




Position paper on revalidation

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The Academy of Medical Sciences

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Introduction

The Academy of Medical Sciences is committed to ensuring that the UK delivers world-class healthcare. Key to achieving this is a first class workforce able to promote innovation throughout the National Health Service (NHS), clinical academic research community and pharmaceutical industry.

The Academy recognises the societal influences behind the current revalidation reforms, which are outlined in the box below, and the importance of maintaining and strengthening public trust in the medical profession. We fully concur with the aim of ensuring all practising clinicians remain up-to-date and competent within their area of clinical expertise. In order to deliver excellence in healthcare, it is essential that doctors continue to learn throughout their career, and a system that facilitates this is highly desirable.

However, the Academy questions whether the emerging proposals for revalidation will achieve the desired objectives and meet public expectation in a cost effective manner. We have particular concerns over the complexity of the processes proposed. These may have a substantial opportunity cost in that they would require much time and effort to be expended in monitoring doctors, the majority of whom would be performing entirely satisfactorily. The proposed system of revalidation might thus have serious unintended consequences in limiting the scope, flexibility and mobility of the medical workforce, compromising in the UK's future ability to deliver high quality clinical research and excellent patient care.

The licence to practise and revalidation¹

In Autumn 2009 any doctor who wishes to practise medicine in the UK will not only have to be registered with the General Medical Council (GMC), but will also need to hold a licence to practise. All doctors who hold a licence to practise will be required to participate in revalidation. Revalidation is the process by which doctors will have to demonstrate to the GMC, normally every five years, that they are up-to-date, fit to practise and complying with the relevant professional standards. Revalidation is an umbrella term that covers two elements: relicensing and recertification.²

- **Relicensing** - The purpose of relicensing is to show that all doctors are practising in accordance with generic standards of practice set by the GMC and based upon the GMC's guidance *Good Medical Practice*.³
- **Recertification** - The purpose of recertification is to show that doctors on the GP or Specialist Register continue to meet the particular standards that apply to their medical specialty or area of practice. These specialty specific standards are being developed by the medical Royal Colleges and Faculties for approval by the GMC.

¹ Taken from, The General Medicine Council (2009). *Revalidation: information for doctors and frequently asked questions*. http://www.gmc-uk.org/doctors/licensing/docs/GMC_Revalidation_FAQ%20document_02_06_2009.pdf

² The processes for implementing these reforms are still being developed, more information is available from <http://www.gmc-uk.org/doctors/licensing/index.asp> and <http://www.aomrc.org.uk/revalidation.aspx>

³ The General Medical Council (2006) *Good medical practice*. http://www.gmc-uk.org/guidance/good_medical_practice/index.asp

This paper sets out the Academy's position on the proposed mechanisms for revalidation, in particular with respect to academic medicine. The Academy supports a simpler approach to ensuring the competency and continued development of individual doctors. The aims of revalidation could be met by relicensing doctors through development of a more robust appraisal system, overseen locally by an appraiser of appropriate knowledge and seniority. A strengthened appraisal system would be designed to apply to *all* doctors and relicense individuals based on their current and potential area of expertise, thereby covering doctors on the Specialist and General Practice Registers. This enhanced appraisal would draw on mechanisms such as Continuing Professional Development (CPD), whilst other methods such as Multi Source Feedback (MSF) should only be implemented when merit is proven. Such an approach would provide appropriate checks on all doctors, and help meet public expectation on standards, quality of care and cost effectiveness.

In the development of this paper the Academy has consulted with the organisations charged with the development and implementation of the forthcoming revalidation reforms. In addition, we have sought views from a range of medical constituencies who work outside the NHS and across inter-professional boundaries with other healthcare sectors.

Academy of Medical Sciences position paper on revalidation

To respond to changing healthcare demands, now and in the future, it is imperative that the UK medical workforce is well-trained, and practically and intellectually flexible. The development and delivery of mainstream clinical medical services depends on a wide range of professional expertise, including (i) discoveries and innovations by academic clinicians working within the NHS, Higher Education Institutions (HEIs), research institutes, primary care and the pharmaceutical industry (ii) excellence in teaching and education (iii) medical management and administration of healthcare delivery and (iv) clinicians involved in public service roles, developing policies at the national and local level.

It is important that the UK promotes and sustains this range of expertise, in order to achieve excellence in all aspects of medical practice. The Academy is supportive of an assessment mechanism that enables doctors to achieve high quality clinical practice and encourages their involvement in activities which complement and inform their practice.

Broad concerns over the proposed revalidation mechanisms

There is concern that the proposed revalidation mechanisms risk becoming overly complex and bureaucratic, and thereby failing to provide the flexibility and mobility required to allow clinicians to undertake diverse roles. A system which constrains individuals to limited responsibilities must be avoided. There is particular concern for clinicians whose roles do not fall within the conventional

NHS framework. Those formulating the proposed mechanisms must consult and engage with employers across the full range of relevant sectors such as universities and industry.

There is continuing uncertainty within the medical community on the nature and timing of the revalidation reforms. In the absence of any co-ordinated communication from the various organisations leading the different aspects of the reforms it has proved difficult to understand the model of revalidation, the developments, and indeed the reasoning, behind the various draft documents, such as those on appraisal, and how these would link together to form an integrated process.

It is essential that sufficient time is allocated to allow careful development and implementation of any revalidation process. There are a number of highly complex issues involved which require deeper consideration and consultation. Streamlining the administrative process would both benefit the workforce and facilitate cross sector working arrangements. The proposed new processes should be extensively piloted before full implementation, not just for clinicians in mainstream NHS posts but for those working in other settings. The rushed implementation of a highly complex system without due thought, critical review, and consequent simplification is likely to result in costly administrative failure.

Principles of revalidation for all clinicians

In this document, the Academy offers general principles on revalidation, applicable to all medical practitioners. It is aware that the detailed mechanisms of revalidation are still being developed by the various bodies involved (principally the General Medical Council (GMC), Department of Health and Academy of Medical Royal Colleges (AoMRC). However, it believes the principles below in general align with the aspirations of the proposed reforms, as for example outlined in a recent GMC information guide for doctors.⁴

We set out the principles here and consider whether the reforms, as currently proposed, meet the expectations required of them.

1. The criteria for revalidation

- Criteria for revalidation must be simple and focus on an individual's current and potential scope of expertise.
- Revalidation should be embedded within existing local appraisal and job planning processes: wherever possible it should use proven established assessment mechanisms (rather than duplicate these).
- Revalidation should be approached and viewed as 'enhanced appraisal'.
- Revalidation should include all registered medical practitioners whose professional knowledge and expertise is relevant to their job

role, irrespective of their work setting.

2. Consistency in approach

A single integrated process of revalidation should apply to all clinicians.

3. Methods of revalidation

Competency-based assessment is essential. This should be focussed on the individual's ability to deliver their defined job plan.

4. Flexibility

Revalidation must allow for appropriate flexibility in an individual's role and future career development.

5. Implementation and governance

Appraisal and revalidation should be centred on the annual appraisal and administered and managed at the local level, with national oversight.

6. Re-entry to clinical practice and the specialist register

There should be robust mechanisms to support clinicians returning to clinical and specialist practice after a period of reduced practice, for example in full time research or policy roles.

These general principles lead on to the following:

- Recommendations for revalidating all clinicians, whatever their job role or setting.
- Specific principles applying to clinicians who contribute to academic endeavour.

⁴ General Medical Council (2009). Revalidation: information for doctors and frequently asked questions. www.gmc-uk.org/doctors/licensing/docs/GMC_Revalidation_FAQ%20document_02_06_2009.pdf

General recommendations for all clinicians

A simple system that focuses on an individual's current and potential scope of expertise

Revalidation must be sufficiently flexible to be achieved by a simple appraisal process. Complicated, lengthy processes and paperwork are more likely to result in administrative failure and detract from the original aim of raising the standard of medical care. To encourage movement between sectors, careful consideration must be given to the alignment of appraisal between the NHS and other healthcare sectors.

The appraisal must be matched to an individual's precise areas of expertise. We strongly support a process which allows clinicians who undertake a variety of roles to be fully relicensed and recertified by assessment of the relevant components of their job role, for example, research, teaching, management, administration. However, this approach must not be at the expense of limiting individual's breadth and future potential in clinical practice or related healthcare activities.

Care must be taken that revalidation does not duplicate existing assessments and introduce new metrics. Existing mechanisms and criteria for assessment, where available, should be used and mapped on to the revalidation process.

A single integrated process of revalidation should cover all clinicians

There should be a single integrated process for revalidation that applies to all clinicians, irrespective of job role or setting. This approach is necessary to ensure consistency and prevent

revalidation from being, or being perceived to be, divisive.

Flexibility

Flexibility is a fundamental requirement for maintaining a first-class medical professional workforce equipped to undertake the wide variety of roles that promote improvement in healthcare. Healthcare needs change over time and any reforms must support a medical workforce that can adapt to meet new demands, and not be hindered by artificial boundaries imposed by revalidation. A major risk of the proposed revalidation mechanisms is that they would inadvertently create a compartmentalised workforce, so limiting flexibility and consequently management and workforce planning.

Revalidation must be transparent and sufficiently flexible to give clinicians confidence that they will have the opportunity to vary the scope of their clinical practice throughout their career and allow for periods of limited practice, for example during a period of full time research. Individuals who focus within a narrow area of clinical practice in a subspecialty should not be prohibited from subsequently broadening their area of practice provided they are competent to do so. If such competence is in doubt, the revalidation process should allow this to be demonstrated or re-established. The approach must ensure standards of care and patient safety. For instance, in surgical specialties and in medical specialties using interventions that require a high degree of procedural skills, individuals would need to demonstrate they remain fully competent to undertake such work.

Revalidation must also have the flexibility to allow mobility of clinicians

across the range of healthcare sectors throughout their career, for instance between academic medicine, the pharmaceutical industry, public administration and clinical service without the deterrent of potential loss of their ability to practise.

Competency based assessment

Competency based assessment must be the basis of both the annual appraisal and revalidation. It is imperative that revalidation focuses on the competency of a clinician to deliver their defined and agreed job plan. In terms of clinical competency, the use of metrics or time-served are not in themselves reliable indicators in assessing fitness to practise and are likely to disadvantage clinicians who undertake a range of activities, but who provide high quality clinical work within a defined area of practice or are time-limited by their other commitments.

Clinicians often work in teams to deliver patient care. A balance needs to be struck between an individually focussed assessment versus recognition of the importance of, and skills associated with, team working. Furthermore, a focussed contribution which is effective when made in the context of a multidisciplinary team or team job plan should be assessed and included in revalidation.

Operational model and governance for revalidation

We strongly support revalidation being embedded within the existing local appraisal and job planning processes, with a designated local 'Responsible Officer'. Local ownership and governance is essential if the system is to operate effectively. A widespread view in the medical community is that individuals

who are performing poorly are often known to their peers and seniors. Effective local management combined with a simple approach to the larger majority of doctors would ensure that attention will be focussed on those where performance needs careful scrutiny.

In the Department of Health's current model, the local NHS Medical Director would become the Responsible Officer (RO), overseeing the annual appraisals and providing institutional sign-off of the quinquennial revalidation process. It is essential that clinicians, irrespective of sector, have access to a RO who has the appropriate skills and expertise to assess their case for revalidation. Careful consideration must be given to clinicians who work wholly or partly outside of the NHS. For example, clinicians working in academic medicine, the pharmaceutical industry and small biotech companies must be revalidated equitably. An appropriate RO for these individuals will need to be identified in each case. We have strong concerns that the suggested default pathway of the local Primary Care Trust (PCT) providing the RO to individuals with no other option, might leave both parties disadvantaged and potentially culminate in an unsatisfactory outcome. Further consideration must be given to identifying appropriate ROs for discrete cohorts of clinicians across varying settings.

The Responsible Officer would report the outcome of an individual's revalidation to the relevant national bodies. The strength of this approach is the single assessment point, which appraises and revalidates an individual on their job plan using established mechanisms. Clearly, the role of the RO is pivotal; the scope of this position and the necessary

support and resource require consideration and consultation.

It will be important that the job plan and other necessary documentation allow an individual to describe the precise nature of their actual role, facilitating an assessment that matches the scope of an individual's field of expertise. The forward job plan and personal development plan (PDP) would be formulated and agreed from this overarching assessment.

Local governance of appraisal and revalidation

Revalidation must be implemented as 'enhanced appraisal' and focussed on an individual's competency to deliver their designated job plan, which is most effectively assessed through established criteria and colleagues and peers at the local level. We are in favour of the appraisal determining an individual's job plan and personal development plan (PDP) and, if appropriate, dictating their scope of responsibility in the local clinical environment.

By agreement between the NHS and University partners, the Head of the Medical School could undertake the role of RO for University employed clinical medical staff, both signing off appraisals and giving the assurance that the standards for revalidation had been met. If necessary, the Head of the Medical School could also adjudicate on differences of opinion. Under existing practice ensuing from the 'Follett Report', Medical Directors and Heads of Medical Schools already liaise closely on appraisal and job planning.⁵ The nature

⁵ Department for Education and Skills (2001). *A review of appraisal, disciplinary and reporting arrangements for senior NHS and university staff with academic and clinical duties.*

of the clinical academic contract being interlocked between the NHS and University provides appropriate checks and balances – a problem in one area of work will impact on the entirety of the contract.

This devolved approach would provide accurate oversight and assessment of an individual's precise portfolio of work. Further, it would assist the individual in career planning and negotiating opportunities to alter their scope of clinical practice.

Award of recertification

The Royal Colleges provide an essential national role in maintaining the standards for the knowledge base within specialties, by setting the training curriculum etc. The Royal Colleges should set the expected standards for local recertification and provide the framework to assist individuals in demonstrating that they meet those standards to their appraisers. An individual would be recertified on the basis of the assurance given from the local Responsible Officer (usually under the aegis of the employer).

National oversight and award of revalidation

The General Medical Council (GMC) would provide national oversight of the revalidation process in its entirety. The GMC would approve and provide the relicensing of an individual clinician on the assurance given from the Responsible Officer of the local governing body.

The proposed system would provide an individually tailored approach that facilitates consistency within the local

<http://www.academicmedicine.ac.uk/uploads/folletreview.pdf>

context. The advantages of local governance include the potential opportunity to identify and monitor poor practice or doctors in difficulty. Harnessing existing assessment mechanisms also allows for the most efficient use of manpower and resources.

We must avoid the development of an unnecessarily complex system of revalidation, which is designed to deal with the minority of situations where an individual doctor's performance, or the institution's appraisal, clinical governance and management processes, are judged to be inadequate. These situations are best dealt with by other strategies.

Clinicians working overseas

Careful consideration should be given to clinicians who opt to work overseas for a period of time. An example would be that of a senior clinician, leading significant clinical and research programmes in Asia or Africa, but retaining close links to their home (UK) Trust, where they undertake defined periods of clinical practice. A position such as this is often dependent on holding UK medical registration and therefore a licence. For the UK to further build its status as a global leader in healthcare and innovation, it is vital that such individuals are supported and revalidated through appropriate mechanisms.

Re-entry to clinical practice and the specialist register following a period of absence

Accessible routes for re-entry into specialist practice should be developed and implemented. Clinicians who have previously been certified in a given specialty must have the entitlement to re-establish themselves with the appropriate support and management

within their local environment. The decision to allow a clinician to follow this course and the mechanisms of re-training or supervised practice required for recertification should be made at the local level. The process and training must not be overly prescriptive, but be matched to an individual's circumstances and skill set.

Enforced/compulsory de-validation

Careful thought needs to be given to 'de-validation' of individuals who do not meet the standards of relicensing and recertification. A transparent process for arbitration and appeals at both the local and national level must be developed. Consideration should be given to the breadth of specialist expertise that will be required in such circumstances.

General principles relating to clinicians who contribute to academic endeavour

Registered Medical Practitioners whose work involves a significant component, or a preponderance, of research, teaching and other academic and administrative work must remain eligible for revalidation. Their work and contributions may range across the following categories (which are illustrative and not exclusive):

1. Those with direct patient contact in a clinical specialty, of equivalent type to full time NHS colleagues. In some cases their clinical practice may be in a focussed area within the specialty (for example academic surgeons practising sub-specialty operative work). Some academic clinicians may have additional clinical exposure through their research activity.
2. Those practising in laboratory specialties or public health, not necessarily with direct patient

contact, but contributing (for example) through clinical skills in diagnostic work, epidemiology or clinical trials – this may equate to the work of those on full time NHS contracts or be restricted to provision of advice in a focussed subspecialist area.

3. Those working in clinical, research or educational management and administration with substantive or honorary NHS contracts.
4. Those working outside the health provision sector, for example in industry, usually without an honorary NHS contract, who may be involved in planning and conducting clinical trials (the pharmaceutical industry has its own supervision and appraisal arrangements which any system of revalidation should allow for and recognise).

Against this background the following general principles should be applied in designing the system for revalidation.

National recognition of the value of academic research

The benefits of clinical and biomedical research, in delivering innovations in healthcare that improve national health and generate wealth, are widely recognised.⁶ UK clinical research is currently benefiting from significant additional investment from Government and research funders and a coordinated cross agency effort to bolster capacity through strategic NHS and University partnerships. Instilling academic values and the spirit of enquiry throughout the NHS will be essential to the research-based agenda for healthcare.

⁶ The Wellcome Trust, Medical Research Council and Academy of Medical Sciences (2008). *Medical research: what's it worth?* <http://www.acmedsci.ac.uk/p99puid137.html>

We are aware of the tension in some Trust managements between delivering clinical commitments (in order to meet business and waiting time targets) and affording consultants time to undertake academic work and other related activities. A clear statement is needed at the national level on the importance of academic medicine, and the expectation that this endeavour will be recognised at the local level to ensure individuals are encouraged to pursue their work and supported through the revalidation processes.

Supporting clinicians who pursue a variety of roles

Recertification should encompass all clinicians whose knowledge and expertise within a given specialty or specialties is relevant to their job role, irrespective of their work setting. We strongly support the principle that clinicians whose balance of work is weighted, or solely focussed on research, education, management or policy (as in the exemplar categories given above), should be able to be fully relicensed and recertified using a component of the revalidation assessment that encompasses their expertise in these activities.

Recertification of doctors undertaking 'non-clinical' activities

The Academy has liaised with the Academy of Medical Royal Colleges' Non-Clinical Working Group, which has the responsibility to develop frameworks that outline the standards and supporting information required for a range of 'non-clinical' work activities undertaken by doctors. However we emphasise that the label 'non-clinical' is inappropriate, although recognising that it derives in part from a GMC definition. The activities grouped under this term include those which clearly make a direct

and essential contribution to clinical care (the pathology and laboratory based clinical specialties) and those with which most, if not all, clinicians should be engaged, namely education, management and research.

It is essential to define the boundaries of revalidation with respect to academic medicine. Revalidation is not an attempt to directly assess academic research competencies and these should therefore be outwith the remit of revalidation. Effective mechanisms are already in place to assess and regulate academic research; duplication, or the creation of new metrics, would not be helpful or effective. Revalidation must not be viewed as an additional hurdle to a clinical academic career.

We urge the AoMRC to adopt an approach based on evidence of compliance with all existing required standards applicable to research. Clinicians engaged in academic research are already required to comply with all applicable laws, regulations, codes of practice and guidelines set out by the Government, their host institution and the funding bodies. The Head of the Medical School or relevant Department should simply sign-off that a given individual has complied with the various regulations and there is no evidence to question their research probity - no additional level of scrutiny should be required.

Joint appraisals for clinical academics

Clinical academics must continue to be appraised by the established Follett principles whereby an individual is assessed by both a clinical and an

academic senior colleague.⁷ The Dean of the Medical School or Higher Education Institute or their delegated nominee (usually a Head of Department), should currently act as the academic appraiser.

The status of clinicians outside the NHS and established medical centres

Consideration must be given to clinicians who are currently working outside the NHS or established medical centres and therefore may not have access to the required appraisal and revalidation processes. There are many doctors employed in a range of settings such as the pharmaceutical industry, private practice, the commercial sector and as locums. We are aware that in some of these settings, such as the pharmaceutical industry, there may be well developed appraisal systems. It will be important that individuals working in these settings are given the opportunity to revalidate through an equivalent mechanism.

Attracting the next generation of clinical academic trainees

The UK must maintain and continue to attract and sustain a clinical academic workforce that will deliver excellence in medical research and its translation in to benefits for healthcare. Sustaining a first class workforce requires flexibility in training and career trajectories. Individuals must be encouraged to apply their knowledge and skills across the range of healthcare sectors. To underpin this, revalidation must support individuals to (i) pursue academic work (ii) re-focus their area of clinical practice if required (iii) re-enter clinical or

⁷ Department for Education and Skills (2001). *A review of appraisal, disciplinary and reporting arrangements for senior NHS and university staff with academic and clinical duties.* <http://www.academicmedicine.ac.uk/uploads/folletreview.pdf>

specialist practice after a period of absence and (iv) continue to act as role models across the breadth of clinical activities.

Appropriate recognition of the role of the clinical academic community in underpinning education and training, formulating good practice guidelines and generating evidence on how new therapeutic interventions benefit patients would greatly assist in recruiting trainees to research.

Engagement of clinical academics with the Medical Royal Colleges

Clinical academic staff must be encouraged to become more actively involved in the work of the Medical Royal Colleges, Faculties and Specialist Societies. Every Specialty Advisory Committee (SAC) should have an academic member and every specialist society, an academic officer.

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