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HSJ REVALIDATION

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IN ASSOCIATION WITH THE GENERAL MEDICAL COUNCIL

General Medical Council

Regulating doctors
Ensuring good medical practice

THE FINAL COUNTDOWN

THE DRIVE TO IMPROVE CLINICAL GOVERNANCE AND QUALITY OF CARE

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Revalidation foundations must be robust

Medical revalidation is one of those much anticipated events that always seems a few years away. But that's about to change. It will be introduced from the end of next year and usher in the most significant reform of medical regulation for over 150 years. It will affect every practising doctor in the UK.

But this is not a matter solely for the profession; in some respects the process is less important than the foundations on which it will rest. To work, revalidation must be built on effective and robust clinical governance systems, which, as we know, are essential prerequisites for high quality care.

It has been a common feature of all recent inquiries into serious failures that clinical governance has been weak. Boards and senior managers have not had access or insight into the realities of the care and treatment for which they are responsible. 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. There are already signs that real progress is being made and there is every prospect this will increase as we move closer to the end of the year.

The report on the state of readiness in England, *A Review of Integrated Clinical Governance in the Context of Medical Revalidation*, published last month by the NHS Revalidation Support Team, is both encouraging and challenging. A great deal has been achieved, but much still needs to be done. Every organisation that employs or contracts with doctors must be ready for the introduction of revalidation next year.

The report found that over a quarter of doctors did not take part in appraisal last year, despite it having been a requirement set out in consultant and GP contracts for many years. Yet this is not just about conforming to contracts, or even making sure that every doctor is part of an appraisal system to support revalidation – it is fundamental to safety. An organisation that is not assessing and supporting its medical staff cannot be monitoring and supporting safe clinical practice.

There is much good practice across the UK, where clinical governance and appraisal systems are already strong. The pathfinder pilots led by the NHS Revalidation Support Team have also been useful in helping the General Medical Council make sure the revalidation process will be proportionate and valuable for both doctors and employers. The absolute focus is making revalidation as straightforward as possible.

Every healthcare organisation employing or contracting doctors is a designated organisation under the legislation. That carries with it a set of clear and significant statutory duties. One of them is to appoint a responsible officer, who in turn must ensure every doctor is taking part in the appraisals. The vast majority of organisations have now done so. These officers will lead the charge in preparing for revalidation locally, but will need support from colleagues inside and outside their organisations.

The GMC is determined to do all it can to support responsible officers. It is putting in place a team of employer liaison advisors who will work across the UK, to support responsible officers. Acting as a link between the GMC and employers, they will advise on when to manage issues locally and when to make referrals to the GMC, and offer revalidation information and support.

Together with NHS Employers, the Royal Colleges and four UK health departments, the GMC will issue guidance throughout the coming year. Further pilots are also taking place with particular groups of doctors, including locums, staff grade and associate specialist doctors.

Every organisation needs to get the necessary systems in place ahead of the secretary of state's assessment of readiness next summer. Making revalidation work well for everyone is our top priority. We hope this supplement will be a useful guide for everyone who is preparing to ensure the system is ready for this major change. ●

Niall Dickson is chief executive of the General Medical Council

MAPPING THE WAY TO REVALIDATION

As the introduction of revalidation looms, the General Medical Council has issued guidance to help ensure organisations are fully prepared for the change

The date for introducing revalidation is fast approaching and momentum is building across the UK. Revalidation is a change in medical regulation that will help drive up the quality of clinical governance systems, allowing organisations to deliver better outcomes for patients.

Patients, doctors and employers are all set to benefit. For patients it will provide further assurance that the doctors they see in the NHS or elsewhere are regularly demonstrating that they are competent in their role and keeping up to date in their area of practice. For doctors it's an opportunity for professional development, recognition and, potentially, the chance to benchmark themselves against their peers in the future. Employers will be reassured about the competence of those they employ.

"Revalidation is about quality of care and patient safety. It is based on an evaluation of doctors' practice through local appraisal using the standards, values and principles that we set for all doctors," explains Una Lane, the General Medical Council's director of revalidation.

As the GMC is the UK-wide regulator of the medical profession, revalidation will be a UK-wide process. "Although the structure and the way that services are delivered are different in each of the four countries of the UK, whether the doctor is in Coventry or Clydebank, Coleraine or Cardiff, the standards we expect of them for revalidation are the same," says Lane.

At the heart of revalidation lies the GMC's core guidance for doctors, *Good Medical Practice*, which sets out the standards expected of the medical profession. Using that as the foundation, the GMC has issued guidance on appraisal and the supporting information doctors will have to collect with the help of their organisation's clinical governance systems. This will then need to be discussed with their appraisers.

'The priority for the GMC and its partners is making sure every organisation has the right systems in place to support doctors'

The process has been designed to be as straightforward and flexible as possible, to work for doctors in all different roles, and to minimise the impact on their practice. Doctors will have to bring feedback from patients and colleagues at least once in each five-year revalidation cycle, thereby ensuring that patients' views are included as part of the process.

"The guidance we've published is primarily aimed at helping doctors," says Lane. "But it also provides employers with the tools they need to strengthen their systems of appraisal for revalidation."

"Our expectation is that, if they are not already, organisations will start running 'revalidation-ready appraisals' to allow their responsible officers to start making recommendations about their doctors from when revalidation is introduced at the end of 2012," she adds.

Revalidation is rooted in appraisal and clinical governance information – both of which have been the responsibility of employers for many years. But Bill McMillan, head of medical pay and workforce at NHS Employers, points out that revalidation and the GMC's guidance will make it more likely that appraisal happens in a consistent, well structured way. "It is more likely to have an impact on the practice of the doctors for the better," he says.

ANNE MILTON

Both patients and the public have a right to expect that their doctors' skills are up to date and they are fit to practise. Medical revalidation, which – subject to the full approval process – will start across the UK late next year, will help to achieve this.

It is essential that we work together with the medical community to have a revalidation system that is efficient, streamlined and produces high quality care. It has to be effective and have the confidence of those that will use it. It will then provide confidence to patients and the public.

Over the next 12 months, clinical leadership is needed to help organisations to get ready for revalidation. The introduction of responsible officers has been an important change in clinical governance arrangements, ensuring a high quality clinical workforce and putting in place the building blocks for medical revalidation.

Responsible officers in England have a duty to ensure that robust, efficient and reliable systems of clinical governance are in place. Healthcare organisations will need to give all possible support to their responsible officer. Clinical governance is also an issue of corporate governance and needs to be at the forefront of ongoing work on quality standards and outcomes for patients.

The final model for revalidation will build on existing local systems of appraisal and clinical governance. The majority of the building blocks are already in place.

Anne Milton is minister for public health

The delivery of revalidation across the UK is being led by the GMC. Co-ordination is coming from the UK Revalidation Programme Board; this was established by the GMC and includes representatives from all organisations that have a role or interest in delivering revalidation, including the four health departments of the UK, NHS Employers, the Academy of Medical Royal Colleges and the British Medical Association. The board is led by Sir Keith Pearson, chair of the NHS Confederation.

Each of the four health departments of the UK has a delivery board responsible for ensuring that healthcare organisations are getting ready for revalidation. They report that readiness back to the UK board.

Dr Ian Finlay is chair of the revalidation board for Scotland and a senior medical adviser for the Scottish Government Health Directorates. He feels that Scotland is well advanced in its readiness for revalidation – sentiments backed by an *NHS Quality Improvement Scotland 2010* report that said: "NHS Scotland is near the UK forefront in terms of preparedness for revalidation." Key to that readiness is the Scottish Online Appraisal Resource, an electronic appraisal system developed for primary care and extended to secondary care. All doctors in Scotland are expected to register with SOAR and responsible officers will be able to monitor who has had an appraisal.

In addition, all appraisers are being trained by NHS Education for Scotland. "That brings us complete uniformity across Scotland for the appraisal," says Dr Finlay.

The priority for the GMC and its partners is making sure every organisation has the right systems in place to support doctors with their revalidation. A critical date for every organisation in England is April/May 2012, when a final assessment of readiness will be carried out by the NHS Revalidation Support Team. To be considered ready for revalidation, every organisation must have an annual appraisal scheme for its doctors that reflects the GMC's guidance, good clinical governance systems and a responsible officer who is accountable for ensuring these systems are in place.

The GMC's other focus is on completing work on various aspects of the policy model and programme. These include agreeing what recommendations from responsible officers will look like and how they should be quality assured, and finalising arrangements for how revalidation will start in late 2012.

The GMC expects to agree its high level approach for implementing revalidation by the end of 2011. It also plans to ensure doctors are aware of their responsibilities as medical professionals when revalidation begins.

Like all organisations, those in the NHS are operating in a financially challenging environment. In England they also face changes to the architecture of the health system. Revalidation is not intended to be a further burden; the foundations of appraisal and good clinical governance should already be in place in every organisation. As Lane says: "It is vital that we all keep our eye firmly on the ball with quality and safety." ●

REVALIDATION RESPONSIBILITIES

Doctors

- Take part in annual appraisal
- Collect a portfolio of supporting information
- Maintain link with a designated body

Responsible officers (medical directors or deputies)

- Ensure clinical governance and appraisal systems are working effectively
- Ensure doctors are supported in participating in revalidation
- Manage concerns about doctors' practice
- Maintain a list of doctors with whom they have a "prescribed connection"
- Make revalidation recommendations to the GMC about doctors who have a prescribed connection to their designated bodies

Designated bodies (boards and senior management teams)

- Establish and maintain local clinical governance systems (including appraisal)
- Nominate or appoint a responsible officer
- Support responsible officers and appraisers with resources and training

The statutory responsibilities of designated bodies and responsible officers are outlined in regulations that took effect on 1 January 2011 (October 2010 in Northern Ireland). The regulations will be amended after a forthcoming Department of Health consultation on where responsible officers will sit in the proposed new NHS architecture in England.

ALAMY

Patients, doctors and employers are all set to benefit from the revalidation programme

SIR BRUCE KEOGH

IMPROVING GOVERNANCE

Responsibility rules

Preparing the NHS for the introduction of medical revalidation is a priority for me as NHS medical director. Since new regulations requiring designated organisations to appoint a responsible officer came into force on 1 January this year, progress has been made – but we still have some way to go.

The role of the responsible officer is pivotal to ensuring strong and visible clinical leadership, and to enhancing local governance systems. It is also essential if we are to realise our ambition to radically improve clinical leadership, accountability and outcomes in the NHS.

Appraisal underpins both clinical governance and revalidation. It is the key opportunity for organisations to talk to their doctors individually about how they can work together to improve the quality of care they offer. Appraisals should be objective, constructive and supportive. The process is vital for engaging doctors with organisational ambition, promoting continuous professional development, clinical quality improvement and identifying early potential problems with clinical service delivery. It facilitates personal and organisational development.

Clinical governance concerns the governance of clinical activity and quality in an organisation. It is an integral part of corporate governance and not a standalone function. The quality of clinical service offered by organisations is an aggregate of different clinical service lines, staffed by different clinical teams. The NHS is itself an aggregate of multiple clinical organisations and the process of appraisal of doctors is fundamental to improving quality of care throughout the NHS and the wider healthcare sector.

I have had a long-standing interest in clinical outcomes and I am often quoted as saying: "If you can't describe what you are doing and how well you are doing it, you have no right to be doing it at all." I believe that, as doctors, we have a professional, moral and social responsibility to be able to describe what we do and define how well we do it – otherwise, we forfeit some of our professional status. In my view, this equally applies to provider organisations and, by extension, their governing boards; this is why quality accounts include expectations that boards will assure themselves of the quality of care in each and every clinical service they offer.

Earlier this year, the Revalidation Support Team worked with strategic health authorities to complete an organisational readiness self-assessment (ORSA) – one of several initiatives being undertaken to prepare the health sector for the introduction of medical revalidation in late 2012. ORSA has provided a baseline against which progress can be measured to ensure appropriate maturity of clinical governance and appraisal systems for doctors.

However, although it showed that systems of clinical governance and appraisal have improved over the past two years, I have a sense from the data drawn that not all organisations have grasped the importance and benefits of this process, either for their staff or the organisation itself. This is all the more worrying given that many of the gaps identified with the ORSA resonate with the 2010 Mid Staffordshire public inquiry findings – namely that the systems designed to improve performance, such as audit, appraisal and professional development, have been accorded a low priority. This cannot continue; we must build on creating an environment in the healthcare sector in which excellence in clinical care can flourish.

> **Clinical governance and appraisal are the bedrock of high quality care**

Good clinical governance and appraisal are the bedrock of high quality care and appraisal has been a requirement of all NHS organisations since 2001. The responsible officer regulations address the gap and it is a statutory requirement that responsible officers ensure all their doctors are appraised annually, irrespective of where they work. Of course, this also forms part of the conditions that organisations must meet in order to be registered by the Care Quality Commission.

As we move towards introducing revalidation, responsible officers should continue to support their doctors; clinical governance and outcome data should be collected, shared and used in a way that supports continuous improvement. In doing so, responsible officers will not only provide the framework to support clinicians in improving the quality of care they provide and ensure their fitness to practise, but also provide that much-needed assurance to patients and the public. ●

Professor Sir Bruce Keogh is NHS medical director

BACK TO BASICS

Appraisals are nothing new but often forgotten. As revalidation brings their importance to the fore, we look at what makes an appraisal system effective

Organisations across the UK are at various stages of preparedness for revalidation, which is due to come into effect in late 2012.

The responsible officer regulations that came into force in January 2011 place new responsibilities on organisations. However, part of the push to prepare for late 2012 is about reminding them of the responsibilities they already have. As Jon Billings, the General Medical Council's assistant director of revalidation, explains: "Even though organisations have always had to manage the delivery of high quality care and support doctors with a well run appraisal scheme, the introduction of the new regulations has moved the issue of clinical governance back up the agenda.

"Revalidation has helped put the focus back on these important issues. At the GMC, we are working with our partners to ensure they have the necessary systems to support revalidation when it starts next year."

While responsible officers will be leading the drive within their organisations to get ready for revalidation, NHS leaders – such as boards and senior management teams – have an equally important role to play.

"Boards have ultimate responsibility for the governance of care being delivered by an organisation," says Sir Keith Pearson, who chairs both the NHS Confederation and the UK Revalidation Programme Board. "Executive and non-executive members should be taking a close and active interest in how their organisations are preparing for revalidation at all their meetings from now through to late 2012.

"Revalidation is a corporate issue, not a medical one," he continues. "And the level of engagement from boards needs to match this."

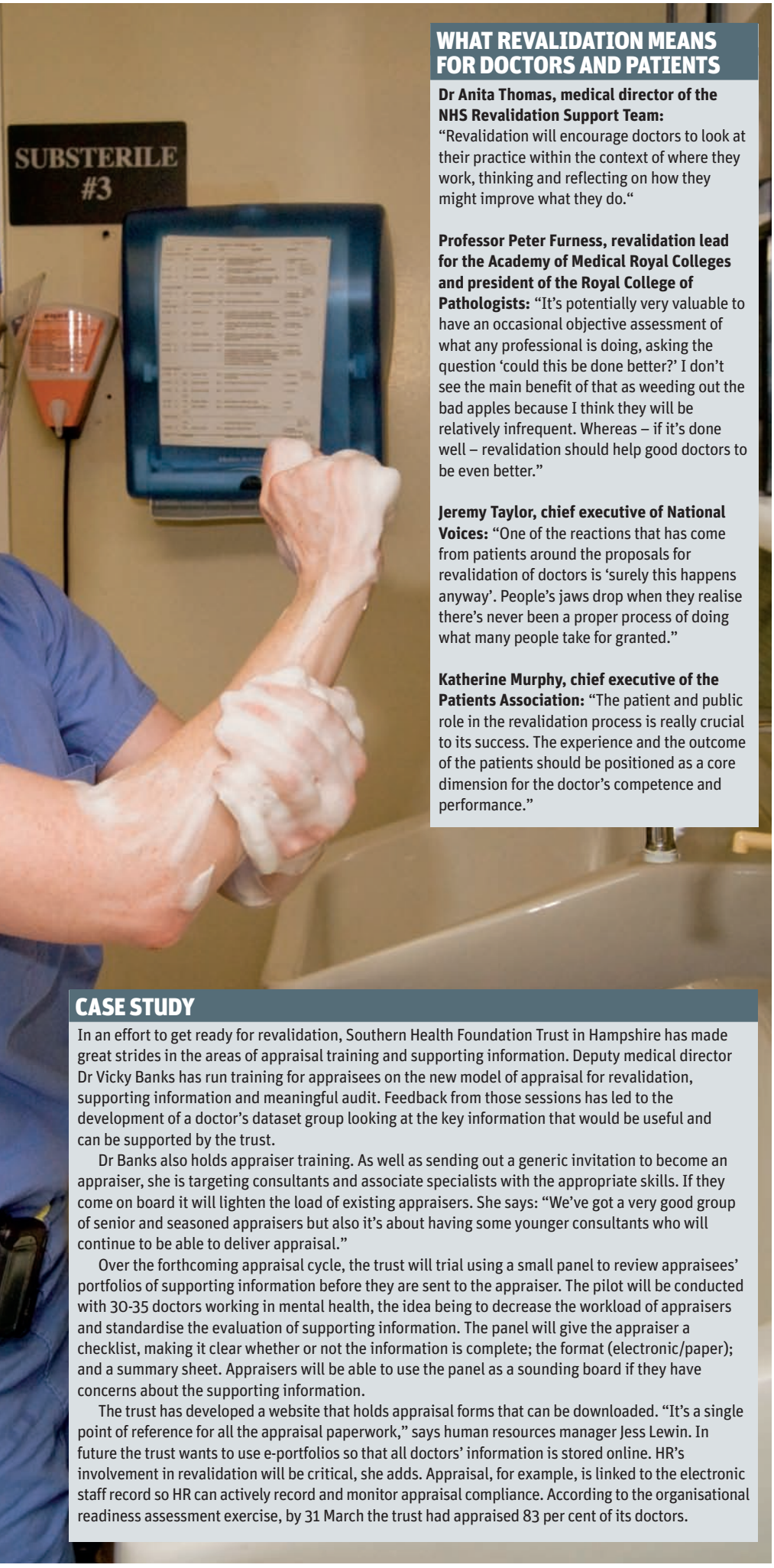
"The link between revalidation and the organisation's processes of safety and quality is of fundamental importance," adds Dr Martin Shelly, organisational readiness programme director for the NHS Revalidation Support Team. "We are finding that those organisations who are embracing this concept are giving themselves a starting advantage in terms of being ready."

The Revalidation Support Team is using its organisational readiness self-assessment tool to monitor and stimulate the progress of organisations in England. As a result of this, organisations are already setting up and implementing local action plans to improve processes where needed.

The results of the readiness exercise, which was carried out in March/April, were published in October and confirm a strong appetite for engagement with revalidation preparations. However, it also found a level of variability in the strength of local clinical governance and appraisal processes – only 75 per cent of doctors had completed an appraisal between April 2010 and March 2011; this figure was higher in primary care (85.2 per cent) than hospital trusts (55.7 per cent). The survey also revealed that, while 70 per cent of designated bodies had a system in place for monitoring the conduct and performance of doctors, only a third had a formal policy for recognising and responding to concerns about their practice and only half of all designated bodies had an appraisal policy in place with "core content".

Bill McMillan, head of medical pay and workforce at NHS Employers, says organisations should get ready by making sure that: their appraisal systems are up to date; doctors have an assigned appraiser; sufficient numbers of trained appraisers are in place; clinical governance data is accessible to doctors for supporting information; and there is clarity on exactly which information can be shared across organisational boundaries when doctors have more than one employer.

Another task is to see how revalidation, appraisal and supporting information link



WHAT REVALIDATION MEANS FOR DOCTORS AND PATIENTS

Dr Anita Thomas, medical director of the NHS Revalidation Support Team: "Revalidation will encourage doctors to look at their practice within the context of where they work, thinking and reflecting on how they might improve what they do."

Professor Peter Furness, revalidation lead for the Academy of Medical Royal Colleges and president of the Royal College of Pathologists: "It's potentially very valuable to have an occasional objective assessment of what any professional is doing, asking the question 'could this be done better?' I don't see the main benefit of that as weeding out the bad apples because I think they will be relatively infrequent. Whereas – if it's done well – revalidation should help good doctors to be even better."

Jeremy Taylor, chief executive of National Voices: "One of the reactions that has come from patients around the proposals for revalidation of doctors is 'surely this happens anyway'. People's jaws drop when they realise there's never been a proper process of doing what many people take for granted."

Katherine Murphy, chief executive of the Patients Association: "The patient and public role in the revalidation process is really crucial to its success. The experience and the outcome of the patients should be positioned as a core dimension for the doctor's competence and performance."

CASE STUDY

In an effort to get ready for revalidation, Southern Health Foundation Trust in Hampshire has made great strides in the areas of appraisal training and supporting information. Deputy medical director Dr Vicky Banks has run training for appraisees on the new model of appraisal for revalidation, supporting information and meaningful audit. Feedback from those sessions has led to the development of a doctor's dataset group looking at the key information that would be useful and can be supported by the trust.

Dr Banks also holds appraiser training. As well as sending out a generic invitation to become an appraiser, she is targeting consultants and associate specialists with the appropriate skills. If they come on board it will lighten the load of existing appraisers. She says: "We've got a very good group of senior and seasoned appraisers but also it's about having some younger consultants who will continue to be able to deliver appraisal."

Over the forthcoming appraisal cycle, the trust will trial using a small panel to review appraisees' portfolios of supporting information before they are sent to the appraiser. The pilot will be conducted with 30-35 doctors working in mental health, the idea being to decrease the workload of appraisers and standardise the evaluation of supporting information. The panel will give the appraiser a checklist, making it clear whether or not the information is complete; the format (electronic/paper); and a summary sheet. Appraisers will be able to use the panel as a sounding board if they have concerns about the supporting information.

The trust has developed a website that holds appraisal forms that can be downloaded. "It's a single point of reference for all the appraisal paperwork," says human resources manager Jess Lewin. In future the trust wants to use e-portfolios so that all doctors' information is stored online. HR's involvement in revalidation will be critical, she adds. Appraisal, for example, is linked to the electronic staff record so HR can actively record and monitor appraisal compliance. According to the organisational readiness assessment exercise, by 31 March the trust had appraised 83 per cent of its doctors.

to other employment processes such as job planning for staff and associate specialist doctors and consultants. "Try and make your whole system work together to the benefit of your patients and your organisational objectives," says McMillan.

A further area that organisations need to think about is the infrastructure they will need to manage the appraisals of their doctors. Unlike the other countries of the UK, there will not be a national IT solution to support doctors appraisals in England. Instead, organisations will need to decide whether they need additional technology to build on the systems they may already have in place. To help them decide, the Revalidation Support Team is producing a raft of guidance on information management that will cover data governance, the interoperability of systems, and the desired functionality of systems that organisations will need. The guidance will be published towards the end of the year.

Doctors have a responsibility to prepare a portfolio of supporting information for their appraisal that demonstrates the quality of their practice. However, organisations must collect that data and make it easy for their doctors to access, says Dr Anne Kilgallen, medical director of Western Health and Social Care Trust in Northern Ireland. She adds: "There's been a lot of focus on systems to give early warnings of harm or near misses. However, the side of the equation that demonstrates quality is something that we've been working at more recently."

The trust has invested in an in-house electronic appraisal system that helps doctors prepare and organise their portfolio. It also allows Dr Kilgallen to see who has participated in appraisal, whether it's been signed off, and allows her to acknowledge receipt of appraisals.

The trust collates quality audit data centrally, which it can systematically provide to doctors. On the risk management side it has an electronic system for recording complaints, incidents, litigation and compliments. Earlier this year it piloted the system, giving medical staff all centrally held information on risk management and audit that was relevant to them. Dr Kilgallen says: "It went very well, with a lot of useful feedback, which allowed us to record more accurately what we had on the database."

In the past the trust has commissioned reports produced at consultant level on activity and some quality indicators, including readmission rates and mortality rates. The value of these reports hinges on the quality of coding, the development of which is still in progress.

The trust and its doctors are well on their way to working out how all the elements contributing to revalidation will be done, but for Dr Kilgallen the big prize is quality improvement. "In my experience doctors are constantly working to improve their services – they do local audit, they reflect on near misses, they change their practice as a result, but revalidation allows us to make it more explicit," she says. "Revalidation is what comes from an embedded approach to quality improvement." ●

ALAMY

ONE STEP AT A TIME

Revalidating practitioners who have more than one place of work will present several challenges, but pilots are under way to make sure it goes smoothly

'The concern that many doctors have is that data collected by organisations is not sophisticated enough to be attributed to individual practitioners'

Many doctors work only in the NHS so revalidation through their responsible officer will be straightforward, but there are a significant number who work across the NHS and independent sector. As locum doctors, particularly GPs, work at different organisations and trainee doctors rotate through posts every six months, employers will need to make sure they have the systems in place that will support them.

Jon Billings, assistant director of revalidation at the General Medical Council, says revalidation will help doctors whose practice can be varied and complex. "The standardisation of governance across the health system will benefit doctors who work in multiple settings. As they move between organisations, they will have the benefit of knowing that wherever they go, the types of things they'll be expected to demonstrate through appraisal will be the same," he says.

However, Billings adds: "The big challenge for organisations, which has been brought under the spotlight by revalidation rather than caused by it, is extending the coverage of their clinical governance systems to cover every doctor they have a relationship with – not just doctors who work for them on a full time basis but also those who are on short term contracts."

The main challenge, as Dr Andy Jones, group medical director of Nuffield Hospitals, explains, lies with generating supporting information for appraisal.

"Where you've got interfaces with doctors working across many organisations and working in practices that aren't supported by teams of other doctors, then it becomes more difficult to produce the required supporting information," he says.

"It's these groups that are going to be the hardest to revalidate and potentially where the risk sits. Many of the big examples of where medical care has gone wrong all involve doctors working in isolation or are between organisations where those bits and pieces weren't there."

This year's pilots run by the Revalidation Support Team are looking at this very issue. Involved are locums, doctors in independent practice, and staff and associate specialists. One of the pilots is focusing on doctors who work in unmanaged care environments and more isolated areas of practice. NHS organisations – primary care trusts in Leicester and London, and acute trusts in Newcastle and London – are also taking part to ensure the GMC's streamlined process works in those settings.

"The GMC's supporting information requirements are sensible and should be able to be collected by all doctors," says Dr Nick Lyons, the Revalidation Support Team's programme director who is leading on the latest round of pilots. "But we know that some doctors will have different challenges to others. Organisations need to recognise those challenges and support them as much as possible."

The concern that many doctors have is that data collected by organisations is not sophisticated enough to be attributed to individual practitioners. The problem is a particular worry for SAS doctors, as Dr Anthea Mowat, an SAS clinical tutor and appraiser, explains.

"The difficulty for SAS doctors is trying to get ideas of things like workload, which is a significant part of the appraisal process... A lot of the information about our work is coded under our consultants' name. There's quite a concern that SAS doctors won't be able to produce evidence because the IT systems in the trust aren't capable of doing that. The fear is then that they'll be told 'you can't revalidate because you haven't got the evidence'."

The Revalidation Support Team's pathfinder pilots, which ended in March 2011, revealed problems with trusts producing supporting information for SAS doctors. The new round of piloting is exploring this issue further.

Another concern for this group is their access to opportunities for professional development. The results of the support team's organisational readiness self-assessment survey, published in October, found that only one in three SAS doctors in England had an annual appraisal between

Some doctors, such as locums and trainees, work at many different organisations or rotate their posts every six months. Employers must ensure they have the correct systems in place to support these practitioners.

April 2010 and March 2011. Employers need to make sure they help doctors, such as trainees or locums, who move around the system and support other employers by sharing information about those doctors, says Bill McMillan, head of medical pay and workforce at NHS Employers.

"The area that comes up most is locums because they are potentially a particularly risky area," he says. "They move out of the system and we don't always get information about them."

A code of practice developed by the Department of Health in 1997 recommends that employers carry out structured assessments of locum appointments. "It's a question of making sure trusts are reviewing that in the context of revalidation," says McMillan. NHS Employers will be refreshing the guidance on how locums should be supported.

A report published by the University of East Anglia in 2010 found that the percentage of secondary care career locums without access to an appraisal was small. It added that these doctors can meet the appraisal requirements if they have access to sufficient information, training and support.

But the challenges surrounding revalidation for GP locums may be more pronounced. Hospital locums may work in one location for weeks at a time but Dr Richard Fieldhouse, chief executive officer of the National Association of Sessional GPs, says that over a month a locum GP can work in 10-15 surgeries and 30-40 consulting rooms. Locums are nearly always given a generic username and password for systems they need to access and are forced to write their notes anonymously.

KEY POINTS

- All licensed doctors need access to clinical governance systems so they can collect supporting information
- Some groups of doctors, such as locums, SAS doctors and those who work across the NHS and independent sector, may find it quite challenging to collect supporting information
- Employers need to pay special attention to these doctors and ensure they provide them with the support they need for appraisal and revalidation

Seven years ago Dr Fieldhouse and two colleagues set up the first locum chambers in the country. He believes every locum should join a chambers as it is a managed organisation and invaluable for appraisal and revalidation. Today there are 70 GPs in seven chambers.

When an annual appraisal is due, chambers managers automatically send out feedback forms to the four practices that the GP has primarily worked in over the previous six months. Members use their chambers website to compare their performance with GPs in the seven chambers and generate an audit report. "Other locums can't do that because they're not working as part of a team," says Dr Fieldhouse. "The biggest problem for locums is isolation."

The London Deanery is running one of the Revalidation Support Team's new pilots with 100 GP locums, 100 GPs in regular practice, 100 acute trust consultants, 50 mental health trust consultants and 50 SAS grade doctors from acute and mental health trusts. It will test the support team's draft *Medical Appraisal Guide*, the amount of doctors' time required in proportion to the benefits, and how easy it is to compile supporting information.

The London Deanery is also participating in a Revalidation Support Team pilot for trainee doctors. Their revalidation will be managed through an annual review of competence progression, which they must pass to complete their training. The pilot will look at the ARCP and see what additional information is needed for revalidation.

A trainee's responsible officer is their postgraduate dean, rather than their employer, as Dr Julia Whiteman, the London Deanery's director for appraisal, revalidation and performance, explains. "Trainees will primarily relate to the dean or the person who is in charge of their training, not their employer, because trainees move around through their training," she says.

Trust medical directors will have to provide a report to deaneries about clinical governance information including concerns, incidents and complaints. "Whether that's going to be a positive statement that every employer has to make about every trainee rotating through their organisation or whether it's going to be just exception reporting is still being looked at," she adds.

Professor Malcolm Lewis, GMC Council member and director of postgraduate education for general practice at the Wales Postgraduate Deanery, says the aim is to make the experience of revalidation a positive one for trainees. "We know that [trainees] are probably the best supervised doctors in the country. We're working very closely with employers in the NHS and deaneries to make sure that we have a straightforward process for trainees that enables them to demonstrate they are up to date without adding additional burdens to their training programme." ●

ALAMY

CASE STUDIES

STEERING TOWARDS SUCCESS

Healthcare organisations in England and Wales share details of the pilot programmes they implemented to help them move successfully towards revalidation

Wales has an established system for GP appraisal that is reaping benefits and is being tested in secondary care. GP appraisal became compulsory in Wales in 2004; prior to that – when it was introduced in England and being run by primary care trusts – the Wales Deanery made a submission to the Welsh Government to run a pilot, which took place in 2001-02.

The pilot was a success and led to a service level agreement with the Welsh Government for the deanery to deliver appraisals for all 2,500 GPs in Wales on behalf of the health boards. Since 2003, the deanery has developed its online e-portfolio system, called the medical appraisal and revalidation system, or MARS.

GPs register with MARS then select their appraiser, agree an appraisal date and enter their appraisal materials. After an appraisal meeting, the summary and personal development plan is produced using the electronic system. A revalidation scorecard has been developed that will provide a picture of GPs' progress towards revalidation. The deanery has recruited and trained 80 appraisers who are organised into eight regional teams.

"One of the benefits of having a single system for Wales is that it's a consistent system," says Katie Laugharne, the deanery's lead for GP appraisal and continuing professional development. "Whether you're a GP in Bangor or a GP in Cardiff, you will be able to experience an appraisal of the same standard."

Some GPs were apprehensive about appraisals at first, but research commissioned by the deanery shows that the majority have found it a positive experience that provides protected time to reflect on their development with a trained peer and plan their continuing professional development. Just over half reported they had made changes to the way they work or learn. The deanery hopes to study what impact such changes have had on patient safety and quality of care.

There are a number of different systems for secondary care appraisal in Wales, which are run by trusts and health boards. After a request from the Welsh Government, the deanery is piloting aspects of its GP appraisal system in secondary care, which might be rolled out across Wales to achieve some consistency and improve uptake.

In England, Newcastle upon Tyne Hospitals Foundation Trust began its journey towards revalidation in July 2009 when it appointed Dr Michael Wright as assistant medical director with responsibility for revalidation. A strategic group was set up that included the director of medical education, dean of clinical medicine, head of medical staffing, director of human resources, and the director of quality and effectiveness. Chaired by Dr Wright, the group reports directly to the medical director, who is the responsible officer.

Revalidation representatives were recruited from more than 20 clinical directorates across the trust and sit on a Directorate Representatives Group, which meets monthly. "They bring issues that are specific to their directorate or specialty and take back to the directorate the progress we've been making," says Dr Wright.

Newcastle's Royal Victoria Infirmary is part of the trust that started its move to revalidation in 2009

'We took a decision that we would try to push as much of the information as we can, rather than doctors having to pull it from central databases'

Three subgroups are responsible for appraisal, supporting information and remediation. The Supporting Information Subgroup, for example, is working on how the trust can provide its more than 700 senior doctors with accurate information on activity, complaints and other areas.

"At a very early stage we took a decision that we would try to push as much of the information as we can, rather than doctors having to pull it from central databases," says Dr Wright. "That's been a useful exercise because it has got senior clinicians engaged with the information structures in the trust and trying to improve the quality of the clinical information that we hold."

Newcastle is taking part in the NHS Revalidation Support Team pilots and will deliver 100 appraisals by the end of the year. It will pilot the support team's *Medical Appraisal Guide* and a new interactive PDF appraisal form, which Dr Wright says on first impressions "appears to be significantly better than the IT system used in the pathfinders".

Newcastle also wants to discover what information responsible officers will need to make decisions about recommendations for revalidation, how much time the whole process will demand from doctors and staff, and whether there are benefits beyond revalidation. Dr Wright says: "For us it's not just about revalidation, it's about developing our overall appraisal system." ●

ALAMY

A HELPING HAND

The NHS Revalidation Support Team is providing designated bodies with guidance on establishing networks of responsible officers and other initiatives that will contribute to creating a consistent appraisal system for doctors

A huge amount of work is under way across the UK to help employers get ready for revalidation. The organisation helping to prepare designated bodies in England is the NHS Revalidation Support Team.

The RST is working with strategic health authorities to support the ongoing development of responsible officer networks, led by the SHA responsible officer, and provide training for them at a regional level. They are also working together to monitor the progress of designated bodies with a series of readiness checks using the RST's organisational readiness self-assessment tool. Along with organisations such as the General Medical Council, the team is producing a range of guidance to help employers and doctors prepare for the start of revalidation.

The RST will publish guidance on information management later this year covering issues such as the information flows for revalidation, information governance, and the essential functionality of appraisal systems, which local employers can use to procure, build or adapt existing systems as there will not be a national IT solution developed for England. The RST will also supplement the GMC's framework for appraisal, which is based on *Good Medical Practice*, with additional advice that will define the essential components of an appraisal system to help ensure a consistent approach for all doctors.

The guidance, the *Medical Appraisal Guide*, will be published in March 2012, after a period of testing.

Also in the pipeline is guidance from the medical royal colleges that will help specialist doctors and GPs identify the supporting information they can bring to appraisal. The GMC's guidance on this is a generic document aimed at all doctors. "The colleges have taken the GMC's guidance and added comments in relation to the different specialities," says Professor Peter Furness, revalidation lead for the Academy of Medical Royal Colleges.

The colleges' next task will be to develop guidance for their specialties on how to interpret the information and what action to take. This specialist guidance is expected to be finalised by March 2012.

The colleges are working on how to provide individualised advice for appraisers, appraisees and responsible officers. Some of the larger colleges are establishing networks of advisers at trust and regional level.

At the GMC, work is under way designing the system that will allow responsible officers to make revalidation recommendations about doctors. The online system is due to be trialled with responsible officers next spring before going live later that year.

Before then, the GMC will introduce a major new service for employers that will see a team of regionally based advisers created to support medical directors with their duties as responsible officers.

The new team of employer liaison advisors will act as a critical friend for responsible officers, providing them with advice about the systems they need to make revalidation recommendations about doctors. They will also help them manage any concerns they have to deal with about doctors' practice or conduct. It's the first time the GMC has had employees in the field. "Our new team will be talking about things before they become a real problem for the trust, for patients and for ourselves," says Anthony Omo, the GMC's assistant director responsible for the new employer service.

The GMC's new service is due to launch early next year. ●

ALAMY

RESOURCES FOR YOU

General Medical Council (www.gmc-uk.org/revalidation)
- overseeing the delivery of revalidation at a UK level
- professional values that will underpin doctors' appraisals and supporting information
- mechanism for responsible officers making recommendations

Department of Health – England (www.dh.gov.uk)
- legislation and regulations for responsible officers and revalidation

The NHS Revalidation Support Team (www.revalidationsupport.nhs.uk)
- helping designated bodies and responsible officers prepare for revalidation with training, guidance and tools
- assessments of readiness in England
- testing and piloting in England

NHS Employers (www.nhsemployers.org/revalidation)
- providing implementation advice to the NHS, the GMC, the DH and other partners
- encouraging joint working of responsible officers with senior managers and the wider HR team

Academy of Medical Royal Colleges (www.aomrc.org.uk/introduction)
- facilitating the development of specialty-specific guidance by medical royal colleges
- co-ordinating work on revalidation-related issues, eg clinical audit, non-clinical work, return to practice, and remediation

REVALIDATION ROADMAP

Support you can expect

What you should be doing

by end of 2011

- GMC consults on draft revalidation regulations (October to January 2012).
- GMC develops with partners a high level approach for implementing revalidation from late 2012 onwards.
- GMC publishes responsible officer revalidation recommendation statement.
- GMC publishes a resource pack for the collection of patient and colleague feedback.
- GMC defines core information requirements for revalidation during implementation period (eg number of appraisals and supporting information requirements).
- RST pilots its medical appraisal guide (October to December).
- RST publishes range of guidance on information management.

To be ready for the start of revalidation in late 2012, we need organisations to ensure they have:

- a responsible officer with the systems in place to support them in their role
- an up to date appraisal system that reflects the GMC's guidance and ensures every doctor is having an annual appraisal
- a sufficient number of trained appraisers in post
- clinical governance systems that can provide doctors with the supporting information they need for appraisal and revalidation
- policies and systems in place for identifying and responding to concerns about doctors
- worked with doctors to establish their correct prescribed connection
- robust links with the other organisations that your doctors may be working for, so information about their practice and any concerns can be shared.

Between now and the end of March 2012, you should be:

- reviewing and strengthening your appraisal and clinical governance systems
- implementing the local action plan you developed in response to the 2010–11 ORSA assessment run by the NHS Revalidation Support Team (RST)
- participating in the interim ORSA assessment in January 2012
- deciding what infrastructure (such as IT) that you need to manage doctors' appraisals and how you will provide feedback to doctors about their practice.

by end of March 2012

- GMC launches employer liaison service to help responsible officers with revalidation readiness and concerns about doctors (January onwards).
- GMC contacts doctors to confirm their prescribed connections with designated bodies.
- RST publishes the final version of its medical appraisal guide.
- RST publishes guidance on responding to concerns about doctors' practice.
- RST publishes guidance for responsible officers on selecting, training and supporting medical appraisers.
- Medical royal colleges publish specialty-specific guidance on supporting information for revalidation.

by end of June 2012

- GMC tests systems for receiving recommendations from responsible officers (April onwards).
- GMC publishes guidance for responsible officers on making revalidation recommendations.

- At the start of the new appraisal cycle, your organisation should make final changes to your appraisal system and begin to run 'revalidation-ready' appraisals for your doctors.
- In April and May, organisations in England will need to complete the ORSA assessment covering 2011/12 to confirm progress is being made.

by end of Sept 2012

- Secretary of State for Health considers readiness assessment (summer 2012).
- GMC publishes guidance on the revalidation pathway for doctors without a prescribed connection to a designated body.
- GMC develops with partners a detailed plan for implementing revalidation at the end of 2012.

- Your organisation should be addressing any actions resulting from the 2011/12 ORSA assessment.
- During this period, responsible officers will need to work with the GMC as it develops a detailed plan for implementation with partners.

by end of Dec 2012

- GMC advises licensed doctors, responsible officers and designated bodies about the schedule for starting revalidation at the end of the year.
- Revalidation regulations come into force (December).
- GMC systems ready to receive recommendations from responsible officers.

from 2013

- Phased implementation of revalidation begins across the UK.
- GMC begins to receive revalidation recommendations from responsible officers.

- Responsible officers ready to make revalidation recommendations to the GMC.