March 2013

Revalidation for NHS GPs

BMA

What is revalidation?

Revalidation is the process for doctors to positively affirm to the GMC, based on the principles and values of good medical practice, that they are up to date and fit to practise.

How will revalidation work?

Doctors will take part in a robust appraisal process and collate a portfolio of evidence to show they meet the necessary standards. They will do this over a 5 year cycle. As part of revalidation, each doctor relates to a responsible officer who assesses their portfolio and reports back to the GMC on the doctor's fitness to practise.

What is the timetable for revalidation?

On 3 December 2012, the Secretary of State for Health confirmed the implementation of revalidation across the UK and the relevant regulations came into force.

The first revalidation cycle will occur in stages .The GMC expects to revalidate:

- the majority of responsible officers and other chosen or volunteered doctors by March 2013

- about a fifth of licensed doctors between April 2013 and the end of March 2014

- the majority of licensed doctors by the end of March 2016

- all remaining licensed doctors by the end of March 2018

What are the roles of the different individuals / bodies involved with revalidation?

Responsible officers

As part of revalidation, doctors relate to responsible officers (ROs) who make a recommendation to the GMC about their fitness to practise. ROs also have a wider role, for example in ensuring that effective systems for appraisal and clinical governance are in place for the doctors who relate to them.

Currently, responsible officers for NHS GPs on performers lists sit within PCOs. When PCTs are abolished in England, these ROs will sit within the NHS Commissioning Board, with NHS GPs relating to responsible officers within the boundary of their NHS Commissioning Board Area Teams (ATs). In Scotland, Wales and Northern Ireland Responsible Officers will continue to sit within the currently existing PCOs.

Appraisers

Appraisers are responsible for carrying out appraisal, for evaluating a doctor’s portfolio of supporting information and helping to inform the RO’s recommendation.

General Medical Council (GMC)

The GMC has overall responsibility for the running of revalidation, and makes the final decision on doctors' revalidation, following a recommendation from the responsible officer.

Royal College of GPs (RCGP)

The RCGP is responsible for proposing the standards for GP revalidation, based on the requirements and guidance laid out by the GMC.

Revalidation Support Team (RST)

The RST is funded by the Department of Health and exists to support the development of revalidation in England.

Local Medical Committees (LMCs)

LMCs have a role in ensuring that local appraisal systems are acceptable. The National Health Service (General Medical Services Contracts) Regulations state that PCOs have to consult with LMCs about the appraisal systems that they provide.

How will appraisal work under revalidation?

GPs are already required to participate in annual appraisal systems run by their PCOs. Now that revalidation is being introduced, the outcome of appraisal will inform the revalidation recommendation made by the responsible officer to the GMC.

The process for appraisal should remain the same as previously, in that it will be split into three stages – pre-appraisal, the appraisal discussion and post-appraisal.

What happens in the pre-appraisal stage?

There are a number of steps that GPs need to take prior to their appraisal date:

- GPs need to define the *scope and nature of their practice* – ie the areas of work that they need to revalidate for, including all of the roles and positions that the doctor has responsibility.
- They need to provide a *commentary* on their achievements, aspirations and their personal development plan from their last appraisal.
- They need to provide a *self-declaration on their health and probity*.
- They need to provide their *supporting information*, of which there are six types. Further information about this is provided under "What supporting information is required?"

What happens in the appraisal discussion?

The format of the appraisal discussion should largely be unchanged from prior to the introduction of revalidation. The GP and appraiser will discuss the information provided in the pre-appraisal stage, and the GP's personal development plan. They will also discuss the outputs of appraisal, outlined below.

What are the outputs of appraisal?

Two of the outputs of appraisal will remain the same as previously:

- *New personal development plan*: This is an agreed plan of objectives for the coming year. It should be relevant to the GP's role and scope of practice and include realistic timescales for completion of these objectives, along with information about how they will be completed.

- *Discussion summary*: This is an agreed summary of the key elements of the appraisal discussion. It should include an overview of the GP's supporting information with accompanying reflections and commentary, including the extent to which the supporting information relates to all aspects of the doctor's scope and nature of work. It should be structured in line with the four domains of the GMC's Good Medical Practice Framework for Appraisal and Revalidation.

There is a further output, however, which is a *series of statements to inform the RO's recommendation to the GMC.* The appraiser's statements should confirm that:

1. An appraisal has taken place that reflects the whole of a doctor's scope of work and addresses the principles and values set out in the GMC's Good Medical Practice.

2. Appropriate supporting information has been presented in accordance with the GMC's Good Medical Practice Framework for Appraisal and Revalidation and this reflects the nature and scope of the doctor's work.

3. A review that demonstrates appropriate progress against last year's personal development plan has taken place.

4. An agreement has been reached with the doctor about a new personal development plan and any associated actions for the coming year.

5. No information has been presented or discussed in the appraisal that raises a concern about the doctor's fitness to practise.

What happens if the appraiser is unable to confirm one or more of these statements?

If the appraiser is unable to confirm a statement, this does not mean that the doctor will not be recommended for revalidation. It will, however, draw the issue to the attention of the responsible officer.

What happens if the GP and appraiser are not able to agree on the appraisal outputs?

In normal circumstances, the GP and appraiser will confirm that they agree on the outputs of appraisal. If they are unable to do so, the RO will be informed. In this situation the appraiser will still submit the appraisal outputs to the RO, but it is the job of the RO to try and understand the reasons for the disagreement. Again, the fact that agreement has not been reached does not mean that the doctor will not receive a positive recommendation for revalidation.

In Wales, this process differs slightly in that if the GP and appraiser cannot agree on the outputs of appraisal, there is an appeals process through an appraisal unit for dealing with this.

If the GP's appraiser or RO believe that there may be issues with making a positive recommendation for revalidation, they should inform the GP immediately so they can put things right if possible. Revalidation is a continuous process rather than high stakes examination at a fixed point in time.

Further information about how the appraisal process should work under revalidation in England is available in the Revalidation Support Team's Medical Appraisal Guide. The RST have also published their MAG Medical Appraisal form, which is one of a number of tools that can be used to record information for appraisal and revalidation, available here.

There are equivalent resources available for Scotland, Wales and Northern Ireland.

Who will appraise me?

Your appraiser should be a fellow GP who has been trained for this purpose.

The appraiser should normally be actively working in general practice and, ideally, work in the area so that he or she is aware of any local issues or problems.

If you are assigned an appraiser who you are uncomfortable being appraised by (e.g. because you know each other well and you fear a conflict of interest), then you should immediately inform your PCO / the NHS Commissioning Board Area Team so that another appraiser can be allocated to you.

What supporting information is required?

GPs need to provide supporting information as part of their appraisal, of which there are six types. This information has to be provided over the five year revalidation cycle, in varying frequencies depending on the type of information being submitted. The different types of information are described in the GMC's Supporting Information for Appraisal and Revalidation.

In its Guide to the Revalidation of GPs, the RCGP provides further information about how these requirements should apply to GPs, including the frequency with which GPs will be expected to provide this information.

The GMC recognises that it may be difficult for doctors to provide all of this information in their first revalidation cycle. They have therefore published guidance on how doctors can meet the GMC's requirement for revalidation in the first cycle.

How many CPD points do I need?

The RCGP has produced guidance on how GPs can provide evidence of CPD. Under the guidance, GPs will usually be expected to accumulate 50 CPD credits per year. This reflects guidance produced by the other medical royal colleges.

Where the RCGP guidance differs, however, is that CPD points can be accumulated both through the number of hours spent undertaking CPD activity and the impact this activity has. This makes the system more flexible than that used by the other colleges.

If you are unable to accumulate 50 credits in a year, you should discuss the reasons for this with your appraiser as soon as you can (rather than wait and submit your portfolio of supporting information with less than the 50 credits). We would expect some flexibility to be used if there are extenuating circumstances for you not being able to accumulate the expected 50 credits.

How many clinical audits do I need to do?

Generally, GPs will be expected to provide evidence of at least one full-cycle clinical audit in the five year revalidation cycle. It is recognised, however, that GPs in certain working circumstances may find this difficult – for example, locum and salaried GPs, and those who work in out-of-hours, walk-in-centres or similar environments. GPs who feel that they made need to use alternatives to participating in clinical audit activity should produce alternative evidence and discuss this with their appraiser.

Further information about this is included under "What supporting information can sessional GPs submit?"

How many significant events should I review? Do I need to be personally involved?

When revalidation is fully established, your revalidation portfolio will be expected to contain an analysis of an average of at least two significant events for each appraisal over the five year revalidation cycle. These can be from any time during the revalidation period. You must only submit analyses of significant events in which you have been directly involved, and where you are involved in the changes being made as a result of the analysis.

Generally, significant events analyses submitted as evidence for revalidation should detail an event that was discussed with fellow team members. However, sessional GPs may not have the opportunity to hold such a discussion with team members, and could therefore instead review the event with a practitioner group or self directed learning group. Further information about this is included under "What supporting information can sessional GPs submit?"

How many colleague and patients surveys should I do, and how should they be done?

GPs will be expected to collect colleague and patient feedback, and discuss their reflections on the feedback at appraisal, at least once in a revalidation cycle.

Questionnaires should generally be administered independently of the GP. However, it may in some circumstances, be impossible for locum GPs to arrange for patient questionnaires to be distributed by a third party. Further details about this are provided under "What supporting information can sessional GPs submit?".

GPs do not have to use a specific questionnaire or choose from an approved list of questionnaires. The GMC states that steps should be taken to ensure that whatever questionnaires are used should comply with their guidance on developing and administering questionnaires for the purposes of revalidation. They expect that any questionnaires used as supporting information for revalidation should:

- Reflect the values and principles in the GMC's core guidance Good Medical Practice
- Be designed in a way that is consistent with the principles of good questionnaire design
- Have been piloted to demonstrate that they are effective for the purpose of revalidation.

Further information about patient and colleague questionnaires, including the free to use questionnaires that the GMC have developed, is provided in the GMC's guidance on questionnaires.

Do I need to do training on Safeguarding Children and Young People?

Carrying out training on Safeguarding Children and Young People **is not a requirement of revalidation**. You do need to keep up to date and demonstrate competence in all aspects of your work, including the area of safeguarding children and young people. However, you can keep up to date and demonstrate competence in a variety of ways. For example, as a minimum, **you can do this by reading appropriate local guidelines.** Completing an e-learning module

would be another alternative. This is explained further in the below statement agreed between the GPC and RCGP, written in conjunction with COGPED:

In 2010 the revised Intercollegiate Guidance on Safeguarding Children and Young People was published. The aim of the intercollegiate framework is to provide guidance in relation to safeguarding competences for different staff groups and at different levels, and to emphasise a flexible approach to knowledge and skill acquisition.

This framework identifies six levels of competence, and gives examples of groups that fall within each of these. GPs practise at level 3:

- ***Level 3: Clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns***

.

For the purpose of revalidation, GPs need to demonstrate that they are up to date and fit to practise in all aspects of their work. Level 3 describes the scope of work of GPs in relation to safeguarding of children and young people. It is the responsibility of GPs to demonstrate that they maintain their competence. A GP may keep up to date in a variety of ways, for instance completing an e-learning module, attending a training session in or out of the practice or reading appropriate local guidelines. There should not be a defined frequency of updates; the important point is that it is the responsibility of the GP, in their appraisal, to demonstrate they are competent and up to date. Case reviews can be used to show how knowledge and skills are used in practise.

We believe that there may have been some confusion over the appropriate level for general practitioners as different levels were used in previous guidance and so we hope that this statement will clarify that under the 2010 Intercollegiate Guidance level 3 is the minimum level required.

Why am I being asked to provide further evidence as part of my appraisal?

We have heard a number of reports of inconsistencies between PCOs, particularly in England, in the evidence requested of GPs as part of the appraisal process. We believe that the evidence outlined above is all that should be requested for appraisal as a matter of course. However, differing objectives for individual GPs may result from the appraisal discussion and be recorded in the GP's Personal Development Plan.

We expect the moving of Responsible Officers and responsibility for the appraisal process to the NHS Commissioning Board to lead to greater consistency in the way that appraisal and revalidation operate throughout England.

How do I store and submit the information required for appraisal / revalidation?

Most GPs now submit their appraisal information electronically, and there are various resources available allowing GPs to do this. We believe that GPs should be free to decide which resource they would like to use, rather than being told to use one particular resource.

What happens at the end of the revalidation cycle?

At the end of the revalidation cycle, the RO will consider the evidence submitted to them, including the outputs from appraisal, and make a recommendation to the GMC about the GP's revalidation. There are three possible types of recommendation, as follows:

- *Positive recommendation.* This is expected to be the recommendation made in the vast majority of cases. It is a formal declaration from the RO that a doctor is up to date and fit to practise. This recommendation will be made when the RO has judged that the doctor has met the GMC's requirements for revalidation, they have participated in systems and processes to support revalidation and they have collected the required supporting information. It also confirms that in the RO's judgement, there are no outstanding concerns about the doctor's fitness to practise.

- *Deferral request.* This is a request by the RO for the GMC to provide them with more time to submit a revalidation recommendation. It means that the RO has judged that the doctor has engaged with revalidation but that there is either incomplete information on which to base a positive recommendation, or there is an ongoing local disciplinary process, the outcome of which the RO will need to consider prior to making their recommendation.

- *Notification of non-engagement.* This is a notification from the RO that the doctor has not engaged in the processes and systems to support revalidation. This can potentially result in a removal of the doctor's licence to practise.

Further information about the RO's revalidation recommendations and the circumstances in which they should be made is available in the GMC's responsible officer protocol.

Can I choose my Responsible Officer?

In England, GP responsible officers will sit within the NHS commissioning board, with the RO sitting within PCOs in Scotland, Wales and Northern Ireland. ROs will be linked to GPs according to the geographical area in which they work. However, if a conflict of interest or appearance of bias exists between a doctor and responsible officer and all existing mediation procedures have been exhausted, doctors have the option to have their revalidation overseen by an alternative responsible officer.

Under what circumstances can I be referred to the GMC?

It is not expected that a referral to the GMC will occur during the standard revalidation process. This is the case even when problems are encountered such as the GP and appraiser being unable to agree on appraisal outputs or the RO making a deferral request to the GMC.

The only situation in which a referral might occur is if concerns are identified about a GP's practice that are sufficiently serious to raise questions about whether they should have a licence to practise. Where such concerns exist, it is expected that they will be identified early and

addressed through relevant local clinical governance processes rather than when a GP is due to be revalidated.

What supporting information can sessional GPs submit?

There are a number of ways that sessional GPs can adapt their approach to the evidence in order to suit their working arrangements. These are summarised below. Across all of these points, however, the sessional GP should make sure they discuss their individual circumstances with their appraiser.

Continuing Professional Development: Many sessional GPs have portfolio careers, working in a variety of different roles. It will be up to the individual GP to demonstrate that they are up-to-date in all the types of clinical practice they are undertaking at the time of their revalidation. However, this does not necessarily mean they will have to present more CPD evidence overall than a GP who works full time in one practice.

Quality Improvement Activity: Many locum and salaried GPs have no involvement in the management of quality in practices in which they work. Therefore, showing quality improvement in a *practice's* clinical care via a standard audit may not be feasible, or relevant to their role or responsibilities. It is more feasible and relevant for such GPs to show quality improvement in relation *to their own practice*, for example reviewing an aspect of their personal clinical practice such as:

a) record-keeping
b) referrals or investigations
c) prospective case based condition reviews
d) random case analysis or review of telephone triage outcomes
e) prescribing

It is important that appraisal allows GPs to select a form of quality improvement activity which is relevant, meaningful and not disproportionately onerous. Examples include:

- A condition based review, in which a series of cases with a given condition are reviewed against the guidelines for the condition (for example, COPD and depression) and the GP identifies key learning points to apply to future practice. The breadth of focus in this type of review means there is no standard setting (unlike with audit).

- A log of all referrals and their outcomes with learning points about changes to future practice and / or a log and follow up of challenging cases with learning points about changes to future practice.

- A review of referral letters focussing on structure and quality of the letter content and the appropriateness of the referral, which are then reviewed with peers. This may include a focus on referrals to any one particular speciality.

- A review of your prescribing – there is an example of this in the Scottish Online Appraisal Resource additional information for sessional GPs.

The Northern Deanery has produced a Quality Improvement Template which can be used to capture and structure these alternative forms of quality improvement activity.

Significant Events: Where sessional GPs are not able to participate in practice based significant event audit discussions, it is acceptable for a sessional GP to review a significant event as part of a practitioner group, self directed learning group or with another colleague rather than at a practice meeting. Where none of these are possible the discussion can take place with the appraiser in lieu of a colleague. However, the significant event audit must still concern an 'event' that the sessional GP was personally involved in.

Feedback from colleagues & patients: Sessional GPs may find both forms of feedback more challenging to compile.

It may be the case that a locum GP does not work on a regular basis with the required number of colleagues to collect a sufficient level of feedback. In these circumstances, it should be acceptable for the locum to submit questionnaires received from different colleagues over a period of time.

Similarly, it may, in some circumstances, be impossible for a locum to arrange for patient questionnaires to be distributed by a third party. If this is the case, the locum can hand them out themselves. Locums who do this may wish to consider a deposit box for the completed questionnaires, and it is important that they do not have access to individual completed responses. Further information about this is provided in the GMC's guidance on questionnaires.

There is some evidence that patients tend to rate doctors with whom they do not have an ongoing relationship less highly. We would therefore expect that this will be taken into account by the appraiser and responsible officer, and that feedback on sessional GPs will be appropriately benchmarked against other sessional GPs. Sessional GPs should enquire with survey providers whether they have benchmarks specific to sessional GPs.

What is the BMA / GPC's view on revalidation?

We support revalidation in principle but have previously had concerns about its readiness to be implemented. These concerns led to the formulation of the BMA's seven principles of revalidation. We recently came to the view that these principles had been sufficiently addressed for the GMC to proceed with its timetable for revalidation. We do believe that there are some outstanding issues regarding revalidation for GPs however, as below:

Remediation: An agreement was reached in 2012 England to establish funding to support GPs who need remediation away from their place of work. However, we are currently awaiting details of how this fund will be accessed and will want to ensure that the rules governing access to the fund are fair for all GPs. Discussions are taking place in the Devolved Administrations to ensure that similar arrangements are put in place to fund remediation.

Inconsistencies between PCOs: We are concerned that PCOs, particularly in England, have been requesting different information from GPs as part of the appraisal process, over and above that outlined in the GMC's guidance on supporting information for appraisal. We have been highlighting these concerns and will be working to ensure that the abolition of PCTs and

creation of the NHS Commissioning Board leads to greater consistency. One of the ways that we are doing this is through the creation of a national revalidation group, which was set up partly to address issues of consistency.

Locum and other "non-standard" GPs: We expect appraisers, appraisal leads and responsible officers to be fully conversant with the differing roles of sessional GPs. Evidence submitted by sessional GPs to reflect their different working arrangements should be accepted as being equally valid to that produced by other GP colleagues.