From the Responsible Officer
Dr David Flower FFOM FACOEM DAvMed

Faculty of Occupational Medicine

3rd Floor, New Derwent House
69-73 Theobald's Road
London
WC1X 8TA

t: 020 7242 8698
f: 020 3116 6900
e: fom@fom.ac.uk
www.fom@fom.ac.uk

Registered Charity No 1139516
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Dear Colleagues.

Welcome to the second *Revalidation Update.*

Although it has been a long road to get here, the first year of revalidation has now ended. Since going live on 3rd December 2012, revalidation has been one of the biggest changes to medical regulation in the UK and I know that we all feel that. I would like to extend my thanks to the appraisers for all their hard work as, without them and their dedication, it would be very difficult to get appraisals suitable for revalidation. I would also like to thank the appraisees for their patience and hard work over the past twelve months, especially in getting to grips with the IT system. Appraisals can be a stressful experience for both parties and with the new issue of revalidation adding more complexity and trepidation, it has, at times, been a tough year.

Although there have been some clear lessons learnt from this first operational year of revalidation, I am very happy to share with you how we have performed.

I have made 32 revalidation recommendations, all of which have been accepted by the GMC. This represents 10% of the total recommendations I am required to make by 2017
I have issued a deferral recommendation to two doctors to allow them more time to gather a complete portfolio of evidence. A deferral is simply a way to give a doctor who is fully engaged with revalidation some additional time and it raises no questions about their fitness to practise.

I am especially pleased to say I have not issued any non-engagement recommendations.

I would like to end this *Revalidation Update* by reiterating what I said in the previous one. We have received a wide variety of feedback on revalidation and would encourage doctors to get in touch if they have any comments or concerns, if they would like guidance on the PReP system or if they have questions about revalidation. After the last *Update*, the Faculty team and I received a number of enquiries from single handed practitioners and this allowed us to address their issues and ensure they were on track for their revalidation. Please do not struggle with the IT or worry about appraisal and revalidation, but get in touch.

If you do have questions, queries, comments or feedback you can contact the Faculty support at admin@fom.ac.uk. Alternatively, you can call the GMC helpline on 0161 923 6277 or e-mail revalidation@gmc-uk.org.

Finally, if you have a personal issue, question or concern to bring to my attention I can be reached at ro@fom.ac.uk.

Kind regards,

Dr David Flower
Responsible Officer

Progress So Far

Appraisals

Overall, the quality of the appraisals has been high and out of the 316 doctors for whom I am responsible for making a revalidation recommendation, 173 or 55% have completed a strengthened medical appraisal between 3rd December 2012 and 3rd December 2013 with a further 25 or 8% of appraisals currently in progress. This leaves 118 to complete an appraisal by the extended deadline of 31st January 2014. The Society of Occupational Medicine, the Faculty and I agreed that, as long as an appraisal was fully arranged through the Society before the 3rd December 2013, then we would be prepared to accept a delayed completion date. All 2012-2013 appraisals must be complete by 31st January 2014 at the very latest and a further appraisal will then be required during 2014 to cover the period 3rd December 2013-2nd December 2014.

If you are in the 118 to have completed an appraisal by the extended deadline, please ensure that your appraisal is closed with all the relevant documentation uploaded to the PReP site by 31st January at the latest.

Currently, in excess of 25% of appraisals are incomplete when they are signed off. The additional questions may have been missed off, the CPD certificate is not uploaded, etc. Sometimes, these documents may have been discussed at the appraisal meeting, but the final step of uploading them to the system is not taken. Although the appraiser is satisfied that the appraisee has met the requirements of revalidation, the appraisal output does not make it clear and some documents are missing. This can then involve sometimes lengthy exchanges of e-mails between the Faculty, the appraisee and appraiser to get information that should already have been uploaded. If you are unsure as to whether you have uploaded all the required information, please drop a line to admin@fom.ac.uk and your account can be checked by the Revalidation Manager.

Areas of Improvement and Development

Rebalancing the Appraisal Load

As many of the appraisers would agree, there is a significant excess of appraisals towards the end of the year. Q1 and Q2 had 50 appraisals, Q3 49 and Q4 74 to date and there are another 143 appraisals to be completed by 31st January 2014. This is clearly not sustainable in the future as it places a very heavy burden on the appraisers, the Society and the Faculty. In NHS London - my designated body - appraisees are instructed which month their appraisal must take place.

As we move into Year Two (3rd Dec 2013 – 2nd Dec 2014), the Society and Faculty will be working together to find ways to rebalance the appraisal year in order to reduce the end of year bulge we currently have. If the appraisal schedule is not rebalanced, it will mean that each year the appraisers will have some very busy months where an unreasonable amount of their time is spent on appraisals. This could affect the high quality of the appraisals and make it harder for me to review them in a timely fashion and make revalidation recommendations.

At the moment we are looking at how other designated bodies set appraisal dates and we are aware of two systems in use elsewhere. The first is for each doctor to be assigned a quarter in which to have their appraisal, giving them a three month window. The second is for the appraisal date to be the birth month of the practitioner. Any change will mean that some appraisees will have their 2013-2014 appraisal less than 12 months after their last one, but without a change, the current system will become even more unmanageable.

Before any change is made, the Society and I will, of course, be in touch with all appraisers and appraisees. I am aware that a number of practitioners have already indicated they would want their 2014 appraisal to be earlier in the year.

Quality Improvement Activity (QI)

Something which has been noticed by the appraisers and me is that there is some uncertainly as to what constitutes a Quality Improvement activity.

A Quality Improvement activity for revalidation purposes requires an appraisee to demonstrate that they regularly participate in activities that review and evaluate the quality of their work. Where possible, the activity should demonstrate an outcome, or change. If an appraisee does not work in clinical practice, they should take part in quality improvement activities which are relevant to their work. Quality improvement activities could take a variety of forms, for instance:

- Clinical Audit – or an equivalent quality improvement exercise - should measure the care with which an individual doctor has been directly involved. Up to now, many doctors have been presenting reports from providers following reviews of their medical records and reports. Whilst there is clearly some learning to be gained from this exercise, it concerns quality *control* rather than quality *improvement*. At the moment I have been accepting quality control activities for non revalidators in Year One, but evidence of clear Quality Improvement activities will be a prerequisite going forward.

- Case Review or discussion – would take the form of documented accounts of interesting or challenging cases that a doctor has discussed with a peer, another specialist or within a multi-disciplinary team.

- Audit and monitor - the effectiveness of a teaching programme, for example.

- Evaluate the impact - and effectiveness of a piece of health policy, or management practice, for instance.

Quality improvement activities should take place at least once every revalidation cycle, however, it would depend on the nature of the activity. When discussing quality improvement activity at your appraisal, you will need to prove that you have evaluated and reflected on the results of your activity or audit.

You should also prove that you have taken appropriate action arising from the outcome of your results.

Finally, following the audit or activity, if an improvement has occurred, you should demonstrate that it is being maintained, this may require a repeat of the activity or a re-audit, after an appropriate period of time.

The BMJ has developed a platform to assist doctors in creating a QI activity which gives access to learning materials, a dashboard, mentors and templates and could ultimately lead to a publishable paper. There is a small fee for this but it may help some practitioners to clearly set up and follow through a Quality Improvement activity.

Good file naming practice in PReP

In order that the appraiser and I can find relevant documents in the system when we need them – and to save PReP users time in the future, when they have a year's/ many years' worth of files uploaded – I have collected some guidelines for good file naming practice.

A good file name is one that enables not just the appraisee but also the appraiser and the Responsible Officer to identify its content and context and to make a decision about its relevance

without having to open the file itself. To achieve this, an appraisee should ensure a file name should be;

- Objective - When you use subjective terms what makes perfect sense to you might be far less clear to someone else, especially if they are unfamiliar with the work you do.

- Meaningful - Abbreviations and personal shorthand are unlikely to be understood by others and may be open to misinterpretation – especially if others use the same abbreviation in another context.

- Concise - Long and rambling file names risk losing the important information amongst the trivial. It can also make it hard for other users to scan quickly through long lists of files to locate the correct one.

- Standardised in your PReP account – keeping the same structure of names, dates, type of file consistent so (for example) SMT is always the Senior Management Team and never the Senior Medical Team.

Most important of all, the same filename should not be used more than once. If a document of 10 pages is uploaded page by page and the same filename is used for each page it is very time consuming to find the single page required.

The Additional Questions for Strengthened Medical Appraisal

The previous *Revalidation Update* dealt with the additional questions in depth and although it has been heartening to see so many being returned, every appraisal since July 2013 needs to include them. In several cases, the questions have highlighted where a doctor's clinical governance could be stronger and development needs have been added to the Personal Development Plan to address them. This has shown their worth and demonstrates that all doctors revalidating through the Faculty are or will shortly be fully compliant with *Good Medical Practice 2013*. This can only be good for patients and clients, individual practitioners and the specialty as a whole.

As Faculty Responsible Officer, I am mindful of the feedback we have received concerning these questions and have had discussions with the GMC, NHS England and my own Responsible Officer concerning them. All accept that corporate and clinical governance is implicit in the revalidation process and that somehow I need to obtain information to assure myself as Responsible Officer that the doctor is working in a well-managed system. The question has really been 'how best to do this', especially as some of the questions are required by legislation and all doctors should be fully compliant with them.

For Year Two, after discussion with the Society and taking on-board the feedback received, we intend to make some adjustments to the questionnaire and the process so I will bring you more information once we have finalised all the details.

Model PReP Input and Output Forms

As part of this *Update* you will find three extra documents. These are examples of completed Input and Output forms from the revalidation management system, PReP, and a document which goes into greater detail about some of the sections on both forms. They have been filled in by experienced appraisers from the Society of Occupational Medicine and give examples to both appraisees and appraisers of best practice in relation to the PReP system and what kind of information I might expect to see in each of the areas. They are intended to be used as guides to help all practitioners get the most out of the PReP system.

Revalidation Checklist

What is required in a year when a doctor *is not* revalidating?

- ✓ Annual appraisals since 3rd December 2012.

These must be performed by an approved appraiser in an approved appraisal system, such as that operated by the Society of Occupational Medicine.

- ✓ Evidence of Continuing Professional Development.

The CPD requirements for revalidation are 250 hours of CPD activity averaged over the five years to 50 hours per year. This is in line with the Faculty's CPD scheme and the Academy of Medical Royal Colleges recommended number of hours.

- ✓ Complaints and Compliments.

Feedback can be provided by way of complaints and compliments which should also be reviewed as part of the appraisal process.

A complaint is a formal expression of dissatisfaction or grievance. It can be about an individual doctor, the team or about the care of patients where a doctor could be expected to have had influence or responsibility.

They should be seen as another type of feedback, allowing doctors and organisations to review and further develop their practice.

You may also choose to bring any compliments you have received to appraisal.

- ✓ Significant events.

A significant event (also known as an untoward or critical incident) is any unintended or unexpected event, which could have or did lead to harm of one or more patients. This includes incidents which did not cause harm but could have done, or where the event should have been prevented.

It can also refer to events outside of the doctor's usual practice which do not easily fit in with any other section of the appraisal.

- ✓ The completed Strengthened Medical Appraisal questions.

These questions have been mapped against *Good Medical Practice 2013* and allow the appraisee to demonstrate that they are compliant with this, as well as answer two questions required by legislation.

What is required in the year when a doctor *is* revalidating and well before the revalidation date?

All of the above plus the following:

- ✓ Multi-source feedback from Colleagues and Patients.

Whilst all practitioners have colleagues, even if these are non-medical staff, not all have patients. If an appraisee has no clinical contact at all, this can be covered in the appraisal meeting and declared to the RO on the Output Form. For those doctors revalidating for the first time, the

feedback must be no more than three years old. Thereafter it will be required once in every revalidation cycle.

- ✓ A Quality Improvement activity.

This requires you to demonstrate that you regularly participate in activities that review and evaluate the quality of your work. Where possible, the activity should demonstrate an outcome or change, as per section 2 of the GMC guidance.

The Role of the Responsible Officer

Although for most doctors the role of the Responsible Officer is seen as synonymous with revalidation, the Faculty of Occupational Medicine, as the Designated Body, and Responsible Officer have statutory responsibilities that go way beyond revalidation (the word revalidation does not even appear in the Responsible Officer regulations). The main role of the RO since the regulations came into force on 1st January 2011, is in the quality assurance of doctors and clinical or medical care. If revalidation did not exist, the Responsible Officer would still have these statutory duties.

For most doctors who work in managed environments there are three main factors which provide broad assurance about the doctor and information about the quality of their practice:

- The doctor has been subject to 'performance review' in their role
- Much of the supporting information is produced and validated through management systems which are independent of the doctor, and
- The information has usually been exposed to some form of review, within clinical teams or multi-disciplinary team meetings, etc.

The assurance is then enhanced by appraisal.

Most of the doctors who have a prescribed connection with the Faculty of Occupational Medicine however do not work in managed environments and matters are therefore less straightforward. Independent doctors are not subject to performance review; the information is generally not validated; and it has not been subject to peer review or external challenge. This makes the role of the RO more challenging and is the principal reason why I have introduced the additional questions relating to clinical and corporate governance.

In addition, in NHS organisations, review is not just focussed on the minimum standards described by the GMC, but on quality improvement for all. This involves using information about the doctor's practice to improve service quality and to support learning and development, not just to enable the GMC to renew the doctor's licence to practise.

The Responsible Officer regulations provide explicit statutory obligations to the RO to ensure that doctor's performance is monitored and that any concerns are identified and managed. For revalidation, the supporting information must demonstrate that the doctor is up to date and fit to practise and so the 'governance' and 'provenance' of this information is critical. One of the criticisms we have received is that the Faculty is 'setting a higher bar' than other designated bodies with regard to supporting evidence and, in turn, the requirements for revalidation. On the contrary, my obligation under the regulations is to bring the situation of doctors who work wholly independently into line with those who are employed or work under direct management oversight. The GMC guidance is explicit:

- The GMC's *Governance Handbook* sets out the criteria for every designated body in relation to governance responsibilities. This leaves no doubt in my mind about the

importance of clinical governance in supporting revalidation and gives full justification where clinical governance systems are not directly managed.

- Domain 2 of the *Good Medical Practice Framework for Appraisal and Revalidation* is all about doctors' clinical governance responsibilities and this is covered in more detail in paragraphs 22-27 of *Good Medical Practice.*

- The GMC's guidance on *Supporting Information: Appraisal and Clinical Governance* states 'You should make sure that your CPD is influenced by your participation in clinical governance processes, individual, organisational and national audit, workplace-based assessments, and other mechanisms that shed light on your professional and work practices.'

- The GMC's *Leadership and Management for All Doctors* has several relevant sections but particularly paragraphs 25 & 26.

As you will be aware from other sections of this *Update,* I have taken your comments about the requirements for supporting evidence very seriously. I recognise the importance of being both proportionate and pragmatic in what is necessary in preparing for each appraisal and, in turn, for revalidation. However, the requirements are clear and the obligation to demonstrate fitness to practise is not just once in every 5 years but continuous and on-going.

We have got off to a good start and I am confident from discussions I have had that the changes we are making in Year Two will help both appraisee and appraiser and would like to thank you for your continued support.