Revalidation – Where are we now?

Update for doctors in paediatric palliative care

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25 November 2011

Outline

- Medical Revalidation update and overview
- Main changes
- Common questions
- Outstanding issues for clarification
- What hospices need to do
- What doctors need to do

- Questions

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Terminology and abbreviations

New language!

- RO Responsible Officer
- DB Designated Body
- ORSA Organisational Readiness Self Assessment (for revalidation)
- RST Revalidation Support Team

- PCT Primary Care Trust
- PCO Primary Care Organisation
- HB Health Board (Scotland)
- LHB Local Health Board (Wales)

- MSF Multi-source feedback
- SEA Significant event analysis

Revalidation

- *'To assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and are practising to the appropriate professional standards'*

  GMC: Revalidation – The Way Ahead 2009

- *'Will be based on* ***robust local systems****, that supports high quality care in the organisations and practice settings where that care is delivered'*

- *'Must not create unnecessary burdens which distract doctors from caring for their patients but at the same time must be robust enough to* ***provide assurance for the public****'*

  GMC: Revalidation – A statement of Intent Oct 2010

Main messages (GMC)

Revalidation will

- Be simpler, streamlined, but still robust.
  (Practical common sense, not to catch people out)
- Be relevant to the doctor's day to day practice
- Add value for both patients and doctors
- Appraisal and clinical governance will remain foundational to the process

GMC: Revalidation – A Statement of Intent Oct 2010

An opportunity to celebrate good practice, support professional development and flag up what needs to change

Revalidation overview

In all the documents there are 2 main themes:

- To improve the quality and safety of patient care
- To strengthen professional development

…. also an additional theme:

- To reinforce systems which identify those doctors who require support

Overview

- Practical common sense, not a catch.
- Opportunity to celebrate good practice and flag up what needs to change.
- Maintain formative and developmental element to appraisal - tricky tightrope but the will is there.
- Note GMC update re supporting information, with specialty specific links for RCPCH, RCGP, RCP
- Note PPC curriculum

Main changes

- **Relicensing (as doctor), not recertification (as specialist or GP).** 1 step, not 2.

  Under discussion: revalidation as fit for *practice* (ie relicensed), not necessarily fit for *purpose* (in specific role and context)

- Much more pragmatic and simpler than initially proposed
- Local discretion and flexibility
- Emphasis on review of '**whole practice**': revalidation appraisal should take account of input from all roles, including PPC input (e.g. from separate hospice appraisal, and from PPC supporting information).
- Not expecting a unified national electronic revalidation **toolkit** (file off-line for now and upload as local processes direct?).

- Many changes in detail and mechanics e.g. New GMC and specialty advice re supporting information, Responsible Officers, Designated Bodies.

Bottom line…

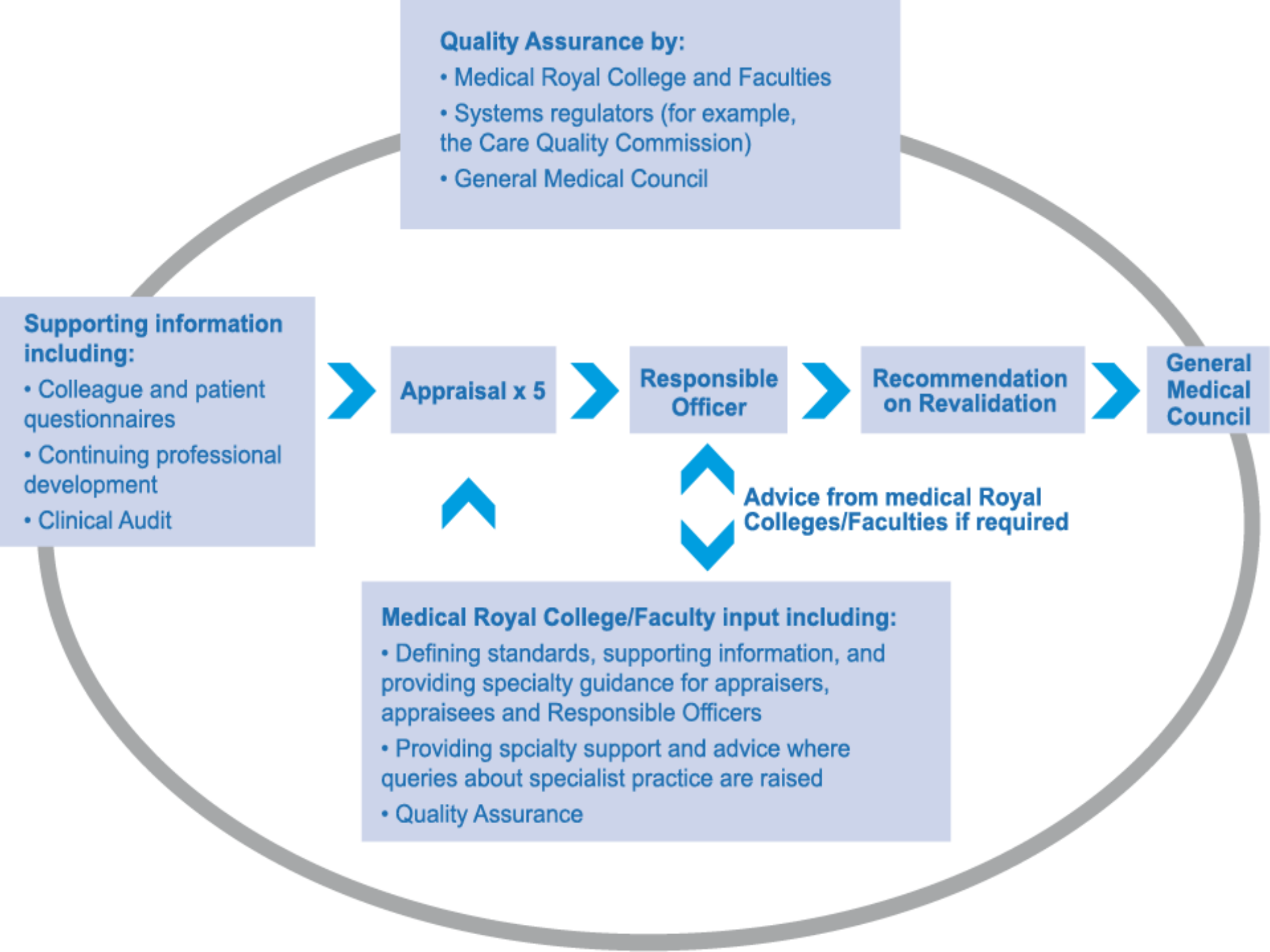
For most doctors working mainly in NHS settings and practising to reasonable standards, revalidation should be straightforward and build seamlessly on current systems for appraisal and supporting information.

(Reassuring for our hospital colleagues and jobbing GPs with only one role, but we still need to work on **whole practice appraisal** incorporating PPC).

For doctors in atypical roles and non NHS settings (e.g. Children's hospices) or with portfolio careers it will be more complex. Systems developing fast, but still unanswered questions about supporting information, whole practice appraisal, Responsible Officers, finance etc.

Good news: the answers we are now getting tend to be responsive, sensible and pragmatic, and we have some opportunity to shape systems according to our need and local networks.

Employers have responsibility for their doctors' revalidation, so work collaboratively to develop systems.


Quality Assurance by:
• Medical Royal College and Faculties
• Systems regulators (for example, the Care Quality Commission)
• General Medical Council
Supporting information including:
• Colleague and patient questionnaires
• Continuing professional development
• Clinical Audit
Appraisal x 5
Responsible Officer
Recommendation on Revalidation
General Medical Council
Advice from medical Royal Colleges/Faculties if required
Medical Royal College/Faculty input including:
• Defining standards, supporting information, and providing specialty guidance for appraisers, appraisees and Responsible Officers
• Providing spcialty support and advice where queries about specialist practice are raised
• Quality Assurance

Expected implementation timetable

2011-12:

- Additional year of testing, piloting and preparation

2012-13:

- Mid 2012: Secretary of State assessment of readiness
- Late 2012: 'Go live' decision
- End 2012/Early 2013: First RO recommendations [for the Designated Bodies which are ready]

2013-14:

- First full year

2014-15, 2015-16, etc:

- Rollout, phased implementation

Recent developments

1. **Supporting information guidance**:

   GMC (mandatory) April 2011; specialty-specific (draft, advisory) Aug-Oct 2011

2. **DB and RO clarity and guidance for hospices** (Nov/Dec 2011)

- ORSAs (since April)
- APPM / CHUK letter and APPM guidance (Sept 2011)
- APM / HTH guidance due Dec 2011

Supporting information (April 2011) – GMC statutory requirements

Framework: 12 attributes across 4 domains

1. Knowledge, skills and performance
2. Safety and Quality
3. Communication, partnership and teamwork
4. Maintaining trust (honesty and integrity, respect for patients, fair treatment of patients and colleagues etc)

Supporting information (April 2011) – GMC statutory requirements

- Demonstrate 12 attributes over 5 year cycle: not now specifically mapped.
- General information, keeping up to date, reviewing practice, feedback on practice

- 6 types of information, each discussed at least once in 5y (some specialties want more in their draft guidance e.g. SEA):

1. **CPD** (focus on evaluation and impact, developmental)
2. **Quality improvement activity** (In order: clinical audit, review of clinical outcomes, case review / discussion e.g. 2 per annum etc)
3. **SEA** (log participation in discussion, learning, actions)
4. **Patient feedback** where applicable or parent / carer feedback (administered independently of doctor and appraiser).
5. **Colleague feedback** (administered independently).

   NB Guidance for standards of both patient and colleague feedback questionnaires now on GMC website, but more info awaited.
6. **Review of complaints and compliments**.

Supporting Information: Specialty-specific

- **Advisory; still in draft (Oct 2011)**

http://www.aomrc.org.uk/news-a-publications/208-speciality-frameworks-and-speciality-guidance-.html

- **RCGP:**

- Patient and colleague feedback by end of year 2 (time to act on feedback and repeat if needed)
- *In addition* to 1 full personalised audit cycle per 5y. *10 SEAs / case reviews (2 per year) with individual doctor involvement or reflection*.

  NB GP SEA definition is broader / different : tends to be case reviews; hospital definition tends to be serious untoward incidents (SUIs), all of which should be reported by all doctors.
- Learning credits: (at least 50hrs per year with impact and *reflection* – for RCGP can count double hours if demonstrate 'impact')

Whole practice appraisal

- *NB RCGP states that 'GPs who work as a doctor outside standard clinical general practice should record all those activities and provide evidence that they are suitably trained and skilled to take on that work; that they keep up to date in that work; and that the quality of that work is appropriate'.*
- *Similar statement in RCP revalidation recommendations.*

- *See PPC curriculum http://www.act.org.uk/page.asp?section=169&sectionTitle=Curriculum+in+Paediatric+Palliative+Medicine)*

Supporting information – specialty-specific

Advisory; still in draft (Oct 2011)

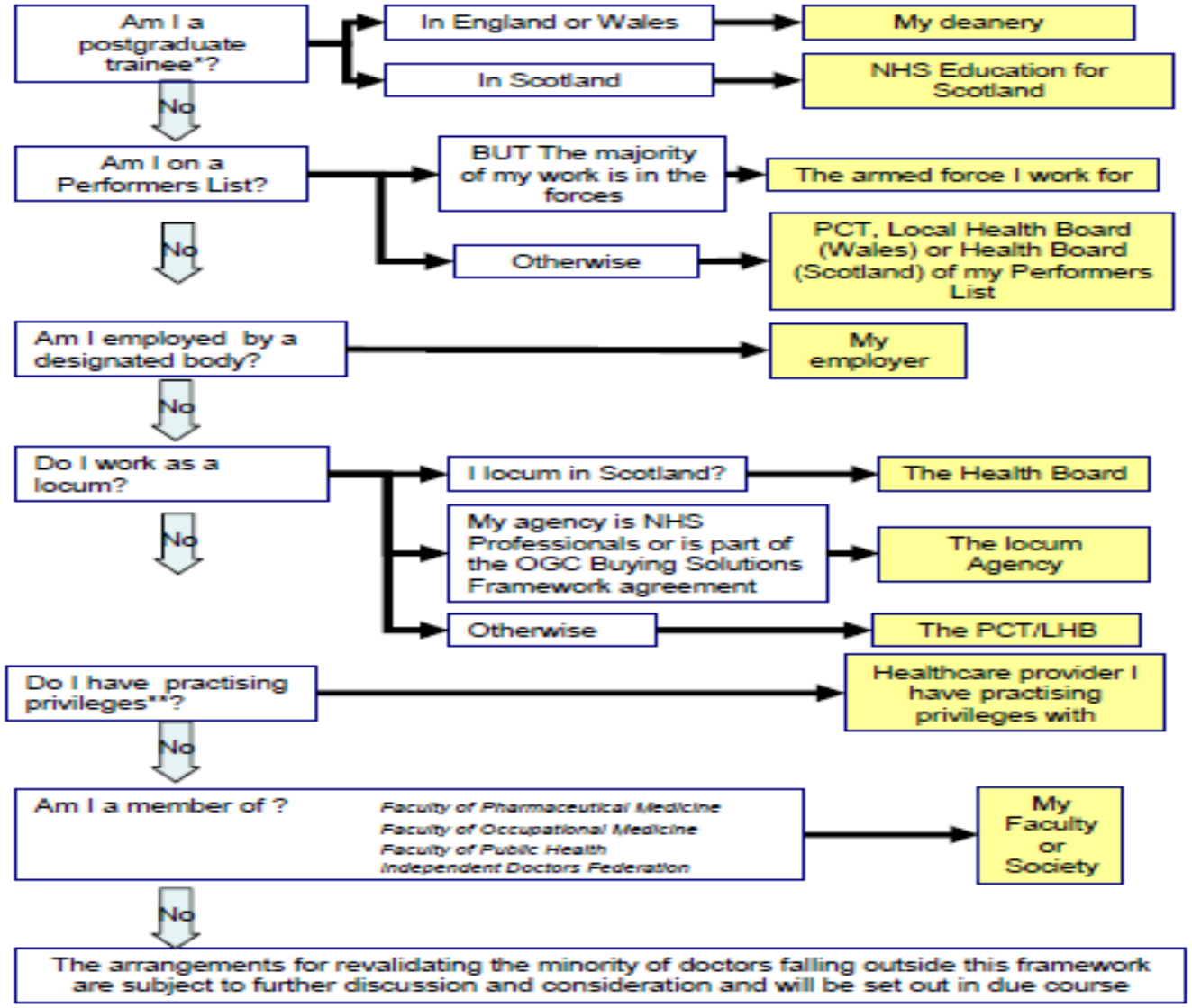
http://www.aomrc.org.uk/news-a-publications/208-speciality-frameworks-and-speciality-guidance-.html

- **RCPCH**
- No doubling of learning credits (cf RCGP)
- *Includes feedback on teaching and training*
- Includes link to a recommended patient /carer feedback tool on RCPCH website. http://www.rcpch.ac.uk/training-examinations-professional-development/revalidation/rcpch-approach/assessment-paediatric-con
- Mentions 2 per annum case review *if can't do* audit or clinical outcomes study.

- **RCP**
- Advice to also consult specialty-specific guidance
- *Include job plan*
- CPD (at least 50h per year) must include 25 h of external credits per year
- Developing forms /tools for most aspects, including colleague questionnaire
- Rehabilitation medicine has a patient feedback questionnaire for learning disability. 'Other methods may be suitable'.
- *10 case reviews alternative to audit* if full audit cycle not possible *(but some medical specialties require both – probably good practice anyhow)*

How to find your responsible officer

3.28 Figure 2 below shows how individual doctors can find out who their responsible officer is. It is intended as a guide to supplement the regulations (Regulation 10).



* The medical practitioner is a doctor in training who is a member of a foundation or specialty training programme managed by a postgraduate medical deanery

** "Practising privileges" means the grant, by a person managing a hospital, to a medical practitioner of permission to practise as a medical practitioner in that hospital

In essence:

- If you work *mainly* in NHS hospital – RO is NHS hospital Trust RO
- If you're on a GP performers list (even if small part of your work) - RO is PCT RO
- If not (e.g. Working solely for independent hospice), hospice needs to appoint an RO…

NB Our task to work collaboratively with employers to develop systems so that revalidation works as simply and usefully as possible.

Designated Bodies (DB) and Responsible Officers (RO) – New guidance for hospices (Nov 2011)

- If hospice employs doctors *directly*, unless all its doctors have a prescribed connection to a RO already, *it will need to complete an ORSA and appoint an RO for those doctors not already connected*.

- RO then needs to agree an appropriate appraisal system for those doctors.

- If hospice employs doctors *indirectly* (e.g. through SLA), position depends on wording of SLA

NB Honorary NHS contracts DON'T dictate the prescribed connection unless the doctor does as many hours with the NHS body as with the hospice. (But might help build links to appoint an NHS Trust RO).

Common questions for hospices and their doctors

Q. Does hospice need to be a **Designated Body** (DB) for revalidation purposes?

A It is a DB in law. It needs to act as a DB for revalidation if it employs doctors who don't have a prescribed NHS route to revalidation (see 'Who is my Responsible Officer' chart + further detail for hospices)

Q Do hospices need to complete **Organisational Readiness Self Assessment (ORSA)**?

A - **No,** if all their doctors have a prescribed NHS route to revalidation (but still useful exercise to inform development of processes).

- **Yes**, if the hospice employs any doctors who don't have an NHS route to revalidation (e.g. Where the doctor's only employed role is for the hospice. Might particularly affect hospice medical directors and hospices with a more developed medical team).

Questions for hospices 2.

Q **Who should we approach to act as Responsible officers (RO) for those who aren't covered by other NHS roles**?

(New guidance for hospices endorsed by Revalidation Support Team, Help the Hospices and Association for Palliative Medicine).

A - Recommendation to approach *local NHS Trust RO (hospital trust or PCT*) to ask them to take on this role rather than the hospice having its own RO for a small number of doctors.

- Alternative would be to *cluster across several regional hospices* for RO function but must be seen to be fair and objective and not 'cosy'. (New recommendations).

- *Costs* to hospice likely £500-£1000 per doctor per year, probably with appraisal. Consider formal agreement as to what is expected

- Need to clarify which areas hospice might delegate to or share with the external RO. (RST / APM will work on a template).

Questions for hospices 3.

Q. What about revalidation for hospice doctors (e.g. Some consultants / medical directors) not covered in NHS systems. Who will do their appraisal, who will pay for it and for their revalidation?

A. Not a problem once RO appointed. If RO is external. RO would agree appropriate appraisal system with the hospice, but hospice may need to pay e.g. £500-£1000 per doctor for RO service.

Q. How will small organisations ensure fairness and objectivity?

A. Use external RO, who may agree for internal or external appraisal. Pt / colleague feedback needs to be independent of appraiser and appraisee (see GMC guidance).

Common questions for all

Q How will we ensure 'whole practice' appraisal (ie ensuring good information flow so that our PPC work is represented effectively in our appraisal processes even if we have multiple roles and our revalidation appraisal isn't a PPC one)?

Important for all of us especially if PPC isn't our sole work.

A. - **May vary** across 5 year revalidation cycle. Need to either have a single appraisal that covers both generalist and specialist roles (if RO is happy for a PPC appraiser, and for this sometimes to be 'internal'), or have 2 appraisals (e.g. one within hospice feeding information into an external one as the 'revalidation' appraisal).

- Need to include **supporting information** from all roles in appraisal documentation.

- Need **balanced PDP** to include items from all areas of work.

- Need to **benchmark PPC element** against APPM curriculum

Common questions for all

Q How many appraisals could be with same appraiser over 5 years?

A. Local recommendations vary, so check: Some recommend 2 or 3 appraisals with same appraiser, some discourage it. *Continuity and depth versus collusion*.

Personally recommend some continuity, and balance of internal and external input over 5 year cycle, but depends on local setting, job mix, and what RO will agree to.

Questions still to be answered…

Q. Does my appraiser have to have specialist knowledge of paediatric palliative care?

A Watch this space. Under discussion: need to balance availability of appraisers and risk of collusion, with value of specialist knowledge especially in a small field. In our region appraisal is being seen as a generic skill.

So probably not, but appraisal needs to cover **whole practice** even if outside appraiser's field.

APPM recommends the ideal would be to have a specialist element if portfolio role. Need to optimise appraisal pattern for each doctor (with agreement from RO if hospice is a DB).

Q. What proxy patient feedback will be accepted for minors and non verbal patients, especially in palliative care?

A. Work ongoing. Await clarification and suggested tools.

Q. How will we work out agreements with a designated external RO?

A. Hospice needs to decide with RO who is responsible for what. We are working with RST, HTH and APM to offer a template agreement for DBs delegating this function for some of their doctors. ORSA helps think through this (Appendix has RO JD).

What hospices need to do now (1)

- Check whether all doctors employed by the hospice have a *prescribed connection to an RO* for revalidation.

- If any doctors don't have a clear route to revalidation and a Responsible Officer, hospice will need to be a '*Designated Body' for revalidation, appoint an RO and undertake ORSA exercise* (original document April 2011, interim update Sept 2011).

- *Consider ORSA* exercise anyhow to support your organisational readiness for revalidation for all your doctors.

- Check / update your *policies and procedures* for medical appraisal, education and training, monitoring of performance and investigation of performance issues.

What hospices need to do now (2)

- Ensure all doctors working for the hospice have a system for *annual peer appraisal reflecting whole practice*.
- Consider how to ensure the *PPC aspect* of their work is reviewed, appraised, and information fed into the revalidation process.
- Review the GMC list (and draft specialty requirements) re *supporting information*, and consider how this can be collected and made readily available for doctors.
- *Consult resources* (see list) for information and updates.

Questions for all doctors to address now:

1. Work out who your **Responsible Officer** will be for revalidation.
2. Agree with your RO what **appraisal model** may be most suitable for you to

   ensure whole practice appraisal if multiple roles.

   Trained appraiser(s). One or 2 appraisals? Internal and /or external? Could APPM help?
3. How will you collect relevant, personalised **supporting information** across all your professional roles during the year?

   How can hospital and hospice systems support you better? What new tools and systems are needed? (Note GMC statutory and draft specialty-specific guidance).
4. Where / how will you store **documentation**?

   On line Toolkits as per local practice, but off line folders as backup through transitions? Needs to be electronic with systems for RO and appraiser to access full 5 year cycle of documentation in due course.
5. **Collaborate with hospice (or hospital department)** to develop processes.

6. Keep watching GMC and RST websites (www.revalidationsupport.nhs.uk) for **updates** – Will also try to put any major changes on revalidation pages of APPM website: www.act.org.uk/appm

New Guidance – October -December 2011 (ie since APPM newsletter)

- **Draft specialty-specific guidance (RCGP, RCPCH, RCP), Oct 2011**
  http://www.aomrc.org.uk/news-a-publications/208-speciality-frameworks-and-speciality-guidance-.html

- **GMC Revalidation guidance for Independent Sector, October 2011 (page 13: What questions should I be asking?)**
  http://www.gmc-uk.org/Revalidation_guide_for_the_independent_sector__October_2011___Final_.pdf_45049240.pdf

- **APM and Help the Hospices joint guidance on revalidation due December 2011**

- NB: APPM revalidation page for updates www.act.org.uk/appm
- Paediatric palliative medicine curriculum http://www.act.org.uk/page.asp?section=169&sectionTitle=Curriculum+in+Paediatric+Palliative+Medicine

Further links and resources

Organisational readiness for revalidation self assessment tool and briefing note

http://www.revalidationsupport.nhs.uk/files/ORSA_2010-11_v1.0.pdf

http://www.revalidationsupport.nhs.uk/files/Briefing_for_DBs_on_ORSA_exercise_010211.pdf

Revalidation Support Team website:

http://www.revalidationsupport.nhs.uk/ and www.appraisalsupport.nhs.uk for more general information about revalidation and appraisal. The former hosts the draft 'Medical Appraisal Guide' at http://www.revalidationsupport.nhs.uk/medical_appraisal_guide/

and 'Responsible Officer newsletters' at : http://www.revalidationsupport.nhs.uk/RO_News.asp

RCGP Revalidation guide for GPs v 6 (Sept 2011)

http://www.rcgp.org.uk/revalidation/revalidation_guide.aspx

NB This may be revised once new specialty-specific guidance has been finalised

www.appraisals.clarity.co.uk/ for an Appraisal toolkit and electronic forms etc. This site includes a proforma 'Structured Reflective Template' (SRT) for each section in the supporting tools. (Note new website address from 21.5.11)

http://www.appraisalsupport.nhs.uk/news4.asp?item=08052007090123 - for structured reflective templates to personalise reflection on supporting information, useful for those without access to the Clarity site.

Other Links and Resources

Responsible Officer guidance (July 2010)

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_119418.pdf . Page 13 has table ' How do I find out who my responsible officer is?'

GMC: 'The Way Ahead: Preparing for the introduction of medical revalidation: a guide for NHS leaders in England' (July 2011). http://www.gmc-uk.org/Revalidation_guide_for_NHS_leaders__July_13_2011_.pdf_42622587.pdf

GMC: Good Medical Practice framework for appraisal and revalidation (revised April 2011)
http://www.gmc-uk.org/doctors/revalidation/revalidation_gmp_framework.asp

GMC: Supporting information for appraisal and revalidation (revised April 2011)
http://www.gmc-uk.org/doctors/revalidation/supporting_information.asp

GMC: Guidance on colleague and patient questionnaires (revised April 2011)
http://www.gmc-uk.org/doctors/revalidation/9575.asp

GMC: 'Good Medical Practice' guidance for doctors (2006)
http://www.gmc-uk.org/static/documents/content/GMP_0910.pdf

THANKYOU

More Questions?

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