General Medical Council

Legal Services Board: Call for evidence

Ongoing competence for doctors

1 We appreciate the opportunity to respond to your call for evidence on ongoing competence in the legal services sector. Our response focusses on your fourth theme (**Competence assurance in other sectors**) by describing the system for assuring ongoing competence for medical practitioners (revalidation) and sharing our experiences of operating it to date.

2 Revalidation also addresses aspects of the other themes, for example maintenance of competence over time, how consumers (patients) can make judgements on the quality of the advice or service that they have received, and patient involvement in competence assurance.

What can consumers (patients) expect from doctors?

3 As you've noted in the call for evidence, it can be hard for consumers '*to assess competence and know whether they are receiving good quality…services*'. This is likely to be the case across different professions including healthcare.

4 We set the professional values, knowledge, skills and behaviours expected of all doctors working in the UK. Our core guidance for doctors, *Good medical practice*, sets out the standards expected of doctors. As well as the core guidance we also publish additional ethical guidance for doctors.

5 We have guidance for patients which gives them the tools to work in partnership with their doctor, and let them know what they can expect from their doctor. In this way, alongside our core guidance for doctors, patients can access information and advice which can help them to make judgements on the quality of the advice or care they've received from their doctor.

Revalidation

6 Being registered with us shows that a doctor has the necessary qualifications and is in good standing. But to be able to practise medicine in the UK doctors must also hold a licence to practise, and this applies whether doctors work in the NHS or privately. The licence gives certain legal rights including, but not limited to, prescribing

controlled drugs, being a physician, surgeon or medical officer in any public institution, working as an NHS GP, and signing death certificates. As these are significant activities, licence holders need to demonstrate a level of continuing competency.

7 In the call for evidence you've noted that legal regulatory bodies generally only formally assess competence when legal professionals join the profession, and that CPD is usually unassessed. You've also found that consumers of legal services generally assume that legal professionals are competent and rely on there being regular, robust checks in place to assure this.

8 In 2012 we introduced revalidation, as a system to assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and fit to practise. Before the introduction of revalidation there was an assumption that, after qualification, doctors remained competent and up to date, unless it was demonstrated otherwise through fitness to practise proceedings. As you've noted the focus '*was on assuring competence on entry to the profession with less attention paid to post-qualification competence',* so doctors could have an entire career in medicine without any formal regulatory assessment of their competency.

9 Now all doctors must revalidate to keep their licence to practise. Revalidation aims to increase the quality of healthcare by encouraging local appraisal, continuing medical education and reflective practice, and supports doctors to develop their practice, as well as driving improvements in clinical governance. Another aim is the early identification and local resolution of concerns about doctors.

Who's involved in revalidation?

Doctors

10 Revalidation focusses on individual doctors and is a key process for all licensed doctors in the UK. It gives assurance to patients and the public that doctors working in the UK are up to date and fit to practise, and every licensed doctor who practises medicine in the UK must revalidate every five years to keep their licence.

Healthcare organisations

11 Revalidation also involves all organisations where doctors work and is part of a wider national assurance framework across healthcare. We set the guidelines for this national framework, but the process is managed locally by healthcare organisations called designated bodies.

12 Designated bodies appoint responsible officers (senior doctors), who provide support to their doctors for their appraisal and revalidation and make recommendations to us about their continued fitness to practise. The link between a doctor and a designated

body is called a prescribed connection and is defined in the Responsible Officer Regulations[1].

Patients

13 Patients have a very important role in revalidation. Doctors want patients to share their experiences of being cared for, so they know how they're doing. Although they can't usually assess medical skills patients can, for example, say how well doctors listened to them or explained what they were doing. Doctors should review and reflect on patient feedback as part of the annual appraisal process.

14 Doctors are required to seek feedback from a sample of patients once every revalidation cycle (usually every five years) using a structured questionnaire. We've recently reviewed our patient feedback requirements, and there's more information about this at paragraphs 30-38 below.

15 Patients and the public can find out more information about what revalidation means on our website. We don't publish detailed specific information about revalidation outcomes for individual doctors, but patients and the public can find out whether individual doctors hold a licence and are subject to revalidation on the online medical register. Searches carried out there will also usually give details of the doctor's designated body and responsible officer. In this way, patients can gain assurance that their doctor is up to date and fit to practise.

How does revalidation work in practice?

16 All licensed doctors in the UK must take part in annual local appraisal, covering the whole of their practice. We've created guidance to explain the supporting information doctors must collect about their practice and take to their appraisal. This information demonstrates that they're meeting our standards as set out under four broad headings in *Good medical practice*.

- ***General information*** – context about what doctors do in all aspects of their work.
- ***Keeping up to date*** – maintaining and enhancing the quality of their professional work.
- ***Review of practice*** – evaluating and improving the quality of their professional work.

[1] *The Medical Profession (Responsible Officers) Regulations 2010 (as amended)* and *The Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010*.

- ***Feedback on practice*** – seeking and acting on feedback about the quality of their professional work.

17 There are six types of supporting information doctors must collect, reflect on and discuss at appraisal:

- CPD
- reviewed complaints and compliments
- patient feedback
- colleague feedback
- significant events
- quality improvement activity.

18 Doctors get this supporting information from their day-to-day practice or from within their workplaces and, at appraisal, it forms the basis of a reflective discussion feeding into their personal development plan (PDP). They also provide a health and probity declaration to confirm they remain fit to practise.

19 Most doctors' appraisal output is shared with their RO who assess their connected doctors' fitness to practise, and make recommendations to us about revalidation, usually every five years. We use these recommendations to decide whether to maintain doctors' licences to practise.

Reviews of revalidation

20 As revalidation was such a signification reform in medical regulation, we made a commitment at the outset to review and learn from the initial experiences of revalidation. We commissioned reviews (detailed below) to consider its impact and whether there were changes we could make to improve it.

Taking revalidation forward

21 In 2016 Sir Keith Pearson, the independent Chair of the Revalidation Advisory Board (RAB)[2], carried out a review of revalidation. He published his report, *Taking revalidation forward*, in 2017, noting that revalidation had '*already delivered significant benefits*'. This review identified that revalidation had ensured annual whole practice appraisal was taking place across UK healthcare, and that the ongoing reflection required by appraisal had started to drive changes in doctors' practice. The

[2] A four-country group of external advisers to the GMC.

review also found evidence to show that clinical governance within healthcare organisations had been strengthened to support revalidation.

22 As well as identifying that revalidation had already produced significant benefits, *Taking revalidation forward* identified areas for improvement. The report contained 15 recommendations, which we have taken forward with partners across the healthcare system. Our response to these recommendations is explained in paragraphs 27-30 below.

UMbRELLA

23 We commissioned the UK Medical Revalidation Evaluation coLLAboration (UMbRELLA)[3], a collaboration of academics and revalidation implementers, to explore the impacts of revalidation during its first cycle of implementation.

24 UMbRELLA's study took place between October 2014-2017, across UK healthcare settings, sampling data from all registered and licensed doctors. They carried out surveys with over 85,000 participants, recorded appraisals and reviewed doctors' portfolios, and interviewed doctors and patient representatives. They published their findings in January 2018.

25 UMbRELLA found that most UK doctors had been brought into revalidation, and that revalidation had led to a rise in doctors' participation in annual appraisal. They also found that some doctors had changed their '*clinical practice, professional behaviour or learning activities as a result of their most recent appraisal'*.

What actions have we taken to improve revalidation?

26 We produced an action plan in July 2017 to address the recommendations in *Taking revalidation forward*, and our final report on the improvement programme details the changes we made and describes initiatives for future improvement. Some examples of the improvements are outlined below.

For doctors

27 We wanted to improve the appraisal experience and reduce burdens for doctors, so we:

- made revalidation requirements clearer so it's clearer for doctors to see what they need to do to revalidate, how ROs make recommendations and how we make decisions

[3] UK Medical Revalidation collaboration involves Belfast Health and Social Care trust, Camera with Plymouth University, Health Improvement Scotland, Manchester Business School, NHS Education for Scotland, UCL and Wales Deanery.

- introduced new overarching principles for all supporting information, including 'quality not quantity' and 'proportionality' in the evidence that doctors should collect

- improved how we publish information about revalidation and now have step by step guides that explain the revalidation process for different groups of doctors.

For responsible officers, suitable persons and healthcare providers

28 Responsible officers and suitable persons play a key role in managing the systems that support revalidation, so we:

- improved our guidance - the new responsible officer hub on our website brings together all the information that ROs need for their role in one place

- developed new information sharing principles, to help support the development of consistent practice across the UK healthcare system

- established a framework for tracking revalidation and accompanying 'best practice' measures to make sure we can continue to understand how revalidation is working in practice and whether it is achieving its aim, to enable us to make improvements in future where necessary.

For patients

29 One of our key priorities was making revalidation more accessible to patients and the public, to increase patient/public awareness of/involvement in revalidation and to increase the impact of patient feedback on doctors' practice. We worked with:

- patients and the public to create an explanation about revalidation, making it easy to understand and including information patients told us they wanted to know

- two hospital trusts to create case studies showing how they involve lay representatives in their local appraisal and governance processes, and promoting the benefits of involving patients in local governance systems.

Consumer feedback

30 Patients are the consumers of doctors' services, and it's important that they have the opportunity to give doctors feedback on the care they receive. We recognise the value of patient feedback for doctors' learning and professional development, and we know that doctors value feedback from their patients and find it one of the most helpful types of supporting information to reflect on at their appraisal.

31 Before 2012 doctors didn't routinely collect or review information from their patients, so we introduced patient feedback as part of revalidation in 2012. As noted above doctors are required to seek feedback from a sample of patients once every revalidation cycle (usually every five years) and have done this using a structured questionnaire.

32 *Taking revalidation forward* found that patient feedback can be the most useful type of supporting information for doctors to reflect on at appraisal. But the review also found that mechanisms for collecting feedback are inflexible, the patient sample too small and not representative, and patients often feel unable to give honest views for fear of a negative impact on their care.

33 Similarly the UMbRELLA review found that patient feedback can have a measurable impact on medical performance, but doctors and patients both identified issues with the way feedback is collected, as well as a need to refine current patient feedback tools and processes.

34 These reviews show that consumers, in our case patients and the public, can play an important role in systems of assuring ongoing competence. This fits with the evidence you've found about the need for consumers to be made aware of competence assurance information and systems, and highlights the importance of active consumer involvement in those systems.

35 As part of our response to the revalidation reviews, in 2019 we publicly consulted on changes to our requirements for doctors to reflect on patient feedback as part of their revalidation. The proposals we consulted on were mainly to allow greater flexibility in how doctors can seek feedback from patients (not having to use a specific questionnaire), and to ensure feedback systems meet the needs of a range of patients (eg allowing different ways to give feedback). We suggested doctors reflect on patient feedback more often, using a range of sources available, including any unsolicited feedback.

36 As a result of feedback we've reconsidered our proposals. Our revised guidance is unlikely to require doctors to take a significantly different approach to seeking patient feedback, but will introduce greater flexibility in how doctors can seek feedback and encourage doctors to consider the range of feedback available to them that they can reflect on.

37 As part of our response to the coronavirus (COVID-19) pandemic we have decided to delay publication of the revised guidance and results of the consultation findings until later this year. This is to support the health service in prioritising frontline clinical care for patients during this challenging time. We'd be happy to send you a copy of the revised guidance when we've published it, if this would be helpful.

Revalidation data

38 We collect a range of data about medical practice and share it online in a variety of formats.

39 GMC Data Explorer is an interactive tool which provides an accessible way to explore and export our data. The revalidation section provides a summary of prescribed connections and an overview of approved revalidation recommendations that are updated daily. It shows how many doctors are subject to revalidation, their connections, demographics and more, as well as how many doctors have been revalidated, deferred or have had a non-engagement recommendation. The data is broken down in different ways, such as by country, designated body type and individual designated bodies, as well as by gender, primary medical qualification (PMQ group), ethnicity and medical specialty.

40 We also publish a revalidation summary report of approved revalidation recommendations for the UK and broken down by UK country, which includes the number of licences we have withdrawn as part of revalidation. You can see from this report that between 3 December 2012 and 31 January 2020 we have approved 305,909 recommendations about a doctor's revalidation and, of those, 247,611 were to revalidate the doctor.

41 Our operational data reports give country-specific breakdowns for England, Northern Ireland, Scotland and Wales of approved recommendations by designated body, as well as a breakdown of these numbers by month.

42 We've also summarised the key statistics from the first five years of revalidation here. This report is intended to be useful as a resource to help understand broad patterns of revalidation, deferral and non-engagement.

Conclusion

43 We hope that the information and resources identified in this response are helpful in your research, and we're happy to follow up this response with further information at any stage.