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Dear Doctor

Re: Appraisal and revalidation update

I am writing to you at the end of the third full year of revalidation for doctors, and following the recent publication of the RCGP Guide to Supporting Information for Appraisal and Revalidation (March 2016).

The vast majority of GPs have now negotiated the revalidation processes, and had their licenses to practice renewed. The RCGP have changed their advice for a number of the areas of evidence GPs are required to submit. There have also been some changes in the GMCs rules relating to probity issues, and in particular to the issue of medical indemnity, and I will also cover those here.

I am taking this opportunity to write to all GPs on the performers list, to briefly outline the changes in evidence requirements for revalidation. This letter is not intended to be comprehensive, but rather to focus on some key points. The detailed guidance for revalidation of GPs is attached as a separate document for reference. I apologise that this letter is necessarily quite long.

I will cover three main areas:

1. The process.
2. Evidence requirements.
    a. Changes
    b. Summary of requirements
3. How much clinical work is required.

I am aware that some doctors with portfolio careers may have specific questions which I do not cover here, I am happy to be contacted to discuss these.

The Process:

As the Responsible Officer (RO) I am required to make recommendations to the GMC as to whether I believe a doctor to have fulfilled the requirements for revalidation. It is the responsibility of individual doctors to ensure they have submitted appropriate evidence, but my team will endeavor to notify doctors of omissions prior to the date of revalidation.

There are 4 possible recommendations:

Positive – I believe a doctor has provided evidence of meeting the requirements for revalidation.

Deferral: because a doctor has not yet provided sufficient evidence. This is a neutral act, and has no bearing on a doctors standing with the GMC.

Deferral: because of an ongoing process. If a doctor is under investigation by the GMC, or NHS England, then revalidation is automatically deferred.

Non engagement – This is rare, and reflects a situation where a doctor is not actively participating in the appraisal and revalidation process. The GMC become involved in these cases immediately, and usually start the process to remove a doctor's license to practice.

In normal circumstances a doctor becomes 'live' on the GMC revalidation system 4 months prior to the revalidation date. At this point we extract the necessary evidence from the accepted appraisal toolkits, and where possible notify doctors of any omissions. The intention therefore is to give doctors a window of around 3 months to provide any missing evidence. If the evidence is sufficient for a positive recommendation, this will be made at this stage; if it isn't I will review it again in the 4 weeks prior to the revalidation date.

It is expected that the evidence to support revalidation will usually be presented at annual appraisals over the course of the revalidation cycle.

Once my recommendation is sent to the GMC, they will usually accept it, and notify the doctor within a few days. The GMC are able to decline my recommendation, but have only done so extremely rarely.

If a doctor has not yet provided sufficient evidence, and I therefore make a deferral recommendation this would usually be for a period of 6 months. Any doctor for whom I recommend a deferral, will receive a letter outlining the reasons and the specific additional evidence which is required. I am always happy to discuss the reasons further, but it is important to be aware there is no appeal process if you disagree with the recommendation.

If a doctor is deferred once, the GMC treat this as a neutral act, and take no specific action. If a doctor is deferred a second time, the GMC take a more active interest and so it is important that any missing evidence is provided and is of a sufficient standard to fully meet the requirements.

<u>Evidence Requirements</u>:

The most significant changes in the RCGP guidance are:

- The removal of 'impact' from CPD, and a strengthened focus on reflection.
- Increased requirements for patient feedback
- Changed requirements for quality improvement
- Changes to probity declarations
- Changes to significant event and complaint reporting.

The detailed requirements are in the attached document. It is important to be aware that the requirements do not differ by work setting. So, for example, the CPD requirements for a part time doctor are the same (50 credits / points per year) as for a full time doctor, and the requirements for a locum are identical to those for a partner or a salaried GP.

I will provide a brief outline of the main requirements, and highlight changes made recently to the RCGP guidelines.

Satisfactory appraisal:

The appraisal must cover the whole of a doctors practice, must demonstrate sufficient CPD points (50/year), and an agreed PDP. There is no longer the option to claim additional CPD points for 'impact'

If a doctor has a portfolio career, the evidence must be provided of satisfactory performance in his / her other roles. The RCGP state that the outputs from any performance review/'appraisal' should be included the appraisal portfolio.

It must also demonstrate that a doctor is doing sufficient work to remain competent and up to date. I will touch on this specific issue later in this letter.

Under the national policy, each GP is allocated an appraisal month. It is important to be aware that unless a postponement is granted due to exceptional circumstances your appraisal must be completed by the end of this month, and signed off within 28 days.

Feedback

The feedback requirements have increased. Previously doctors had to complete formal patient and colleague feedback once in every 5 year cycle.

This requirement remains:

At least once in every revalidation cycle doctors are required to collect both patient (PSQ) and colleague (MSF) feedback. The RCGP no longer recommend specific tools, but have previously confirmed that the following are suitable:

- Sheffield Peer Review Assessment Tool Version 2 (GP-SPRAT)
- Colleague Feedback Evaluation Tool Version 2 (CFET)
- General Medical Council Questionnaire
- Edgecumbe 360° Colleague Feedback
- 2Q MSF

For each of these tools there is a set requirement for the number of completed returns. It is also a requirement that the scores are benchmarked so a doctor can reflect on their feedback compared to other doctors. For the GMC feedback tools benchmark scores are published, the commercial providers of feedback tools will also carry out benchmarking.

Although you could choose to use a different toolkit:

- it MUST be based on the specific domains addressed in current GMC guidance
- It MUST include benchmarked scores against a national cohort of GPs

- It MUST be specific to an individual doctor, not a practice (this specifically means that the GPAQ survey is not suitable)

A key part of the process is the doctor's reflections on feedback.
Low scores are not a specific bar to revalidation; clearly some doctors must be scored below average. However, if feedback scores are low, I would expect to see evidence that the doctor had reflected upon this, and usually adapted their PDP accordingly. It may also be appropriate in such cases for doctors to consider repeating the feedback within the next year.

For the avoidance of doubt, a set of consistently low feedback scores, without evidence of reflection and understanding, will lead to a recommendation for deferral. On the other hand, a low feedback score, with evidence of reflection, and a plan to address any areas of concern is likely to lead to a positive recommendation.

The RCGP now strongly recommend that the feedback tools are completed in the first 3 years of the revalidation cycle. This is because if significant changes are required as a consequence of feedback, then the survey is likely to need repeating prior to revalidation.

In addition there is a new requirement:

There is a new RCGP requirement to include patient feedback, and a doctor's reflection upon it, in every annual appraisal. This feedback could be from a range of sources and could include:

- Annual practice surveys
- Locally conducted or service specific patient questionnaires (so for example surveys from minor surgery or family planning clinics)
- Compliments received from patients
- NHS choices responses
- PPG feedback

<u>Quality Improvement Activities (QIAs)</u>

The RCGP previously required:

- a 'Quality Improvement Project' during the revalidation cycle, which usually took the form of a completed audit cycle demonstrating improvement.
- At least 2 significant event analyses every year

Although some doctors found these requirements restrictive, they were very clear, and it was easy to tell if the requirements were met.

These requirements have now changed:

- Doctors must provide evidence of representative quality improvement activities in every appraisal. These activities should reflect and demonstrate how you review and improve the quality of your practice every year
- This can take many forms – including large scale national audit, formal audit, review of outcome data, PDSA cycles, significant event analyses (SEAs) and reflective case reviews.
- No fixed number of QIAs is specified; but it must cover the whole scope of your work over the 5 year cycle, and must clearly demonstrate how you review and improve the quality of your practice every year

Although the 'new' guidance is on the face of it more flexible, it does make it much harder for me to set out a 'clear line in the sand' of what meets the requirements. I will be discussing how we best keep track of this with the appraisers, and will send a further update once we have considered this.

Significant Events

The specific requirement that at least 2 significant events or individual case reviews are considered in each year's appraisal has been removed.

The revised requirement is that you report all 'GMC level' significant events in which you were personally named or involved. You should include your reflections on the incidents, and actions agreed as a result.

You must also include all complaints in which you are personally named or involved

There will also be 'lower level' significant events which most practices discuss, but which do not meet the GMC definition. You can include these as QIA evidence.

Probity Declarations

We all currently sign a declaration stating that we are compliant with the requirements on probity set out in Good Medical Practice.

There has been a specific change to the GMC's License to Practice regulations, which specifically require doctors to have appropriate and adequate indemnity cover for the work you are doing. Clearly the level of cover which is appropriate and adequate will vary by medical specialty. NHS England will soon be writing to all GPs, setting out the levels of cover believed to be adequate for General Practitioners.

These levels are likely to be:

- £10 million of cover (this is based on advice from Defence Organisations about the size of actual claims)
- No exclusions of particular clinical conditions. (for example – a small number of GPs have policies which exclude meningitis)

In signing your probity declaration, you will specifically be confirming that you meet these requirements for indemnity.

Mandatory training

Inclusion in the Performers List requires that GPs have up to date level 3 child protection training.
Adult safeguarding and CPR training are not an absolute requirement of the Performers List regulations, but are considered to be required by the CQC.

Therefore you should provide evidence of up to date training in your appraisal.

How much clinical work is required?

This issue has been the cause of much debate, both in terms of revalidation and performers list regulations, I will briefly outline the situation for both:

Revalidation: The RCGP publish the specific requirements for the revalidation of GPs. These requirements change at regular intervals; with the most recent version published last month.

In versions 1-7 the RCGP set a specific minimum amount of clinical work to be able to revalidate – at various points in time the minimum was set at 50 sessions per year, 40 sessions per year, or 200 sessions over 5 years. This specific requirement has been removed; instead the guidance makes clear that the responsible officer should consider whether a doctor is doing sufficient clinical work to remain competent and up to date in all aspects of his or her work. I am aware of further discussions and a debate over whether a fixed 'target' will be re-introduced at some stage.

In my view it is helpful for individual doctors to have a specific understanding of the basis on which I am likely to make my recommendations. It is also my view that this should be set to ensure that it will meet any likely minimum set by changes to the RCGP guidance.

Therefore:

- In normal circumstances, my expectation is that doctors will be able to provide evidence of carrying out at least 50 clinical sessions as a GP each year. As a matter of routine I would consider this sufficient to allow me to make a positive revalidation recommendation.
- There will always be some specific circumstances (maternity leave, illness, sabbaticals career breaks etc) which will lead to a doctor not meeting this requirement in an individual year.
- As a matter of routine, for doctors without such circumstances, it is unlikely that I would make positive recommendations for doctors doing less clinical work than this.
- My advice to appraisers is that in normal circumstances an appraisal demonstrating less clinical work than this will be deemed as unsatisfactory.
- When doctors intend to be absent from NHS clinical work for a prolonged period (for example to work overseas, or take a career break) the GMC can advise whether the doctor should relinquish their license to practice in the UK (and re-apply on their return) or to seek to maintain their license. If doctors are planning long absences, I would recommend early contact with the GMC. I am also happy to discuss specific circumstances with individual doctors.

Performers List: The amount of clinical work a doctor is doing can also have implications for his/her continued inclusion on the Performers List. Although this is not directly linked to revalidation I think it is helpful to comment on it here.

- A doctor who does no NHS General Practice for a period of 1 year would usually be automatically removed from the Performers List. There are of course some exceptions to this. Being removed on this basis, of course, does not prevent the doctor from re-applying for Performers List inclusion when he/she wishes to return to clinical practice.
- A doctor who does very limited amounts of clinical work might be removed from the Performers list (or might have conditions applied to their inclusion) under the regulations pertaining to efficiency. Again, this would not preclude re-applying in the future.

Summary

I have tried to set out, as simply as possible, the specific requirements for revalidation, and particularly how these have been changed by the latest changes to the RCGP guidance. Some of the changes do, unfortunately, make things slightly less clear than was the case previously.

I hope this letter has been useful, and addresses any queries you might have. My intention is to provide clarity, to give local GPs every opportunity of providing the evidence which will allow me to make positive recommendations to the GMC.

If you have a specific query which I have not addressed, then feel free to contact the team at ssat.appraisal@nhs.net (for Shropshire and Staffordshire GPs) or england.revalidation-support@nhs.net (for Derbyshire and Nottinghamshire GPs) and we will try and provide a clear response.

Yours sincerely

Dr Ken Deacon (Medical Director)