

*Towards healthcare that is effective, personal  
and safe.*



Revalidation Support Team

# Revalidation Update

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## Purpose of 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*

# What will revalidation be like?

“based on robust local systems, that support high quality care in the organisations and practice settings where that care is delivered”

“appraisal and clinical governance will remain the key foundations of the process”

*GMC: Revalidation – a statement of intent October 2010*

# What will revalidation be like?

“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 October 2010*

# Revalidation Update

## Organisational Readiness

NHS restructuring

Responsible Officer Training

Data and Information

Pathfinder Pilots

Appraisers

What's next?

# GMC Layers of Professional Regulation

**Integrated governance and organisational responsibilities lie in these areas**

Personal regulation	Team-based regulation	Workplace regulation	National regulation
Collects folder of evidence	Provides 360-degree feedback	Operates a quality assured appraisal scheme	GMC generic principles ( <i>Good medical practice</i> )
Reflects on practice through participation in appraisal	Patient surveys	Operates effective clinical governance systems	GMC guidance on folder content
Submits completed revalidation submission	Action when a colleague's conduct, performance or health puts patients at risk	Provides local certification	College specialty related standards and evidence
		Prompt and effective action if actual or emerging impairment	GMC approves working environments
			Prompt and effective action to deal with impairment



# **Organisational Readiness Self Assessment Tool**

**End of Year Report for 2010-2011**

# Organisational Readiness Self Assessment

- Streamlined, simpler, end of year report
- Coordinated by SHAs
- 2 stage self-assessment
  - April/May 2011 - new baseline current state of readiness
  - April/May 2012 - inform formal assessment of readiness and inform organisation's progress
- Interim Reports – short reports, key metrics
  - October 2011
  - January 2012



# Organisational Readiness Self Assessment

## **Section 1: Details of Designated Body**

Numbers of doctors the RO has responsibility for

## **Section 2: Responsible Officer**

RO has been appointed

Appropriate RO training undertaken

Appropriate RO support available

Funding and resource is sufficient to undertake the role

# Organisational Readiness Self Assessment

## **Section 3: Appraisal system**

Numbers of doctors who have completed their appraisal

Audit of all missed or incomplete appraisals

Appraisal policy in place

Appraisers have been trained

Appraisers supported in the role and receive feedback on performance

Number of appraisers is sufficient

# Organisational Readiness Self Assessment

## **Section 4: Organisational governance**

Governance in place, subject to external review

Monitoring performance, fitness to practise of doctors

Key information available at appraisal

Information for new doctors obtained from previous organisations

Audit and patient/colleague feedback systems in place

Process for investigating concerns

Policy for rehabilitation, remediation and targeted support

RO monitors compliance with GMC conditions/undertakings

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# The impact of NHS structural changes

- SHAs remain statutory bodies until March 2012
- PCTs remain statutory bodies until March 2013

Statutory organisations will remain Designated Bodies until these dates even if they delegate responsibilities to a transitional or shadow organisation

Currently unclear but in the future:

- Possibly Commissioning Consortia or Clusters
- Possibly intermediate tier of National Commissioning Board

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# Introductory Responsible Officer Training

Not a full 'training programme'

Aims:

- To ensure all incoming ROs have sufficient knowledge of the scope and statutory responsibilities of the role
- To provide an understanding of the competencies and resources required to carry out the role in accordance with the regulations and guidance
- To ensure there is an established training programme for the future [including the training specification and materials and regional training expertise]

# Introductory Responsible Officer Training

- Coordinated through SHAs
- March to October 2011
- Centrally defined training specification/materials
- 1.5 days, 3 modules, local, flexible
- Free for ROs, other relevant staff can attend
- Ongoing support and development through regional RO Support networks



# Responsible Officer Competencies

- Communication
- Managing the process of medical revalidation, appraisal, quality assurance of appraisers, remediation, mediation, negotiation, investigation and rehabilitation, equality and diversity issues, dealing with colleagues about whom there is concern
- Knowledge of regulation and the law as it relates to medical revalidation and of the specific underpinning processes. Understanding of principles of natural justice and the legal process, accountability and governance

# Responsible Officer Competencies

- Maintaining the knowledge and skills needed for the role, consistency, rigour and accountability
- Strategic responsibilities of the RO, building and maintaining external relationships, accessing the organisation's resources
- Clinical governance, quality improvement and quality assurance of systems underpinning revalidation, information flows

## Module 1: Revalidation overview and the RO regulations and guidance

- General background to revalidation, legislation, proposed timetable, impact of NHS structural changes
- Range of the RO's responsibilities
- Prescribed connections
- Process for conflict of interest
- Support and resources available for the RO

## Module 2: Organisational governance, information and appraisal systems

- Accountability for performance, quality, fitness to practise
- Monitoring performance
- Information flows within and between organisations
- Appraisal system, appraisers training/support
- Ensuring the Designated Body is ready for revalidation

## Module 3: Responding to concerns about a doctors performance, conduct or health

- Fitness for purpose vs fitness to practise
- Thresholds for intervention : knowledge, skills, performance, conduct/behaviour and health
- Using resources, support and advice
- Good practice in performing investigations
- Good practice in support, rehabilitation and remediation
- Formal action plan agreements and behavioural contracts
- Ensuring compliance with GMC conditions and undertakings
- Equality and diversity issues

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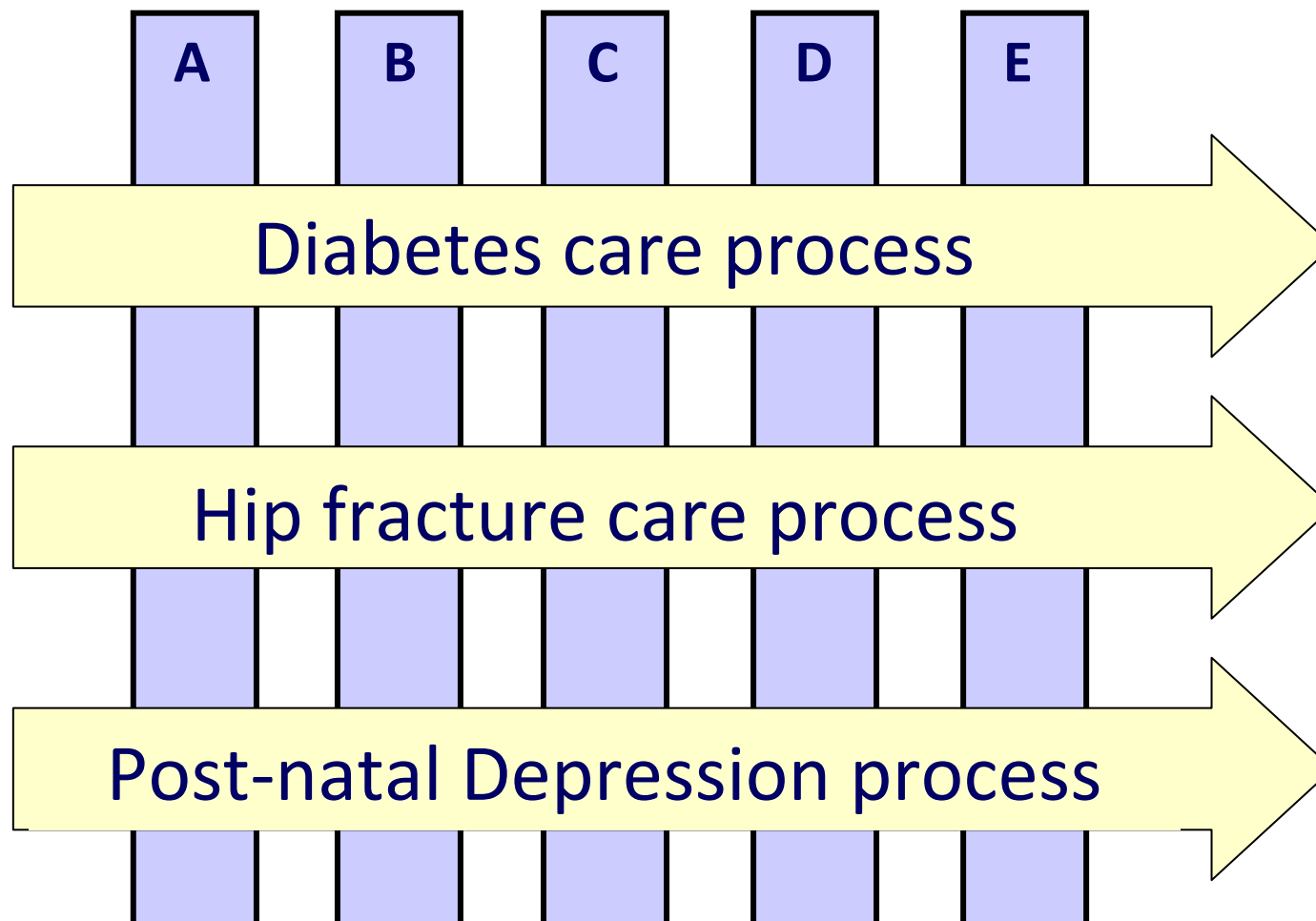
Appraisers

What's next?



*“Data rich  
but information  
Poor...”*

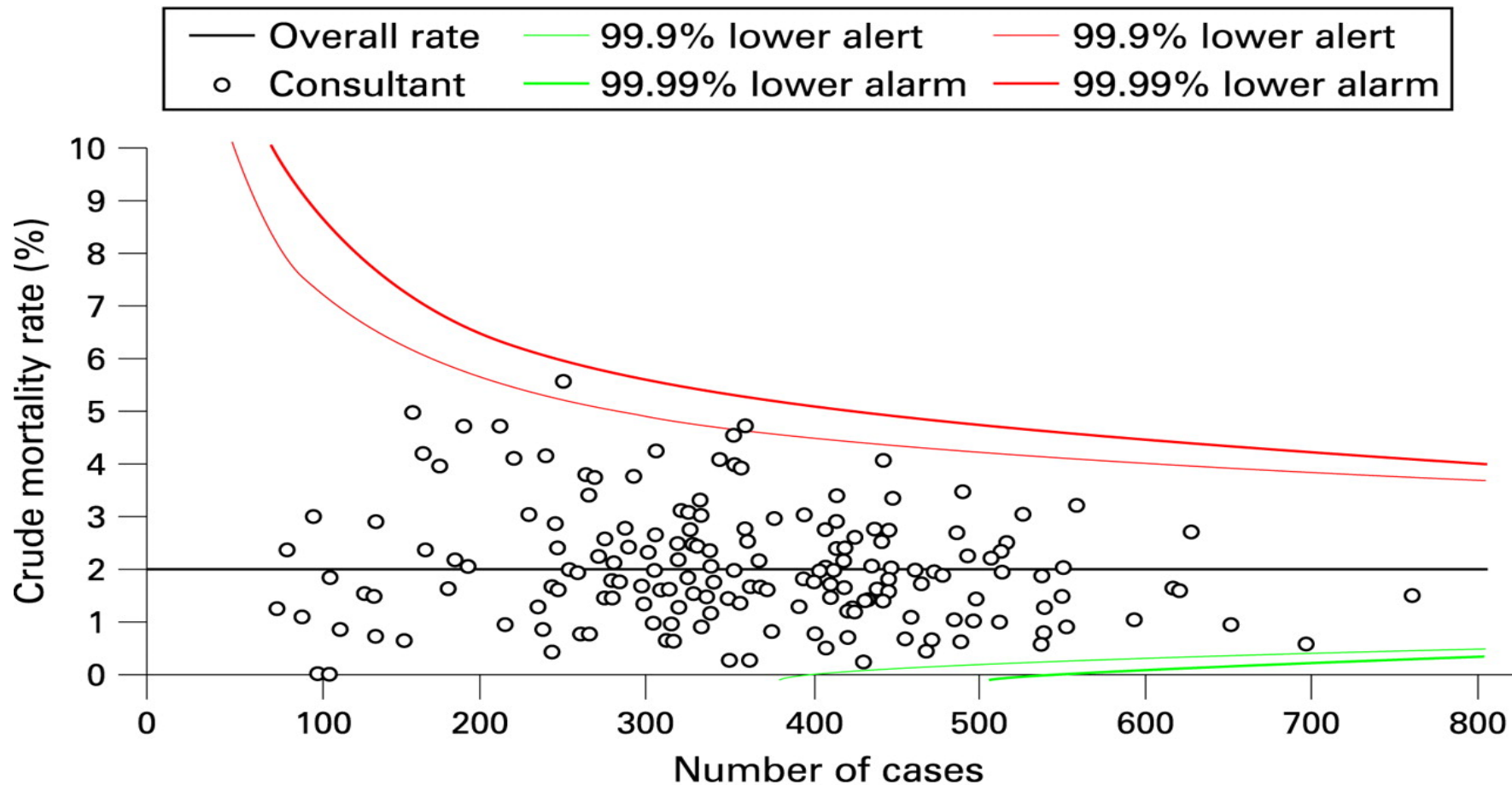
# Working in Teams



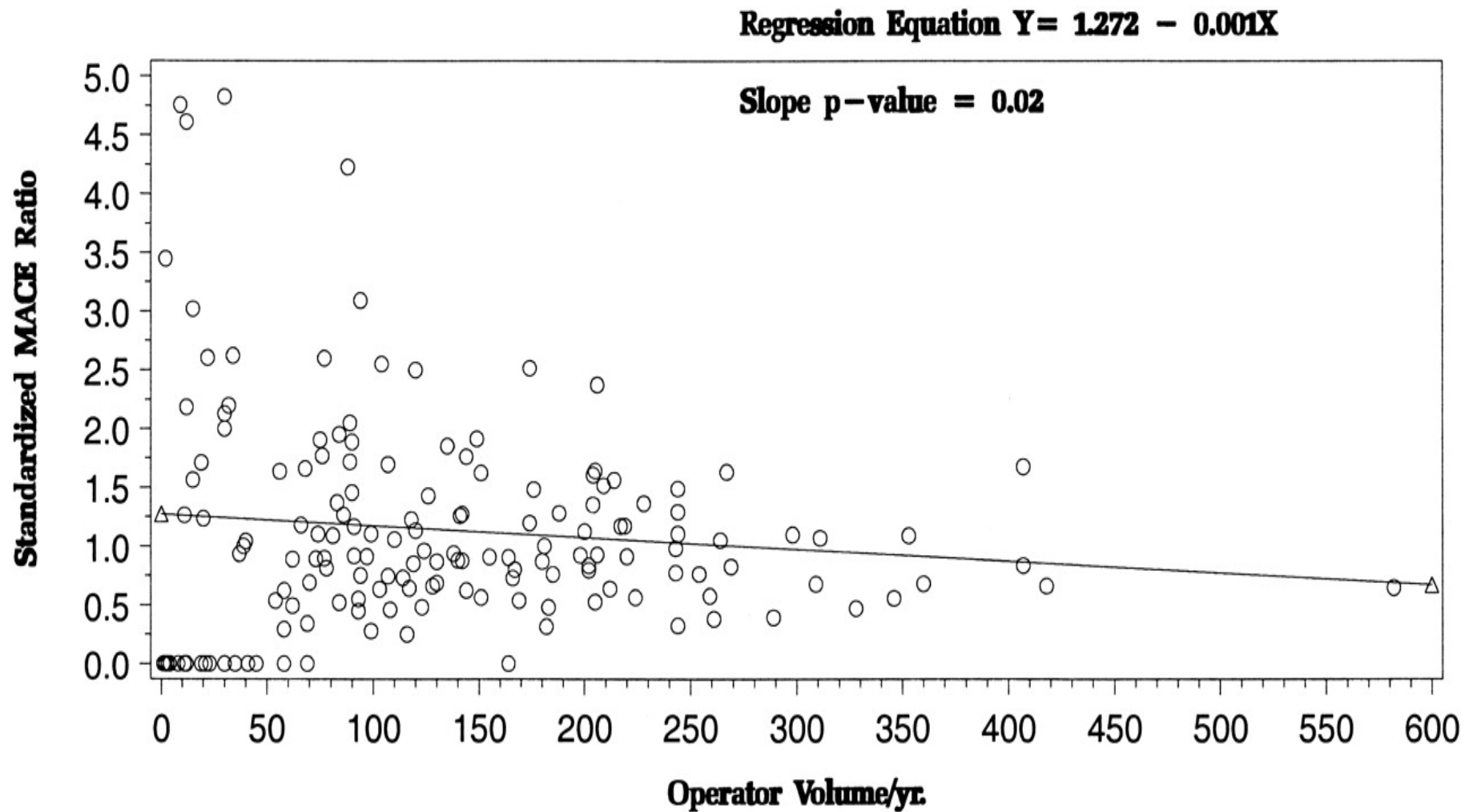


# Funnel plot of all UK cardiac surgeons observed mortality over a 3 year period

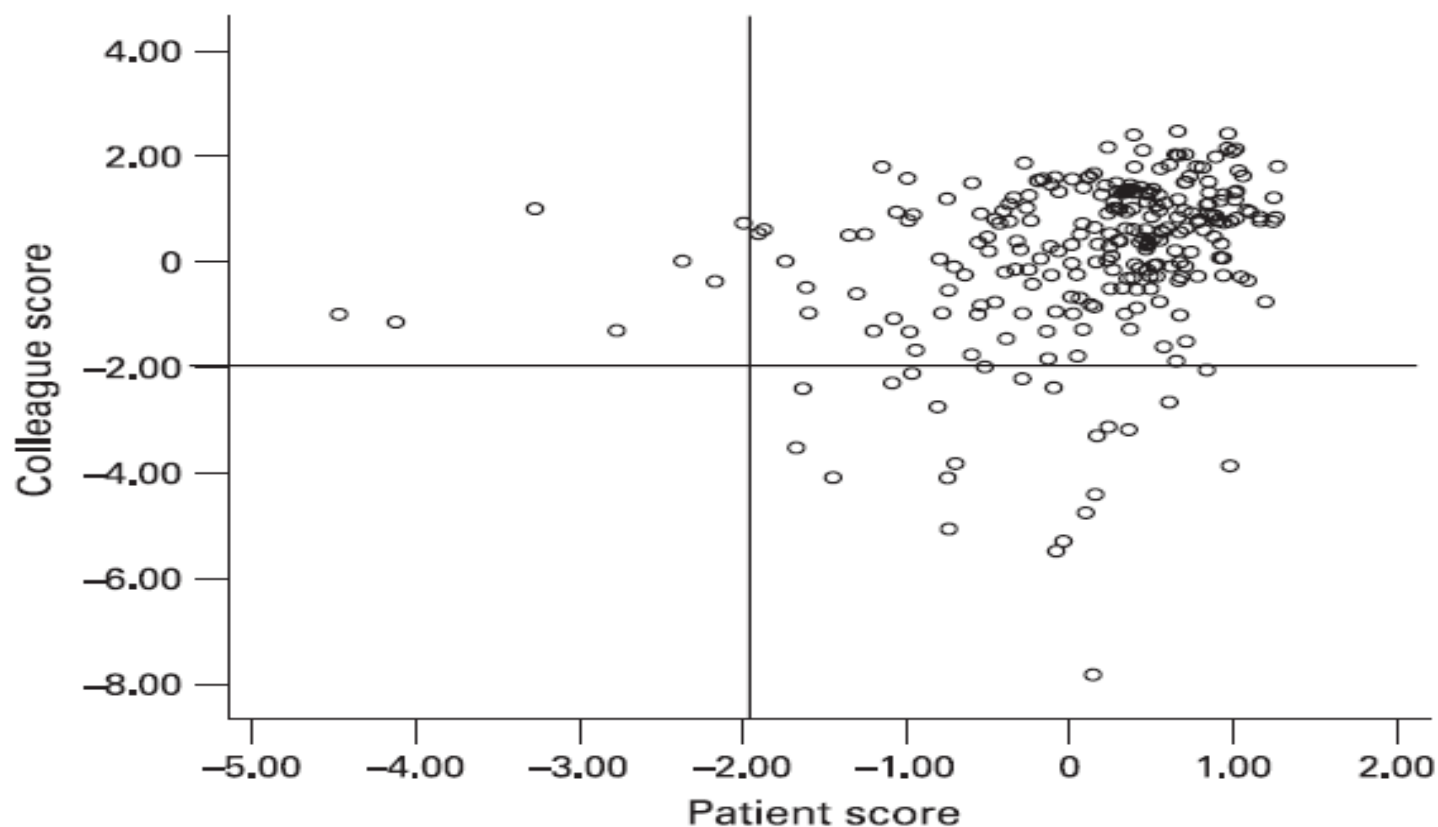
UKCSR: funnel plot 3 year isolated CABG data by consultant;  
financial years 2001–2003 (n = 64 488)



# PCI: volume of procedures v adverse outcomes

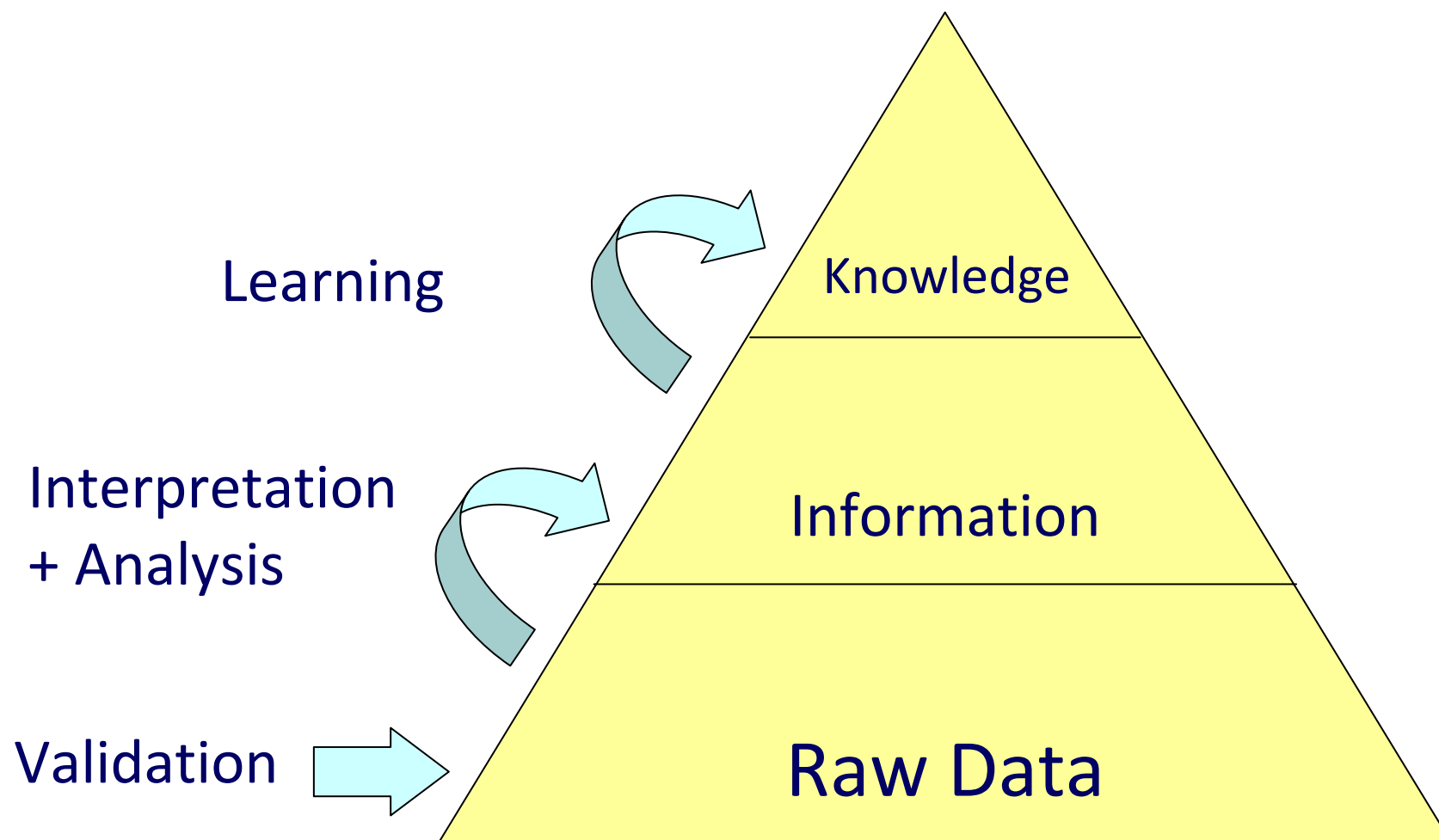


# Patient and Colleague Feedback Questionnaires



**Figure 2** Patient and colleague scores (standardised measures) for 252 doctors with  $\geq 22$  patient questionnaires and  $\geq 8$  colleague questionnaires. Internal reference lines added at  $z < -1.96$ .

# Using Data and Information



# Monitoring Clinical Performance and Quality

Ideally, data for appraisal revalidation is:

- **Accurate:** so it forms a firm foundation to build on
- **Independently produced:** so it is objective, not 'selected'
- **Verifiable:** so original material can be sourced
- **Relevant:** relates to the quality of the team/doctor's work
- **Collected using standard method and definitions:** so performance and quality can be benchmarked against comparators
- **Validated:** so has been through a review process – usually team or peer review
- **Related to the individual:** so the individual doctor's clinical performance is measured

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# Pathfinder Pilots

## Pathfinder Pilots cover:

- Possible components of a strengthened form of appraisal
- Collection of supporting information
- Organisational systems of appraisal and clinical governance
- Specialist and GP frameworks
- Training of appraisers
- Evaluation of portfolio of supporting information
- No evaluation of a specific model of MSF
- Appraisal discussion
- Responsible Officer role – training, competencies, support
- Information flows
- Impact, costs, benefits

## Interim Report Feb 2011

Appraisees in both primary and secondary care found the following most useful in terms of evaluating their own standards of practice and planning how to improve patient care:

- CPD
- Audits and informal data review
- Significant events / Case reviews

colleague and patient feedback tools were not considered by pilot participants under this section



## Interim Report Feb 2011

Some appraisees found the additional emphasis on reflection helpful.

The majority of the appraisers agreed that the appraisal discussion added value to the assessment process.

In the majority of cases, the appraisees' self-assessment agreed with the appraiser assessment.

# Interim Report Oct 2010

## Appraisees

- Smaller proportions of GP appraisees undertake management, research or teaching than consultants
- Most appraisees spend over 70% of their time working in their main area of clinical work
- CPD: acute care = 87.1 hours; primary care = 75.5 hours
- 67% appraisees spent 10 hours or less (average = 5.9 hours) collating information and preparing for appraisal last year

## Appraisal discussions

Pre appraisal prep	GP 2.5 hours	Consultants 1.6 hours
Appraisal meeting	GP 2.5 hours	Consultants 1.6 hours

# Interim Report Oct 2010

## Appraisers

84% received training for their appraisal role

37/232 appraisers not trained: [26 secondary; 7 MH; 0 primary]

64% primary care - additional training at least annually

58% acute care - no additional training

## Number of appraisees per appraiser

Secondary	average = 6 [0-8]
primary care	average = 12 [6-20]
MH	average = 4

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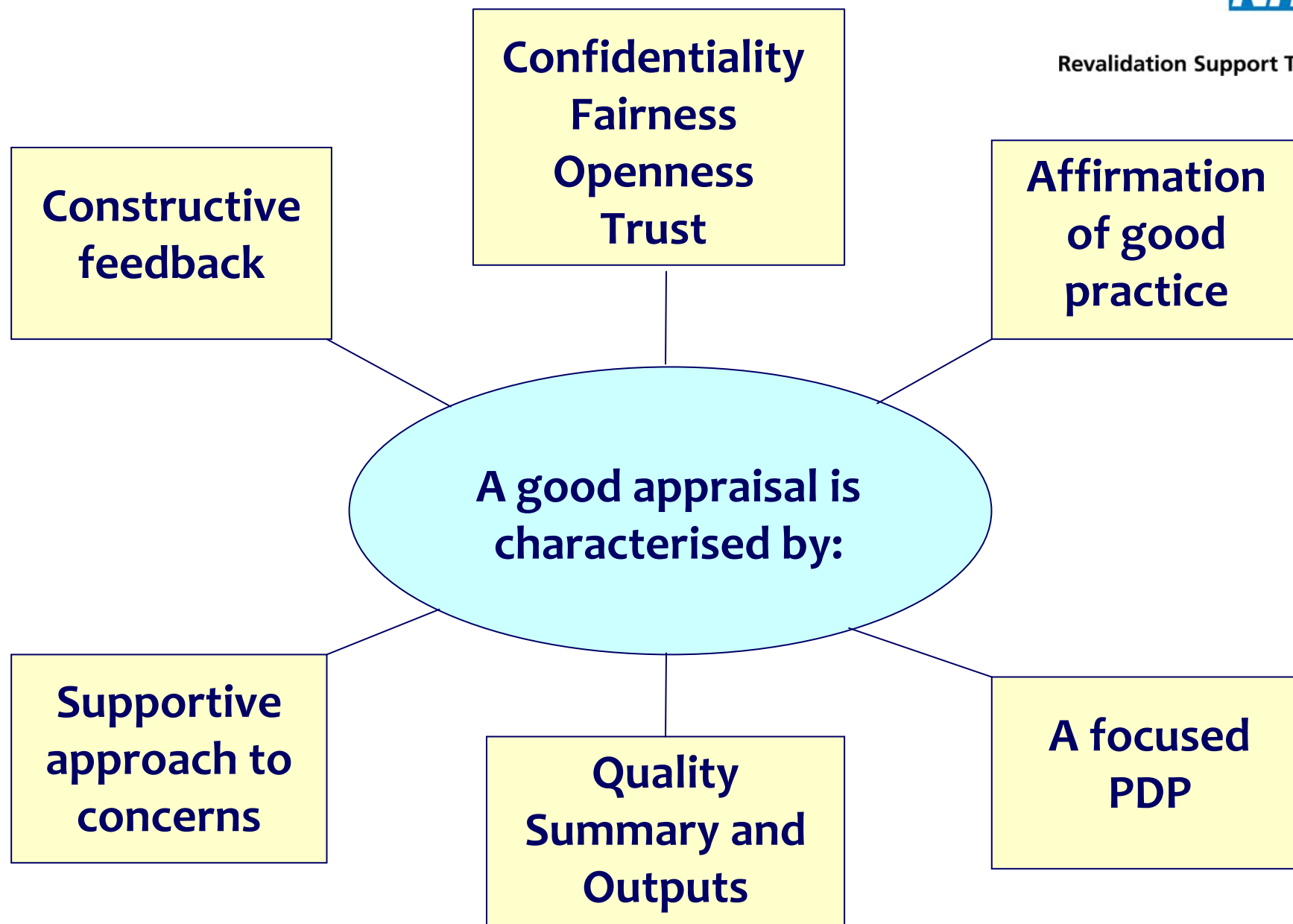
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# The Skilled Appraiser

- Recruitment and selection
  - Core elements of person specification and job description
- Skills, knowledge, behaviour
  - Core competencies
  - Training specification and materials
- Development and support
  - Ongoing support
- Feedback on performance in the role
  - Guidance and methods

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