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Dear Colleagues

Welcome to the first Revalidation Update.

This is a way for me, as the Faculty Responsible Officer (RO), and for those supporting revalidation at the Faculty to communicate with all you who are revalidating through the Faculty and, hopefully, to demystify the process and highlight what progress we are making – individually and as a designated body. Many doctors revalidating through the Faculty work in independent and / or part time practice, and so revalidation places an additional burden on already busy lives. Even those who are employed full time for an Occupational Health provider can feel under pressure and feel that the process is complex or that they are unsure how to proceed.

There will be an Update every three months and it will be a way to make sure that revalidation is not a remote or worrying process, but rather a core element of a doctor's practice in which all feel able to take full part and benefit from.

In this first Update, as well as Faculty progress so far, we have dealt with three major issues which have been flagged up to us by our members;

- Why is there a requirement to address clinical governance as part of a strengthened medical appraisal via the Additional Questions?
- Why has SEQOHS been referenced in the Additional Questions and what is its relationship to appraisal and revalidation?
- Hints and tips for getting the most out of PReP, based on some frequently asked questions.

For those who feel unsure of PReP, there is now a practice space where you can try everything out without logging in to your own account. It is a place to experiment and to get a feel for how to use the system without fear that your own account will be affected.

We have received a wide variety of feedback on revalidation and would encourage doctors to get in touch if they have comments or concerns. It is easy to feel isolated and under pressure from these requirements, particularly if you are in single handed practice and we encourage you to get in touch rather than face these issues alone.

If you do have questions, queries, comments or feedback then please do get in touch at admin@fom.ac.uk. Alternatively, there is a GMC helpline on 0161 923 6277 or they can be e-mailed at 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

Progress so far

There have been around 10,000 revalidation recommendations made in total since 3 December 2012 across the medical profession. Here at the Faculty, the Responsible Officer has made 24 positive recommendations for revalidation, leaving around 280 to go by 2017. Over 100 of these will take place in 2014 and more than 150 in 2015.

For some doctors, it may be necessary to make a deferral request. This does not affect the doctor's licence in any way; it is simply a change of date for the revalidation recommendation and can be for a number of reasons – for example, a doctor may be on parental leave, sick leave, have taken a career break or the doctor may have not provided sufficient supporting information for the RO to make a recommendation to the GMC. If a deferral may be necessary, it is important that the Responsible Officer is informed as soon as possible.

Revalidation in relation to part-time practice

A number of doctors revalidating through the Faculty have raised the issue of revalidation in relation to their practice as they work part-time, perhaps only a few sessions a month and therefore the requirements to revalidate – annual appraisals, Continuing Professional Development and colleague and patient feedback – can seem onerous.

However, the GMC requirements for revalidation are the same whether a doctor works one day a month or full time. These requirements may seem excessive, especially for an experienced practitioner who now only sees a small number of patients in a month, but they are what we all have to work with as determined by Parliament and the regulator.

Feedback

"Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise. Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the GMC."

http://www.gmc-uk.org/doctors/revalidation.asp

Revalidation can be a stressful time for doctors, especially in this first cycle where the regulatory and legislative environment is still changing and the process is new. Many doctors will have been having regular appraisals, gathering colleague and patient feedback, maintaining a good level of continuing professional development and have been compliant with Good Medical Practice for years but could still feel anxious. This is normal but we would urge those who are feeling worried about the process, its requirements or revalidation overall to contact the Society or the Faculty as appropriate. In addition, the GMC also have an extremely helpful revalidation helpline. We are working together to make revalidation as smooth a process as possible but rely on our members' feedback to help us address areas where there is confusion, uncertainty or where we could perhaps do things differently.

We have received a wide variety of feedback on revalidation and would encourage doctors to get in touch if they have comments or concerns. As many practitioners in Occupational Health work in single handed practice and / or part time, it is easy to feel isolated and under pressure from these requirements. We encourage you to get in touch rather than face these issues alone.

If you do have questions, queries, comments or feedback then please do get in touch at admin@fom.ac.uk or admin@som.org.uk.

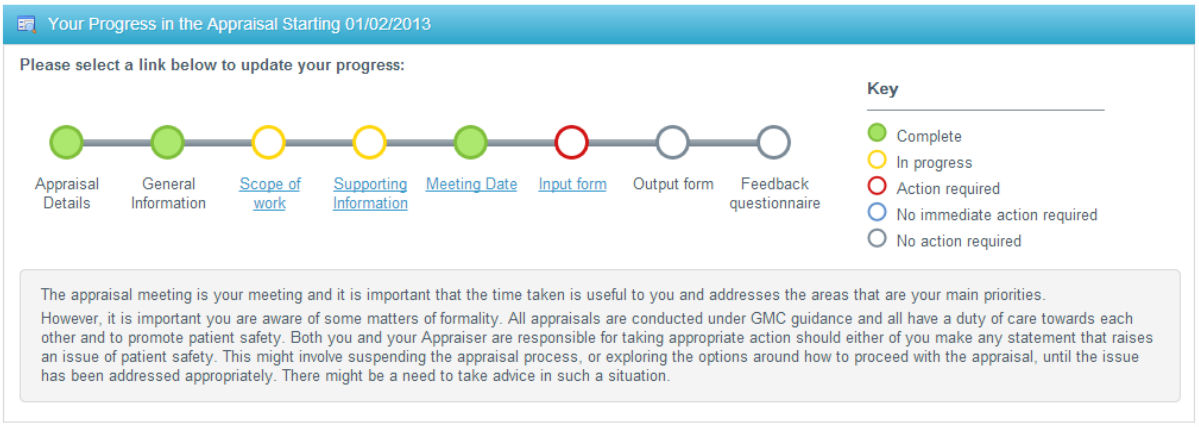
PReP Tips

"I think PReP is terrific. I use it several times a week entering things that I would previously have overlooked as not relevant. As a 74 year old self employed curmudgeon who was terrified of revalidation I am now confident and enjoying it. At the recent SOM meeting I was urging all my dithering colleagues to get stuck in."

A doctor revalidating through the Faculty

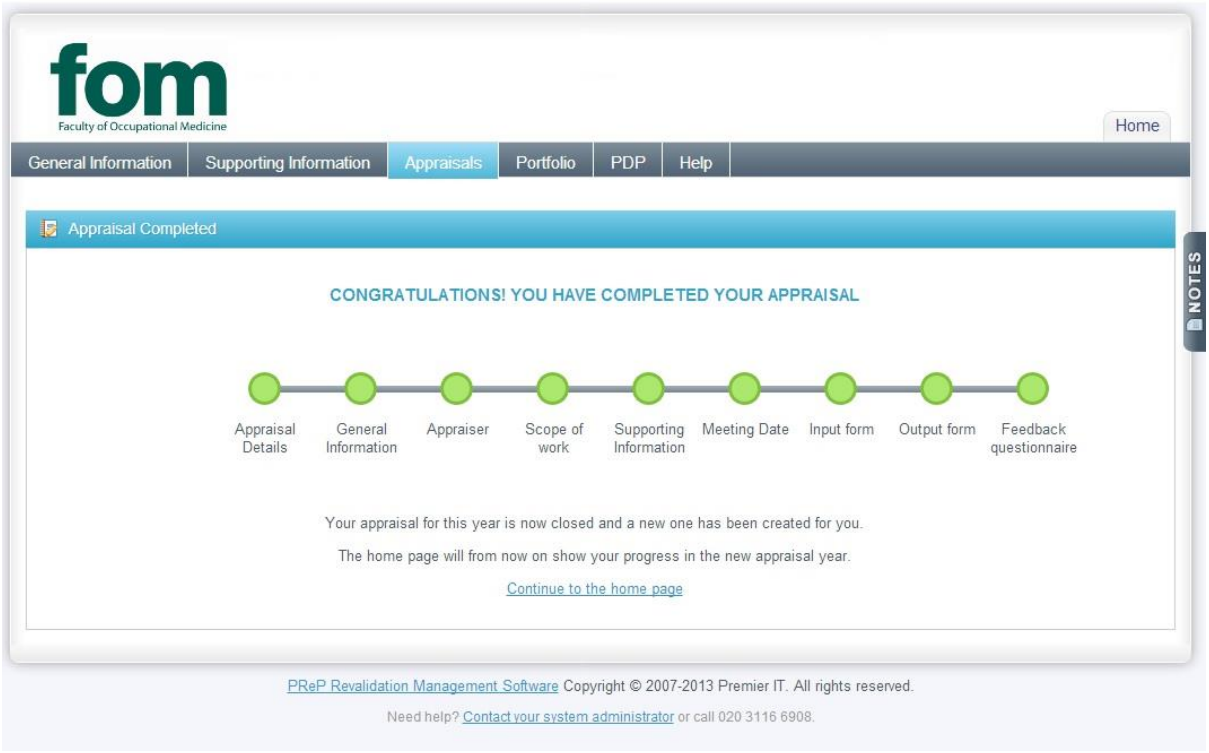
Your Progress in the Appraisal bar – the progress bar on your home screen shows you what stage in the appraisal process you are up to. When you are preparing for your appraisal, you will need to enter your appraisal details, general information, scope of work, upload your supporting information and set your meeting date. In order to be able to commence the appraisal, you must have the meeting date set, your scope of work entered, supporting information uploaded and a connection to an appraiser. Without these, you will not be able to generate the appraisal input form.

When you have uploaded your information and are ready to start the appraisal, your progress bar will look like this:



You will notice that the scope of work and supporting information circles are still yellow, indicating they are in progress. This is to enable you to amend your scope of work and add or change supporting information right up until your appraisal, once you send the input form off to your appraiser they are marked as complete and no further changes can be made. Clicking on Input form under the red circle will generate your appraisal input form and start the appraisal process. Once this form is signed off by your appraiser, your PDP is developed in conjunction with your appraiser. Then your appraiser completes the appraisal Output form, which you must sign off before the appraisal is marked as complete.

Once you have completed the appraisal cycle, you will see the screen overleaf:



Appraisee / Appraiser connection in PReP – in the PReP system each doctor should be linked to the Responsible Officer, David Flower, and their appraiser. For enhanced data protection and to ensure each doctor is using an appraiser approved by the Faculty as being of the standard required for revalidation, the Faculty establish the connection between a doctor and their appraiser in PReP. If there are any issues with your appraiser details in PReP, please contact admin@fom.ac.uk as only Faculty staff can update this information.

Appraisal anniversary – this is set by the date of your last appraisal when you log into the system. Once set, your set appraisal anniversary date reminds you when your next appraisal is due. This date differs to your appraisal meeting date. Your appraisal meeting date does not need to be on your appraisal anniversary date, nor will your appraisal meeting date change your appraisal anniversary date.

If you want to change your appraisal anniversary date, email admin@fom.ac.uk with the date you wish to make your appraisal anniversary and Faculty staff will update it for you.

No reflection – no CPD points! – you will notice when uploading a supporting information item there is the option to add reflective notes. Checking this box opens up free text boxes to enter your reflective notes, and also gives you the option to claim CPD credits for the activity. You must reflect on an activity if you want to claim CPD credits for it.

Available events – attending a Faculty conference or event? We've made it easier for you to upload this as a supporting information item. Under the My Training tab on the home screen for doctors revalidating through the Faculty and all CPD diary users is the Available Events section. This is currently a list of available Faculty events but will soon include some external Faculty approved CPD activities.

Remember you will still need to do your reflection afterwards to claim the CPD points!

Additional tip: There is no magic number of supporting information items to upload, you should focus on **quality** over **quantity** and do your best to provide evidence that

effectively demonstrates how you meet the Good Medical Practice guidelines. It is also helpful for your appraiser and the Responsible Officer if you title supporting information items and relevant documents with filenames that appropriately reflect what the document or item is. It will help your appraisal progress smoothly if your appraiser can easily locate a supporting information item, and isn't overwhelmed by a vast quantity of supporting information items with similar filenames.

Practice space in PReP

Want to experiment with PReP but worried about using your own account?

There is now a space where all those revalidating through the Faculty can practice using PReP without the fear of making a mistake on their own account. This is an unbranded space and it contains some functionality which the Faculty is not using (such as Doctor 360), however it is an area which allows full experimentation in a safe environment. Every night the system database will be wiped clean so as a result no data will be copied or saved overnight.

The URL to access this training environment is training.preprevalidation.co.uk and a user name and password is available from admin@fom.ac.uk. There are a limited number of log ins but they are reusable.

In addition to the PReP user guides, tailored for doctors and appraisers, there are also helpful eLearning modules available for doctors. These modules take you through the most common tasks you will need to undertake in the PReP system, such as updating your general information, scope of work and qualifications, uploading supporting information, setting your appraisal date and completing the appraisal forms.

The link to these help modules is
https://portfolio.fom.ac.uk/help/view/eLearning_for_appraisee

However if you get stuck with anything, don't hesitate to call the Faculty for support. We're here to help! You can call either Sara Shortt on 020 3116 6902 or Sam Hutchinson on 020 3116 6908, or email your query through to admin@fom.ac.uk

Frequently Asked Questions

CLINICAL GOVERNANCE

- How Clinical governance Fits into Revalidation
- Why is the Responsible Officer concerned with my clinical governance?
- Clinical governance and Good Medical Practice 2013

How clinical governance fits into revalidation

"To work, revalidation must be built on effective and robust clinical governance systems, which, as we know, are essential prerequisites for high quality care … Revalidation is no silver bullet, but it should act as a catalyst for the most far reaching and concerted push to improve clinical governance and, through that, can help improve the quality of care provided."

Niall Dickson, Chief Executive of the GMC

http://www.gmc-uk.org/hsj_supplement_17_november_2011.pdf_45733033.pdf

Why is the Responsible Officer concerned with my clinical governance?

The Faculty does not manage any of the doctors with whom it has a prescribed connection and there is currently no way for the Responsible Officer (RO) to ensure that there is effective clinical governance in place for the doctors about whom he is responsible for making a revalidation recommendation.

We are aware that some doctors have stated that they have colleagues who are General Practitioners or who have a prescribed connection to another designated body and that their requirements are 'lower' or not as stringent with regard to clinical governance and have described the current approach as 'making the bar higher' for those revalidating through the Faculty. However, this is just a reflection of the different governance issues that arise between very different types of designated bodies. Designated bodies such as NHS Trusts have direct 'line of sight' over those revalidating through their Responsible Officer and have clearly publicised clinical governance standards. This is not the case for the Faculty which is a designated body which does not have any management oversight or indeed influence over the clinical governance of any of its revalidating members.

In order for the Responsible Officer to meet his responsibilities and for the Faculty to meet theirs as a designated body, both have certain obligations under the legislation and expectations from the regulator that extend to ensuring that effective clinical governance is in place.

The Medical Profession (Responsible Officers) Regulations 2010 gives Responsible Officers in England a range of duties embracing wider responsibilities relating to clinical governance. These are further clarified in the Department of Health document, Closing the Gap in Medical Regulation – Responsible Officer Guidance which, in Section 3.9, specifically states that "*the Responsible Officer will be accountable for ensuring that the systems for appraisal, clinical governance and for gathering and retaining other local relevant supporting information are in place and are effective*". Sections 4.14 – 4.22 further clarify those additional responsibilities.

In relation to trainees, RO's "*…need to consider clinical governance information that assures you about their fitness to practise in order to make a recommendation to the GMC. This includes information from all organisations in which they have undertaken clinical placement*."

In turn, revalidation is cited as being a key driver in clinical governance. Section A.2 (The purpose and effect of revalidation), of Ready for Revalidation, Making revalidation recommendations: the GMC Responsible Officer protocol states that "*The purpose of revalidation is to provide assurance for patients and the public, employers and other healthcare professionals that licensed doctors are up to date and fit to practise. Revalidation should contribute to the provision of high quality healthcare in the UK by…acting as a driver for improving clinical governance at the local level and, ultimately, improving standards of patient care."*

http://www.gmc-uk.org/static/documents/content/Responsible_Officer_Protocol.pdf

Doctors are also asked to ensure that clinical governance is addressed in their continuing professional development. The GMC document Supporting information for appraisal and revalidation states that "*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*".

http://www.gmc-uk.org/Supporting_information100212.pdf_47783371.pdf

It is therefore clear that clinical governance is a key issue which it is the responsibility and duty of both the RO and individual doctors to address. Due to the fact that the Faculty RO is responsible for over 300 doctors, many in individual practice, spread across the UK, the only practicable way to ascertain the clinical governance in place is by a specific questionnaire and the best time to address this is during annual appraisal.

Clinical governance and Good Medical Practice 2013

All of the additional questions have been mapped against Good Medical Practice 2013. These are therefore questions concerning clinical governance where doctors should already be compliant and if they are not then the appraisal is the best area to address them.

ADDITIONAL QUESTIONS

- What is the purpose of the Additional Questions?
- Why are the Additional Questions important?
- Who should fill out the Additional Questions?
- What should I do with the Questionnaire when it is complete?
- Are the Additional Questions a detailed assessment of clinical governance?
- As an appraiser, I feel uncomfortable signing off on clinical governance questions when I have not inspected the practice premises, etc
- These questions are taking a long time to answer
- The questions seem to be excessive and very extensive considering what other specialities are required to do
- Are all of the questions necessary and relevant?
- Why was there not consultation with the appraisers?
- My appraisee works as a contractor for several organisations and has their own small private practice. How can I assure clinical governance across all these sites?

- I work across many different sites, do I need a questionnaire for each site?
- Could clinical governance be covered by self-declaration as with probity and personal health?
- Could these requirements not be introduced gradually or even left to the second cycle?
- Do I have to see photographic ID for all my appraisees? What if I have known them for 20 years?
- Why do I, as an appraiser, have to assess the language skills of the appraise?

What is the purpose of the Additional Questions?

A formal recording of clinical governance issues is required to provide an audit trail in order to maintain the integrity of the revalidation process in its duty to patient safety. It is possible that the Faculty, the Responsible Office and the appraiser will at some point be subjected to close legal and / or media scrutiny regarding a doctor who, having had a successful appraisal and received a positive revalidation recommendation, is found engaging in practices which raise serious concerns, particularly if they relate to patient safety. The appraiser and Faculty RO need to be able to demonstrate that they have taken all steps necessary to undertake a robust and complete appraisal and revalidation process and the additional questions ensure that clinical governance is adequately covered.

This audit trail also ensures that the appraisee can demonstrate that questions regarding their clinical governance were addressed in their annual appraisal should this be an issue for them at a later date.

Why are the Additional Questions important?

Where a doctor may be operating with weak clinical governance, the additional questions ensure that this is identified, can be acted upon and development monitored. It should help to improve standards across the profession and the specialty and will identify issues relating to clinical governance before they become a fitness to practise issue.

The Responsible Officer has a legislative and regulatory responsibility for the revalidation recommendations he makes and requires sufficient information to be able to do so. If clinical governance was omitted then the RO could not make a clear recommendation to the GMC.

If a doctor does not engage with the process then, of course, there will have to be consequences to such actions. As Dr Flower said in the e-mail accompanying the questions "…*I will be unable to make revalidation recommendations to the GMC without this information. All appraisees will therefore need to undertake this*."

Further to this, the Individual Agreement which is signed by every doctor revalidating through the Faculty states;

4.3 In particular (but not exclusively) the doctor must:

4.3.6 supply any further information that may be required by the Faculty RO and in the format as required by the Faculty RO in a timely manner (including the doctor's scope of practice)

4.3.12 comply with Good Medical Practice

Therefore these additional questions fall under 4.3.6 as well as 4.3.12.

Who should fill out the Additional Questions?

Appraisers and appraisees should both have copies of the questions and they should be addressed during the appraisal. As with other areas of the appraisal process, these questions can be discussed, information can be shared and documentation provided before the meeting.

What should I do with the Questionnaire when it is complete?

The appraisee should upload the document, or a scanned version, to their Supporting Information area on PReP with an appropriate filename.

Are the Additional Questions a detailed assessment of clinical governance?

A detailed review is explicitly not being requested with the Additional Questions and where there are concerns or shortcomings these can often be best addressed as an area of development in the Personal Development Plan (PDP). If the discussion around clinical governance takes a significant amount of time this may point to issues that need to be addressed. However, in the first year of revalidation it is reasonable to expect that some aspects of appraisal will take longer than expected as they are being addressed for the first time under the new system.

Neither are appraisers being asked to perform an evidence based review of their appraisees' probity in relation to the questions. These questions help to identify areas where clinical governance may be weak and can be improved via the PDP. If serious concerns are revealed then these can be raised as a matter of urgency and resolved before a risk to patient safety occurs.

As an appraiser, I feel uncomfortable signing off on clinical governance questions when I have not inspected the practice premises, etc.

The appraiser is not being asked to sign off on the statements but to confirm that they have asked the questions and recorded the appraisee's responses. This ensures that clinical governance is an explicit part of appraisal and creates a firm audit trail should such activity be necessary at a later date.

There are various areas of appraisal where the appraiser has to take on faith that the appraisee is being completely honest during the process and not omitting anything, despite the obligations they have. Failure to do so is covered by the standard requirements of GMC probity and if a doctor chooses to lie or omit in relation to these questions and this is discovered, this would clearly be a serious matter just as it would be for other areas of appraisal and revalidation.

These questions are taking a long time to answer

In the first year of revalidation it is reasonable to expect that some aspects of the appraisal will take longer than expected as they are being addressed for the first time under the new system. As revalidation becomes a part of each doctor's normal practice, I would expect the workload associated with it to lessen, not that requirements will be dropped, rather that the mechanics of it will be part of routine behaviour. For example, once the recently circulated additional questions on clinical governance have been

answered the first time, it should be quicker to complete them the following year, quicker the year after that and so on.

In addition, once clinical governance issues have been identified in the first appraisal then these can be addressed as part of the appraisee's Personal Development Plan and progress assessed at the next appraisal.

I would expect the extra questions to take no more than 15 - 20 minutes and usually be achieved by discussion rather than detailed review of supporting information. However, we will monitor the amount of time it takes for the questionnaires to be completed and look to our members to provide us with such feedback. After the questions have been answered once, we would expect the time taken to complete them the second and third, etc, time to reduce as clinical governance questions become a regular part of appraisal.

The questions seem to be excessive and very extensive considering what other specialties are required to do

Most other specialties appraisals are conducted within a known governance framework – such as a hospital – and so a Responsible Officer does not need to make specific enquiries in regards to clinical governance. This is not the case with the Faculty.

Are all of the questions necessary and relevant?

In recognition that individual circumstances differ between practitioners, not all questions will apply to all doctors.

- Two questions (1,3) are required by legislation.
- Question (5a) asks the appraiser to 'review' published materials such as a website or a leaflet.
- Question (5b) asks the appraiser to 'inspect a sample' of clinical records, review an audit or peer review of the records.
- Question (5e) asks the appraiser to 'review' written protocols.
- Four questions (5f-5i) should only be answered 'if applicable'.
- Six questions (6a-6f) only apply if the appraisee employs staff.
- Every other question is 'if applicable' or based on appraiser enquiry.

Why was there not consultation with the appraisers?

The context of appraisal has changed with revalidation and the document Making Revalidation Recommendations: the GMC Responsible Officer protocol (Guide for Responsible Officers) states that an RO has a duty to "*…(ensure) that your designated body or bodies carries out robust and regular appraisals…*" and that …"*To recommend a doctor for revalidation, your judgement must be that the doctor's annual appraisals do reflect the requirements of the GMP Framework*". To satisfy these duties it was therefore necessary for the RO to issue the additional questions as they are directly related to GMP 2013.

My appraisee works as a contractor for several organisations and has their own small private practice. How can I assure clinical governance across all these sites?

The additional questions are concerned with the clinical governance of the doctor's own practice. If they work for an Occupational Health provider then clinical governance issues

for that portion of their work will be covered by that organisation. As a guide, if the appraise works:

- ***100% of the time for an OH provider*** –clinical governance will be managed by that provider and so the Additional Questions can be quickly answered;

- ***100% of the time in independent OH practice*** – the questions will help the appraiser to determine the robustness of clinical governance and the appraisee to address areas of weakness;

- ***50% of the time in independent practice and 50% of the time in contracted work for an OH provider*** – the 50% of work the doctor does independently will be relevant in regards to the questions as the clinical governance arrangements of the OH provider are covered by their internal systems.;

- ***20% of the time in independent practice, 30% of the time in contracted work for an OH provider and 50% of the time in contracted work for the NHS*** - the 20% of work the doctor does independently will be relevant in regards to the questions as the clinical governance arrangements of the OH provider and the NHS are covered by their internal systems.

I work across many different sites, do I need a questionnaire for each site?

The additional questions are concerned with the clinical governance of the doctor's own practice. If they work for an Occupational Health provider then clinical governance issues for that portion of their work will be covered by that organisation. However, if they work at a number of different sites as part of their own independent practice then it may be necessary to address a number of the additional questions separately for each of the sites.

For instance, each site must be considered with regard to facilities and equipment (Question 5f) or there may be different systems for the maintenance of health records (Questions 5b, 5c and 5d) in place at different sites.

Could clinical governance be covered by self-declaration as with probity and personal health?

Self-assessment and signed statements regarding aspects of practice can and do have an important part in appraisal. Indeed, it was considered in relation to clinical governance, but as this is such a vital element of a doctor's practice it needs to be formally addressed.

Could these requirements not be introduced gradually or even left to the second cycle?

These are areas of core clinical governance that all doctors should already be compliant with. The questionnaire allows the appraiser to formally record the appraisee's compliance with a basic framework of clinical governance. Delaying their introduction until 2018 would be unacceptable and the Faculty does not have the power to delay aspects of revalidation.

Do I have to see photographic ID for all my appraisees? What if I have known them for 20 years?

The importance of identification is specifically mentioned in The Medical Profession (Responsible Officers) Regulations 2013 16.2.(c) which states that Responsible Officers must *"…take any steps necessary to verify the identity of medical practitioners*". The appraisee must be positively identified, either through photographic identification **or** based on previous acquaintance. Many appraisers will appraise doctors they have not met before which is why identification is important.

Why do I, as an appraiser, have to assess the language skills of the appraisee?

This requirement has been established by legislation. The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 4.2.(a) (aa) states that Responsible Officers must *"….ensure that medical practitioners have sufficient knowledge of the English language necessary for the work to be performed in a safe and competent manner".*

SEQOHS

- Why was SEQOHS mentioned in the Additional Questions?
- Do I have to be SEQOHS ready or SEQOHS accredited?
- Is this about promoting SEQOHS?
- Will the Faculty benefit financially from the Additional Questions because of their link to SEQOHS?

Why was SEQOHS mentioned in the Additional Questions?

The questions were mapped to SEQOHS as an accepted and respected standard of occupational health governance. However, they were also mapped to Good Medical Practice 2013 which all doctors must be compliant with.

The reason for GMP 2013 and the SEQOHS standards being mapped as references for the questions was to provide context as to what was being asked and how it fitted into both a specialist and the wider GMC framework. The Additional Questions Appraisal Guide was also developed to provide a plain English guide to what is being asked and how the question might be answered. As Dr Flower said, *"I have used the GMC's Good Medical Practice 2013 and the SEQOHS (Safe Effective Quality Occupational Health Service) Standards for Accreditation to highlight and map key areas of enquiry and to develop a limited number of additional questions related to clinical governance for appraisals".*

Do I have to be SEQOHS ready or SEQOHS accredited?

No. At no time has the Faculty said that individual practitioners must be SEQOHS accredited to revalidate through the Faculty.

Is this about promoting SEQOHS?

No. SEQOHS is entirely a voluntary standard, there is no requirement for individual practitioners to be SEQOHS accredited and the Faculty has not stated that this is the case. The SEQOHS standards are not being used to assess clinical governance for individual doctors. Instead, they are being used as a reference – along with GMP 2013 – to give context to the questions and serve as a guide to what is being asked and why.

Will the Faculty benefit financially from the Additional Questions because of their link to SEQOHS?

No. The Faculty has not benefitted and does not seek to benefit financially by adding these extra questions to appraisal. On the contrary, as for appraisers, it entails additional work for no additional income.