

**SOCIETY OF CARDIOTHORACIC SURGEONS**  
**OF GREAT BRITAIN AND IRELAND**

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**SCTS Annual Business Meeting March 2008**

**REPORT FROM THE Pan-Specialty Recertification Project Board**

The Recertification Project Board is a pan-specialty group which has been established by the four surgical colleges to recommend the methods by which surgeons will be recertified. It is co-chaired by the Vice President of the RCS England (Anne Moore) and the President of the Federation of Surgical Specialty Associations (James Steers). Its membership comprised representatives from the 9 Surgical Specialty Associations, Patient Liaison Group, GMC and the CEO RCS England. It reports to the Forum Recertification Governance Group for oversight and communication and the 4 College Councils for sign-off.

**Background**

Liam Donaldson's report "Good Doctors, Safer Patients" and the subsequent white paper "Trust, Assurance and Safety" confirmed a system of revalidation for doctors which would include an element of specialist recertification for those doctors on the specialist register. It is envisaged that doctors will be revalidated every five years – revalidation will be the result of successful recertification and relicensure processes. Whilst relicensure will be the result of cumulative appraisal performed in employing Trusts and will be largely generic, recertification will be affirmation of a doctor's fitness to practice in his/her chosen specialty. The GMC has overall responsibility for revalidation and has specific responsibility for relicensure, whereas the Medical Royal Colleges have responsibility for carrying out the recertification process and issuing a positive statement of assurance to the GMC. The processes of recertification and relicensure will run concurrently and draw on the same sources of evidence.

**Criteria for Recertification.**

1. **Professional standing.** Every surgeon must hold a current, unrestricted licence to practise.
2. **Life-long learning and self assessment.** Every surgeon must fulfil the CPD requirements agreed by the Colleges and relevant Specialty Association and establish and maintain an up-to-date portfolio.
3. **Test of Knowledge.** Surgeons should demonstrate that they continue to meet the required standard of cognitive expertise relating to their practice. The College and Associations should develop an interactive educational activity, embodying a test of knowledge, tailored to specialist interest.

4. **Evaluation of performance in practice.** Each surgeon must maintain a record of their operative caseload, clinical activities and outcomes for review by the relevant College and Specialty Association

#### **Time Frame**

As yet there is no firm time frame for the introduction of recertification/relicensure. We are currently working on introduction in 2010.

The current timetable for the work of this board is:

Establish Project Board	October 2007
Establish Project Board Sub-groups	December 2007
Sub-groups complete work needed to undertake pilots	Dec 2007 – Sept 2008
Colleges and associations develop implementation systems	Dec 2007 – Dec 2008
Pilots	Jan 2009 – Dec 2009
Evaluation and Review	Jan 2010 – Jun 2010
Commence Recertification	July 2010

#### **How would Recertification for Surgeons work?**

1. **Identify the surgeons to be revalidated.** It is reasonable to assume that 20% per annum will be assessed and that they will be chosen by GMC number.
2. **Collecting Evidence.** It will be the surgeon's responsibility to collect, in a portfolio, the evidence required to support recertification. It will contain:
  - Activity and outcomes
  - Record of CPD activities, audit etc. A compulsory system of CPD will need to be implemented to ensure that CPD activities reflect an individuals practice and will include a balance of learning methods and providers. A minimum of 50 hours per year would be required.
  - Annual appraisals. Appraisal will remain the cornerstone of the review of much of the evidence for recertification and relicensure. The appraisal will be informed by such processes as multi-source feedback and outcomes data
  - Report from Multi source feedback
  - Results of test of knowledge. This will be tailored to the surgeon's specialty and based at CCT level – the current view of the GMC is that this should be in the surgeon's area of practise rather than in the totality of their CCT specialty.
  - (Peer review of outcomes of a defined case range)

3. **Review of Evidence.** This will be both local and national – locally for audit, appraisal etc, and a combination of local and national for CPD, MSF and outcome review and nationally for the test of knowledge.

### **Working Sub-Groups**

The board has established three subgroups to consider three aspects of recertification

#### **1. Assessment**

Leslie Hamilton sits on this group

- Consider the work involved and focus of a learning activity involving a test of knowledge.
- Consider the benefits of specialty specific MSF
- Consider simulator tests
- Consider how appraisal can be formulated to provide evidence for recertification
- Consider observation of practice.

#### **2. Outcomes and Peer Review.**

Ben Bridgewater chairs this group

- Set framework for specialties to undertake assessment of outcome measurement in their specialty
- Ensure equivalence between specialties

#### **3. CPD**

John Pepper sits on this group

- Consider Academy of Medical Royal Colleges proposals
- Consider RCS paper "Continuing Professional Development – A new direction for the College"
- Consider position of those in non-standard careers
- Set standard for CPD in surgery and define minimum requirements for categories
- Establish common elements of specialty specific CPD accreditation systems.

### **Current Issues and Tasks for SCTS**

- All surgeons should keep a logbook.
  - What should be in it?
  - What is the role of employing Trusts?
  - Is the collection of data by unit data managers acceptable or does it have to be done by each individual?
- What will the test of knowledge be like?

The Specialty Association will have to determine their own proposals for their test of knowledge for submission to the main board for approval. There are several issues to consider: I believe our proposal to use SESATS has many advantages in that it has already been developed and validated and contributes both educational and assessment elements; however it has been designed to be used to assess all elements of cardiothoracic surgery and not just individual elements such as adult cardiac surgery. I do not detect any desire (either amongst our specialty or in the members of the pan-specialty board) for surgeons to prove knowledge across the whole of their SAC-defined specialty but this has to be debated. The view was expressed fairly strongly by the Patient Liaison Group representative that the public will expect an exam to look like an exam – this view was not supported by other members of the board nor by the GMC but again has to be debated. My own view is that the test of knowledge should be in our areas of practice but we should not allow these to be defined too narrowly – I would suggest that the areas of practice in Cardiothoracic Surgery are:

- Adult Cardiac Surgery
  - Congenital Cardiac Surgery
  - Mixed practice – adult and congenital
  - Thoracic Surgery
  - Mixed practice – cardiac and thoracic.
- What will our outcome measures be?

Although we are further down the line than any other surgical specialty on this issue we have only developed a method for assurance of performance in adult cardiac surgery, though congenital surgery is now almost in the same position. We need to develop a system of assessment of surgical performance for thoracic surgery – potential measures would be mortality in index operations, return to theatre, wound infection, re-admission to hospital. Do we also need to define acceptable outcomes for each sub-group?

We also need to consider the role of peer review of cases (such as the ABTS system of structured review of a surgeon's last 100 cases) and also of audit.

- The services provided by the Society for individuals to be re-licenced has a value and non-members could legitimately be charged for these services.

**S Livesey**

**SCTS Representative on Pan-Specialty Recertification Project Board**