
Minutes 7 April 2009

Attendance

Sir Michael Pitt	Chairman of the Board
Dr Frances Elliot	Scottish Government Health Directorates
Professor Steve Field	Academy of Medical Royal Colleges
David Grantham	NHS Confederation
Gavin Larnar	Department of Health (England)
Dr Malcolm Lewis	General Medical Council
Kaliani Lyle	Patient and Public Affairs
Professor Hugo Mascie-Taylor	NHS Confederation
Dr Hamish Meldrum	British Medical Association
Joan Saddler OBE	Patient and Public Affairs
Finlay Scott	General Medical Council
Professor Jenny Simpson	British Association of Medical Managers
Sally Taber	Independent Healthcare Advisory Services
Anne Weyman	General Medical Council
Dr Jane Wilkinson	Welsh Assembly Government

Apologies

Dr Judith Hulf	Academy of Medical Royal Colleges
Dr Paddy Woods	Department of Health, Social Services and Public Security, Northern Ireland

Also in attendance:

Dr Maurice Conlon, NHS Revalidation Support Team National Director

Paul Buckley, Una Lane, Claire Herbert, Tim Walker and Will Blair, from the GMC.

Welcome

1. Sir Michael Pitt announced that he was standing down as Chairman of the Board following his appointment as Chair of the Infrastructure Planning Commission. The Board welcomed the appointment by the GMC of its new Chairman, Mr Keith Pearson who will take up his position from 15 April 2009. Mr Pearson is Chair of the NHS East of England Strategic Health Authority.

2. MP opened the second meeting of the UK Revalidation Programme Board, and welcomed Ms Kaliani Lyle as a new Board member, representing patient and public affairs as well as acknowledging the attendance of Hugo Mascie-Taylor, David Grantham and Anne Weyman for the first time. Dr Malcolm Lewis was also in attendance for this meeting on behalf of the GMC.

Minutes of last meeting

3. The minutes of the last Board meeting held on Tuesday 10 February 2009 were approved with one amendment.

High Level Project Plan

4. UL presented the High Level Project Plan to the Board, and the timescales listed were acknowledged to be achievable and realistic for many work streams, but more challenging for others, such as the end of the piloting phase and the proposed dates for the beginning of the roll out.

5. UL particularly highlighted the critical path between the introduction of the licence to practise, the appointment of Responsible Officers, the work establishing specialty standards being led by the Academy and the medical Royal Colleges and putting in place robust systems of appraisal for all licensed doctors.

6. Regarding the recertification workstream led by the Academy, SF highlighted the varying levels of readiness amongst the specialties, and suggested that a breakdown of progress on recertification according to specialty could be submitted to the Board. This would contribute to a more accurate and reliable timeline for this workstream.

7. JW requested clarity as to who is accountable for making decisions about the phased implementation of revalidation and where the early adopter sites would be. FS clarified that ultimately this was a decision for the GMC in consultation with the four Departments of Health once there was assurance that robust local systems were in place.

8. There was discussion over how to manage potential progress disparity between the four countries, and how far all countries should be developing and implementing the programme in concert. The commitment to a phased approach to the implementation of revalidation across the UK was reiterated, which would be based on success and progress, rather than a randomised approach. It was acknowledged that further detail and explanation on how this phased approach will work is needed.

9. The draft project plan indicates that the first doctors would not be revalidated until at least the first quarter of 2011 and only if all the necessary components of

revalidation are in place and the GMC is assured they are fair and robust enough to support revalidation.

10. JS suggested a communications workstream be included in the project plan, so as to ensure information on all projects and pilots is effectively disseminated.

11. It was agreed that greater emphasis on communication and dissemination of information was needed on the progress of the projects and pilots. Positive statements need to be issued to fill an 'information vacuum' that is perceived to exist on revalidation development. HM stated that the Board also needs to publicly say what hasn't yet been agreed.

12. Whilst further detail is needed, the Board acknowledged the great value of having a comprehensive project plan at this stage, proposing the milestones, dependencies and timelines for the implementation of revalidation. The overarching timetable gives the Board the beginnings of a 'story' which can be taken to the profession.

Implementing Medical Appraisal in England

13. Dr Maurice Conlon from the NHS Revalidation Support Team gave a presentation to the Board on the progress made in strengthening appraisal systems across the NHS in England, to ensure they are rigorous enough to support revalidation. MC explained that the purpose of medical appraisal was to review performance, identify learning needs, and take appropriate action in the light of these observations.

14. The Board welcomed the presentation, and looked for further engagement from the RST with the Independent Sector and the other three Departments of Health. It was acknowledged that although the RST's draft quality assurance framework for appraisal (AQMAR – Assessing the Quality of Medical Appraisal for Revalidation) was presented in a very England-centric form, it had taken account of various pilot studies including that on GP appraisal in Wales.

15. It was acknowledged that sensitivity was required over how the work on appraisal was further articulated. HM commented that the BMA was unhappy with use of the term 'enhanced appraisal' and much preferred 'effective appraisal'. ST commented that the Board must have regard to appraisal for independent sector doctors and reminded them that a framework for whole practice appraisal is currently being developed.

16. An important distinction was made between the responsibility of the medical regulator, which is to ensure doctors are fit to practise, and that of employers, which is to ensure doctors are fit for purpose in their job. It was agreed that the remit of the Board was to look at appraisal in terms of fitness to practise and revalidation.

17. In conclusion the Board agreed that appraisal must be robust enough to demonstrate that doctors are fit to practise, that appraisal proposals must take account of all practice settings and that ultimately it is the GMC that will decide what is the appropriate level of evidence for a doctor to be successfully revalidated.

Appraisal Project Pilots

18. Members received a report detailing the progress of various pilots in the four countries.

Implementing Responsible Officers – UK wide

19. Jenny Simpson gave a presentation to the Board on the proposals for the implementation of Responsible Officers. She particularly emphasised the dual culture of management and the profession existing in NHS organisations and that communicating the role, purpose and requirements for the ROs need to be articulated differently to these different audiences. She also described a proposed model whereby the RO is responsible through the Board (or equivalent) for making recommendations to the GMC.

20. The Board suggested that a programme of piloting should be conducted on the role of the Responsible Officer in the light of the postponement of the deadline for appointment from October 2009. The launch of the consultation on RO guidance was suggested as a suitable start point for piloting.

21. GL agreed that time was needed to pilot ROs and informed the meeting that an economist had recently been appointed by DH to undertake a cost-benefit-analysis of the developments that need to take place in the service to support more effective systems of appraisal and clinical governance.

22. HM felt that ROs would need professional support above trust level. The pilots would need to ensure that when ROs are in place, they are confident, capable, supported and well resourced.

23. The Board was eager for further details from the Department of Health on the RO workstream, so that the four countries can better understand the role and build on existing local health structures. HM-T highlighted the potential challenges arising from a perceived dual responsibility of ROs: one to the Trust as an employee, and one to the GMC.

24. JS felt that progress on this had been made on the professional side of the NHS, and now dialogue needed to begin with the organisational side. It was suggested that engagement with David Nicholson, Chief Executive of the NHS, would be helpful.

ACTION: GL to bring these issues to NHS Management Board in May and discuss with David Nicholson, Chief Executive of the NHS.

Delivery Board Progress – England

25. GL presented the England Delivery Board progress report to the Board, which included work on ROs with JS and Ministers, piloting, planning and the appointment of an economist to work on costings.

Delivery Board Progress – Scotland

26. FE gave a presentation to the Board, including information on the first meeting of local health board medical directors who will form the network of Scottish Responsible Officers. The first Scotland Delivery Board meeting will be held on 15 April 2009.

Delivery Board Progress – Wales

27. JW reported on the first meeting of the Wales Delivery Board on 1 April 2009, at which the governance arrangements were established, and early thoughts given on timings and progress. A local implementation timetable will shortly be produced.

Delivery Board Progress – Northern Ireland

28. A progress report had been submitted to the Board in the absence of Paddy Woods.

Communications and Engagement Plan

29. TW introduced the plan, explaining that it contained the proposed key messages concerning the revalidation programme as it progresses. The purpose of the common statements were simply to find common ways of describing revalidation processes at this stage – particularly in the context of a wide number of factors that are yet to be determined.

30. The statements were agreed as an acceptable basis from which to start developing more common messages, although a number of suggestions were made for additional statements. HM requested a more explicit statement on sharing communications strategies between stakeholders. It was very important to be proactive in allaying fears and providing reassurance to the profession, avoiding vacuums of information on the programme. KL requested that greater reference be made to diversity issues. A statement emphasising the need for support for and independence of ROs was requested.

31. Members suggested the establishment of a Communications Group to bring all revalidation communication leads together to ensure consistency and coherence.

A common Frequently Asked Questions document should also be developed and then adapted for use by all Board member organisations.

ACTION: Amendments to be made, and a revised plan to be e-mailed to Board members.

ACTION: A Communications Officer group to be established.

Date of next meeting

32. The date of the next meeting would be Wednesday 10 June 2009 at the GMC, commencing at 14:00 under the chairmanship of Mr Keith Pearson.