

# Lay involvement in revalidation

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# Lay involvement in revalidation activities

Sol Mead

Lay representative

Academy Revalidation Committee

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# LAY INVOLVEMENT IN REVALIDATION

## 1. Introduction

This document sets out how lay representatives are now involved in revalidation processes at national, regional and local level and includes information on the roles being undertaken by lay representatives and how they are being recruited, trained and briefed.

The information contained in this report is based on data provided by Health Professionals working in the within the revalidation system, lay representatives and representatives from different health organisations.

The report also references 'Taking Revalidation Forward' [Taking Revalidation Forward Report](#) and the General Medical Council Action Plan [Action Plan](#) where there is strong support and commitment for promoting and encouraging lay involvement in revalidation in designated bodies.

## 2. A history of lay involvement in revalidation

Lay involvement in revalidation began in the design and development stages when the Royal Colleges and the Academy involved lay representatives in the work of their revalidation Committees. At the same time the General Medical Council began consulting with patient organisations and individuals in an *ad hoc* manner as they developed their supporting information guidance. In July 2012, patient organisations, across the UK agreed a statement with the GMC supporting the introduction of revalidation.

This lay involvement in Colleges and the Academy continued in the implementation stages with lay representatives joining the Department of Health's Revalidation Support Team's (RST) Programme of Work Advisory Group. At a regional level, South Central Strategic Health Authority was one of the RST pilot sites testing out the new appraisal format. As part of the testing exercise a steering group was created, which included two lay representatives so plans were discussed by a broader group with lay involvement.

In March 2013 the GMC created the Revalidation Implementation Advisory Board with Lay representation, which later became the Revalidation Advisory Board in March 2015. The Board was replaced by the Revalidation Oversight Group (ROG) in March 2017. This group were given the task of overseeing the implementation of the recommendations from Sir Keith Pearson's report, Taking Revalidation Forward (TRF) including the section of the report on lay involvement.

### 3. Sir Keith Pearson's view on lay involvement in revalidation and the GMC response

The 2017 report set out in clear terms how public confidence in the revalidation process can be increased. Sir Keith Pearson said, *'I am aware that many organisations already provide opportunities for patients and lay Representatives\* to contribute to local regulatory processes. For example, the Southern region of NHS England has six appointed lay representatives who are involved in the appointment of appraisers and in visits to service providers to quality assure local revalidation processes. Both Scotland and Wales include lay representatives in their revalidation review arrangements. This is to be encouraged. Such representatives provide a degree of independent scrutiny and challenge of the revalidation process.'*

*'I would like to see all healthcare organisations set out more clearly and publicly their local assurance arrangements, including the role played by appraisal and revalidation. I would also like to see local patient representatives invited to review periodically how those arrangements are working in practice, thereby gaining confidence on behalf of the wider public that local governance is robust. This will provide external validation of the revalidation process. Local patient representative groups will need support and guidance from both national patient organisations and local healthcare providers in order to fulfil this role effectively.'*

In response to the TRF report the GMC published on 20 July 2017 an [Action Plan](#) with 6 workstreams to be implemented in stages through 2018. Workstream One of the plan covers patient and lay involvement and has its objective, 'to increase patient/public awareness of, and involvement in, revalidation'. This would be on the basis that they would share examples of patient involvement in local revalidation processes by, *'working with healthcare organisations, patient representatives and other interested parties, we will collect examples of patient and public involvement in local revalidation processes. We will publish case studies on our website to help healthcare organisations assess what models might work best for them'*.

*Target date: March 2018*

The Action Plan also includes commitments from Stakeholders. These included:

- **NHS England will:**
  - Continue to include a session in patient and public involvement, facilitated by lay members, in its responsible officer training
  - Undertake a joint pilot project with Healthwatch to improve patient and public involvement
- **The Welsh Government will:**
  - Work with Community Health Councils, Health Boards and the Wales Deanery's Revalidation Support Unit (RSU) to make information about the processes of revalidation and clinical assurance available in GP surgeries and hospitals
- **Lay representatives on ROG will:**
  - Provide examples and assist the GMC in developing a mechanism which will allow the sharing of ideas and existing practice around patient and public involvement in local revalidation processes
- **NHS Improvement will:**
  - Promote good practice for patient and public involvement in revalidation to trust boards.

This work will take place alongside a series of wide ranging activities both from the GMC and other stakeholders to build strong patient and public awareness of revalidation. The impact of increasing the wider awareness of revalidation has the potential to lead to an increase in the pool of individuals who would want to contribute to the revalidation system by becoming involved in different revalidation activities at different levels within the system.

\* Lay representatives are drawn from the non-medical community but do not represent any specific patient group

## 4. Developing lay involvement in revalidation

### 4.1 The role of lay representatives

In 2014 a checklist was published by NHS England that set out the type of roles that lay reps could play. It can be viewed [here](#).

This list is still relevant today in that it highlights the opportunities for lay reps to be involved in

- Appraisal processes
- Governance roles
- Responding to concerns activities
- General revalidation activities

In addition to the above document there is another useful and more recent NHS England document entitled 'Lay Partner for Medical Revalidation - Role description template' a copy which is attached as Appendix C. The document provides important information on

- The role of the lay partner
- Responsibilities of the lay partner
- The required skills of lay partners
- A person specification
- The support for lay partners
- Payment for the role
- The need for confidentiality
- What lay partners will expect gain from being involved

Also attached is Appendix D, is a copy of the role description, used by East Sussex Healthcare

It is important to note that the lay revalidation role is different from other patient representative roles which are either linked to a specific medical condition where the expertise of the patient rep is essential in contributing to the work of doctors who are treating patients with that specific

condition, or in a wider '*patient experience*' role covering the general day-to-day functions within a health organisation.

The role of lay representative involved in revalidation is to provide an 'independent voice' within a regulatory system covering the employment of doctors. This involves contributing to governance issues and quality assurance processes that ensure revalidation is working effectively in terms of providing that assurance to patients and the public that all licensed doctors are up to date and working in accordance with the GMC's Good Medical Practice Guidance requirements.

#### 4.2 The recruitment of lay representatives

The information gathered from the organisations listed in Appendix A show that different formal and informal recruitment methods are used when recruiting lay representatives. These include:

- Advertising in the hospital newspaper
- Recruiting from the existing local pool of lay representatives
- Recruited Non-Executive directors or ex-Primary Care Trust lay members
- Recruiting lay governors
- Recruiting through personal knowledge of individuals and contacts
- Contacting local patient groups
- Organising a public focus group
- General public recruitment advertisements.

An excellent example of recruiting lay representatives to become involved in revalidation is at Gloucestershire Hospitals where they developed a comprehensive recruitment strategy stimulated by involvement in the Leading Together Programme. To demonstrate how they developed their recruitment strategy they produced a poster (copy attached as Appendix E) which mapped out all the outcomes and activities they undertook.

The top two boxes of the poster are brief explanation about revalidation. The two boxes below explain (to the left) the aim of the project and (to the right) the different audiences they sought the views from. The next set of boxes (to the left) sets out the outcomes as a result of the survey and the forum meetings and the box (to the right) the reflections and the actions to be taken as result of they had learnt from their research. The boxes under 'What We Found' provide more detailed information on the views expressed in the surveys and in meetings

Decisions were then taken on where to advertise for lay reps and it was decided that, in the first instance, to seek people from within the Foundation Trust membership who had already expressed an interest in being actively involved in something in the Trust. This led to interested people being invited to a focus group to explore the issue which included having to complete an application form to attend.

Flowing from these activities a lay representative role description and specifications were generated based on information from the initial recruitment package for lay reps to the Leading Together Programme, but also information from the Royal College of Anaesthetists and Royal College of Surgeons' websites, where they have recruited lay advisors to various roles. This was followed by formal interviews and an appointment on a job share basis

The management of the project was led by members of the revalidation team with excellent support by the Gloucestershire Hospital Patient Experience Team who were invaluable in providing advice and support on how to approach recruitment.

### 4.3 Training lay of representatives

As with the recruitment of lay representatives there are different training and briefing methods currently being used, both formal and informal. Good advice on training lay representatives is set out in a document entitled 'Medical Revalidation - A training guide for lay representatives' (which is attached as Appendix F) The guide, which covers all aspects of revalidation, has been produced by Stephen Barasi who is a lay representative involved in revalidation both in England and Wales, the GMC and the Academy of Medical Royal Colleges.

Other forms of training have included the Leading Together Programme in 2016 which started in NHS England South and involved different cohorts of lay representatives. Among those groups there were those who were involved in working with revalidation health professionals on a joint approach to revalidation. One of the important features of this cohort was that the lay reps on the programme had access to the Responsible Officers' e-learning model. The Programme was an example of how lay people can gain knowledge of the revalidation processes and expand the pool of lay representatives that can be involved in different revalidation activities. Further information can be found [here](#) and [here](#).

The current training examples provided by the organisations listed in Appendix A, range from formal sessions of training through to formal and informal briefings which include:

- Formal national training for members of Performance Advisory Groups and Performer List Decision Panels
- Formal one-to-one briefing by the Medical Director
- Regular briefings by the Responsible Officer
- Attendance at appraiser network meetings
- Induction courses
- Pre-meeting briefings prior to revalidation meetings
- Tailored briefings for individual reps dependent on their previous knowledge of revalidation

It important that if the lay representatives are going to be able to play a meaningful role in the activities referred to in 4.1 and apply those skills mentioned in 4.2, above, it is essential to provide them with proper training/induction to ensure that they are able to contribute fully.

#### 4.4. Guides and other Information on PPI

When considering the issues raised under 4.1 to 4.3 above it will be important to look at the different types of advice and guidance already provided in connection with facilities and arrangements that cover other types of lay/patient involvement which are relevant to the role of lay reps involved in revalidation. These include

- The very useful guide *'Working Together'* produced by Sam Regan de Bere, Rebecca Baines and Suzanne Nunn from the PPI Research Team at CAMERA, Plymouth University, who have drawn on extensive evidence, and is relevant to lay involvement in revalidation and different aspect of patient and lay involvement in the health service
- The West of England Academic Health Science Network have also published a useful guide entitled *Working Together: A toolkit for health professionals on how to involve the public*
- The NHS National Institute for Health Research through the CLAHRC [Collaboration for Leadership in Applied Health Research and Care] Partnership programme also provides information on different types of patient and public involvement as highlighted in the *August 2017 newsletter*.

While lay involvement in revalidation is growing slowly there exists other types of lay involvement in the health service which is now well embedded according to *the NHS England annual report 2017*, especially in Clinical Commissioning Groups (CCG) where advice is widely available on the role, recruitment and training of CCG lay representatives, such as:

- The *NHS England tool kit* sets out good advice for CCG lay member appointments. The recently updated *Patient and Public Voice [PPV] Partners Policy* sets out how NHS England supports PPV partners to be involved in its work. PPV partners include patients, service users, carers, families and other members of the public who are involved in NHS England's work in different ways. The policy sets out the support and governance arrangements in place to enable PPV partners to be effective in their roles.
- The recent publication of a *checklist* by the NHS Clinical Commissioners (NHSCC) provides further advice.
- HQIP [Healthcare Quality Improvement Partnership] have developed two guides entitled "A guide to Patient and Public involvement in quality improvement" and "Developing a patient and public involvement panel for quality improvement they can be found *here*."

Much of the information on lay involvement in CCGs is relevant to the recruitment and training of revalidation lay reps and can be used when developing similar facilities and arrangements within a designated bodies.

## 5. Benefits of Lay Involvement in Revalidation

Surveys show that there are different views amongst Responsible Officers (RO) on lay involvement in revalidation with many still being sceptical about the lay contribution. This is against a background where currently less than half of designated bodies have lay involvement in a range of different revalidation roles. Research conducted on behalf of the Department of Health led by Kieran Walsh at Manchester University, with colleagues from University of Plymouth and York University, has considered the benefits of PPI in medical revalidation. Their work is currently under review for publication in 2017, but emerging findings contain some positive examples including the following quotations from text questions

A notable theme that emerged within free text responses was that PPI can provide a patient perspective, or a different viewpoint, to medical regulation and the processes surrounding revalidation. One RO explained how the two lay representatives on his revalidation steering group, *'.....often bring some very pragmatic contributions to discussions...it is very valuable to perceive fitness to practice through their eyes.'*

A number of ROs highlighted the potential value that lay representation could deliver in patient safety, cases of doctors causing concern and fitness to practice. One RO related an example of this in his organisation where a PPI representative provided a check to internal group decision making, *'....a valid challenge at a senior appraiser meeting when the PPI representative challenged 'group think' from senior appraisers about the patient safety impact of accepting a doctor's evidence.'*

One respondent went further, and argued that PPI can not only serve as a gauge to establish what the public expect from assessment and remediation of doctors, but it can also give assurance within the medical profession that self-regulation is being administered fairly and effectively, *'....In terms of decision-making, action planning, support and remediation for doctors identified as having fitness-to-practice concerns or support needs, PPI could act as a beneficial measure of public expectation of the revalidation process and so as an anchor to reduce the inherent 'normalisation' of concerning behaviour that can come from a profession regulating itself internally...'*

What is clear is that those designated bodies that already have PPI see it as an important benefit with lay representatives and health professional working in a collegiate approach in the interest of both patients and doctors. The independent voice that lay involvement brings or 'the public in room' [the UCL description of lay involvement in QA visits] or 'critical friend' [as described by others] is recognised as providing that questioning that needs to take place on behalf of patient and the public.

Sir Keith described the situation clearly in his report when he said *'representatives provide a degree of independent scrutiny and challenge of the revalidation process,'* adding. *'I would also like to see local patient representatives invited to review periodically how those arrangements are working in practice, thereby gaining confidence on behalf of the wider public that local governance is robust.'*

The outcomes from the TRF report, as set out in the GMC Action Plan flowing shows there is now a willingness and strong support in promoting and encouraging lay involvement in revalidation at local designated body level and applying the benefits that lay participation brings.

## 6. Summary

The information in this document is an updated version of a document that was first published in October 2016 which was the first attempt to collect and document information on the extent of lay involvement in different revalidation activities. It remains the case that the majority of the local information reflects what is happening in NHS England South but, there are now examples from other regions. This work should continue with additional information being added to illustrate the extent of lay involvement in the revalidation process. I see this as an ongoing piece of work and therefore additional information will continue to be sought of examples of wider lay involvement from other parts of the health service.

If you have any additional information to add to this list, please email [sol.mead@btinternet.com](mailto:sol.mead@btinternet.com)

Sol Mead

Patient Lay representative

Academy Revalidation Committee

December 2017

With thanks to:

All those at local, regional and national level who assisted me in collecting this information through email exchanges and direct conversations.

Sol Mead contributed to the development and implementation stages of revalidation as a lay representative through involvement in the RCR, the Academy of Medical Royal Colleges, Department of Health and GMC and he continues to contribute a lay point of view through being:

- A lay member on the GMC Revalidation Oversight Group (and its predecessor bodies)
- Involved in a range of different revalidation activities in NHS England London and South Regions including quality assurance visits to designated bodies
- A member of the Academy of Medical Royal Colleges Revalidation and Professional Development Committee and the Academy's Patient Feedback Group
- Chair of the CAMERA PPI Revalidation Forum, which provides a lay input to the UMBRELLA work on revalidation

## Appendix A: Current examples of lay involvement in revalidation

### NATIONAL LEVEL

General Medical Council Revalidation Oversight Group	The General Medical Council Revalidation Oversight Group was created to oversee the Taking Revalidation Forward Implementation plan. The group, which has a wide-ranging membership, includes representation from the Department of Health in England, Northern Ireland, Scotland and Wales, the independent sector, the Academy, the British Medical Association, other Regulatory organisations and Education bodies. There are three lay representatives who play a full role in contributing to the items under discussion.
NHS England	The NHS England Stakeholder Reference Group was disbanded in 2016, which included two lay representatives. Consideration is currently being given to relevant lay representation within the various meetings and working groups across NHS England. Lay representation exists within the Framework for Performer concerns used by all local office Medical Directors across NHS England. Guidance can be found <a href="#">here</a> .
DH Scotland	There is lay representation on the Scottish Delivery Board and a panel member of the External Quality Assurance exercise conducted Healthcare Improvement Scotland.
DH Wales	There is a lay member on the Welsh Revalidation and Delivery Board and the Revalidation and Appraisal Implementation Group.
DH Northern Ireland	The Revalidation Delivery Board has a lay member.
Health Education England	There are lay advisers involved in the overseeing of the sample of panels dealing with the full Annual Review of Competence Progression (ARCP) scope of practice reviews, which is the equivalent appraisal process. This is in addition to lay representation at designated body board level.
Public Health England	There are two lay representatives on the PHE Revalidation Steering Group which oversees and scrutinises processes to support the role of the RO in PHE. The two representatives are from PHE's Peoples' Panel and are competitively selected.
Academy of Medical Colleges Revalidation and Professional Development Committee and sub Committees, including the Patient Feedback Group	All the Royal Colleges and Faculties are represented on the Academy Committee as well as representatives from England, Scotland, Ireland and Wales, the GMC, NCAS, COPMED, NHS Employers and the independent sector plus four lay representatives. The Committee discusses all aspects of revalidation such as remediation, return to work and CPD. The lay representatives contribute fully to all the discussions. The Patient Feedback Work Group has six colleges represented, NHS England and the GMC and lay representatives. Its aim is to consider the current patient feedback process and how it can be improved.

<p>Royal College of Psychiatrists (RCPsych)</p>	<p>There is a Revalidation and CPD Committee with two lay reps, one carer and one service user who input into developing College policy on revalidation. This Committee links to the Colleges' Patients and Carers Committee which meets three times a year.</p>
<p>Royal College of Ophthalmologists (RCOphth)</p>	<p>Lay representatives, including service users, sit on the Education Committee and the Professional Standards Committee among others. Both these committees have input from the CPD Committee and Revalidation teams and allow for collaborative working.</p>
<p>Royal College of Anaesthetists (RCoA)</p>	<p>There is a Revalidation Committee with lay membership, with ongoing work streams around issues such as patient feedback, returning to practice and remediation resources. The terms of reference for the Committee include developing and updating specialty guidance and contributing to national consultations. Another important group at the RCoA is the CPD Board which has responsibility for the quality assurance of CPD approval across the specialty. It also includes lay representation and it is an independent group with terms of reference including the provision of a shared forum for all matters relating to CPD. The RCoA <a href="#">Lay Committee</a> was established in 1998 and provides an independent, non-clinical view across most of College activities. Members' roles include attending visits to hospitals under the <a href="#">ACSA</a> accreditation scheme, to assess how the hospital experience might appear to a patient, contributing to the College responses to consultation documents and also contributing to question setting in the Primary exam, with a particular emphasis on doctor/patient communication.*</p>
<p>Royal College of General Practitioners (RCGP)</p>	<p>There is patient representation on all relevant boards and committees since the College started developing revalidation proposals in 2009. A representative from the RCGP Patient and Carers Partnership Group (PCPG) is included on the College's Revalidation Working Group (RWG) and a member of RCGP Scotland's patient representative group, P3, is included on the Professional Development and Quality Programme Board - the programme area the RWG is accountable to. The PCPG also feeds into revalidation work informally. The RCGP hosted patient representative workshops in July 2015 and July 2017 which help shape the RCGP Guide to Supporting Information for Appraisal and Revalidation, particularly the recommendation that GPs reflect on other sources of patient feedback on an annual basis, in addition to undertaking a GMC-compliant survey once per revalidation cycle. The findings of the 2017 workshop have fed into the Royal College of Physicians London patient feedback for revalidation project. The RCGP has sought comment from PCPG representatives on revalidation resources, including the Guide to Supporting Information for Appraisal and Revalidation and RCGP Myth busters: Addressing Common Misunderstandings about Appraisal and Revalidation.</p>

<p>Royal College of Surgeons of Edinburgh (RCSEd)</p>	<p>A College Vice President and the Director of Professional Affairs oversee appraisal and revalidation for the College and have roles on the Academy's Revalidation and Professional Development Committee. The day-to-day affairs are conducted by the public affairs and policy office based at the RCSEd Birmingham Regional Centre. These officers attend and brief the College Lay Advisory Group (LAG) on all relevant matters and seek advice as necessary. The LAG is currently in the process of establishing its Lay Reference Network throughout the UK to allow multicultural feedback to the LAG, the Birmingham Centre and the Professional Affairs Department. The LAG is chaired by the other RCSEd Vice President, so broad opinions can be consolidated at the College Office Bearers' regular meetings. The Education Department deals with revalidation enquiries and the LAG is an important source of intelligence and support.</p>
<p>Royal College of Obstetricians and Gynaecologists (RCOG)</p>	<p>The RCOG Revalidation Committee was established in 2009 with lay representation. However, following the roll-out of revalidation, it was felt that the Revalidation Committee had served its purpose and a decision was then made to disband the Committee in March 2015. In its place a Revalidation Clinical Lead was appointed who would serve on a new UK Board, responsible for revalidation, and on a new Professional Development Committee which was formed in June 2015 with the remit to develop a new framework and recording system for CPD with a lay member from the RCOG Women's Network. The RCOG has also published (Feb 2015) Patient information leaflet on revalidation which explains about appraisal, colleague feedback and patient feedback, including how patients can give their feedback (<a href="#">Revalidation- How do I know my doctor is up to date?</a>) The College is currently a partner in the Academy commissioned project around patient feedback in revalidation, led by the RCP. Members of the Women's Network have been involved in the project's associated workshops.</p>
<p>Royal College of Surgeons of England (RCSEng)</p>	<p>All revalidation discussions fall under the scope of RCS (England) Career and Professional Development Committee and any policy decisions relating to these discussions are further discussed and finally approved by the College Council. Both groups include lay/patient representation as each has members drawn from our Patient and Lay Group (PLG). These representatives discuss issues with the other members of the PLG and can contribute directly to the discussions and input the patient/lay voice to ensure that these vital issues are attended to and to ensure that 'institutional blinkering' is minimised. Further to this, any changes to documentation or new guidance relating to Revalidation are given for consultation to the PLG with opportunity to ask any questions and offer any feedback on draft documents prior to their publication.</p>

<p>Royal College of Paediatrics and Child Health (RCPCH)</p>	<p>The College has a number of committees that look at revalidation issues, most specifically their strategic Education and Training Divisional Committee. It has moved to a specific engagement model working closely with the RCPCH Children and Young People's Engagement Manager. The approach is based on seeking Children and Young Person (CYP) and/or Family reps input on particular projects or consultations, choosing the right consultation model. For example, they have been a running a focus group with Children and Young People and Family representatives to support the Academy's patient feedback project, which will also be used to improve the RCPCH patient feedback tool for revalidation.</p>
<p>The Federation of the Royal Colleges of Physicians of the UK</p>	<p>The Federation is a working partnership between the three Physician Colleges. The Federation CPD Management and Policy Board has patient and lay representation and is chaired by the Federation of Medical Director for Revalidation and CPD. Board members are invited to contribute to discussions relating to both revalidation and CPD, to inform decision-making and influence policy and guidance.</p>
<p>The Royal College of Physicians, London (RCPL)</p>	<p>The College's Executive Board has patient and lay representation and is chaired by the Vice-President for Education and Training whose responsibility includes revalidation. Board members are invited to attend meetings and contribute to discussions. It receives minutes and relevant papers for comment. All major revalidation projects, such as the Academy of Medical Royal Colleges' grant funded project into Patient Feedback, which the RCP is leading, has patient and lay representative input and consultation.</p>
<p>Faculty of Medical Leadership and Management (FMLM)</p>	<p>The Faculty provides appraisal and revalidation guidance for doctors in leadership positions including example portfolios, completed personal development plans (PDPs) and a summary of the appraisal discussion, as well as a revalidation helpdesk. It has a Revalidation and Appraisal Group, which has lay involvement.</p>
<p>Faculty of Pharmaceutical Medicine (FPM)</p>	<p>There are two lay representatives on the Faculty's Board which regularly discusses revalidation and appraisal. The Board oversees governance of the FPM Designated Body. Discussions are ongoing about how further lay input could add value to various aspects of revalidation</p>
<p>The UK Medical Revalidation collaboration (UMbRELLA) Forum</p>	<p>The UMbRELLA study is supported by a Patient and Public Involvement (PPI) Forum. The Forum comprises PPI representatives involved in medical revalidation nationally and regionally. It is responsible for overseeing the design, implementation and evaluation of all PPI aspects of both the UMbRELLA study for the GMC and a separate Department of Health funded revalidation evaluation study. It has played an active role in the development and delivery of the UMbRELLA research, and has for example contributed to the development of survey questionnaires. It meets quarterly.</p>

## REGIONAL LEVEL

### Quality Review teams visiting designated bodies in NHS England regions and in Wales

The Higher-level RO Quality Reviews (previously called Independent Verification visits) have been in operation for over three years and in NHS England South there have been over 93 Quality Reviews in that period. The Quality Reviews are an ongoing process which is now also taking place in all 4 NHS England regions and Wales. However, there is only lay involvement in NHS England South, London and the North plus in Wales. There is no lay involvement in the reviews in NHS England Midlands & East region.

The purpose of the reviews is to enable discussions to take place between the key members of a designated body (responsible officer plus others) and the regional team representing the higher-level RO to discuss:

- Compliance with the Responsible Officer Regulations (2010 and 2013)
- Examples of good practice that could be shared more widely
- Areas of challenge
- Ways in which the designated body could be supported to develop further
- Development of an agreed action plan for the designated body.

The lay participation in these visits is an excellent example of 'hands on' lay involvement in quality assuring the local revalidation processes and procedures by being part of the team that visits different designated bodies to check how the revalidation process is being managed locally. These can include visits to public and independent hospitals (large and small), locum agencies, clinics, telemedicine agencies and organisations responsible for GP revalidation. As part of the team, the lay representative participates in the meetings with a local RO, the Human Resource Team, and drop in sessions with some of the local appraisers and a group of doctors who are subject to the local revalidation process.

Some visits also include talking to the complaints manager, health and safety officer and others who have specific roles in the local revalidation system. The lay representatives contribute freely to the discussions that take place with these groups and are part of team decision making when commenting on different aspects on whether the revalidation processes are being applied to a satisfactory standard.

	<p>The 2016 University College London report on these revalidation QA visits described the patient and lay participation as having 'the public in the room'. It also said that 'Lay representation should become a standard practice, confirming that their role is important and should include their ability to comment widely on the performance of the organisation and not limit their role to patient feedback or PPI. This report was further confirmation of the important role that lay reps can play in revalidation and is very good example of medical and lay reps successfully working together.</p>
<p>Higher Level Responsible Officer Advisory Groups in NHS England</p>	<p>NHS England South and London have established Higher Level Responsible Officer Advisory Group (HLROAG) with lay involvement with the North and Midlands and East having different arrangements, details of which are set out below.</p> <p>A key objective of these advisory groups is to consider key items requiring decision-making to support the role of the higher- level RO, including but not restricted to:</p> <ul style="list-style-type: none"> <li>▪ Requests for advice regarding the appointment of alternative responsible officers due to a conflict of interest or appearance of bias</li> <li>▪ Revalidation recommendations, particularly in complex situations</li> <li>▪ Concerns regarding a responsible officer and the application of the Policy for Responding to Concerns for Responsible Officers with a prescribed connection but no organisational link to NHS England</li> <li>▪ Complex issues related to appraisals for ROs</li> <li>▪ Cases brought by responsible officers to the attention of the higher-level RO where broader discussion by the group would be beneficial</li> <li>▪ Complaints to the HLRO</li> <li>▪ Any other issues relevant to the role of the higher level responsible officer.</li> </ul> <p>For the purpose of calibration across NHS England the cases and key decisions by the Groups are shared anonymously with the other regions through the Higher Level Responsible Officers Calibration Group which meets quarterly. Any learning from other regions can be shared with the HLROQAG at the next meeting. The quorum in the South requires a lay rep to be present at meetings. Lay members participate fully in the discussions on the individual cases on a confidential basis and can freely express views within the group on the way they think a problem could be resolved.</p>

	<p>In the Midlands and East Region they hold a monthly Revalidation Meeting which considers all aspects relating to revalidation i.e. looks at QA, appraisal rates, visit plans etc. with the exception of performance management which is dealt with by the Performance Management Group. This meets fortnightly to deal with the same issues as the HLROAG. Neither group has patient representation at present.</p> <p>In NHS England North they have Revalidation Committee which deals with general revalidation matters and no formal HLROAG. Instead performance issues are dealt with as part of the regular meetings between the HLRO, the MD lead for the RO function and GMC Employer Liaison Adviser and, where appropriate cases, are fed into the HLRO Calibration Group in the normal way. The regional revalidation team provides leadership and support to the ROs which is thought felt to enable the early identification of concerns and their timely resolution. This is underpinned by the relationship with the ROs and with the GMC ELAs and other resources. There is no lay involvement in the Committee or the HLRO/ELA meetings. However, there is lay involvement in the Revalidation Oversight Group which covers GPs within one of the Local Offices.</p>
<p>Lay involvement in Local Decision-Making Group relating to concerns about ROs</p>	<p>NHS England has a framework which sets out processes for managing concerns about ROs who have a prescribed connection to the HLRO in the four regions of NHS England. The aim of the framework is to bring a consistent, fair, proportionate approach - in line with the regulations, when enacting changes or imposing sanction where necessary to improve patient safety and the quality of healthcare services.</p> <p>The Framework provides for the setting up of a Local Decision-Making Group which may include; CEO, Chair, HR Director, Lay person, Medical Director if different from RO and an external RO if not. The group should usually include at least three out of four of the above with the option for one to nominate a deputy. NCAS and the GMC ELA [may/could] be used in an advisory manner and informed of relevant investigations in line with the designated body's policy.</p>
<p>Involvement in RO training</p>	<p>A lay representative attends the two-day training course for ROs in NHS England South and on the second day gives a Power Point presentation on the benefits of PPI and facilitates a discussion on how it can be developed further.</p>

## LOCAL LEVEL

All NHS England Local Offices	
Involvement in Performance Advisory Groups and Performer List Decision Panels	<p>Across NHS England (based in Local Offices) there is lay membership of Performance Advisory Groups (PAG) and Performer List Decision Panels (PLDP) both of which are linked to the revalidation processes in dealing with performance issues.</p> <p>The PAG is a repository of expertise provided by individuals with in-depth knowledge of performance procedures and professional standards and is able to provide advice on handling individual performance cases. The PAG's role is investigative and advisory. It can instruct an investigation where it considers it appropriate and it can agree voluntary undertakings with a performer when low level concerns which have been identified and the performer accepts this to be the case.</p> <p>The primary role of the PLDP is to make decisions under the Performers lists regulations. This does not prevent the PLDP from taking any action that the PAG can take. The lay representative chairs the PLDP.</p> <p>Both Bodies therefore make an important contribution to the revalidation processes with lay involvement.</p>
NHS England (South)	
Members of Appraiser appointment panels – South Central	<p>In NHS England South Central a lay representative has been included in the appointment panels for new appraisers. The lay representative participates fully in asking interviewees questions and in the decision- making discussions in relation to the appointment.</p>
Reviewing revalidation documentation - Phyllis Tuckwell Hospice	<p>Phyllis Tuckwell Hospice (which covers across the whole of West Surrey and part of North East Hampshire) has a trained lay representative as part of their revalidation team. The three reviewers must reach a consensus before recommendations are agreed.</p>

<p>Governor appointed as Lay representative for revalidation – Western Sussex NHS Foundation Trust</p>	<p>The lay revalidation representative is also a Public Governor who represents and reports to the Council of Governors on the progress of medical revalidation of doctors at West Sussex Hospitals Foundation Trust. The Lay representative's participation is through the Medical Appraisal and Revalidation Group (MARG), which meets quarterly to review all aspects of appraisal and revalidation. The Group comprises the delegated RO, project manager, several appraisers and report to the Medical Director (the formal RO).</p> <p>The lay representative is also a volunteer at Worthing hospital and a member of the Membership and Engagement Committee, whose responsibility it is to ensure that the Trust has sufficient public members across its constituencies and through them engage on Trust issues. Both roles and through public meetings of the governors provide significant interaction with the patient perspective and issues, which adds to the lay representative's ability to contribute to the MARG.</p>
<p>Patient Reference Panel supports Revalidation – Buckinghamshire Healthcare Foundation Trust</p>	<p>The Panel reports quarterly to the Board on patient involvement across the Trust with patients being trained to Chair consultants' appointment panels.</p>
<p>Involvement in Appraisal meetings – Royal Air Force</p>	<p>There is lay involvement in the Royal Air Force quarterly appraisal quality assurance meetings.</p>
<p>Revalidation Steering Group - North Bristol NHS Trust</p>	<p>North Bristol NHS Trust include a lay representative on its revalidation steering group to provide challenge.</p>
<p>Revalidation Action Group – South Central</p>	<p>The Revalidation Action Group which includes lay representation was created by South Central to cover GP's appraisals across the counties of Oxfordshire, Berkshire, Buckinghamshire, Bath and North-East Somerset, Gloucestershire, Swindon and Wiltshire. The group consider appraiser recommendations in relation to fulfilment of Good Medical Practice criteria in portfolios of evidence provided by individual doctors for appraisal and revalidation and make recommendations to the RO. The group's quorum requires a lay member to be present. The lay member was recruited from the pool of lay reps in the Health Education England Thames Valley.</p>

Attendance at appraiser training courses –Southern Health Foundation Trust	In Southern Health, a lay representative attends and contributes to the appraisal training courses and the appraisers' network meetings.
Oversight Role - Berkshire Healthcare NHS Foundation Trust	A lay representative has a role in providing oversight of the Trust's implementation of the action plan agreed during the HLRO Quality Review.
Involvement in a Panel that provides scrutiny – East Sussex Healthcare	East Sussex Healthcare has a Medical Revalidation Advisory Panel (MRAP) which acts as a scrutiny panel that checks appraisal outputs and provides support to the RO in relation to recommendations, quality assurance, recruitment and discharge of appraisers, remediation processes and the RO transfer forms for doctors leaving the Trust. They also attend internal medical appraiser training.
Involvement in Oversight Committee - Oxford University Hospitals Foundation Trust	There are two lay members who sit on the Medical Revalidation Committee which has an oversight of revalidation within the Trust following attendance at the Learning Together programme.
Member of the RO Advisory Group - Avon and Wiltshire Mental Health Partnership	A lay member has been recruited from the non-Executive body to become a full member of the RO Advisory Group, which meets monthly.
Reviewing Revalidation Processes - Oxford Health Foundation Trust	A Lay member was recruited from the Local Deanery via a competitive interview and was appointed for a year under a voluntary [honorary] contract and is being used to scrutinise revalidation processes.
Attendance at RO meetings – Great Western Hospital NHS Trust	A lay Governor attends the ROs monthly revalidation and appraisal meeting.
Involvement in Quality Assurance – Kent Community Health Foundation Trust	The lay representative is involved in quality assuring appraisals.
Representation on Appraisal Panels – Royal Navy	There is lay representation on appraisal panels for junior doctors and on the RO Advisory Board.
British Army	The lay representative is a member of the Responsible Officer Advisory Group (ROAG), which formally advises the RO on revalidation decisions and on casework involving doctors in difficulty. Their attendance at ROAG is mandated within the Terms of Reference of the group. The revalidation processes within the British Army operates on the basis that in recent times they have had a number of service

persons treated in the field and within deployed primary and secondary care facilities on overseas military operations. This includes having to deal with patients who have suffered life changing injuries, often requiring the use of advanced prosthetics. Therefore, when seeking to appoint an appropriate lay representative they have sought to ensure that the individual has a clear and personal understanding of the issues raised by this and understand the environment in which Army doctors practice within such operations. The lay representative's contribution and insight is invaluable in assisting the Responsible Officer and is a greatly valued as a source of advice, common sense and clarity when dealing with matters under consideration including decisions on difficult cases.

NHS England (Midland and the East of England)

Nottingham University Hospitals NHS Trust (NUH) Medical Appraisal and Revalidation Advisory Group

NUH has a Medical Appraisal and Revalidation Advisory Group (MARAG) which aims to maintain and develop the Trust's medical appraisal and revalidation systems and processes. The group is directly accountable to the RO, and the membership includes eight specialty Lead Appraisers who oversee and support the appraiser faculty of 120 appraisers, as well as representatives from clinical academics, Heads of Service, LNC, SAS doctors and a PPI member. The PPI member was recruited and appointed following an advert in the Trust newsletter. The PPI member is a retired person and brings experience from the business world (including performance management). The PPI input is very useful, particularly around policy regarding patient MSF. The PPI member has a Job Description which says their role is to:

- Oversee and ensure that NUH medical appraisal and revalidation processes remain focused on improving the quality and safety of care provided to patients, and increasing public trust and confidence in the organisation
- Provide MARAG with guidance on its approach to creating and updating the Medical Appraisal and revalidation policy and procedure documents, ensuring they are consistent with the needs and views

	<p>of patients/carers and the wider local community</p> <ul style="list-style-type: none"> <li>▪ Assist MARAG in understanding the perspectives of patients and public, including identifying other potential opportunities/roles for patients and the public to be effectively involved in appraisal and revalidation processes</li> <li>▪ Assist MARAG in appointing new Lead Appraisers as necessary.</li> </ul>
<p>Attendance at RO Committee - Milton Keynes University Hospital</p>	<p>The RO committee meets monthly. Its membership consists of 4 doctors, HR representative, MD office and lay member. One of the roles is to look at appraisal not assured by the appraisal summary which means they will 'drill down' into the appraisal documents to gain assurance of the content. The committee starts to look at documents at least 3-4 months before the due date for revalidation.</p>
<p>NHS England (London)</p>	
<p>South London and Maudsley Mental Health Trust Revalidation Advisory Group</p>	<p>South London and Maudsley is a Mental Health Trust that employs approximately 350 doctors with currently prescribed connections who are based in 90 different locations across eight London Boroughs, plus a small number of doctors in Jersey and Germany.</p> <p>A Lay Representative sits on Revalidation Advisory Group. The purpose of the Group is to provide oversight and scrutiny of the process by which consultants and SAS level doctors are appraised and revalidated thereby supporting the Responsible Officer (RO) in ensuring high standards of medical practice. The frequency of meetings is every two months for first six months and then quarterly.</p>
<p>NHS England (North)</p>	
<p>Yorkshire and Humber Office Assurance and Oversight Group for Managing Performers Concerns</p>	<p>The group provides support to the Principal RO from the perspective of assurance and oversight for the delivery of the Framework for Managing Performer Concerns and the actions of the Performance Advisory Group (PAG) and Performers' List Decision Panel (PLDP). The membership includes PLDP Lay Chairs and the Lay PAG members plus Local Health Professionals.</p>

# APPENDIX B:

## Examples of Terms of Reference and Membership of Revalidation Bodies with Lay involvement

### 1. General Medical Council

#### ORGANISATIONS REPRESENTED ON THE GMC OVERSIGHT GROUP

UK-wide

Sir Keith Pearson – Special Adviser to ROG

Academy of Medical Royal Colleges

Association of Independent Healthcare Organisations

British Medical Association

General Medical Council

Royal College of GPs

#### England

Care Quality Commission

Department of Health England

Health Education England

NHS Employers

NHS England

NHS Improvement

Patient/Lay representative

#### Scotland

Healthcare Improvement Scotland

NHS Education for Scotland

Scottish Government Health Directorates

Patient/Lay representative

#### Wales

Wales Deanery

Welsh Government

Healthcare Inspectorate Wales

Patient/Lay representative

### Northern Ireland

Department of Health Northern Ireland

Northern Ireland Medical & Dental Training Agency

Regulation and Quality Improvement Authority

Patient/Lay representative

### Purpose

To oversee the delivery of the improvements to revalidation based on the recommendations from Sir Keith Pearson's Taking Revalidation Forward (TRF) report.

### Objectives

The objectives of the Revalidation Oversight Group (ROG) are to: a. Collaborate through joint action and an implementation plan for the delivery of improvements to revalidation.

Coordinate any agreed activities for the delivery of improvements to revalidation.

Monitor progress against the agreed plan.

Agree revisions to the plan as required.

Receive regular reports from the organisations responsible for delivery.

## 2. Quality Review teams visiting designated bodies in NHS England regions (and in Wales)

### Key objectives of the visits:

This process will provide assurance to boards (or equivalent governance or executive group) of designed bodies and the higher level responsible officer, that the organisation is fulfilling its statutory obligations in ensuring that effective systems are in place to underpin the statutory responsibilities of the responsible officers.

The identification and sharing of examples of good practice will assist with the development of consistency across designated bodies and driving up standards.

### Membership:

The review team may include:

Medical Director / Responsible Officer (RO) – South Region

Deputy Director (Revalidation) – South Region

Associate Medical Director (Revalidation & Quality) – South Region

Regional Revalidation Team members – South Region

Local Office Medical Director or delegate

A Medical Director / Responsible Officer or member of their team from another designated body

Lay Members

### Process:

The review team will consist of members of the revalidation team and person(s) advised in the above list who will be agreed by the participating designated body prior to the HLROQR.

Date and programme to be agreed between the designated body and the review team at least 6 weeks in advance of the visit whenever possible. Identified staff members of the organisation that are to be included in the visit programme will be made aware of the timings of the programme by the organisation and of any documentation that they may be required to bring to the review meeting. The revalidation team will provide information prior to the review and areas for review will be focused on the core standards for implementation of the Responsible Officer Regulations,

All discussions between the review team and the designated body will be treated confidentially and not discussed further outside the group except with the express permission of the group. Agreement will be sought for sharing of examples of good practice.

### Outcome:

The output from the visit will be an agreed summary highlighting examples of good practice and identifying areas for development. It is expected that the designated body will develop an Action Plan based on the agreed areas for development.

Any learning identified through this process will be shared as appropriate e.g. designated bodies, other regions, responsible officers.

### 3. Academy of Medical Colleges Revalidation and Professional Development Committee and sub Committees including the Patient Feedback Group

#### Revalidation and Professional Development Committee: Terms of Reference

The group shall be known as the Revalidation and Professional Development Committee.

#### Purpose:

To work collaboratively with Royal Medical Colleges and Faculties, and key stakeholders to ensure the continued effective implementation of all UK-wide elements of revalidation.

To advise doctors and other senior professionals allied to the Medical Royal Colleges and Faculties, on the development and administration of their CPD and so far as possible, harmonise the administration and quality assurance of such schemes.

#### Responsibilities:

To ensure that specialist processes developed by Colleges and Faculties in support of CPD and revalidation are robust and effective.

To share information and expertise between Colleges and Faculties, and other relevant key stakeholders, on all matters relating to CPD and revalidation.

To set up revalidation and CPD work streams relating to issues of priority for Royal Colleges and Faculties.

To act as a communication conduit on behalf of the Royal Colleges and Faculties at meetings of NHS England's England Revalidation Implementation Board, the GMC's Revalidation Implementation Advisory Board and Departments of Health in the four countries.

#### Membership:

The Committee's membership will comprise:

One representative from each Royal College and Faculty represented on the Academy. Each College/Faculty Representative may also appoint a deputy to attend if they are unable to attend the meeting.

## Representatives from the following organisations:

GMC

Academy Patient/Lay Group (2)

Academy SAS Committee (1)

COPMED (1)

NHS England (1)

DH Four Nations (4)

Royal Society of Medicine (1)

NCAS (1)

IHAS (1)

NHS Employers

## Terms of Reference of the Patient Feedback Group

### Background

The GMC mandated the use of colleague and patient feedback as one element of supporting information that revalidating doctors need to bring to the appraisal process. Currently, colleague and patient feedback must be collected by revalidating doctors once every 5 year cycle.

Patient feedback can be instrumental in confirming and improving the quality of a doctor's professional work, but evidence so far suggests that the process of collecting feedback is proving very difficult for some specialties. Where it is being collected, it is not always proving sufficiently reliable to be used as an effective measure of a doctor's performance.

### Aims and Purpose of the Patient Feedback Work Group

The Workgroup aims to consider the current patient feedback process and how it can be improved.

### To achieve these aims the Workgroup will:

Define the purpose of the patient feedback process and what it is meant to achieve.

Define the current challenges of/and significant barriers to collecting patient feedback, focusing on both the content of questionnaires, and the process of collecting patient feedback.

Explore possible solutions, including the development of alternatives to questionnaires.

Agree the deliverables for the future work programme.

### The Workgroup will then:

Oversee the development of a project plan\* setting out further proposed work in light of the initial findings of the group.

Oversee the project plan and ensure timely achievement of the deliverables, and act as an ongoing resource to the project.

Following an initial feasibility study for revised questionnaires / alternative methods, to provide an updated/enhanced method of obtaining patient feedback to be piloted.

In light of the project's findings, review the current principles and criteria set by the GMC for patient questionnaires.

Make recommendations on how to make the process of collecting patient feedback more consistent across the regions and countries of the UK, with special reference to 'seldom heard' groups.

Make recommendations on how doctors and appraisers handle patient feedback focusing on the importance of reflection and benchmarking.

Make recommendations for patient/lay involvement in the wider revalidation processes.

Define the purpose of the patient feedback process and what it is meant to achieve.

Define the current challenges of/and significant barriers to collecting patient feedback, focusing on both the content of questionnaires, and the process of collecting patient feedback.

Explore possible solutions, including the development of alternatives to questionnaires.

Agree the deliverables for the future work programme.

Oversee the development of a project plan setting out further proposed work in light of the initial findings of the group.

Oversee the project plan and ensure timely achievement of the deliverables, and act as an ongoing resource to the project.

Following an initial feasibility study for revised questionnaires / alternative methods, to provide an updated/enhanced method of obtaining patient feedback to be piloted.

In light of the project's findings, review the current principles and criteria set by the GMC for patient questionnaires.

Make recommendations on how to make the process of collecting patient feedback more consistent across the regions and countries of the UK, with special reference to 'seldom heard' groups.

Make recommendations on how doctors and appraisers handle patient feedback focusing on the importance of reflection and benchmarking.

Make recommendations for patient/lay involvement in the wider revalidation processes.

Membership

Chair of the Academy Revalidation and Professional Development Committee
Academy Revalidation and CPD Manager
Patient/Lay representative
Patient/Lay representative
Royal College of Emergency Medicine rep
Royal College of Paediatrics and Child Health rep
Royal College of Physicians of London rep
Royal College of Obstetrics and Gynaecology rep
Royal College of General Practitioners rep
Royal College of Psychiatrists rep
NHS England [South Region]rep
Royal College of Anaesthetists rep
General Medical Council rep

#### 4. Higher Level Responsible Officer Quality Advisory Groups in NHS England (South) Terms of Reference

##### **Purpose:**

The purpose of revalidation is to provide assurance to patients and the public that licensed doctors are up to date and fit to practice. The higher level Responsible Officer (HLRO) has a key role in ensuring the effective implementation of the Responsible Officer Regulations. An advisory group to support the role of the higher level RO provides the opportunity for greater calibration of decision-making and the involvement of lay members. The group will provide input to the assurance process for designated bodies and their responsible officers in the south region.

##### **Key objectives:**

The advisory group will consider key items requiring decision-making to support the role of the higher level RO, including but not restricted to:

Requests for advice regarding the appointment of alternative responsible officers due to a conflict of interest or appearance of bias

Revalidation recommendations, particularly in complex situations

Concerns regarding a responsible officer and the application of the Policy for Responding to Concerns for Responsible Officers with a prescribed connection but no organisational link to NHS England

Complex issues related to appraisals for ROs

Cases brought by responsible officers to the attention of the higher level RO where broader discussion by the group would be beneficial.

Complaints to the HLRO

Any other issues relevant to the role of the higher level responsible officer

A second part of the meeting will enable discussion on any other topic relevant to quality improvement through appraisal and revalidation.

##### **Membership:**

The advisory group includes:

NHS England (South) Higher level Medical Director / Responsible Officer

NHS England (South) Medical Directors/responsible officers (south west, south central, south east, Wessex) and deputies

Deputy Director (Revalidation)

Associate Medical Director (Revalidation & Quality)

Regional revalidation team members

NHS England revalidation delivery team (central) representative

A provider organisation Medical Director / Responsible Officer

A representative from one of the other NHS England regions (Medical Director/Deputy/Associate Director)

GMC Employer Liaison Advisor

Lay Members

Additional members may be recruited as required for specific items / advice as required e.g. GMC Employer Liaison Advisor, HR Director, Communications Leads, representatives from specific types of organisations such as independent sector.

#### Quorum:

A quorum will be six members from the above list and must include at least one lay member, two members of the south region revalidation team, an NHS England south medical director / RO or deputy.

#### Process:

The Advisory Group exists within a system for dealing with concerns raised in a timely manner and for enabling calibration across the regions of NHS England as described below:

When concerns are raised with the higher level responsible officer or a member of the regional revalidation team the details are taken to the Revalidation recommendations and concerns Group (RRCG) which consists of the HLRO, Associate Medical Director (Revalidation & quality), Deputy director (revalidation) and Senior revalidation manager for timely discussion and agreement on any immediate action.

Cases discussed at the RRCG will be brought to the next HLROQAG with an update on the current position and actions already taken if applicable. This is to ensure that actions are not delayed by waiting for the next HLROQAG meeting.

The Advisory Group will meet at least three times per year. Meetings may take place using technology to avoid travelling where possible e.g. WebEx, video or teleconferences. Details will be circulated with the agenda for each meeting.

Where urgent decisions are required additional meetings may be convened in a timely manner.

Discussions will be held on any issues relevant to decisions to be made by the higher level RO. Brief notes will be made of the discussions and decisions reached. If the Medical Director / RO is not present the key points from the meeting will be communicated to the RO as soon as

possible after the meeting to inform decision-making. Documentation will be stored securely in a restricted folder. Any papers printed and used during the meetings will be disposed of by confidential shredding following the meeting. A summary of decisions and actions will be provided at the start of subsequent meetings to update the group.

At the beginning of each case discussion members will be asked to disclose any conflict of interest and as cases are presented anonymously, if a conflict of interest becomes apparent at any time members are expected to bring this to the group's attention for a decision to be made whether to exclude them from further discussions.

All discussions by the group will be treated confidentially and not discussed further outside the group except with express permission of the group.

For the purpose of calibration across NHS England the cases and key decisions will be shared anonymously with the other three regions through the Higher level responsible officers Calibration Group which meets quarterly. Any learning from other regions can be shared with the HLROQAG at the next meeting

#### Product:

The product following the discussions by the group will be a recommendation for the higher level responsible officer. The higher level responsible officer will make decisions and determine actions based on the group's discussions and will feedback to the group at the next meeting.

Any learning identified through this process will be shared anonymously as appropriate e.g. with other regions, with responsible officers.

#### Review of term of reference:

The term of reference for Higher Level Responsible Officer's Quality Advisory Group will be reviewed annually.

Lay members participate fully in the discussions on the individual cases on a confidential basis and are able to freely express views within the group on the way they think a problem could be resolved

## 5. Performance Advisory Groups (PAGs) and Performer List Decision Panels (PDLPs)

Membership of PAG consists of four voting individuals. These are:

A senior NHS manager with a performance role who will chair the PAG

A discipline-specific practitioner nominated by the medical director

A senior manager with experience in primary care contracting and/or patient safety and experience

A lay member

### **PAG Objectives and Duties:**

To ensure that all concerns and all complaints related to a named primary care practitioner included on the performers list or on the pharmaceutical services list are considered, investigated where appropriate, and managed in the interest of patient safety and high standards of patient care.

To ensure that primary care practitioners whose performance, conduct or health has given cause for concern are supported to return to a satisfactory standard where possible.

To ensure a fair, open, consistent and non-discriminatory approach to the management of concerns.

To facilitate the resolution of concerns through appropriate agreed local action and support for improvement.

To consider each individual case related to a named primary care performer or pharmacy contractor and decide whether further action or further information is required, or that there is no case to answer .

To decide upon and agree, ideally through consensus but if not through the majority, a relevant course of action, the level of support required and the resources required.

To ensure that details of the primary care performer or pharmacy contractor where a concern has been discussed, details of the actions and outcome, and details of the whistle-blower, if applicable, are managed in accordance with the NHS England policies.

To monitor progress in relation to the investigation of concerns and where appropriate of compliance and progress with remediation for cases and action plans which have been agreed outside of the NHS (England) (Performers Lists) Regulations 2013, and decide when the case can be closed, or whether further action is required.

Where appropriate, to request a formal investigation

Where appropriate, to refer to occupational health

### PLDP Membership:

The PLDP will take overall responsibility for the management of performance; decide on actions required on individual performance cases in line with the Performers Lists Regulations and any other statutory regulations and make referrals to other bodies where appropriate. Membership of the PLDP comprises of the following individuals:

1. A lay member who will chair the PLDP.
2. A discipline-specific practitioner.
3. A senior NHS England manager/director with responsibility for patient safety/experience.
4. The medical director for an NHS England team or their nominated deputy.

All four members need to be present for the PLDP to be quorate and have a vote and the chair has the casting vote, if necessary.

Additional non-voting members and advisors may also be invited by the chair from time to time. In addition the performer may be accompanied by a legal representative or an advocate or may be an LRC member

Each member of the PLDP will be appointed to their role in line with a competency framework and relevant training will be provided.

### PLDP Objectives and Purpose:

To take overall responsibility for the management of applications to the performers lists and concerns of those on the performers lists. OFFICIAL Framework for managing performer concerns - final [4] 29

To consider and take appropriate action on all referrals of a serious nature in relation to concerns of primary care performers.

To consider whether action may be required under the NHS (Performers Lists) (England) Regulations 2013 and to invoke action under the Regulations where this is agreed as the course of action.

To agree relevant and appropriate action in the interest of patient safety or the safety of colleagues. To consider information provided by the PAG and where necessary any other source in relation to primary care performers included on the relevant list.

To consider any response by a performer in relation to concerns or complaint raised about them.

To ensure that action is taken in line with NHS England policy and procedure, and in line with the performers' lists regulations.

Following consideration of applications to join the NHS England performers lists decide whether to invoke through the PLDP process Regulations in respect of on invoking deferral, conditional inclusion or refusal.

To consider the information received, consider any recommendation made by PAG and make one or more of the following decisions:

Take no further action and refer back to the PAG for case closure.

Refer for further investigation or monitoring and, if agreed, delegate the actions to PAG.

Consider referral to the primary care contracts team for consideration under the relevant contract regulations.

Refer to the relevant regulatory body.

Refer to the police.

Refer to NHS Protect.

Refer to any other organisation for remediation or intervention agreed.

## 6. Supporting Best Medical Practice Group – Southern Health

### **The aim of the Group is:**

To promote the highest standards of medical practice within the Trust.

To provide a forum where Medical Practice is monitored, and best practice supported, in line with the Trusts obligations for Revalidation of doctors.

To provide a forum where standards of medical practice are set and thresholds for raising and acting on concerns are monitored for consistency, both internally and externally.

To provide a developmental forum for medical managers in the Trust.

To provide a forum for discussing excellence in practice, encouraging development and identifying career opportunities for individuals.

To share information about doctors where there are actions in relation to practice, both internally and externally.

To provide a forum for anonymous discussion of concerns about individuals in order to assist medical managers in deciding thresholds for acting on concerns.

To provide guidance for medical managers in relation to specific cases

To promote effective triangulation of information where there may be a number of potential sources of intelligence about an individual.

To ensure that concerns that warrant further action are formally reported to the R0 and Medical Director.

To maintain strict confidentiality around material discussed.

To receive a summary of appraisal processes and emerging themes, and discuss ways of addressing these.

To receive a summary of Revalidation processes, including deferral and non-engagement in order to support best practice.

To report emerging themes to the Medical Advisory Committee, or other committees as appropriate

Membership of the Group is as follows:

Responsible Officer for Revalidation

Medical Director

Clinical Director [ HR, Workforce and Communications] [vice chair]

Lead for Revalidation and Appraisal

Director of Education

Medical HR Representative

Lay representative

Clinical Directors, and Clinical Service

[7. Revalidation Advisory Group for NHS England Southwest, includes South Gloucester, Bristol, Somerset, Devon, Cornwall and Isles of Scilly](#)

**The remit of the Group:**

Provide oversight and scrutiny of medical appraisal outputs and relevant documentation to support the Responsible Officer in the process of making recommendations for medical revalidation for individual doctors to the GMC

To support patient safety and improve patient care and outcomes

To ensure national policy and guidance is implemented

Agree consistent decision making for revalidation, ensuring transparency, fairness, and lack of discrimination. To streamline a process for revalidation and appraisal across the peninsula, maintaining confidentiality and governance processes.

Develop an agreed process to deal with individual circumstances, to maintain contact, and to support doctors enabling them to continue working safely

Act as a forum where doctors may seek further clarification of the revalidation process.

Agree and oversee any action plans devised for deferment of revalidation, and those with long term breaks from GP practice.

Proactively manage GMC connect and RMS to ensure doctors are aligned, informed and enabled to prepare for appraisal and revalidation

Oversee information flow to doctors about local processes

To work with Performer list and Performance teams to ensure all doctors are engaged, and working within our area.

To 'Close the loop' via appraisal discussions and reflected learning etc arising from Performance concerns.

To identify emerging themes and concerns.

**Members of the Group include:**

Responsible Officer /Medical Director or

Deputy Medical Director, Revalidation, Appraisal & Performance

Lay Member

Head of Professional Performance

Appraisal & Revalidation Manager

Appraisal Lead or deputy

Senior appraisers on a rotating basis

Appraisal administration

## 8. Revalidation Action Group – South Central

### Terms of Reference:

This programme informs the Group's work which, in turn, enables the Responsible Officer (RO) to be assured that their evaluation of doctors' fitness to practise is based upon the transparent conduct of a systematic approach to the achievement of continuing improvements in patient care and medical professionalism across South Central.

The overall purpose of the Revalidation Action Group is to determine whether there is (or is not) clear evidence that individual doctors have demonstrated a continuing commitment to the values and principles expected of their profession, as set out in Good Medical Practice (GMP)

To achieve this aim, the Group considers any available pertinent information concerning doctors who have been listed for revalidation on the GMC Connect website. It is intended that the Group will consider the revalidation of doctors on the GMC list in quarterly cohorts.

### The objectives of the Group are to:

Receive and consider "In Confidence" the Senior Appraisers' recommendations in relation to fulfilment of GMP criteria in portfolios of evidence provided by individual doctors for appraisal and revalidation;

Receive and consider "In Confidence" any other information available in NHS governance systems which might be material to the RO's decision to recommend a doctor's professional revalidation;

Make a recommendation concerning each doctor's revalidation to the RO. NOTE - Members of the Group must decide upon one of three possible outcomes: They may (1) confirm the available information supports a positive recommendation, or (2) in cases where the portfolio does not fully meet GMC requirements, they may suggest a period of deferral sufficient to allow the doctor to collect or collate missing elements. In cases where it has been established that all reasonable efforts to encourage a doctor to comply with their duty to participate in appraisal and revalidation have failed, the Panel may (3) confirm the doctor's non-engagement.

- Ensure a common and consistent approach to managing cases and making decisions in relation to medical revalidation in South Central
- Continually review and consider the development of common assessment tools and procedures in relation to revalidation;
- Identify and pursue appropriate management of emerging issues, and work with Appraisers via Team Leaders to reach agreed solutions in relation to revalidation.
- Manage and ratify appraisal postponement requests, appeal against allocated appraiser requests, the non-participation process and any complaint made against an appraiser - each via the relevant nationally agreed process.
- The Quorum\* for the Group is - one NHS England officer, the Lay Representative, and one Locality Appraisal Team Leader to be present to constitute a formal meeting of the Group.

**Members of the Group are:**

Deputy Medical Director

Appraisals Lead (NHS England)

Programme Manager (Revalidation)

Appraisal Project Officer

Lay Representative

All Senior Appraisers

\*As this is not a statutory body, there is a local agreement that, although every effort will be made to achieve full attendance as above, if a lay member cannot attend the meeting will still be allowed to go ahead. The current lay members were included in the agreement process.

**9. East Sussex Healthcare Medical Revalidation Advisory Pane (MRAP)**

**The objectives of the MRAP are to:**

Provide oversight and scrutiny of medical appraisal outputs and relevant documentation to support the Responsible Officer in the process of making recommendations for medical revalidation for individual doctors to the GMC;

Provide clinical governance assurance to the Responsible Officer in the process of making recommendations for medical revalidation for individual doctors to the GMC in the role of a 'failsafe mechanism'; the Clinical Units will have the responsibility of providing this data to individual doctors and monitoring within their unit;

Provide robust quality assurance of the medical appraisal process and the medical appraisers

Provide support to the Responsible Officer in the recruitment and discharge of medical appraisers

Provide support to the Responsible Officer in the oversight of remediation of doctors who are not compatible with a positive recommendation for medical revalidation

Provide support to the Responsible Officer in the completion of the RO transfer form for doctors who are leaving the Trust

## 10. Lay Representative on Revalidation Advisory Group - South London and Maudsley FT \*

### The purpose of the Group is to:

Provide oversight and scrutiny of the process by which consultants and SAS level doctors are appraised and revalidated thereby supporting the Responsible Officer (RO) in ensuring high standards of medical practice. The frequency of meetings is every 2 months for first 6 months and then quarterly. Each meeting to last one hour.

### The Terms of Reference of the Group are:

To receive reports on doctors seeking revalidation and supported by the RO and to comment as appropriate;

To review reports on doctors not engaging with the process or subject to referral and comment as appropriate. To receive reports on the outcome of actions in respect of these doctors;

To receive and scrutinise reports on doctors giving cause for concern to confirm that there is a clear plan of action, where an investigation is undertaken that this leads to an action plan with clear time frames, and to receive evidence that action plans are completed;

To sign off the Annual Report to the Trust Board on appraisal and revalidation;

### Membership of the Group is as follows:

Non-executive Director

Governor from the Public constituency

Responsible Officer (Medical Director)

Deputy Medical Director

Chair Trust wide MAC

Revalidation Administrator

Associate Medical HR Business Partner

## 11. Royal College of Anaesthetists

### Introduction

The revalidation and CPD work at the College is overseen by the Revalidation Committee, and by the CPD Board.

### Revalidation Committee

The Revalidation Committee is accountable to Council of the College and has responsibility for the development and implementation of processes, procedures, tools and guidance. The Committee works collaboratively with national bodies and organisations to develop common approaches in revalidation.

### The Committee has the following Terms of Reference:

Review and set appropriate specialty-based professional standards against which doctors in anaesthesia, intensive care and pain medicine will be appraised and revalidated.

Update and issue specialty guidance on revalidation issues and processes, including appraisal, the supporting information requirements, continuing professional development (CPD) and remediation.

Establish, train and support a network of specialty advisors to provide specialty advice on revalidation issues to doctors, appraisers and/or Responsible Officers.

Develop and make available tools and resources to help individual doctors in their revalidation.

Work with other RCoA, FICM and FPM departments, committees, boards and working groups to prioritise issues important to revalidation, in particular those areas relating to outcome measures, clinical audit, CPD, remediation and good practice in anaesthesia, intensive care and pain medicine.

Review national and specialty developments in CPD, how they link with revalidation and update guidance when necessary.

Continue with the work on all areas of multisource feedback.

Participate in the development of national policies relating to revalidation through committees and working parties, and respond to consultation documents issued by the Academy, GMC, Departments of Health, NHS Revalidation Support Team and other stakeholder bodies.

Quality assure internal RCoA, FICM and FPM processes relating to revalidation, including the provision of advice to doctors, appraisers and Responsible Officers; and contribute to national and regional quality assurance models and processes being developed by regulatory and representative bodies.

Highlight to Fellows and Members new developments and issues in revalidation through outreach visits, presentations at events and regular contributions to RCoA, FICM and FPM publications, websites and other communications media.

### CPD Board:

The CPD Board has responsibility for the quality assurance of CPD approval across the specialty, and also for the review and revision of the CPD Matrix.

The CPD Board has the following Terms of Reference:

To agree and implement appropriate mechanisms for the quality assurance of CPD approved under the RCoA's CPD scheme.

To ensure consistency of practice in the approval of CPD through an annual review of the register of approved CPD and by sampling applications for CPD approval and subsequent decisions.

To monitor the appointment and performance of the CPD assessors on an annual basis.

To review the RCoA's CPD Matrix and be responsible for future revisions.

To ensure that the suggested list of level 3 CPD for the special interest areas is maintained and reviewed on a regular basis.

To provide a shared forum for matters relating to Continuing Professional Development and report back to respective Councils and Board on any new developments.

To produce an annual report.

## APPENDIX C

### Lay Partner for Medical Revalidation: role description template

Role	Lay Partner, Medical Revalidation & the Responsible Officer Regulations
Duration	1 year in the first instance, renewable to a maximum of x years
Expenses	Travel expenses and other appropriate out-of-pocket expenses are reimbursed. An honorarium of £x per full day will be paid (for those people not representing or supported by an organisation) for an estimated time commitment of x days per year.

When you visit a doctor, whether this is your GP or a doctor in a hospital, you want to know that the doctor you see will provide you with the best possible care. The aim of revalidation is to give extra confidence to patients that their doctor can provide this care by being up to date and fit to practise.

The Medical Profession (Responsible Officers) Regulations 2010, as amended by the Medical Profession (Responsible Officers) (Amendment) Regulations 2013, were passed with the intention of improving patient safety. These regulations give organisations in which doctors work statutory responsibilities for making sure the environment in which they practise is focussed on improving and maintaining the quality and safety of patient care.

The law requires designated bodies to appoint a senior doctor – often the medical director – as a Responsible Officer (RO). The RO's role involves making sure their organisation has robust governance systems and processes in place to evaluate doctors' practice on an ongoing basis. These include annual medical appraisal and procedures to investigate and refer fitness to practise concerns about doctors to the profession's regulator, the General Medical Council (GMC). ROs make revalidation recommendations to the GMC about every doctor who works in their organisation.

<https://www.england.nhs.uk/revalidation/about-us/what-is-revalidation/>

The ROs make revalidation recommendation about a doctor's fitness to practise to the GMC based on the outcome of a doctor's annual appraisal and other clinical governance information, usually every five years. Following the responsible officer's recommendation, the GMC decides whether the doctor can continue to hold a licence to practise in the UK.

Responsible Officers are accountable for the quality assurance of the appraisal and clinical governance systems for the doctors in their organisation.

NHS England leads the National Health Service (NHS) in England setting priorities and direction for the NHS and encourages and informs the national debate to improve healthcare. Regional medical directors in NHS England provide leadership and support on medical issues for organisations and have the role of Higher level Responsible Officer to whom all responsible officers are connected, thereby linking virtually all doctors working in organisations meeting the criteria for a designated body in to NHS England.

NHS England is committed to the involvement of patients and the public in healthcare and the Pearson review, Taking Revalidation Forward, commissioned by the GMC endorses the involvement of patients and the public in the processes supporting revalidation and the role of the Responsible Officer.

<https://www.england.nhs.uk/participation/>

[http://www.gmc-uk.org/FINAL\\_COPY\\_Taking\\_Revalidation\\_Forward.pdf\\_68910907.pdf](http://www.gmc-uk.org/FINAL_COPY_Taking_Revalidation_Forward.pdf_68910907.pdf)

Role, responsibilities and required skills of Lay Partners

The Lay Partner will bring views, perspective and challenge to the Responsible Officer role and medical revalidation team. This role is essential in championing the public, service user, patient, carer or family points of view, ensuring that this aspect is considered.

The role of the Lay Partner is to:

Act as a “critical friend” offering informed constructive challenge in issues related to medical revalidation

Champion and advocate for increasing patient and public involvement and awareness of the responsibilities of the responsible officer including:

- appraisals of doctors
- revalidation recommendations
- monitoring the performance of doctors
- responding to concerns about doctors
- ensuring the appropriate pre-employment checks are undertaken during the recruitment of doctors including identity, qualifications, experience, references, English language
- sharing information as appropriate with other responsible officers

Responsibilities of the Lay Partner are:

- To give an impartial and independent view
- To give the patient/public perspective when involved in discussions/activities relevant to the role of the Responsible Officer through participation in: **[tailor as appropriate]**
- membership of the responsible officer's advisory group/steering group
- recruitment of doctors
- monitoring the performance of doctors
- the development of systems for patient feedback
- the development of policies and processes
- To provide the responsible officer with the patient/member of the public point of view regarding doctors appraisals through participation in: **[tailor as appropriate]**
- recruitment of medical appraisers
- training of medical appraisers
- review of appraisal outputs
- quality assurance of medical appraisers or other activities organised by the medical revalidation team
- To identify their own support, training or development requirements and seek appropriate support from the responsible officer or medical revalidation team

What will you gain?

Increased knowledge of the Responsible Officer Regulations and medical revalidation

The opportunity to influence medical practice, improve patient care and safety

The opportunity to be involved in developing a patient centred healthcare with broader opportunities for public and patient involvement.

The opportunity to represent the public on clinical governance groups

Monitoring progress of lay involvement in appraisals and other medical revalidation processes.

Person specification

Skills and experience required for this role	Essential	Desirable
Some knowledge and understanding of the NHS and how health services are commissioned and organised		<input checked="" type="checkbox"/>
Experience of working in a similar setting, and ability to contribute actively to the discussions and work, including undertaking specific tasks or projects as appropriate	<input checked="" type="checkbox"/>	
The confidence to question information and explanations supplied by others, who may be experts in their field.		
Access to existing patient experience and involvement networks, or the ability to identify them	<input checked="" type="checkbox"/>	
Experience of chairing a group meeting/committee		<input checked="" type="checkbox"/>
Experience of advocating for patient /public involvement at a strategic level	<input checked="" type="checkbox"/>	
A demonstrated commitment to improving the quality of patient outcomes and the quality of healthcare		<input checked="" type="checkbox"/>
Some knowledge and understanding of good governance and the difference between governance and management	<input checked="" type="checkbox"/>	
A demonstrated ability to interact with multiple		

stakeholders at a senior level	<input checked="" type="checkbox"/>	
Ability to take an objective view, seeing issues from a non-clinical perspective and especially from an external perspective.	<input checked="" type="checkbox"/>	
Ability to display sound judgement and objectivity	<input checked="" type="checkbox"/>	
Ability to communicate effectively, verbally and in writing, via email and teleconference, with a variety of audiences including other patients/members of the public, clinicians, and members of the voluntary sector	<input checked="" type="checkbox"/>	
Understanding of the need for confidentiality	<input checked="" type="checkbox"/>	
Ability to devote at least x day(s) per month to the role	<input checked="" type="checkbox"/>	
Ability to travel to meetings	<input checked="" type="checkbox"/>	

#### Support

You will be offered support on practical issues such as help with claiming expenses, accessing meeting papers, support during meetings, answering queries and any additional advice as needed. In addition you will be enabled to receive training and learn as much about the Responsible Officer Regulations and medical revalidation as you feel you need to fulfil this role. This will be done by mutual arrangement with you at times and in ways to suit you and the responsible officer/medical revalidation team.

#### Payment

Travel and carer expenses will be reimbursed. In addition, a payment of £x [rate determined by each organisation] will be made for each meeting attended.

#### Confidentiality

You must not communicate any confidential information you learn as a result of this role. If you are unclear about whether or not the information that you have access to is confidential, please seek clarification from the organisation. You will be requested to sign a confidentiality agreement.

## Appendix D

### Role Description

Job Title:	Lay Representative - Revalidation
Accountable to:	Medical Director/Responsible Officer
Supported by:	The Appraisal Lead and the Assistant Director – Revalidation
Pay Band	Voluntary role with Honorary Contract

The purpose of the role:	The role holder will contribute to a robust, comprehensive and high quality medical revalidation system. The role holder will contribute non-medical professional, expertise and provide constructive challenge to decisions, processes and outputs of the medical appraisal and revalidation system in support of the Responsible Officer for medical revalidation.
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#### Key duties and responsibilities

The role of the Lay Representative is to:

Contribute to the governance and decision-making processes within relevant fora and meetings, such as the quarterly Medical Revalidation Advisory Panel meetings, in a constructive manner, offering ideas and opinions which reflect their non-medical professional expertise;

Contribute to the quality assurance processes for medical appraisal and medical revalidation by assisting in the review of appraisal outputs with the Responsible Officer and/or his Deputy, and other members of the revalidation team at regular intervals (i.e. approximately once or twice per year);

Contribute towards the decision-making process by sitting on the interview panel with the Responsible Officer/Deputy Responsible Officer when recruiting new medical appraisers or a Medical Appraisal Lead (approximately once per year);

Keep abreast of local and national news, developments and policy with regards to medical revalidation and medical appraisals, to consider the impact of this on medical revalidation in the Trust, and to contribute to the continuous improvement of the system and process of medical revalidation and medical appraisals;

Assist in the twice annual training of existing medical appraisers and the annual training of new medical appraisers by providing a lay perspective on matters relating to medical revalidation and appraisals, in particular regarding issues such as multisource feedback;

Contribute to project work which has been identified as an area of need by the Responsible Officer. This may sometimes require collaborative working with other group members and at other times working autonomously. Lay Representatives should not agree to take on projects, which they feel are outside of their remit, beyond their skill or knowledge level, or would require a time commitment which they are unable to keep;

Disseminate good practice from medical revalidation to other areas of work in which the role holder is involved as a Lay Representative;

If Lay Representatives have any queries relating to their role and responsibilities, they should contact the Assistant Director – Revalidation or the Responsible Officer.

Lay Representatives will be asked to sign a confidentiality agreement and hold an Honorary Contract with the Trust.

General Duties & Responsibilities applicable to this role description

To be familiar with and adhere to the policies and procedures of the Trust.

To achieve and demonstrate agreed standards of personal and professional development within agreed timescales.

To participate in surveys and audits as necessary in order to enable the Trust to meet its statutory requirements.

To be aware of the Trust's emergency planning processes and follow such processes as necessary, in the event of an unexpected incident.

Personal Specification: Lay Representative - Revalidation

Minimum Criteria	Desirable Criteria
Knowledge of medical revalidation legislation, systems and processes	Knowledge of the function of GMC in relation to medical revalidation or a willingness to learn
Knowledge of the NHS, its structure and functions	Experience of developing working relationships with senior staff in an acute Hospital or Healthcare Trust
Excellent oral and written communication skills	Knowledge of relevant Trust Policies
Evidence that behaviour reflects Trust values	
Understanding of the confidential nature of the role	

Manager's signature

Date:

Post holder's signature

Date:

**Revalidation** is the process by which doctors are issued with a licence to practice by the General Medical Council to show that they are up to date and fit to practice. A licence has to be renewed every 5 years. In order to revalidate a doctor needs to take part in annual **appraisal**. **Revalidation was introduced in December 2012**

**Appraisal** is a review of a portfolio of evidence submitted by the doctor to demonstrate compliance with the General Medical Councils standards of good medical practice. It is a facilitated review carried out by a trained appraiser.

**Project Aim:**

- To understand the public perception of medical appraisal and revalidation,
- To identify areas for public involvement in the process and the potential for co-designing future development
- To identify skills and attributes for lay representatives

**What we did:**

- Survey questionnaire to public, secondary doctors both appraisers and appraisees
- Public discussion forum
- Appraisers discussion forum

**How has this made a difference?**

- Identified lack of public awareness
- Identified public interest to know more
- Identified public willingness to be involved particularly in QA of process
- Identified health care scepticism about public involvement
- Clarified attributes and areas for involvement of lay representatives

**What is our learning?**

- Need to do more locally about informing public about process and outcomes of medical appraisal and revalidation to promote confidence and transparency
- Raise the awareness of revalidation with the public
  - a certificate on the wall
  - on practice / trust websites – adding it to doctors [biog](#)
  - adding to practice leaflets
- Importance of moving beyond tokenism in public involvement
- Need for more work to facilitate health care understanding of value of public contribution
- Explore role of lay voices in conversations with doctors in difficulty

**What we found**

When asked the question:

“Do you agree that lay representatives can make a significant contribution to the appraisal and revalidation of doctors.”

69% of lay respondents either strongly agreed or agreed compared to 17% of medical staff

Eight members of the public were recruited from the GHNHSFT membership and attended a public focus group facilitated by Head of Patient Experience Team

Collated results from public forum suggest:

- Awareness of process felt to be low
- General feeling that doctors competency assessment was already in place – surprise at newness of system
- Caution about whether system will pick up poorly performing doctors
- Wariness about how to measure competence
- Caveats about public involvement requiring training, careful selection, clear role specifications and limited tenure
- Unwillingness to be involved in actual appraisal discussions

Possible role in:

- quality assuring process
- quality assuring summaries
- contributing to steering groups
- looking at feedback summaries
- displaying information about process and benefits to public
- investigation of complaints

Considering areas in which lay representatives could be involved these are the areas where more than 50% of respondents said “yes”, however the absolute numbers of medical staff responding to these questions is small (22/52)

Areas	Lay	Medical
	% yes	% yes
Quality assurance of process	81	75
The response to complaints against doctors	80	70
Assessing concerns raised about doctors and deciding what action to take	73	60
Steering groups responsible for the appraisal and revalidation	63	70

Considering possible skills and attributes for lay representatives the top 5 showed consistency as shown in the table below; data is given as percentage response

Skills and Attributes	Lay Response %			Medical %		
	Essential	Desirable	Not Important	Essential	Desirable	Not Important
Ability to listen	93	7	0	86	12	2
Ability to represent the point of view of general public	71	21	7	54	28	18
Ability to review and pull together information from different sources	71	29	0	82	18	0
Ability to represent a collective patient view	64	29	7	65	24	12
Be familiar with the way that doctors work	57	29	14	82	16	2

# APPENDIX F

## Medical Revalidation - A Training Guide for Lay Representatives

### Introduction

Lay representatives are increasingly involved in the process of medical revalidation at local, regional and national level (see Appendix A) A number of Trusts, Health Boards and independent care providers have indicated that they would like to recruit lay members but find it difficult to recruit suitably trained lay people. This training guide is intended to provide a background to the revalidation process for those who would like to become lay reps and includes links to the various statutory requirements for the implementation of revalidation and processes reviewing compliance.

This background information is important because finding one's way around the guidelines and governance procedures is complex and even with an understanding of NHS structures, not always easy. There is also a link to a comprehensive review of examples of lay involvement in appraisal and revalidation drawn up by Sol Mead. This invaluable resource will be of interest to anyone wishing to review the current extent of lay involvement and contribution to the governance processes of revalidation (See Appendix B)

After describing these processes in broad terms, references to web based information are provided to enable the user to navigate around the various web sites outlining the relevant information. Offering contact details of experienced lay representatives who will be able to provide support/mentoring should assist those who are considering taking on this role or who want further clarification. This may either be offered via telephone contact or ideally by offering one-to-one or small peer group support to reinforce and clarify the training package and the relevant legislation. Appendix 3 provides an example of a checklist summary of the areas of governance that are reviewed by representatives of higher level responsible officers reviewing how effectively Trusts/Health Boards are implementing the extensive revalidation regulations. Finally reference is made to current GMC lead discussions regarding how the second cycle of revalidation will differ from the first and in particular how patients and the public may become more involved.

## Background

Medical revalidation was introduced in December 2012 as a response to serious concerns raised by a series of system failures including Dr Shipman, the Bristol children's heart surgery scandal and the Mid Staffs enquiry. The General Medical Council ( GMC) states that ' the purpose of revalidation is to ensure that patients and the public, employers and other healthcare professionals are confident that licensed doctors and registrants are up to date and fit to practise'. It is still unclear whether appraisal and revalidation would have detected Patterson at an earlier point.

Before explaining the revalidation processes it is worth noting the difference between a doctor's licence to practise and registration with the GMC. Since 2009 doctors who are registered with the GMC must also have a licence to practise. Since December 2012 all licensed doctors must demonstrate on an ongoing basis that they are up to date and fit to practise as demonstrated by an annual appraisal and revalidation once every five years. It is to meet these requirements that through legislation ( RO Regulations and the GMC License to Practise) revalidation was introduced. Doctors who have no medical practice can elect to give up their licence but remain on the medical register.

Significant changes to the way in which doctors' performance is monitored has had to be introduced to meet the needs of revalidation. Every doctor is now linked to a Responsible Officer ( RO), this is known as his/her prescribed connection. The RO has the legal responsibility to recommend to the GMC whether a doctor is a safe and competent practitioner once every five years. The RO also reviews doctor's annual appraisals and clinical governance data and is responsible for ensuring that every doctor has an annual appraisal that meets the standard requirements (see later). It should be noted that doctors also undergo annual reviews of their clinical competence using clinical audit tools although this is not the stated aim of either annual appraisal or revalidation. The clinical governance process reviews a doctor's professional actions whereas the appraisal is the opportunity for the doctor to demonstrate that they are a learning practitioner ( see reference to the reflective process and quality improvement activity later).

A suitable person (SP) is a licensed doctor approved by the GMC who has similar roles and responsibilities as a RO and can carry out this role for doctors working in non-typical employment providing they do not already have an RO, e.g. tribunal services, health informatics etc. Only about 1,000 doctors fall into this category and there are about 30 SPs.

## Implementing Revalidation

Most ROs working in a secondary care setting ( ie non primary care or general practitioners) are senior doctors in hospitals- often the medical director (MD). ROs in different health care settings may vary in the number of doctors they are responsible for. This ranges from perhaps a half a dozen doctors or less working in smaller hospices or specialist private health care providers, to very large Trusts/HBs with many hundreds of doctors. RO regulations outlined by the GMC are described in:

<http://www.gmc-uk.org/doctors/revalidation/12385.asp>

ROs are required to undergo training and regularly engage with local RO networks to help them exchange examples of good practice and keep up to date.

ROs are usually supported by a revalidation officer having an administrative role who will ensure that doctors are reminded of the need to arrange their appraisals and may also help to manage the process of matching appraisee to appraisers. In most, but not all Trusts, the doctor select their own appraiser. It is also the case that most doctors are appraised by a colleague from the same specialty although other models are being implemented.

ROs also often establish a small group of senior colleagues who can provide support and advice when considering appraisal outcomes (sometimes known as Revalidation and Appraisal Advisory Groups -RAAG). In larger Trusts there may also be more experienced appraisal leads who provide support for appraisers.

In larger organisations the HR department provides a supporting role to the RO particularly when newly appointed doctors receive an introduction to appraisal and revalidation or if the RO has a concern about a doctor not fully engaging with appraisal/revalidation. They may also assist with information flows for newly appointed doctors from the previous RO where there is a need to confirm previous satisfactory performance including appraisals.

Trusts in England (and the seven Health Boards in Wales) are known as the Designated Body ( DB ) which is the organisation that employs the doctor and provides appraisals and assists with revalidation. Many DBs, particularly in London, may be organisations offering private health care. A number of these DBs are small, the RO only being responsible for a handful of doctors. Where a doctor works in several different settings the DB to which he/she is connected is the one in which they spend most of their professional working time. All doctors must have a connection to a DB and although those employing the large majority of doctors are Trusts/Health Boards, others may be locum agencies and or private health care providers.

In England all GPs working in the NHS are on what is termed the performers list (which means they have been accepted as suitably trained doctors specialising in primary care). Their DB is an organisation that manages the performers list. In England the DB is NHS England and there are 16 ROs based in local offices where the RO manages the local or area team. These teams can manage several thousand GPs. This contrasts to some small private health care providers where the RO may be responsible for a handful of doctors.

In each of the four regions there is a Higher Level RO (HLRO) who is responsible for ensuring that ROs implement revalidation in accordance with the GMC regulations. In addition if a doctor feels that they have been treated unfairly by their RO they can appeal to the HLRO.

The comparable organisation in Wales for GPs is the Welsh Deanery and the Revalidation Support Unit. The HLRO is the Chief Medical Officer.

Representatives of the HLROs in both England and Wales are currently visiting Trusts/Health Boards to determine whether ROs are implementing the guidelines effectively (HLRO Quality Review visits HLRO QR).

## The Appraisal Process

The effectiveness and robustness of the appraisal process is central to the success of revalidation. Appraisers are often colleagues of the doctors they are appraising and work in the same speciality. After three successive appraisals the doctor should consider selecting a new appraiser. Every appraiser has an initial training (a two- day course is recommended) and an annual top up session. Quality review processes require the appraisee to provide feedback on the appraisal process and the appraiser's summaries to be reviewed by the RO.

Every doctor connected to a DB has an annual appraisal conducted by a trained appraiser who subsequently sends the appraisal summary to the RO. The RO or one of his/her advisory team review each summary to check that all the necessary information has been included and that the appraisal is judged to be satisfactory.

When a revalidation is due (every five years) the RO reviews the doctor's appraisals and other clinical governance information and decides either to recommend to the GMC to either revalidate or defer a decision for a determined period (usually several months and possibly associated with a period of maternity leave or illness). Very occasionally a doctor is regarded as not engaging in the appraisal and revalidation process and a recommendation of non-engagement is made to the GMC. This may ultimately result in a loss of licence.

A referral to the GMC for fitness to practise issues should be made at any time and is not related to the revalidation process.

Appraisal 'inputs' or domains of evidence include the following:

Using electronic templates the doctors provide supporting information addressing the following six areas:

### 1. Continuing professional development( CPD)

An average of fifty hours per year over the five year period is generally recommended and may involve further training, attending medical conferences, reading research papers etc. The emphasis is on the doctor describing their reflections on what they learnt through attending training, reading article or discussions with colleagues. The appraiser will also ask what changes to practice have been made as a result of the CPD work.

### 2. Quality Improvement activity.

There is a specific requirement for a quality improvement activity- often this may be clinical audit although there is increasing focus on demonstrating the impact of QI activity on patient care.

### 3. Significant Events.

A significant event (sometimes known as an untoward or serious incident) is one where significant harm could or did come to a patient. Doctors are expected to list all such events on an annual basis and indicate the learning following the event and how they have changed their practice.

#### 4. Colleague Feedback

Doctors are asked to nominate a number of colleagues (who may include nurses and administrative staff) to receive a questionnaire focussed on their professional performance. This will include their clinical competence and ability to relate effectively with both medical and nonmedical colleagues.

#### 5. Patient Feedback

The GMC guidelines recommend at least 34 patient questionnaires be collected for every doctor undergoing revalidation. In practice many doctors are expected to sample about half that number. The large majority of doctors are able to sample their patients adequately. For a small number of doctors who work with patients in difficult circumstances (emergency medicine, pathology, forensic psychiatry, neonatology, child health etc.) this may be difficult and alternative (proxy) representative groups such as carers or relatives may be sampled. Currently doctors are only required to sample patient feedback once every five years. In addition many doctors regularly receive patient feedback via alternative routes. Increasingly more progressive Trusts are sampling patient and colleague feedback every three years.

Doctors must also ensure that they are not involved in the process of selecting patients receiving the questionnaire. In practice most doctors ask their receptionist or ward or clinic staff to hand out the patient questionnaires.

#### 6. Complaints and compliments.

Doctors must report and review all complaints and compliments received over the current year and reflect on what they have learned and how they may have changed their practice.

The following general principles apply to all appraisals:

Scope of practice.

Doctors must describe their scope of practice including all roles in addition to their main one, these may include private work, education, research activity and voluntary roles requiring a license to practise.

Reflection as part of appraisal.

The GMC emphasises the need for appraisees to reflect on both CPD and feedback from colleagues and patients. It is incumbent on the doctor to indicate not only what has been learnt (from both good and bad experiences) but how this has been used to improve his/her practice and importantly improve patient safety or care.

Patient Feedback.

From the lay perspective patient feedback is clearly important and the nature of the feedback and the way it is collected is crucial. Currently this varies across the UK. The GMC provides guidelines covering the collection of patient feedback (the nature of the questions included in questionnaires and the number of patients sampled and how they were to be sampled). However reviews of how DBs are implementing this part of the process reveals significant variations across the UK. Commercial organisations which have been contracted to carry out the process of collecting and collating feedback may develop one generic questionnaire used in a Trust despite different specialities ideally requiring their own modified

questionnaire to fit their own patient groups. It is also clear that these different service providers require different numbers of completed patient questionnaires ( ranging from 17 to over 30)

Improving the quality of appraisals.

There is agreement that the success of revalidation is based on effective appraisals which are valued by doctors. More recently attention has been focused on improving the quality of the appraisal process and ensuring that all appraisers are well trained and offered feedback on the quality of their appraisals. A number of tools monitoring appraisal quality ( ASPAT is widely used) are now employed to provide the RO with information about the effectiveness of appraisers. Every doctor who has been appraised is encouraged to provide feedback to their appraiser and the RO reviews all appraisal summaries before deciding to recommend to the GMC that a doctor be revalidated.

Some DBs have employed an external organisation to carry out a QA exercise reviewing how effective their appraisals are being carried out. Others use a self audit system.

Current Reviews of the benefits of revalidation.

By summer 2016 the first cycle of revalidation was largely complete and almost all 225,000 doctors in the UK have been revalidated. Following its introduction the GMC reports that 2,800 doctors have lost their licence to practice. It is unclear how many took this action as a result of the challenge of revalidation. Anecdotal evidence suggests that a number of doctors approaching retirement have elected to avoid revalidation and give up their license to practise.

Although it is still also unclear what the benefits to patients are from revalidation, one significant advance is that every doctor practising in the UK now has an annual appraisal where performance is reviewed and every doctor is now linked to a senior doctor who has responsibility for his/her entire clinical practice.

To evaluate the impact of revalidation the following reviews are being conducted:

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## 1 UMBrELLA Study

This is a very extensive and ongoing study coordinated by Plymouth University Medical School and a number of collaborators around the UK. The project is reviewing how all those involved in revalidation perceive the process and is seeking evidence and impressions of the benefits gained. Lay representatives, patients and patient groups are also being surveyed. An interim report, published in early 2016 reporting on a sample of 26,000 doctors, revealed:

One third of doctors believe that revalidation has had a positive impact on clinical practice.

50% report that patient feedback systems help doctors improve their practice. However only 27% believe that current patient feedback systems are effective.

The Interim report can be found on the following GMC web site.

<http://www.gmc-uk.org/about/research/29074.asp>

The full final report is to be published in late 2017 and will provide a comprehensive review of revalidation from the profession, the NHS and patients

## 2. Pearson Review

Sir Keith Pearson presented his report to the GMC in early 2017. The GMC subsequently identified five priority areas.

1. Making revalidation more accessible to patients and the public. The review also indicated that patient feedback mechanisms should be improved. (the current review into patient feedback being funded by the Academy will report by the summer 2017 and will, it is hoped, help to inform changes to this area).
2. Reduce unnecessary burdens and bureaucracy for doctors.
3. Improve the monitoring of short term locum doctors.
4. Ensure that all doctors who need a licence to practise in the UK are connected to an RO.
5. Measure and evaluate the impact of revalidation.

Sir Keith's full review is available on the GMC website.

## 3. Academy of Medical Royal Colleges

The role of the Academy in revalidation is to facilitate the work of the medical Royal Colleges and encourage them to share their experiences and expertise for the development of revalidation methods.

<http://www.aomrc.org.uk/revalidation-cpd/>

As part of this remit the academy is undertaking a review of patient feedback. The report will detail a review of the effectiveness of current forms of patient feedback and their shortcomings and propose alternative ways to sample patient feedback. This report is likely to be completed in mid 2017.

Opportunities for public and patient involvement in revalidation.

There are several different forms of public and patient involvement in revalidation. Sol Mead has developed an extensive record of this involvement and a list of some of these opportunities is shown in Appendix 2

Those lay members active in the processes of the governance of revalidation expect to provide constructive challenge to the management of revalidation. Experience has shown that lay members of revalidation and appraisal groups or appraiser appointment panels can offer an alternative view from outside the profession. Lay members of QR teams visiting a designated body are likely to question not only patient feedback related matters but all aspects of the governance of revalidation. The presence of lay reps. in these roles is still developing and there is a need for more trained lay representatives. To date there is no independent assessment of the benefits of lay involvement although the current (2016/2017) UMBRELLA study will address this.

The various NHS regions have developed sets of prompt questions (based on the core standards outlined in the Framework Quality Assurance document) that are used during a HLRO QR visit. The list of questions is an excellent guide to the areas of responsibilities of ROs, Revalidation Support teams, appraisers and appraisees. An example of one of these lists of questions is shown in Appendix 3.

Web sites providing information and guidelines.

These are often very detailed documents providing explicit guidelines. There is also considerable overlap between the different websites.

1. GMC web site Good Medical Practice. This is a framework for appraisal and revalidation The document is crucial as it sets out what the GMC regards as being the fundamental responsibilities of doctors.

[http://www.gmc-uk.org/guidance/good\\_medical\\_practice.asp](http://www.gmc-uk.org/guidance/good_medical_practice.asp)

2. GMC web site revalidation guidelines. There are a series of pages related to revalidation which include RO responsibilities, ensuring quality assurance, with frameworks and the training and monitoring of appraisers. The Good Medical Practice Framework for Appraisal and Revalidation is a good starting point. Other examples include

- An introduction to revalidation
- Supporting information for appraisal and revalidation.
- Effective Governance to support medical revalidation
- Guidance for Responsible Officers

<http://www.gmc-uk.org/doctors/revalidation.asp>

<http://www.gmc-uk.org/doctors/revalidation/9612.asp>

[http://www.gmc-uk.org/doctors/revalidation/revalidation\\_information.asp](http://www.gmc-uk.org/doctors/revalidation/revalidation_information.asp)

Monitoring and evaluating revalidation

<http://www.gmc-uk.org/doctors/revalidation/9610.asp>

3. Academy of Medical Royal Colleges.

Revalidation guidance.

Links to the Royal Colleges sites providing support and guidance for the different medical specialties.

4. NHS England

Extensive information relating to revalidation.

<http://www.england.nhs.uk/revalidation/ro/>

<http://www.england.nhs.uk/revalidation/qa/>

> NHS medical revalidation and Framework for Quality Assurance and core standards

> Appraisal Systems

> Medical Appraisal Guide ( MAG) and Guide.

> Key information and documents.

Further support for lay representatives interested in revalidation.

Becoming familiar with the revalidation process and its related quality assurances processes isn't straightforward. To assist in the process of becoming familiar with the subject it is anticipated that it will be possible to provide mentors who are experienced lay reps. who will offer telephone support and ideally a face to face meeting. Funding to cover travel costs should be met by lay reps. home organisations.

I am happy to provide clarification on aspects of the process and provide contacts with experienced lay reps. who could act as mentors.

Stephen Barasi Autumn 2017 V3.6

[stephenbarasi@gmail.com](mailto:stephenbarasi@gmail.com)

The author has been involved as a revalidation lay representative since 2010. He is currently one of several lay reps, who are asked to join Higher Level RO Quality Review visits to DBs in England and Wales. He is also a member of the Welsh Revalidation Delivery Board and Academy Revalidation and Professional Development committee and GMC Revalidation Oversight Board

This training guide has been reviewed by the NHS England south revalidation team who have agreed that the contents are helpful in assisting lay people who are becoming involved in revalidation to develop a greater understanding of the processes.

## Annex 1

Areas of concern regarding the current implementation of revalidation.

### 1. Patient sampling

There are explicit guidelines covering the way in which doctors select patients who receive the patient questionnaire. Doctors must not select which patients receive the questionnaire and often either a GP receptionist or ward or clinic nurse or administrator has this responsibility. However early reports from the UMBrella study indicate that about 30% of doctors acknowledge that they make the selection. This raises the possibility of intended or unconscious selection bias.

### 2. The appraisal

Appraisal standards are increasing however there remains concern that not all appraisers are as rigorous as they should be and that standards vary across the UK. The training, and importantly the need for top up training, is also likely to be patchy. More recent GMC guidance about the need to demonstrate reflection during the appraisal is sometimes missed.

Although some DBs provide the appraiser with a record of any patient complaints and significant events relating to the doctor being appraised, most do not. The appraiser then relies on the honesty (probity) of the doctor who, working in a professional capacity, is implicit, however for a very small number of doctors who may not be well known to colleagues and the RO, this could be problematic. This may be particularly relevant when considering locum doctors.

The same concerns apply to the need for doctors to report fully on their whole scope of practice. Doctors should sample patient and colleague feedback from all areas of their professional work including private work, out of hours work and work engaged with voluntary and sporting organisations. This is another area that some doctors fail to represent in their appraisal documentation.

### 3. RO revalidation governance.

ROs are expected to attend RO network meetings during which updates on RO guidelines are discussed. The majority of ROs and particularly those in the larger Trusts/HBs general have good support systems which encourages higher standards and effective compliance with the regulations. However ROs linked to small DBs often have minimal colleague and administrative support and may not be complying with all the guidelines.

### 4. Information flows

When a doctor moves from one DB to another it is important that the new employer has information about previous appraisals etc. This information flow between ROs is often incomplete and it is unclear whether such information should be 'pushed' by the original RO or 'pulled' by the new employer. This is particularly important in the case of locum doctors being provided by locum agencies. The following link provides recent ( 08/2016) guidance for ROs

<https://www.england.nhs.uk/revalidation/ro/info-flows/>

## Annex 2

Over the last few years the number and extent of lay representatives working in the revalidation area has expanded considerably. The following (abbreviated) list provides examples of current lay rep. involvement.

1. Members of national bodies
  - GMC Revalidation Advisory Board two members
  - England The NHS England Stakeholder Reference Group
  - Wales
    - Member of the Welsh Revalidation and Delivery Board and Revalidation and Appraisal Implementation Group
  - Northern Ireland- lay rep. involvement.
  - Health Improvement Scotland Revalidation Group
2. Members of Higher Level RO Quality Assurance teams visiting designated bodies in NHS England regions (south, north and London) and in Wales
3. Members of the UMBrella PPI Forum
4. Members of the Academy of Medical Colleges Revalidation and Professional Development Committee and sub Committees including the Patient Feedback Group
5. Higher Level Responsible Officer Quality Advisory Group in NHS England South
6. Member of Panels/RAGs reviewing appraiser decisions
7. Involvement in RO training
8. Members of appraiser appointment panels
9. Involvement in Performance Advisory Panels and Performer List Decision Panels
10. Members of local Panels/Committees covering areas such as
  - Supporting Best Medical Practice Group
  - Reviewing revalidation documentation
  - Revalidation Steering Group

A more extensive report developed by Sol Mead is available from the Academy of Medical Royal Colleges

### Annex 3

The Framework for Quality Assurance includes a set of core standards which describe the process required to demonstrate compliance with the RO Regulations. Higher Level responsible officer quality reviews are undertaken with the designated bodies to determine compliance and the focus of these reviews is the core standards, see section 4

The following is an example of a checklist (developed by Dr Ruth Chapman AMD NHS London) used by HLRO visiting teams when visiting a DB to determine if the RO is applying the revalidation regulations. The checklist is sent to the DB before the visit for completion. They may also be used as a basis for discussion by other peer external review teams. The answers to these questions may contribute to a report or as a minimum, a list of good practice and recommendations with an action plan (see end of document).

You may notice that there is little reference to PPI/Lay involvement in the governance of revalidation in this checklist. The presence of a lay rep during the visit should help to address this area.

This documentation should be submitted as supporting information to the RO's own appraisal and could also be shared with the NHS England London revalidation team for information. [england.revalidation-london@nhs.net](mailto:england.revalidation-london@nhs.net)

This list of questions is not exhaustive, may develop over time and some questions may not be relevant to all types of designated bodies.

The usual officers in attendance at a visit are:

Responsible Officer
Medical Director
Chief Executive (not always present)
Appraisal Lead
Appraisal Manager
Human Resource Manager
Two or more appraisers
Any other relevant staff such as quality or compliance officers

The following documents are made available for review prior to the visit:

Annual Organisational Audit
Statement of Compliance
Board report
Quarterly report
External Quality Assurance report (if available)
Never Events Summary (if applicable)
Care Quality Commission Report (if available on CQC website)
Relevant policies

The following documents are made available at the visit:

Examples of appraisal summaries
Examples of PDPs

Purpose of Visit

- To provide assurance that there are robust systems in place to underpin the statutory responsibilities of the RO and that they and their designated bodies are meeting the core standards in the FQA.
- To identify and disseminate good practice, maintaining and improving standards of quality and performance.

Name of Designated Body:

Name of Responsible Officer:

Have they attended RO training and completed all RO modules?

How many RO networks have they attended this year? (Expected to attend three out of four)

Name of Appraisal Lead:

Do they attend appraisal lead network meetings? (Prior to the RO network meetings quarterly)

Have they taken part in the London Appraisal Lead Leadership and Development project?

Number of connected doctors:

Is the board supportive of appraisal and revalidation?

Which policies relating to appraisal and revalidation do you have?

Responding to concerns policy?

Information governance policy?

Equality and diversity policy?

Complaints policy?

Chaperone policy?

Others?

What is your contingency plan in case the RO is off sick/AL?

Is your MD also the RO?

Ask about potential COI between the CEO/RO roles – are the CEO and RO related? (This has occurred in small DBs)

Indemnity – ask RO about their own level of cover and how other doctors' indemnity is checked?

AOA discussion – consider missed and incomplete appraisals, appraisal rates, external reviews etc.

Are the reasons for incomplete/missed appraisals checked and documented?

What are the reasons?

### Appraisal

Toolkit used:

Number of appraisers:

What training have they had? (State company used)

Do appraisers attend appraisal workshops/network meetings?

Do you carry out appraisal output audit? (For example using ASPAT)

Do you carry out appraisal lead - appraiser 1:1s?

Are you aware of the NHS England appraisal policy annexes?

(Useful annexes include annex J – appraiser assurance and the postponement of appraisal form annex D)

Other useful documents to discuss:

NHS England Logistics Handbook

NHS England Inputs Quality Assurance Guidance

NHS England Information Flow document

Quality Assurance of Appraisal document

(The last three documents are currently in draft form only and not yet available – as of Jan 16)

Do you gather doctor feedback for appraisers?

Do your appraisers appraise anyone or only those in the same specialty?

Do line managers (e.g. a doctor's clinical director) appraise doctors? (Not encouraged as may potentially affect the dynamic of the discussion)

Do you have SAS appraisers (if relevant – secondary care only)?

#### Revalidation systems and responding to concerns

What e-mails do you send out to doctors prior to their appraisal?

And prior to their revalidation?

And when they are missing deadlines?

Are you aware of the postponement of appraisal form (annex D)? (This may be used as a tool to prompt engagement as it has to be completed by the doctor and is sent to the RO for approval of postponement)

And:

REV 6 non engagement concerns – request for GMC to send a non-engagement concern to doctor

REV 4 use to bring revalidation recommendation date forward

When do you defer?

Do you make a 'contract' with the doctor after deferral?

Do you keep an audit trail? E.g. file all emails in a folder

Ask about delegation of RO duties – does the RO see enough information prior to making a decision about a recommendation? How much is delegated? Who actually presses the button on GMC connect?

Do you have a RO advisory group for decision making (around difficult decisions regarding recommendation for example)?

Do you use a revalidation recommendation checklist?

Do you have a case investigator?

#### Supporting information

How does the DB support doctors to gather relevant SI?

Do you have a central bank of complaints, SEAs/SUIs that are easily accessible for doctors?

What other data provided by your DB can they use?

What feedback tool do you use? (Patient and colleague)

Is the feedback gathered appropriately (according to GMC guidelines) and benchmarked?

Do you have any doctors for whom gathering patient feedback is more challenging and if so what do you advise them?

## HR

When doctors join your DB do you routinely ask them when they last had an appraisal and when their revalidation is due?

What is your system to check GMC details, identity, indemnity, qualifications, references, DBS?

(Particularly relevant if you use locums/short term employment)

Does your RO ever contact a doctor's last RO or use the MPIT form?

Do doctors have an appraisal talk as part of their induction?

How else do you sign post them about appraisal?

Can doctors choose their own appraiser/decline an appraiser? (Guidance suggests that the revalidation and appraisal team should allocate appraisers but if there is a COI then the doctor/appraiser can request another appraiser).

Do you have any Temporary and Occasional registration doctors working with your organisation (they will not be connected and do not require revalidation)?

## Appraisers

How many appraisals does an appraiser do each year?

How long does each appraisal take? (Include prep, 1:1 and write up)

Do you feel that you have enough support as an appraiser?

Is there good leadership in appraisal?

Do you attend network meetings and/or appraisal workshops?

Have you had any feedback or benchmarking relating to your appraisal work?

Have you ever had a 1:1 with the appraisal lead?

When appraising do you look for SI covering scope of work? Is there any resistance to this from doctors? This includes work elsewhere, private work, sports medicine work etc.

Is there any confusion over job planning/DB objectives vs personal learning needs?

Do you evidence your appraisal work for your own appraisal and include appraiser items in PDP?

## Examples of outputs – refer to ASPAT

Are there good detailed summaries?

