To consider

Revalidation projects and pilots

Issue

1. Reviewing project and pilot activity across the UK.

Recommendations

2. The Board is invited to:

   a. Note the project reports at Annex A (paragraphs 8 to 27).

   b. Note current project and pilot activity across the UK outlined in Annex B (paragraphs 28 to 30).

   c. Agree that it should consider a more detailed paper on project and pilot strategy at its meeting in December 2009 (paragraphs 31 to 33).

Further information

3. Rhian Williams 020 7189 5359 rwilliams@gmc-uk.org
Background

4. The White Paper, *Trust, Assurance and Safety - Regulation of Healthcare Professionals in 21st Century* emphasised the need for careful implementation of revalidation, based on good evidence and piloting to ensure the processes which underpin revalidation are fit for purpose.

5. The CMO’s working group on medical revalidation noted in its report, *Medical Revalidation: Principles and Next Steps*, that there needed to be several approaches to piloting:
   
   a. test the concepts;
   
   b. evaluate the potential impact;
   
   c. describe the components and processes; and
   
   d. assess the state of readiness of the different sectors and localities.

6. The report also noted that some this work had already begun.

Discussion

7. This paper begins to pull together and monitor revalidation project and pilot activity across the UK. It provides the Board with summaries of the projects and pilots which have concluded and an overview of current activity. It also begins to discuss how future project and project work could be co-ordinated to optimise its value, both to the implementation of revalidation and also to the continued development of the revalidation model.

Reports from projects which have already concluded

8. In 2007 and 2008, the GMC embarked on a number of revalidation projects and pilots in collaboration with a number of organisations. The projects and pilots were diverse in terms of scale and the areas of the revalidation process they covered. The overarching aim of the projects was to gain a better understanding of how certain components of revalidation work in practice, to learn more about the challenges which particular groups of doctors may face and to help organisations start preparing for revalidation.

9. Three projects have now completed and final reports can be found at Annex A. The paragraphs below provide a summary of the reports.

Revalidation in General Practice in Wales

10. In 2007, the GMC and the School of Postgraduate Medical and Dental Education in Wales (Wales Deanery) embarked on a joint project to examine appraisal and clinical governance systems for GPs in Wales. The Wales Deanery delivers GP appraisal on behalf of the Welsh Assembly Government (WAG) to
around 2500 GPs in Wales. Given the strong links the Wales Deanery had developed with Local Health Boards (LHBs) since managing GP appraisal is was decided at a very early stage that we would work with LHBs looking at the systems and processes they had in place.

11. The project had two main objectives:
   a. to assess the readiness of GP appraisal and clinical governance systems in Wales to support revalidation.
   b. to develop an assessment tool to provide LHBs with feedback on the readiness of their systems.

12. In April 2008, during a period of high activity in the project WAG announced proposals for the restructure of the NHS in Wales. Despite this over half of the LHBs in Wales continued to participate in the project during what was a period of significant change, demonstrating their commitment to the project and more broadly to revalidation.

13. The findings from the project indicate that the appraisal process for GPs in Wales is likely to be fit for purpose within the timescales for readiness identified by the UKRPB. It already has many of the components which will be necessary to support the revalidation of individual doctors, including robust internal quality assurance processes. In addition, findings indicated that the LHBs had effective high-level clinical governance strategies in place and in some cases there were All-Wales clinical governance processes which provided a certain level of consistency. An area in which variation was identified was the way in which LHBs assured themselves of clinical governance at practice and individual GP level. Although, in some cases, LHBs demonstrated good practice in this area generally there was a lack of clarity around where the responsibility for clinical governance rested.

14. The self-assessment tool which was developed during the project can be found at Annex B of the report. The tool was developed in close collaboration with LHBs and comments were sought from other key interest groups in Wales. In general, LHBs thought the last iteration of the tool was user-friendly and they were able to identify easily what was required against each criterion.

15. There were a number of recommendations from the project, many of which will be taken forward by the Delivery Board in Wales and include building on the good practice identified, addressing areas for development and reviewing how the self-assessment tool could be used to assess the new NHS healthcare organisations in Wales. Learning from the project will also help to inform GMC policy development in areas such as quality assurance and also highlighted the importance of working in collaboration and consulting with organisations which will play a vital role in supporting revalidation.

Buckinghamshire PCT

16. The aim of this project was to understand in more detail the type, quantity and quality of supporting information brought to appraisal by GPs. In order to achieve this
the GMC, together with appraisers from Buckinghamshire PCT developed a questionnaire for appraisers to complete about information presented at the appraisal discussion.

17. The questionnaire was split into two sections; the first asked appraisers to provide quantitative feedback on the supporting information presented and how it satisfied Good Medical Practice (GMP) and a second section asked more qualitative questions around specific pieces of supporting information including CPD, multi-source feedback (MSF) and audit. The second section also asked appraisers whether they were able to make a judgement on whether the supporting information satisfied certain categories of GMP.

18. In total, 49 questionnaires were completed between February and April 2009 and analysed. On average 25 pieces of information were submitted at each appraisal; the least number submitted was one, and the most was 55. An average of 12 different types of supporting information was presented.

19. The project also concluded that appraisers could not always establish a definitive link between CPD and action plans.

20. There was a wide range of CPD and MSF tools being used with appraisers being able, on the whole, to make judgements about the information brought to appraisal. Several said their ability to make judgements was enhanced by the appraisal discussion.

21. These findings will help inform the GMC’s policy development in relation to supporting information requirements for doctors, MSF principles and criteria, and the role of CPD and audit in revalidation. It also helped to establish that appraisers are able to make judgements about supporting information brought to appraisal but that further guidance and support would provide the process with greater consistency. It also concluded that the judgement-making in appraisal will need to be tested further during future projects and pilots.

NHS Professionals (Doctors)

22. NHS Professionals provides flexible staff including doctors to Trusts across England. Since 2004, it has offered annual appraisal to locum doctors who work over 500 hours per annum. During this project locum doctors were invited to participate in an appraisal process with a trained appraiser and asked to provide feedback on their experience. Appraisers were also asked to provide feedback on the appraisal process through a series of questionnaires and a focus group.

23. The number of doctors eligible to participate in the project was 53. Of these, 17 volunteered and 7 eventually participated in a truncated appraisal process which concluded in May 2009. While the number of participants was low it serves to underline that locum doctors are a mobile and transient population with diverse career paths. In addition, those doctors who participated in the project found the appraisal experience enjoyable and beneficial to their professional development.
24. Areas in which nearly all doctors struggled to obtain information included CPD, audit and clinical governance data. In addition, although the number of exit reports completed by the host Trusts was higher than normal there were a number of Trusts which did not provide reports on placements.

25. In contrast it appeared that locum doctors were able to easily obtain feedback from colleagues, which on face-value seemed valid and reliable. Patient feedback was not a requirement, although the assumption was that this would be more difficult to secure.

26. While the project did highlight the challenges locum doctors face in obtaining information about their locum practice, it also reinforced the benefits of appraisal for this group of doctors and ultimately for their patients. As the mechanisms for relating to a Responsible Officer role are finalised it will become clearer how locum doctors across the UK will be able to plug into appropriate appraisal and clinical governance processes.

27. It will also become clearer whether for the vast majority of doctors over a five-year period locum work, this would only contribute to part of their clinical practice over that period or whether it would be their only form of practice.

**Recommendation:** The Board is invited to note the project reports at Annex A.

**Current project and pilot activity**

28. There are a number of other projects and pilots underway or in planning stage across the UK. The project matrix at Annex B gives an initial overview of those projects and pilots. In addition there are pieces of work taking place, which although not directly to revalidation, may result in important learning in relation to areas such as appraisal. The matrix will be updated regularly as information about different projects, pilots and studies emerges.

29. The matrix currently provides information about the following:

   a. Project/pilot title.
   b. Timeframe.
   c. Lead organisation(s).
   d. Country in which the project/pilot is taking place.
   e. Area or component of revalidation.
   f. The sector in which is taking place i.e. primary, secondary, tertiary or independent.

30. It will help the Board to keep track of which component parts of revalidation which have been tested and where learning has been captured.
**Recommendation:** The Board is invited to note the project and pilot matrix at Annex B.

*Looking ahead*

31. As we move towards implementing revalidation it will be important to ensure that future projects and pilots are, as far as possible, co-ordinated to ensure that learning is shared, opportunities for joint work are optimised, and all areas of revalidation which require testing are covered.

32. Developing an overarching strategy and underlying principles which build on programmes of work already underway, such as the Revalidation Support Team’s pathfinder pilots and others, will provide consistency and assurance to the Board.

33. This work will need be taken forward with the four Departments of Health and the Academy of medical Royal Colleges.

**Recommendation:** The Board is invited to agree to consider a further paper on project and pilot strategy at its meeting in December 2009.