the additional year in the summer of 2012, we will have robust evidence of readiness in three areas:
 - design readiness: medical revalidation is right for doctors and for patients and has been properly streamlined and made proportionate;
 - organisational readiness: the health sector has the systems in place to be able to move to implementation (responsible officers, appraisal, clinical governance, etc.);
 - business case readiness (testing the components of revalidation): so that we have clear evidence of the benefits that revalidation will deliver and that it can be implemented in a way that is cost effective and affordable.

4. Purpose of Revalidation

Recommendation 3: Although the Committee agrees that the focus of revalidation for most doctors should be a commitment to practice improvement, it believes that the need to identify inadequate and potentially dangerous doctors must not be overlooked or diminished in the general move to use revalidation to eliminate unsatisfactory practice and improve overall performance. (Paragraph 26).

16. The Government recognises that the vast majority of doctors deliver a very high quality of care and believes that revalidation must support doctors in their innate professional desire to improve their practice and raise the quality of patient care and experience still further. In essence, revalidation provides a positive affirmation of a doctor's fitness to practise. Alongside this, enhanced systems of appraisal, clinical governance and responsible officers that underpin revalidation must be robust enough to identify and tackle poor performance at an early stage.
17. This will ensure that, where possible, any performance or practice that falls short of the expected standard can be improved. However, in those cases where improvement is not possible it will ensure that patients are not put at risk while the concerns are investigated and referred to the GMC.

5. Doctors whose performance gives cause for concern

Recommendation 4: The Committee finds it unsatisfactory that so little attention has been given to the issue of how to deal with doctors whose practice gives cause for concern. We regard this as an important weakness in the current proposals which the GMC needs to address if the introduction of revalidation is to help sustain public confidence in the medical profession. (Paragraph 30).

Recommendation 5: The Committee is concerned that instinctive use of the word "remediation" in cases where a doctor's performance gives cause for concern may have the effect of pre-judging the appropriate response to a particular set of circumstances. While it is important to ensure the rights and legitimate interests of individual doctors are safeguarded, the primary purpose of revalidation is to protect the interests of patients. (Paragraph 31).

18. The Department's view is that dealing with doctors whose conduct and performance is a cause for concern is primarily a clinical governance issue and is usually best dealt with at a local level. The GMC is concerned with fitness to practise. If revalidation is to be effective then action needs to be taken long before an issue is serious enough to trigger fitness to practise procedures.
19. For the vast majority of doctors, the more systematic annual appraisal will provide the basis for reflective practice and improvement, an essential developmental process. For the small proportion of doctors about whom there may be concerns, the strengthening of local clinical governance and a more objective annual appraisal provides the means for identifying problems earlier and either putting in place remediation or, if not possible, taking steps to remove them from clinical practice.
20. Support and guidance is already available from organisations such as The National Clinical Assessment Service and the medical Royal Colleges that supports those managing doctors' conduct and performance. We consider that it is more appropriate for these organisations with expertise in this area to provide such guidance.
21. The Responsible Officer (RO) Regulations came into force on 1 October 2010 in Northern Ireland and on 1 January 2011 in England Wales and Scotland. They make it obligatory for designated health bodies to nominate or appoint a responsible officer (usually the Medical Director in the NHS). The Regulations set out how an individual doctor will be connected to a designated body and therefore to a responsible officer.

22. In England and Wales, work is currently underway to provide the necessary training for responsible officers. It is intended that this will cover training on identifying and managing concerns. Strategic Health Authorities will shortly be providing training to the responsible officers in their areas. Scotland and Northern Ireland are making their own arrangements.
23. During 2010, the Department established a remediation steering group to explore the options available for providing remediation for doctors. We understand that the report of this group is nearly complete. We expect it to be presented to Ministers shortly.

Recommendation 6: The Committee therefore recommends that the GMC publishes clear guidance to Responsible Officers about how they should deal with the cases of doctors whose performance gives rise to concern. (Paragraph 32).

24. The Department agrees there is a need for guidance that makes it clear to responsible officers and doctors when a doctor's conduct and performance can be considered to be below the level which is acceptable and fitness to practise procedures will be triggered. The Department also considers there is a need for guidance about the processes that will be in place when a responsible officer is unable to make a positive recommendation about revalidation. Officials will be working with the GMC to ensure that this guidance is in place before the first recommendations are made.
25. We understand that the GMC will shortly be appointing Employer Liaison Advisers who will work with responsible officers to provide advice and guidance on specific cases of poor conduct and performance. In addition, Strategic Health Authorities are establishing networks of responsible officers that will be able to draw on each other's knowledge and skills in dealing with poor performance. Pilots of the GMC Affiliate concept pointed to this approach being useful in helping responsible officers manage difficult or new concerns.

6. Appraisal

Recommendation 7: It is clearly unsatisfactory that there is such a degree of variation across the country in relation to appraisal, and unacceptable that some doctors are apparently not subject to appraisal at all. If an adequate appraisal system is not provided for all doctors, then revalidation, as currently envisaged, will not work. The GMC needs to satisfy itself that all organisations which employ doctors have satisfactory, robust and consistent systems of appraisal in place on a timescale that makes possible its objective of introducing revalidation in late 2012. (Paragraph 37).

26. The Government agrees with the Health Select Committee's recommendation. Whilst the process of medical appraisal has been mandatory in the NHS since 2002 it is recognised that appraisal is patchy, although more developed in Primary Care.
27. It is the role of responsible officers, as set out in the Responsible Officer Regulations to ensure that effective appraisal arrangements are in place that involve obtaining and taking account of all the available information relating to a doctor's fitness to practise.
28. The RST has designed a readiness assessment tool named ORSA (Organisational Readiness Self Assessment tool) to inform the England Revalidation Delivery Board and the GMC regarding progress towards readiness in England. ORSA will include an assessment of the degree of consistency with which medical appraisal is being implemented in each organisation. Results from the information gathered will contribute towards the Secretary of State's assessment of readiness for revalidation in 2012.
29. The learning from the current pathfinder pilots and the extra year of testing will lead towards a consistent appraisal process known as the Medical Appraisal Framework, built on *Good Medical Practice*⁵.

7. Requirements of doctors

Recommendation 8: It is clearly undesirable that doctors should be required to provide an immense amount of documentation for their appraisals. We agree that much of what is required should already be in place, and that if institutions have effective systems for clinical governance then information that is required for that use will also be available for appraisal. (Paragraph 44).

30. The Government agrees that revalidation should be designed and implemented in a way that makes effective use of doctors' time. The additional year of testing will enable the approach to be streamlined so that it is proportionate and makes use, wherever possible, of existing clinical governance systems whilst properly demonstrating that a doctor is fit to practise.
31. Following the GMC consultation in 2010, the GMC and medical Royal Colleges and Faculties are reviewing the specifications of information that could be useful in demonstrating that a doctor meets the standards of *Good Medical Practice*⁵ and is fit to practise. We understand that the GMC will be publishing two sets of guidance in Spring 2011. The first covers embedding the Good Medical Practice Framework in the appraisal process, the second discusses the types of supporting information required for appraisal and the frequency with which it should be provided over the course of each revalidation cycle.
32. The *Responsible Officer Regulations*⁶ require that responsible officers ensure that appraisals must take account of all available information relating to the doctor's fitness to practise. We would expect that this would include information from clinical governance systems relating to the doctor's practice.

Recommendation 9: The Committee supports the approach set out in the GMC's consultation review document aimed at making the process simpler and more flexible. In particular we agree that the different components of revalidation should be integrated into a single process, and that the requirements of that process should be integrated into the appraisal and clinical governance systems operated by employers. (Paragraph 47).

33. The Department welcomes the recommendation.

8. Patient and colleague involvement

Recommendation 10: In its response to the consultation the GMC commits itself to further development of its proposals for colleague and patient feedback. We welcome this commitment; we hope the GMC will undertake a review of best practice in gathering the views of patients and colleagues and develop its proposals in the light of that review. (Paragraph 53).

34. The Government welcomes patient and colleague involvement in the revalidation process. In England, the NHS White Paper, *'Equity and Excellence'*² aims to put patients at the heart of the NHS and to strengthen the collective voice of patients.

9. Responsible Officers

Recommendation 11: We believe the risk of conflicts of interest arising from the dual role of medical directors as Responsible Officers within the revalidation system, and members of the employers' senior management team, is real. (Paragraph 56).

Recommendation 12: We also believe, however, that this is the inevitable consequence of using appraisal as the basis of revalidation. Appraisal is part of robust clinical governance and is a key requirement of good management; it is therefore, inevitably, part of the responsibility of the medical director of the employer. (Paragraph 57).

Recommendation 13: In the light of this unavoidable risk of conflicts of interest arising we recommend that the GMC publish clear guidance to Responsible Officers about how such conflicts should be handled. We also recommend that the GMC consider further what safeguards may be desirable to protect the interests of individual doctors in circumstances where they believe a conflict of interest may have influenced the decision of a Responsible Officer. (Paragraph 58).

35. The Department published guidance on how conflicts of interest should be managed in its *responsible officer guidance*⁷. The Department does not consider that there is a need for further guidance at this stage. We will however keep this under review and amend the guidance if necessary.

Recommendation 14: The GMC needs to satisfy itself within a timescale that will allow introduction of revalidation by 2012 that there is clarity about where Responsible Officers currently based in PCTs will be situated in future. (Paragraph 60).

36. The Department recognises that clarity is needed about responsible officers currently based in PCTs and with connections to doctors on performers lists and those secondary care locums who do not work through an agency on the Office of Government Commerce (OGC) Buying Solutions Framework. Where these responsible officers will be situated under future arrangements in England will depend on the form and functions of the new bodies.
37. Ministers gave commitments in both Houses during debates on the Responsible Officer regulations that we will consult on responsible officers in the new architecture in the Spring of 2011.

10. Doctors with non-standard careers

Recommendation 15: The Committee welcomes the clarification provided in the Medical Practitioners (Responsible Officers) Regulations 2010. It believes this clarification will resolve many uncertainties, but it looks to the GMC to provide a further detailed response to the other concerns raised on this subject in its consultation. (Paragraph 65).

38. The Government supports the recommendation. The extra year of testing provides the opportunity to widen the scope of work and to test that the streamlined model is applicable for doctors working across different environments and with varied work patterns.

11. Doctors from elsewhere in the European Union

Recommendation 16: We regard the ability of a doctor to communicate effectively with his or her patient as fundamental to good medicine. As the body responsible for revalidation, and with a commitment to introducing it by late 2012, we expect the GMC to satisfy itself that it has the necessary powers to fulfil this role; if it is not satisfied (whether as a result of EU legislation or for any other reason) we expect it to say so publicly and report to Parliament what changes are necessary to allow it to fulfil its function effectively. (Paragraph 68)

39. The Government is committed to ensuring that all doctors working with patients in the United Kingdom have the clinical skills and language skills to practise safely and effectively. The Department of Health is working closely with the GMC to develop proposals to ensure this is the case.

12. Notes

1. Revalidation: A Statement of Intent, Department of Health, Scottish Government, Welsh Assembly Government, Department of Health, Social Services and Public Safety Northern Ireland, General Medical Council, October 2010.
2. Equity and excellence: Liberating the NHS, Department of Health, July 2010.
3. The Operating Framework for the NHS in England 2011/12, Department of Health, December 2010.
4. Enabling Excellence, Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers, Department of Health, February 2011.
5. Good Medical Practice, General Medical Council, March 2009.
6. The Medical Profession (Responsible Officers) Regulations 2010, Department of Health, July 2010, available from: <http://www.legislation.gov.uk/ukdsi/2010/9780111500286/resources> (accessed 23 March 2011).
7. The Role of Responsible Officer: Closing the gap in Medical Regulation, Department of Health, July 2010.



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