

GENERAL MEDICAL COUNCIL

*Protecting patients,
guiding doctors*

25 June 1999

Note of the General Practitioners Consultative Group

Present:

Dr Krishna Rao Korlipara (chair)	GMC and Revalidation Steering Group Member
Dr Tina Ambury	National Association of Non-Principals
Dr Alison Baker	RCGP
Ms Frances Blunden	Patients Forum
Dr Maura Briscoe	Department of Health – Northern Ireland
Mr Michael Downing	ACHCEW
Professor Jacky Hayden	COPMED
Mr Tim Jones	NHS Confederation
Dr Surendra Kumar	ODA
Dr Philip Leech	Department of Health – England
Ms Sue Leggate	GMC and Revalidation Steering Group Member
Dr Quereshi	Locum Doctors Association
Dr David Snadden	COGPED
Dr Hugh Whyte	Department of Health – Scotland
Dr Jane Wilkinson	Department of Health – Wales

GMC staff:

Antony Townsend	Director of Standards and Education Directorate, GMC
David Skinner	Head of Regulation, Standards and Education, GMC
Gemma Collings	Revalidation Policy Adviser, Standards and Education, GMC
Ben Griffith	Revalidation Policy Adviser, Standards and Education, GMC
Alan Meyrick	Head of Registration Policy, Registration Directorate, GMC

Apologies:

Dr Nicholas Bradley	NHS Primary Care Group Alliance
Mr John Brunt	Institute of Health Services Management
Dr John Chisholm	BMA – General Practitioners Committee
Dame Rennie Fritchie	BAMM
Dr P Harvey	BMA – Non-Principals Sub-Committee
Dr Brian Keighley	JCPTGP
Ms Barbara Meredith	NCC
Dame Helena Shovelton	NACAB

Overview of the development of revalidation

1. Antony Townsend gave a presentation on the background to the development of revalidation proposals. The group's first task was to contribute to the gathering of information which would then be used to develop a model for revalidation.
2. The group noted that revalidation would require resources both in terms of finance and manpower. However, if revalidation built on existing systems of local quality assurance, the revalidation process itself should not entail too much in the way of extra resources.
3. The group heard that the LMC conference had debated revalidation and had welcomed it.
4. From the patients' point of view, the ACHCEW representative confirmed that revalidation was welcomed and that ACHCEW was keen to play a role with respect to general practice.
5. The group noted that revalidation arrangements for locum doctors needed to take account of the fact that they often work in several local settings, and sometimes in more than one specialty.
6. The group agreed that there would need to be mechanisms to ensure that revalidation arrangements were fair for all doctors, including locum doctors. This fairness would be achieved by external audit of the local processes, the fact that the person responsible for signing off a doctor as being fit to practise would be accountable, and the fact that the only way in which a doctor would have their registration affected would be through the existing legally based fitness to practise procedures.

Categories of doctor on the register

7. David Skinner gave a presentation on the draft report.
8. The group noted that there were particular issues to be addressed with respect to doctors returning to medical practice following a career break.
9. The group discussed the issue of doctors who practised in more than one chosen field. It was noted that the revalidation process might encompass data taken from more than one source.
10. The group noted that arrangements for revalidation of GPs needed to take account of the fact that the nature and the organisation of general practice would be changing in the next few years with the advent of primary care groups and primary care trusts and their equivalents.
11. The members of the group agreed to provide comments on this report by the end of August 1999.

Existing and local profiling arrangements

12. Gemma Collings gave a presentation on the draft report.
13. The group noted that the behaviour and attitudes of doctors were already the subject of specific guidance in *Good Medical Practice* and could be dealt with under the existing fitness to practise procedures, and would therefore form part of the revalidation process.
14. The group noted that general practice needed a framework within which revalidation could operate. Clinical governance in the NHS would be developing before revalidation was implemented. However, it was also noted that not all doctors would work within a clinical governance framework.
15. The issue of standards was raised, and in particular, whether the same standards of practice would be applied across the board irrespective of the difficulties inherent in different working environments.
16. The group noted that it would not be acceptable for decisions on revalidation to be made by someone who had not had direct contact with the doctor concerned. This issue was particularly relevant for locum doctors.
17. The group noted that there were already models for local profiling in existence, notably the local profiling record recently introduced by the National Association of Non-Principals, and the arrangements already in place for the review of GP training practices. Moreover, the Royal College of General Practitioners were looking at how to use *Good Medical Practice* to produce more specific guidance for GPs.
18. The members of the group agreed to provide comments on this report by the end of August 1999.

Periodic peer review of the processes

19. Ben Griffith gave a presentation on the draft report.
20. The group noted that the review of training practices provided one model which could be built on.
21. Members agreed to provide comments by the end of August 1999.

Date of next meeting

22. The next meeting of the General Practitioners Consultative Group will be held some time in September. Possible dates will be canvassed from all group members in due course.