



**DEFENCE MEDICAL
SERVICES
&
FOREIGN &
COMMONWEALTH
OFFICE**

**GP REVALIDATION
PILOT**

SEP 10 – MAR 11

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METHODOLOGY

Introduction

1. A national revalidation system is being established in response to concerns raised by inquiries into the conduct of several doctors, including Harold Shipman. All doctors wishing to undertake clinical work will be required to demonstrate to the General Medical Council (GMC) that they are up-to-date, and fit to practise. Doctors who take part in revalidation will be granted a licence to practise, and will be reassessed every 5 years.

2. The GMC has delegated responsibility for proposing the criteria and standards for revalidation of doctors in each clinical specialty to their respective Royal Colleges, Faculties and Specialist Associations. The Royal College of General Practitioners (RCGP) is developing the revalidation requirements for doctors wishing to relicense as General Practitioners. Doctors will relicense in the job that they actually do. As General Practice is a broad church, the RCGP's revalidation requirements must be realistic, proportionate and achievable for all GPs, irrespective of the setting in which they work. Accordingly, to inform their '*Guide to the Revalidation of General Practitioners*' (available at: www.rcgp.org.uk) in conjunction with the NHS Revalidation Support Team's Pathfinder Pilots, the RCGP commissioned a series of pilot studies to explore the revalidation challenges facing GPs currently working in NHS and non-NHS settings.

3. The Defence Medical Services (DMS) constitute one of the largest single groups of GMC-registered GPs who ordinarily work outside the NHS. The Surgeon General, as the DMS' End to End process owner, and the Foreign & Commonwealth Office (FCO)'s Responsible Officer must ensure that GPs (whether military or civilian) working within their organizations are able to comply with the GMC and RCGP's requirements for GP revalidation when roll-out begins in December 2012. As the nature of their peacetime roles, and thus the potential revalidation challenges facing DMS and FCO GPs are very similar, the DMS and FCO partnered to comprise one non-NHS pilot site within the RCGP's national pilots programme.

4. Annual appraisal for all DMS doctors has been defined in Defence-wide policy since 2002. FCO GPs have been included in the DMS appraisal system for the last two years. Accordingly, volunteers in the DMS & FCO GP Revalidation Pilot did not regard annual appraisal or revalidation as a threat. Almost all DMS and FCO GPs had previously provided supporting information for their Annual Appraisals in 'hard copy'. Although the logistical challenge of organizing supporting information appropriately within the Department of Health (England)'s Pilot e-Portfolio was recognized, overall DMS & FCO GPs considered themselves to be well-informed about the required process, and well-prepared for the roll-out of revalidation.

Background

5. The Medical Act 1983 (as amended in 2000) defines the purpose of regulation as being: 'to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine'.

6. The Report of the Bristol Inquiry, 2001, added that in ensuring safety and quality for patients, healthcare regulation should: 'involve all matters affecting the performance of the individual, and cover initial education, training, appraisal, continuing professional development and, where relevant, disciplinary action.

7. The DMS and FCO recognize the link between performance monitoring, healthcare regulation and life-long learning. Working within a necessarily hierarchical organization, military GPs are already familiar and comfortable with the GMC's four-layer model of regulation: personal regulation; team-based regulation; workplace regulation; and national regulation. As Defence is not devolved, DMS GPs deliver equivalent capability in England, Scotland, Wales and Northern Ireland. Furthermore, due to their unique global role, DMS and FCO GPs also appreciate the importance of international co-operation.

8. The *'Medical Revalidation – Principles and Next Steps: The Report of the Chief Medical Officer for England's Working Group'* defined the purposes of revalidation as:

a. To confirm that licensed doctors practise in accordance with the GMC's generic standards.

b. For doctors on the Specialist Registers and GP Register, to confirm that they meet the standards appropriate to their specialty.

c. To identify for further investigation, and remediation, poor practice where local systems are not robust enough to do this or do not exist.

d. To sustain and enhance public confidence in the profession as a whole by providing periodic assurance that doctors continue to be fit to practise.

e. To improve the quality and reduce the risks of patient care.

9. GP revalidation will be a single process incorporating the previously proposed single tenets of relicensing and recertification.

10. The RCGP has been empowered by the GMC to set the standards for those in General Practice by agreeing the evaluation methods and supporting information for those GMC-registered doctors who wish to remain licensed as GPs. After extensive consultation, the GMC will then agree these proposed standards and methods of evaluation. The volunteers in the DMS & FCO GP Revalidation Pilot have explored how the proposed GP evaluation methods and supporting information will impact upon GPs who ordinarily work outside the NHS.

Aims

11. The DMS & FCO GP Revalidation Pilot aimed to explore:
 - a. Whether the RCGP's requirements for supporting information, defined in the RCGP's '*Guide to the Revalidation of General Practitioners*' are realistic, proportionate and achievable for GPs working within the DMS & FCO's non-NHS managed healthcare systems.
 - b. The challenges associated with collating the supporting information required for GP revalidation within a Pilot electronic portfolio (e-portfolio) provided by the Department of Health (England).

Objectives

12. The objectives of the DMS & FCO GP Revalidation Pilot were to:
 - a. Test the feasibility of supporting information collection by GMC-registered GPs in non-NHS settings within the UK and overseas.
 - b. Identify any needs that the DMS and FCO Responsible Officers might have in interpreting the contents of their GPs' portfolios to inform fair and consistent relicensing recommendations.
 - c. Identify any generic demands upon non-NHS organizations that may result from the RCGP's revalidation proposals.

Participants

13. All participants in the DMS & FCO GP Revalidation Pilot were volunteers. Participation in the Pilot conveyed neither career advantage nor disadvantage.
14. The DMS & FCO GP Revalidation Pilot involved:
 - a. GPs ordinarily working outside the NHS. To provide proportionate quantitative balance to the 120 NHS GPs recruited in RCGP-Warwick University's 'mainstream' NHS GP Revalidation Pilot, a total of 63 GPs were recruited: 20 Royal Navy; 20 Army; 20 Royal Air Force; and 3 FCO. The Research Team contacted each designated body and the FCO to obtain the names and contact details of volunteers within each cohort. Each cohort included a representative sample of GPs working within that organization (ie. military uniformed Medical Officers and Ministry of Defence-employed Civilian Medical Practitioners; experienced GPs and newly-qualified GPs; GPs in full-time clinical appointments; GPs working as medical managers or in educational posts; and GPs based in UK and overseas). All GPs in the pilot were working full-time. [The revalidation challenges facing sessional doctors have been considered through a separate RCGP pilot study].

- b. Nominated Responsible Officers. The four DMS Responsible Officers (Director Royal Naval Medical Services; Director General Army Medical Services; Chief of Staff Health/Director General Medical Services (Royal Air Force) and the Defence Dean) undertook a revalidation familiarization session with the GMC and provided their opinions regarding the RCGP's current criteria and standards required to inform their GP relicensing recommendations.
- c. Experienced GP Appraisers. Experienced DMS GP Appraisers were asked to provide feedback on the required supporting information.
- d. Department of Health (England) IT Consultants. The Royal Navy, Army and Royal Air Force revalidation leads undertook 'Train the Trainer' training delivered by Sapient, the software supplier of Department of Health (England)'s e-portfolio to familiarize them with the operating platform's functionality.

Ethical Considerations

15. As the DMS & FCO GP Revalidation Pilot did not involve any interventions that could potentially harm the individual physically, mentally or in career terms, ethical approval from the Ministry of Defence's Research Ethics Committee was not required.

Data Collection

16. Military and civilian GPs working within the DMS and FCO in the UK and overseas volunteered to submit items of supporting information as defined within the RCGP's *'Guide to the Revalidation of GPs'* via an e-portfolio supplied by the Department of Health (England). Data was collected between Sep 10 and Mar 11.

Assessment Tools

17. A mixture of qualitative and quantitative assessment tools was used to address the DMS & FCO GP Revalidation Pilot's aims and objectives. The data sets collected were to:

- a. Explore whether the collection of supporting information as required by the RCGP's *'Guide to the Revalidation of General Practitioners'* is realistic, proportionate and achievable for GPs ordinarily working outside the NHS (AIM 1). Participants completed an:

- (i) E-Portfolio. Participants provided their supporting information within Sapient's Revalidation Pilot e-portfolio provided by Department of Health (England). The Research Team provided an IT central administrator function for all participants (Squadron Leader Trevor Hopper). All participants received oral and written guidance on how to collect their supporting information, and had access by e-mail

and telephone to members of the Research Team for the duration of the pilot.

(ii) Issues log. Participants completed a 'free text' Issues Log to record their observations, personal perspectives (positive & negative) and/or challenges or problems that arose whilst they were collecting and uploading their supporting information.

b. Explore the challenges associated with collating this supporting information within an e-portfolio (AIM2). Participants:

(i) Self-assessed and scored the quality of their own supporting information on a scale of 0-7 defined as: 1 - Excellent; 2 - Very Good; 3 - Good; 4 - Average; 5 - Worse than Average; 6 - Poor; 7 - Very Poor; 0 - No submission.

(ii) Scored the ease with which they were able to attain the required supporting information from 0-4: Score 1 - Very Easy; 2 - Moderately Easy; 3 - Moderately Hard; 4 - Very Hard; 0 - No submission.

(iii) The participants' data regarding their self-assessment of the quality of their supporting information and the ease with which they were able to collate it were provided on a Returns Form as below:

DMS & FCO GP REVALIDATION PILOT VOLUNTEER RETURNS FORM

Domain	Supporting Information ¹	Sep 10 – Mar 11	Self-Ass ²	Ease ³
1	Description of Roles	✓	0 - 7	0 - 4
2	Exceptional Circumstances	✓	0 - 7	0 - 4
3	Evidence of Appraisals	Two	0 - 7	0 - 4
4	PDPs	Two	0 - 7	0 - 4
5	Reviews of PDPs	One	0 - 7	0 - 4
6	Learning Credits	25	0 - 7	0 - 4
7	Multi-Source Feedback (MSF) from colleagues	Either one MSF or one patient survey	0 - 7	0 - 4
8	Patient Survey			
9	Review of Complaints	✓	0 - 7	0 - 4
10	Significant Event Audit	One	0 - 7	0 - 4
11	Conventional 8-part Audit	One	0 - 7	0 - 4
12	Probity & Health statements	✓	0 - 7	0 - 4

c. Identify any needs that the DMS and FCO Responsible Officers might have in interpreting the contents of their GPs' portfolios to inform fair and consistent relicensing recommendations to the GMC. The four DMS Responsible Officers (Director Royal Naval Medical Services; Director General Army Medical Services; Chief of Staff Health / Director General Medical Services (Royal Air Force) and the Deanery Dean) undertook a revalidation familiarization session facilitated by Una Lane (GMC) and provided their opinions regarding the RCGP's current criteria and standards required to inform their GP relicensing recommendations.

¹ A full description each type of supporting information is provided at: http://www.rcgp.org.uk/PDF/PDS_Guide_to_Revalidation_for_GPs.pdf

² Self-Assessment rating tool: 1 - Excellent; 2 - Very Good; 3 - Good; 4 - Average; 5 - Worse than Average; 6 - Poor; 7 - Very Poor; 0 - No submission.

³ Ease of collation of supporting information: 1 - Very Easy; 2 - Moderately Easy; 3 - Moderately Hard; 4 - Very Hard; 0 - No submission.

18. The DMS & FCO GP Revalidation Pilot did not include the undertaking of a bespoke GP Appraisal as all participants were already subject to Annual Appraisal within their parenting organisations.

Risk Areas and Mitigations

19. The following factors were identified as areas of risk:

- a. Risk 1: Inability to recruit adequate numbers of GPs who ordinarily work outside the NHS. Mitigations: involvement of Royal Navy, Army and Royal Air Force Advisors in General Practice; and recruitment presentations at the DMS Appraisers Conference and DMS GP Refresher Course. A letter providing information about the DMS & FCO GP Revalidation Pilot was sent to all DMS and FCO GPs (D/SGD/5/2/1 dated 1 Nov 10).
- b. Risk 2: Participants dropping out. Mitigation: maintenance of regular contact between the Research Team and the Royal Navy, Army and Royal Air Force Advisors in General Practice to enable 'case tracking' and to provide insight into why any participants dropped out.
- c. Risk 3. Lack of access to the e-Portfolio. Mitigations: The Department of Health (England)'s pilot e-portfolio was made accessible via the Internet (so NHS N3 access was not required). Squadron Leader Trevor Hopper acted as an Administrator for all participants; IT support was available for all participants from Sapient via the Administrator.

Reporting

20. Regular DMS & FCO GP Revalidation Pilot updates were provided to the Royal Navy, Army and Royal Air Force Responsible Officers, the FCO proposed Nominated Officer (Dr Dipti Patel) and HQ Surgeon General via:

- a. Monthly narrative reports on the DMS & FCO GP Revalidation Pilot activities.
- b. Highlight Reports: to inform RCGP Stakeholders Meetings attended by the Defence Director of Postgraduate General Practice Education (Group Captain Alison Amos), identifying:
 - (i) Progress against milestones shown on the project timeline.
 - (ii) Any issues or risks identified.
 - (iii) Any variation from the pilot protocol and/or change to the proposed timeline.

21. In addition, the DMS Revalidation Lead (Group Captain Richard Withnall) provided verbal updates regarding the DMS & FCO GP Revalidation Pilot at RCGP Revalidation Team meetings.

RESULTS

Recruitment

22. All 63/63 (100%) required GMC-registered GPs who ordinarily work outside the NHS were recruited from within the DMS and FCO-managed healthcare environments: 20 Royal Navy (32%); 20 Army (32%); 20 Royal Air Force (32%); 3 FCO (4%).

Inclusions

23. All GPs working within the Defence Medical Services and the Foreign & Commonwealth Office were eligible to be included in the DMS & FCO GP Revalidation Pilot. Accordingly, all 63 volunteers were included in the Pilot.

Participant Submissions

24. 43/63 (68%) participants successfully:

- a. Logged into the Department of Health (England)'s pilot e-portfolio;
- b. Uploaded their supporting information as defined within the RCGP '*Guide to the Revalidation of GPs*' and provided an Issues Log; and
- c. Completed Returns Forms that:
 - (i) Self-assessed and scored the quality of their own supporting information; and
 - (ii) Scored the ease with which they were able to attain, collate and upload their supporting information.

25. Three volunteers (5%) provided complete portfolios in 'hard copy', and offered 'free text' observations within Issues Logs highlighting their experiences and observations whilst collecting and trying to upload their supporting information. These comments have been included anonymously in the narrative that follows. Nevertheless, as these individuals did not provide Returns Forms scoring the quality of their own supporting information, nor scoring the ease with which they were able to attain, collate and upload their supporting information, these three participants were excluded from the quantitative analysis.

26. Similarly, two volunteers from the FCO (66%) provided 'free text' data, but none of the FCO participants provided Returns Forms. Hence, these individuals' anonymised data have also been included in the narrative, but no FCO participants have been included in the quantitative analysis. Accordingly, of the original 63 volunteers recruited, the final 43 (68%) included in the numerical analysis were:

- 14/20 (70%) Royal Navy.
- 16/20 (80%) Army.
- 13/20 (65%) RAF.

Participant Drop-Outs

27. Twenty volunteers initially recruited into the DMS & FCO GP Revalidation Pilot (32%) failed to:
- a. Log into the Department of Health (England)'s e-Portfolio; and/or
 - b. Upload their supporting information as defined within the RCGP '*Guide to the Revalidation of GPs*'; and/or provide an Issues Log; and/or
 - c. Complete Returns Forms that:
 - (i) Self-assessed and scored the quality of their own supporting information; and
 - (ii) Scored the ease with which they were able to attain, collate and upload their supporting information.
28. The reasons provided for volunteer drop-out were:
- a. Pressure of work in the 'day job' (8 volunteers, 40%).
 - b. Inability to access the Department of Health (England)'s e-Portfolio (3 volunteers, all of whom had Mac-derived e-mail addresses, 15%).
 - c. Nomination for deployed Operations (3 volunteers, 15%).
 - d. Change of role into a Command (non-GP) appointment (1 volunteer, 5%).
 - e. No reasons given despite follow-up (5 volunteers, 25%)

GP Data sets

29. The Self-Assessment scores for each participant to demonstrate score distribution are shown at Annex A.
30. The Ease of Collation scores for each participant to demonstrate score distribution are shown at Annex B.
31. The mean DMS data for self-assessment and ease of collation scores from the participants' Returns Forms are provided in the table below:

MEAN DMS DATA FOR QUALITY SELF-ASSESSMENT AND EASE OF COLLATION

Domain	Supporting Information ⁴	Sep 10 – Mar 11	Self-Ass ⁵	Ease ⁶
1	Description of Roles	✓	3.3	1.8
2	Exceptional Circumstances	✓	0.2	0.1
3	Evidence of Appraisals	Two	2.3	1.8
4	PDPs	Two	2.7	1.0
5	Reviews of PDPs	One	3.0	2.0
6	Learning Credits	25	3.1	2.1
7	Multi-Source Feedback (MSF) from colleagues	Either one MSF or one patient survey	3.2	2.3
8	Patient Survey		4.3	2.1
9	Review of Complaints	✓	2.9	1.9
10	Significant Event Audit	One	3.3	2.0
11	Conventional 8-part Audit	One	3.5	2.7
12	Statements of Probity & Health	✓	3.0	2.0
Mean score for all supporting information domains			2.9	1.8

⁴ A full description each type of supporting information is provided at: http://www.rcgp.org.uk/PDF/PDS_Guide_to_Revalidation_for_GPs.pdf

⁵ Self-Assessment rating tool: 1 - Excellent; 2 - Very Good; 3 - Good; 4 - Average; 5 - Worse than Average; 6 - Poor; 7 - Very Poor; 0 - No submission.

⁶ Ease of collation of supporting information: 1 - Very Easy; 2 - Moderately Easy; 3 - Moderately Hard; 4 - Very Hard; 0 - No submission.

PARTICIPANT NARRATIVES

32. Description of Roles

Participants' Mean Self-Assessment Rating: 3.3 (Good)

Participants' Mean Ease of Collation Rating: 1.8 (Very Easy)

- a. The GMC is basing revalidation on 'the jobs that doctors actually do'. Therefore, to ensure that Appraisers and Responsible Officers understand what activities their GPs undertake within each appraisal / revalidation cycle, all posts undertaken as a doctor (paid or voluntary) must be included in a GP's Description of Roles.
- b. DMS (military & civilian) and FCO GPs are provided with 'Terms of Reference' by their employing organizations defining the nature of their roles and responsibilities. The breadth of DMS and FCO GPs' responsibilities are arguably broader than those of most NHS GPs, as day-to-day activities include 'extended responsibilities' in clinical areas such as: pre-hospital emergency medicine, occupational medicine, travel medicine, sports and exercise medicine, public health, environmental health, aviation medicine, diving medicine and military community psychiatry. Many DMS GPs are also externally accredited GP Trainers, or Associate Trainers supervising General Duties Medical Officers (potential Hospital Specialists gaining wider military medical experience in a community setting). The DMS GPs are asked to sign their Terms of Reference to say that they accept the defined roles at the beginning of each appointment. DMS GPs change appointments approximately each 2-3 years; FCO doctors may stay 'at Post' for longer. Hence, participants found it very easy to provide a description of their roles.
- c. The relative quality of this supporting information was only regarded as 'Good to Average' as, despite the extended responsibilities, most Terms of Reference were considered to be relatively generic. Furthermore, Terms of Reference do not include any activities (paid or unpaid) that DMS GPs undertake 'outside their day jobs'. With Line Manager's authorization, DMS GPs are permitted to undertake clinical and educational activities in addition to their 'day jobs' (eg. NHS out-of-hours sessions; RCGP Examiner duties; research; voluntary work; medical cover for sporting events etc). Some individual DMS GPs are afforded the opportunity to undertake full-time academic or managerial roles. Nevertheless, the majority of DMS & FCO GPs work within clinical service-provision orientated frameworks defined by their employing organizations. DMS GPs undertaking additional non-Defence activities recognized the need to reflect these within their Description of Roles.
- d. DMS and FCO participants expressed their confidence that their Responsible Officers would have genuine insight into 'the jobs that they actually do'. The DMS Responsible Officers endorsed this view by confirming that they would have 'no difficulty' interpreting the Description of Roles within their doctors' revalidation portfolios.

33. Exceptional Circumstances

Participants' Mean Self-Assessment Rating: 0.2

Participants' Mean Ease of Collation Rating: 0.1

- a. Only three participants provided supporting information regarding exceptional circumstances. These all related to period within the last 12-months when the volunteer had been overseas on deployed military Operations, and thus they perceived it would have been challenging to collate supporting information for a 'real' revalidation e-Portfolio. As the absence of exceptional circumstances was considered an important observation when assessing the achievability of the RCGP criteria, nil returns (scored as zero) were included in the mean calculation. Accordingly, both means were <1.0.
- b. DMS and FCO participants welcomed the fact that the RCGP's *'Guide to the Revalidation of GPs'* recognizes that doctors may be absent from British clinical General Practice during each reporting cycle due to their 'working abroad' (the reason cited by the three volunteers) or other reasons such as: pregnancy; illness; career breaks; sabbaticals; or taking on non-clinical roles (which may apply to some DMS GPs undertaking purely managerial appointments).
- c. The DMS Responsible Officers agreed that notwithstanding such 'exceptional circumstances', there should be a minimum content to a portfolio if it is to be considered in the routine manner. They were comfortable with the RCGP's criterion that there should be active participation in approved appraisal with a PDP agreed and a review of a previous PDP in at least three of the five years in the revalidation cycle, irrespective of the exceptional circumstances.
- d. The DMS Responsible Officers highlighted potential difficulties associated with varying definitions of *'clinical'*. They observed that more senior DMS GPs might be required to undertake full-time Managerial Appointments alongside senior colleagues from other medical Specialties, especially Occupational Medicine. Current differences in definition between RCGP and Faculty of Occupational Medicine's revalidation guidance may result in inequity within the wider medical profession, and inequity within the DMS as a single organization between two colleagues of differing backgrounds who wish to remain on their respective GMC Registers despite their undertaking the same type of managerial appointment: the Faculty of Occupational Medicine defines clinical practice as *'carrying clinical risk'* (which Medical Managers undoubtedly do) without a necessity to maintain face-to-face patient contact. The RCGP's *'Guide to the Revalidation of GPs'* currently suggests that: 'a clinical half-day would normally last 4 hours and include at least 2.5 hours of *'face-to-face clinical contact'* and be conducted in an approved environment within the United Kingdom'. It was suggested that it would be helpful if the definition of Clinical Practice could be agreed and standardised at Academy of Medical Royal Colleges level.

34. **Evidence of Appraisals**

Participants' Mean Self-Assessment Rating: 2.7 (Very Good)

Participants' Mean Ease of Collation Rating: 1.8 (Very Easy)

- a. Participation in annual appraisal has been a requirement for all doctors in the DMS since 2002 as defined in Surgeon General Policy Letter 05/02. At the end of a satisfactory annual appraisal, the Appraiser signs a Form R4C which is provided to the Appraisee and the Medical Director General of the Royal Navy, Army or Royal Air Force (depending upon which Service the Medical Officer is from, or which organization the Civilian Medical Officer is working within). These Medical Director Generals are also the nominated DMS Responsible Officers.
- b. FCO GPs are now included in the DMS GP Annual Appraisal process. The FCO GPs, and their nominated Responsible Officer, also receive Form R4Cs to confirm satisfactory completion of Annual Appraisal.
- c. Participants considered that their extant appraisal documentation was high quality, and fit-for-purpose in the context of revalidation. The experienced DMS Appraisers who reviewed the supporting information endorsed this view. The DMS & FCO GP Revalidation Pilot volunteers found it easy to include the Form R4Cs within their revalidation portfolios.

35. **Personal Development Plans (PDPs)**

Participants' Mean Self-Assessment Rating: 2.7 (Very Good)

Participants' Mean Ease of Collation Rating: 1.0 (Very Easy)

- a. Surgeon General Policy Letter 05/02 directs that an annual PDP should be derived from participation in each annual appraisal. It is signed off by the Appraiser and the Appraisee, and represents the agreed plan for the forthcoming appraisal year.
- b. Participants considered that their extant PDP documentation was high quality, and fit-for-purpose in the context of revalidation. The experienced DMS Appraisers who reviewed the supporting information endorsed this view. The DMS & FCO GP Revalidation Pilot volunteers found it easy to include the PDPs within their revalidation portfolios.
- c. Although the policy does not define a minimum or maximum number of goals to be proposed within a PDP, most volunteers' had set themselves 5-6 goals reflecting: their own developmental needs; the breadth of their practice; and the health needs of their population at risk. It was noted from the RCGP's *'Guide to the Revalidation of GPs'* that most NHS GPs set themselves 3-4 objectives within their PDPs.
- d. The DMS and FCO Responsible Officers recognised the need to ensure that the amalgamated PDPs submitted in a 5-year revalidation period represented an appropriate spread of development across all areas

included within that GP's 'Description of Roles', including the GPs' activities undertaken outside the DMS or FCO.

e. In accordance with wider military task-setting activities, the DMS Responsible Officers favoured the use of SMART objectives:

- (i) **Specific:** described in such a way that the goal and what it was intended to achieve can be understood.
- (ii) **Measurable:** specifying how the GP, the appraiser and the responsible officer will know if it has been achieved.
- (iii) **Achievable:** the goal should be realistic given the GP's position and resources available.
- (iv) **Relevant:** the goal must be relevant to the needs of the GP, and the goals overall should be relevant to the clinical work undertaken by the GP.
- (v) **Time bounded:** there must be a specified time by which the goal will be achieved.

36. **Review of PDPs**

Participants' Mean Self-Assessment Rating: 3.0 (Good)

Participants' Mean Ease of Collation Rating: 2.0 (Moderately Easy)

- a. The review of the previous year's PDP and the Appraisee's reflections upon progress towards their developmental objectives are central tenets within the current DMS and FCO GP Appraisal processes.
- b. Participants considered that their extant PDP review documentation was of good quality, and fit-for-purpose in the context of revalidation. The experienced DMS Appraisers who reviewed the supporting information endorsed this view. The DMS & FCO GP Revalidation Pilot volunteers found it easy to include the PDP review documentation within their revalidation portfolios.
- c. It is recognised that not all objectives within a PDP can always be achieved; nevertheless, the experienced DMS Appraisers that reviewed the supporting information agreed that, in their experience, SMART objectives are more likely to be achieved.
- d. The DMS Responsible Officers opined that educational goals, whether met or not, should show supporting information of reflection on the development achieved or, if appropriate, the reasons for non-achievement.

37. Learning Credits

Participants' Mean Self-Assessment Rating: 3.1 (Good)

Participants' Mean Ease of Collation Rating: 2.1 (Moderately Easy)

- a. Within their extant annual appraisal processes, DMS and FCO GPs record their educational activity and are encouraged to reflect upon the impact of this learning upon their own development, their clinical practice and (where appropriate) the impact upon their patient outcomes.
- b. The DMS & FCO GP Revalidation Pilot was considered helpful in introducing participants to the system of continuing professional development learning credits developed by the RCGP to ensure that every GP: updates and applies his or her knowledge and skills; promotes patient confidence; and ultimately improves patient care.
- c. Within the DMS & FCO GP Revalidation Pilot, participants awarded themselves credits based upon the hours undertaken and the impact of the education on themselves, their patients and their service delivery. For the purposes of the 6-month Pilot, volunteers were asked to provide supporting information to support the award of 25 credits. Acceptable educational activity included: formal courses; lectures; seminars; small group or practice-based learning events; online learning; reading; learning a new skill; mentoring someone; action learning; becoming a GP Trainer or Associate Trainer; undertaking individual reflective activity, etc. Experienced DMS GP Appraisers were asked to confirm that recorded activities within the portfolios were genuinely 'educational'.
- d. Participants in the DMS & FCO GP Revalidation Pilot considered that the RCGP Learning Credits scheme was appropriate for all GMC-registered practising GPs, throughout the UK and overseas. They also endorsed the RCGP's current position that the credit system should not be purely based on time spent, but also reflect the impact and outcomes of that educational activity. Most DMS & FCP GP Revalidation Pilot portfolios contained reflective records for each developmental activity.
- e. Participants considered that their Learning Credit supporting information was of good quality, and fit-for-purpose in the context of revalidation. This view was endorsed by the experienced DMS Appraisers who reviewed the supporting information. The DMS & FCO GP Revalidation Pilot volunteers found it moderately easy to include the Learning Credit documentation within their revalidation portfolios. There was frequently a need to scan in 'hard copy' certificates from educational events, then upload them into the Department of Health (England)'s e-portfolio with free text reflection added to describe the impact of the learning. Participants hoped that, in future, those facilitating educational events may provide confirmation of participation in 'soft copy' to reduce the resource implications (time, scanners) of uploading such supporting information.
- f. The DMS Responsible Officers noted that the RCGP Learning Credit

'multiplier' for reflection was an exception. All other medical Royal Colleges, Faculties and Specialist Associations are using purely time-based Learning Credit systems with a minimum of 50 credits in a year and 250 credits in a 5-year cycle to support a positive revalidation decision. The RCGP credit system will, therefore, infer different Learning Credit criteria for doctors in different specialities working within the same non-NHS organization.

38. **Multi-Source Feedback (MSF) from Colleagues**

Participants' Mean Self-Assessment Rating: 3.2 (Good)

Participants' Mean Ease of Collation Rating: 2.3 (Moderately Easy)

a. Participants in the DMS & FCO GP Revalidation Pilot were asked to produce supporting information of either one MSF or one Patient Survey. The majority of volunteers (34/43,79%) provided evidence of Multi-Source Feedback from Colleagues.

b. DMS and FCO GPs already undertake Annual Performance Reviews with written reports produced by clinical and non-clinical colleagues to inform that GP's future development. The DMS system is both summative and formative. Within '*Officers Joint Appraisal Reports (OJARs)*', grades and written narratives are provided against the attributes of: Leadership; Professional Effectiveness; Effective Intelligence; Judgement; Management; Initiative; Reliability; Powers of Communication; Subordinate Development; and Courage & Values. Further narrative is then offered regarding a GP's potential, including developmental advice where appropriate.

c. The majority of participants considered that their OJAR Annual Performance Reviews should provide adequate MSF information for revalidation. The participants considered that their extant OJAR documentation was comprehensive, of good quality, and fit-for-purpose in the context of revalidation. This view was endorsed by the experienced DMS Appraisers who reviewed the supporting information; these Appraisers also write OJAR Annual Performance Reviews on their subordinate GPs, so were considering this supporting information from two different perspectives: authors & reviewers. The DMS & FCO GP Revalidation Pilot volunteers found it moderately easy to include the OJAR Annual Performance Reviews within their revalidation portfolios: most OJARs were available in 'soft copy', although some had to be scanned and then up-loaded into the Department of Health (England)'s e-portfolio.

d. The DMS Responsible Officers were keen that RCGP should recognise OJAR Annual Performance Reviews as acceptable forms of MSF from colleagues, and potential alternatives to: the GMC MSF; the Sheffield Peer Review Assessment Tool Version 2 (GP-SPRAT); and the Colleague Feedback Evaluation Tool Version 2 (CFET). They considered that the philosophy of the RCGP's '*Guide to the Revalidation of GPs*' is currently practice-focused in requiring GPs to: 'identify a number of GP colleagues and other people (nurse, practice manager, practice secretary, receptionist, etc.) with whom he or she works sufficiently closely to enable informed and

representative opinions to be made'. Whilst this is entirely appropriate for the majority of NHS GPs, the DMS Responsible Officers observed that some GPs working in non-NHS settings may spend the majority of their time working outside a practice. Therefore, multi-source feedback from colleagues reflecting 'the job those GPs actually do' might also need to include non-practice based clinical and non-clinical colleagues.

e. It was agreed, however, that the most important aspect of doing colleague surveys is reflecting upon the results and, if appropriate, implementing changes.

39. **Patient Surveys**

Participants' Mean Self-Assessment Rating: 4.3 (Average)

Participants' Mean Ease of Collation Rating: 2.1 (Moderately Easy)

a. The RCGP's '*Guide to the Revalidation of GPs*' highlights that: 'once revalidation is fully established, the portfolio should include the results of a patient survey undertaken in the first 3 years of the 5-year revalidation period. On the basis of its own externally-commissioned reviews, the RCGP currently considers that: the GMC Patient Questionnaire; the Improving Practice Questionnaire (IPQ); the Edgecumbe 360 Version 2; and the Doctors' Interpersonal Skills Questionnaire (DISQ) are fit for purpose for revalidation. GPs will need to seek the views of the patients *actually consulting*. Practice-based surveys of the registered population will not be acceptable.

b. Participants in the DMS & FCO GP Revalidation Pilot were asked to produce supporting information of either one MSF or one Patient Survey. The majority of volunteers provided evidence of Multi-Source Feedback from Colleagues; only 9/43 (21%) provided a Patient Survey. The Returns Forms indicated this was because participants found it logistically easier to insert a copy of their last OJAR Annual Performance Review than to conduct a bespoke Patient Survey.

c. Those participants that did include a Patient Survey considered that they were only of 'average' quality. This was the lowest mean self-assessment rating of any supporting information criteria. Patient numbers per survey ranged from 10 – 30 (mean 16).

d. DMS respondents highlighted the potential confounding influence of undertaking a Patient Survey within a necessarily hierarchical organisation, such as the Military, where the rank of the GP may in some instances be significantly higher than the patients they are consulting. Furthermore, DMS GPs were concerned that the typically high turnover of Service personnel and their families within military practices as a result of individuals' 'postings' could constrain patient feedback and challenge the ability of individual doctors and their wider Primary Healthcare Teams to demonstrate progress against recommendations made within patient feedback surveys. They reflected this potential bias within their self-assessment rating scores.

e. These concerns reduced with the relative experience of the participant GP. Several of the participant DMS GP Trainers, two of the FCO GPs and the experienced DMS GP Appraisers who reviewed the supporting information, regarded Patient Surveys as the most valuable and insightful data in facilitating professional development – irrespective of the rank, social standing or mobility of the patients. Accordingly, they highlighted the need for Patient Surveys to be undertaken early in the revalidation cycle to allow time for reflection, change and a further patient survey to be undertaken demonstrate improvement.

f. The DMS Responsible Officers highlighted that historically, the Ministry of Defence has had reservations about the administration of even anonymised feedback questionnaires asking more junior members of staff to comment upon their Superiors – even if this is to offer constructive criticism or socialise issues they might feel uncomfortable to do face-to-face. However, such feedback processes are now routinely adopted as a component of Senior Staff development in both the Ministry of Defence and Foreign & Commonwealth Office, as exemplified within Military and Civil Servant Executive Management Courses undertaken in partnership with respected organizations such as the Ashridge Business School.

40. **Reviews of Complaints**

Participants' Mean Self-Assessment Rating: 4.3 (Average)

Participants' Mean Ease of Collation Rating: 2.1 (Moderately Easy)

a. The extant DMS and FCO Annual Appraisal processes already include a review of complaints, whether they have been received at the tactical (practice), organisational (Royal Navy, Army or Royal Air Force Headquarters) or strategic (HQ Surgeon General) level. The Ministry of Defence has had a contract with the National Clinical Assessment Service for the last three years, so external assessment of any DMS GP causing concern can be facilitated. Referral to the GMC is obviously also an option. The Defence Postgraduate Medical Deanery can provide remediation packages for any DMS GP at any stage of this process, and an Assistant Director is appointed within the Defence Deanery as a central point of contact and advice regarding performance concerns.

b. Complaints against GPs in the DMS and FCO are rare. Participants considered that their Review of Complaints documentation was only of 'Average Quality' as most submitted nil returns. They believed, however, that the requirement to provide information about any complaints received was fit-for-purpose in the context of revalidation. This view was endorsed by the experienced DMS Appraisers who reviewed the supporting information. The DMS & FCO GP Revalidation Pilot volunteers found it only moderately easy to include Review of Complaints documentation within their revalidation portfolios as many commented that they had nothing to submit as no complaints had been received. It was recognised, however, that complaints could prove a powerful driver for self-reflection and future development.

41. **Significant Event Audit**

Participants' Mean Self-Assessment Rating: 3.3 (Good)

Participants' Mean Ease of Collation Rating: 2.0 (Moderately Easy)

- a. Significant Event Audit within a non-blame culture has been acknowledged as an important quality tenet within the military and the airline industry for several decades. DMS General Practices routinely undertake Significant Event Audits as part of their clinical, organisation and administrative governance processes.
- b. For the purposes of the DMS & FCO GP Revalidation Pilot, participants were asked to provide documented evidence of a single Significant Event Audit demonstrating how that GP reflected upon, and learned from, an occurrence to improve their quality of care. The occurrence could have been something that went well, or (in the majority of Significant Event Audits that were submitted within the e-portfolios) something that could have been done better. It was highlighted that the Significant Event Audit should not allow patients to be identified and should comprise the specific components in accordance with the Department of Health (England)'s e-Portfolio: the title of the event; the date of the event; the date the event was discussed and with whom; a description of the event; what went well?; what could have been done differently?; reflections on the event; changes that have been agreed; and changes that have now been carried out.
- c. Participants considered that their Significant Event Audits were of good quality, and fit-for-purpose in the context of revalidation. This view was endorsed by the experienced DMS Appraisers who reviewed the supporting information. The DMS & FCO GP Revalidation Pilot volunteers found it moderately easy to include the Significant Event Audit data within their revalidation portfolios. The electronic template was considered quite cumbersome to use: information could not be 'cut & pasted' into the e-Portfolio from pre-existing Significant Event Audit files created in 'Word' or 'Notes'. Instead, the information had to be re-typed into each free text field, and each field had to be completed before a participant could move onto another field within the template.

42. **8-Part Audit**

Participants' Mean Self-Assessment Rating: 3.5 (Good)

Participants' Mean Ease of Collation Rating: 2.7 (Moderately Easy)

- a. The RCGP's '*Guide to the Revalidation of GPs*' highlights that all GPs should already be familiar with the principles and practice of clinical audit. Hence, when revalidation is fully established, each GP should be able to demonstrate that they have taken part in at least one full audit cycle (initial audit, change implemented, re-audit to demonstrate improvement) during the revalidation period. It is understood that the RCGP is exploring methods of clinical audit and may, in time, recommend a range of acceptable types of local, regional and national audit supporting information.

b. All 43 GPs submitting portfolios in the DMS & FCO GP Revalidation Pilot had prior experience of presenting audits for peer scrutiny within Summative Assessment, MRCGP or annual appraisal processes. Despite their familiarity with the required process, DMS Appraisers reported that their Appraisees regularly needed encouragement to undertake clinical audit, and the participants' mean score for ease of collation indicated that they found 8-part clinical audit to be the most difficult of all the required components of supporting information to collate.

c. Experienced DMS GP Appraisers quality-assured the audits to ensure they included: the title of the audit; the reason for the choice of topic; the dates of the first data collection and the re-audit; the criteria to be audited and the standards set, with their justification (reference to guidelines etc); the results of the first data collection in comparison with the standards set; a summary of the discussion and changes agreed, including any changes to the agreed standards; the changes implemented by the GP; the results of the second data collection in comparison with the standards set; the quality improvement achieved; and reflections on the clinical audit.

d. All participants had fully contributed to the choice of topic and the standards set. It was noted, however, that the DMS and FCO GPs personally undertook the data extraction and the analysis within their audits - which is not a necessity for revalidation.

e. Participants reported that obtaining data for clinical audits was a challenge due to technical issues within the DMS' 'DMICP' medical information management system. Whilst practice-based audits were easily achievable within both the DMS and FCO, population-based data (such as E-PACT to demonstrate prescribing pattern comparisons) are not currently available. Work is ongoing to remedy this capability gap. Nevertheless, the additional effort required to obtain reliable data from the current medical information system may have influenced the participants' ease of collation scores. Delegating the data collection activities could, however, have reduced the concerns expressed in the free-text Issues Logs that it was challenging to complete two complete data collections and demonstrate a positive effect in terms of patient outcome within the 6-month duration of the DMS & FCO GP Revalidation Pilot.

43. **Statements of Probity & Health**

Participants' Mean Self-Assessment Rating: 3.0 (Good)

Participants' Mean Ease of Collation Rating: 2.0 (Moderately Easy)

a. In their narrative Issues Logs, participants reported that they had previously found it 'difficult to know what to write' regarding their own probity and health. Accordingly, they reported that being asked to verify a standard statement (or to provide an alternative statement) that would be very similar for all doctors was a welcome handrail to address these issues within annual appraisal and revalidation.

b. The participants were comfortable to consider a standard statement confirming that:

(i) There are no issues of probity in their work.

(ii) There are no health issues that might affect their ability to deliver safe care to patients (including infections, immunisation status such as against hepatitis B, problems with drugs and alcohol, mental health concerns and other significant diagnoses or problems);

(iii) If appropriate: they have a health condition which is being treated adequately and that their own doctor has no concerns about their fitness to practise.

(iv) They are in a position to receive independent, impartial healthcare advice (eg. not consulting a family member), and that he or she can access that health care appropriately.

(v) They have appropriate and current insurance or indemnity cover for all aspects of his or her work.

c. The participants noted that they benefit from Crown Indemnity cover for all their primary duties (as described in the Terms of Reference) or other activities they are asked to do by their parenting organizations. Both the Ministry of Defence and the Foreign & Commonwealth Office recommend that their GPs take out additional insurance or indemnity to cover any medical activities undertaken outside their core roles. The majority of DMS and FCO GPs follow this advice, and participants in the DMS & FCO GP Revalidation Pilot were content to provide the name of the organization providing their insurance or indemnity cover and their membership number.

d. The DMS participants also observed, however, that although the RCGP's *'Guide to the Revalidation of GPs'* suggests that: 'Unless there is good reason, it is best practice for a GP to be registered in a practice in which he or she does not work', uniformed Medical Officers are required to register with a military GP for their own primary healthcare. Sometimes, due to geographical constraints (eg. Serving overseas) this has to be the practice in which they work. The DMS Responsible Officers were confident that such constraints could be considered a 'good reason' within the spirit of the RCGP Guide.

CONCLUSIONS

44. Overall Results

Participants' Mean Self-Assessment Rating: 2.9 (Very Good)

Participants' Mean Ease of Collation Rating: 1.8 (Very Easy)

a. Overall, the participants in the DMS & FCO GP Revalidation Pilot considered that the collection of supporting information as required by the

RCGP's *'Guide to the Revalidation of General Practitioners'* is realistic, proportionate and achievable for GPs ordinarily working outside the NHS.

b. Few participants reported any significant difficulty in collating the required supporting information. Overall, the most challenging components were: Patient Satisfaction Surveys (that received the lowest mean self-assessment rating); and 8-part Audit (that received the lowest mean ease of collation rating).

c. The DMS Appraisers and DMS Responsible Officers reported they were comfortable to interpret the DMS and FCO GPs' supporting information, and felt the RCGP's proposed areas of supporting information were relevant and appropriate.

d. The Appraisers and DMS Responsible Officers expressed some surprise at the relatively low amount of supporting information required of GPs (eg. One Patient Survey per 5 years). It was felt at least two data collections for each criteria were required within any one 5-year revalidation cycle in order that a doctor can demonstrate either change or consolidation between the data collections.

Use of the Department of Health (England) e-Portfolio

45. The Department of Health (England) acknowledged that their e-portfolio was only intended to act as a vehicle for the duration of the national revalidation pilots; it was never presented by Sapien as a definitive solution. Unfortunately the pilot e-portfolio proved unpopular with the DMS and FCO volunteers, as it was not considered to be 'user-friendly'.

46. Volunteers reported that it took a disproportionate amount of time to upload supporting information into the e-portfolio due to: an inability to 'cut and paste' information into it from other pre-prepared documents; and a requirement to fill each template or free-text field before being able to progress onto the next within the e-portfolio. Furthermore, as it was not guaranteed that the supporting information uploaded into the Department of Health (England)'s e-portfolio would be retrievable at the end of the DMS & FCO GP Revalidation Pilot, participants had to keep back-up copies of each component of their submission. Accordingly, the participants' consensus was that the additional time and effort expended in using the e-portfolio conveyed no additional value over submitting the supporting information in hard copy.

47. Conversely, the nominated DMS Responsible Officers and experienced DMS Appraisers saw utility in Appraisees submitting supporting information within e-portfolios. Such vehicles assist the tracking of supporting information (eg. using clinical dashboards) and allow Appraisers and Responsible Officers an expeditious means of searching for, and drilling down into, individual pieces of supporting information as required.

48. As a variety of e-portfolios are being developed by commercial providers, the British Medical Association, the RCGP etc, participants in the DMS & FCO GP

Revalidation Pilot have been encouraged not to discount e-portfolios out of hand based upon their experiences with the Department of Health (England)'s pilot e-portfolio. It remains unclear, however, whether e-portfolios will be compulsory vehicles within revalidation. It is understood that the British Medical Association's General Practitioners Committee is still advocating the opportunity for GPs to submit their supporting information for annual appraisal and revalidation in 'hard copy'.

49. The DMS and FCO Responsible Officers agreed that the Ministry of Defence and the Foreign & Commonwealth Office will need to await, then follow national guidance on supporting information collation mechanisms when this is confirmed.

IT systems

50. Whilst it is recognized that individual GPs will be responsible for producing their own supporting information, the DMS & FCO GP Revalidation Pilot highlighted that the organizations' current IT systems will need to be strengthened to expeditiously generate valid and reliable data to support clinical audit, outcome monitoring and patient safety systems. Whilst progress is being made through a tri-Service Medical Information Management Strategy, the current inability to obtain such information quickly and reliably is considered by DMS GPs to be a capability gap. However, the British Medical Association has reported that the NHS is not in a position to provide such data yet either, implying that the DMS and FCO GPs are no worse off than their NHS colleagues.

Workload

51. The enhanced appraisal and revalidation workload needs to be manageable. The proposed supporting information is considered to be achievable, but flexibility will be required to allow appropriate time for the Appraisees to collate the necessary formation and to undertake the appraisals. Within the current DMS appraisal model, Appraisees are given ½ working day to collate their supporting information. Appraisers are also given ½ working day to review the supporting information in advance of the appraisal. The appraisals are then timetabled to last ½ working day for Appraisees and Appraisers. The Pilot indicated this was an appropriate amount of time. Hence, the total impact of each appraisal is the equivalent of two working days of clinical service delivery (one day for the Appraiser; one day for the Appraiser).

Remediation

52. The Department of Health (England) anticipates that there will be a 75% increase in the number of cases involving remediation. This increased remediation requirement was not manifest in the DMS & FCO GP Revalidation Pilot. Although the volunteers constituted a representative sample of the DMS and FCO GP community, no supportive information was provided that indicated to experienced GP Appraisers that the submitting participant required remediation. Nevertheless, the importance of a parallel remediation system was recognized.

53. Although at the national level, there is still a paucity of firm information about: who will carry out remediation; how it will be resourced; and the interface with GMC

Fitness to Practise procedures, the DMS & FCO GP Revalidation Pilot reinforced to the Ministry of Defence and the Foreign & Commonwealth Office the value of the transparency and support provided by contracts with external bodies, such as the National Clinical Assessment Service.

Responsible Officers

54. Although the Responsible Officer role of overseeing revalidation in the NHS is likely to fall to Medical Directors, within the DMS system, the Responsible Officer function is likely to be discharged by the Medical Directors General (the equivalent of NHS Chief Executives). It was anticipated that this level of seniority could give rise to 'concerns at the coalface' regarding potential conflicts of interest: is the Responsible Officers' main duty to support their GPs through the revalidation process, or to be accountable to the single Service Chiefs of Staff as the GPs' 'employers'? However, the DMS & FCO GP Revalidation Pilot confirmed that the participants were reassured by their Medical Director Generals' involvement as Responsible Officers. The participants opined that such experience and authority would ensure that the Responsible Officers have subject matter expertise regarding the specific contexts in which their GPs work, and that they have the ability to 'dip down' and/or mobilise resources to support or remediate individual GPs if required.

Equality

55. The DMS and FCO volunteers endorsed the RCGP's perspectives that revalidation needs to be a fair and open process, and that standards for General Practice should be equivalent to those of secondary care specialties. It was considered important that no-one, irrespective of their specialty, rank or seniority, should be asked to produce any more or less supporting information than their peers. The military GPs highlighted that on occasion, such as whilst serving overseas on deployed Operations in places such as Afghanistan, the ability to record and collate supporting information can be challenging. It is considered important that no GPs should be penalised within the revalidation process simply because they are unable to collect the evidence they need in the short-term. Accordingly, the RCGP's pragmatism regarding justifiable gaps in supporting information was welcomed.

The Value of the Pilot

56. The DMS & FCO GP Revalidation Pilot was considered a valuable process to test the proposed supporting information; to involve GPs from the Royal Navy, the Army, the Royal Air Force and the FCO in the national-level discussions regarding GP revalidation; and to publicise the volunteers' perspectives about GP revalidation at the strategic, organizational and tactical levels. The DMS & FCO GP Revalidation Pilot also provided an opportunity for each of the single Services and the FCO to learn lessons, and for improvements to be made to extant annual appraisal processes.

Generic Revalidation Resource Requirements for Non-NHS Healthcare Delivery Organizations

57. The DMS and FCO's experiences within this Pilot suggest that to comply with the RCGP's criteria and standards for revalidation, non-NHS healthcare delivery organizations will need to proactively apportion adequate resources. It is recommended that such considerations include:

- a. Socialisation of the RCGP's *'Guide to the Revalidation of GPs'* to all their GPs through their non-NHS delivery organization's policy mechanisms.
- b. Confirmation of the prescribed relationships between the non-NHS delivery organization's Responsible Officer(s) and their GPs.
- c. Access to appropriate data to inform the GPs' submission of supporting information.
- d. Appropriate IT and/or hard copy data collection and storage vehicles.
- e. Staff support to assist the GPs in their data collection.
- f. Protected time for Appraisees to collate and produce their supporting information.
- g. Protected time for annual appraisals for Appraisees and Appraisers.
- h. Quality assurance of the Appraisers.
- i. Remediation processes to run in parallel with the annual appraisal process to assist any GP colleagues needing additional support.
- j. Protected time for the Responsible Officer(s) to derive and deliver their recommendations to the GMC.

References

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ANNEX A: SELF-ASSESSMENT SCORES FOR EACH PARTICIPANT

Participant						Domain							TOTAL
	Roles	Exc Circum	Appraisals	PDPs	Review PDPs	Learn credits	MSF Colleg	Pt Surveys	Complaints	SEA	8-part audit	Prob & Health	
RN1	0	0	0	0	0	0	0	0	0	0	0	0	0
RN2	0	0	0	0	0	0	0	0	0	0	0	0	0
RN3	0	0	0	0	0	0	0	0	0	0	0	0	0
RN4	0	0	0	0	0	0	0	0	0	0	0	0	0
RN5	4	0	2	4	4	4	4	0	4	4	4	4	4
RN6	4	0	2	3	4	3	3	0	3	3	4	4	2
RN7	4	0	2	2	4	2	3	0	2	3	3	2	2
RN8	0	0	0	0	0	0	0	0	0	0	0	0	0
RN9	4	0	2	2	3	2	2	0	2	3	3	3	3
RN10	3	0	2	2	4	2	0	4	3	3	4	4	4
RN11	3	0	2	3	3	3	3	0	3	3	4	3	3
RN12	4	0	2	2	2	2	0	3	2	3	3	3	3
RN13	4	0	1	2	2	3	3	0	3	3	3	2	2
RN14	0	0	0	0	0	0	0	0	0	0	0	0	0
RN15	4	0	1	4	3	3	3	0	3	3	3	3	3
RN16	5	0	1	2	2	2	3	0	2	3	3	2	2
RN17	3	0	1	3	3	3	4	0	3	3	4	4	4
RN18	3	0	2	3	3	3	2	0	3	3	3	3	3
RN19	3	0	3	3	3	3	0	3	3	3	3	3	3
RN20	4	0	3	4	4	3	4	3	3	3	4	4	4
TOTAL RN	52	0	26	39	44	38	34	13	39	43	48	42	42
MEAN RN	3.5	0	1.7	2.6	2.9	2.7	3.2	6.5	2.6	3	3.5	2.8	2.8
Army 1	3	0	2	3	4	3	4	0	3	3	3	3	3
Army 2	0	0	0	0	0	0	0	0	0	0	0	0	0
Army 3	0	0	0	0	0	0	0	0	0	0	0	0	0
Army 4	0	0	0	0	0	0	0	0	0	0	0	0	0
Army 5	3	0	3	3	3	3	3	0	3	3	3	3	3
Army 6	4	0	3	4	3	3	4	0	3	3	4	3	3
Army 7	4	0	1	1	3	2	3	0	2	2	3	2	2
Army 8	3	3	1	1	2	1	3	0	2	2	3	2	2
Army 9	2	0	2	2	2	2	2	0	2	2	2	2	2
Army 10	3	0	3	3	3	3	3	0	3	3	3	3	3
Army 11	4	0	3	3	3	4	4	0	4	4	4	4	4
Army 12	3	0	3	3	3	3	4	0	3	3	3	3	3
Army 13	2	3	3	2	2	3	3	0	3	2	3	2	2
Army 14	2	2	2	3	3	3	3	0	3	3	3	3	3
Army 15	3	0	3	3	3	4	4	0	4	4	4	4	4
Army 16	4	0	2	2	3	3	3	0	3	3	3	4	4
Army 17	3	0	2	2	3	2	0	3	2	4	4	3	3
Army 18	3	0	2	3	3	3	4	0	3	3	3	3	3
Army 19	0	0	0	0	0	0	0	0	0	0	0	0	0
Army20	2	0	2	2	3	2	3	0	2	3	3	3	3
TOTAL ARMY	48	8	37	40	46	44	50	3	45	47	51	47	47
MEAN ARMY	3	0.5	2.3	2.5	2.9	2.8	3.3	3	2.8	3	3.2	2.9	2.9
RAF1	3	0	2	2	2	3	3	3	3	3	3	3	3
RAF2	3	0	3	3	3	3	0	3	3	3	3	3	3
RAF3	2	0	2	3	3	4	0	3	4	4	3	3	3
RAF4	0	0	0	0	0	0	0	0	0	0	0	0	0
RAF5	4	0	4	4	4	4	4	0	4	4	4	4	4
RAF6	4	0	4	3	3	4	3	0	4	4	4	3	3
RAF7	4	0	2	2	3	4	4	0	3	4	4	4	4
RAF8	3	0	2	3	3	3	4	0	3	3	3	3	3
RAF9	4	0	2	2	3	4	4	0	3	4	4	3	3
RAF10	4	0	3	3	4	4	0	4	4	4	4	4	4
RAF11	3	0	3	3	3	3	4	0	4	4	4	3	3
RAF12	0	0	0	0	0	0	0	0	0	0	0	0	0
RAF13	0	0	0	0	0	0	0	0	0	0	0	0	0
RAF14	3	0	3	3	3	3	4	0	3	3	3	3	3
RAF15	0	0	0	0	0	0	0	0	0	0	0	0	0
RAF16	0	0	0	0	0	0	0	0	0	0	0	0	0
RAF17	3	0	3	3	3	3	3	0	3	3	3	3	3
RAF18	0	0	0	0	0	0	0	0	0	0	0	0	0
RAF19	4	0	3	3	3	3	3	0	3	3	3	3	3
RAF20	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL RAF	44	0	36	37	40	45	36	13	44	46	45	42	42
MEAN RAF	3.4	0	2.8	3.1	3.1	3.75	3.7	3.3	3.4	3.8	3.75	3.3	3.3
FCO1	0	0	0	0	0	0	0	0	0	0	0	0	0
FCO2	0	0	0	0	0	0	0	0	0	0	0	0	0
FCO3	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL FCO	0	0	0	0	0	0	0	0	0	0	0	0	0
MEAN FCO	0	0	0	0	0	0	0	0	0	0	0	0	0
Participant	Roles	Exc Circum	Appraisals	PDPs	Review PDPs	Learn credits	MSF Colleg	Pt Surveys	Complaints	SEA	8-part audit	Prob & Health	TOTAL
MEAN RN	3.5	0	1.7	2.6	2.9	2.7	2.7	6.5	2.6	3	3.5	2.8	34.5
MEAN ARMY	3	0.5	2.3	2.5	2.9	2.8	3.3	3	2.8	3	3.2	2.9	32.2
MEAN RAF	3.4	0	2.8	3.1	3.1	3.8	3.7	3.3	3.4	3.8	3.8	3.3	37.5
TOTAL DMS	9.9	0.5	6.8	8.2	8.9	9.3	9.7	12.8	8.8	9.8	10.5	9	104.2
MEAN DMS	3.3	0.2	2.3	2.7	3	3.1	3.2	4.3	2.9	3.3	3.5	3	34.7
TOTAL FCO	0	0	0	0	0	0	0	0	0	0	0	0	0

ANNEX B: EASE OF COLLATION SCORES FOR EACH PARTICIPANT

Participant	Roles	Exc Circum	Appraisals	PDPs	Review PDPs	Domain	Learn credits	MSF Colleague	Pt Surveys	Complaints	SEA	8-part audit	Prob & Health	
RN1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
RN2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
RN3	0	0	0	0	0	0	0	0	0	0	0	0	0	0
RN4	0	0	0	0	0	0	0	0	0	0	0	0	0	0
RN5	2	0	2	1	1	2	2	0	1	1	2	2	2	2
RN6	1	0	2	2	2	3	3	0	2	2	3	3	2	2
RN7	2	0	2	1	2	2	2	0	2	2	2	2	2	2
RN8	0	0	0	0	0	0	0	0	0	0	0	0	0	0
RN9	1	0	1	1	1	1	3	0	2	1	2	2	1	1
RN10	2	0	2	1	2	2	0	3	2	2	2	2	2	2
RN11	3	0	1	2	2	2	2	0	2	2	2	2	2	2
RN12	2	0	1	2	2	3	0	3	2	2	3	3	3	3
RN13	2	0	2	1	1	2	3	0	1	2	3	2	2	2
RN14	0	0	0	0	0	0	0	0	0	0	0	0	0	0
RN15	1	0	2	2	2	2	3	0	2	2	3	2	2	2
RN16	2	0	2	2	2	2	2	0	2	2	3	2	2	2
RN17	2	0	1	2	2	2	3	0	2	2	4	3	3	3
RN18	2	0	2	2	2	2	3	0	3	2	3	2	2	2
RN19	2	2	1	2	2	2	3	0	2	3	3	3	3	3
RN20	2	0	2	2	2	2	3	0	2	2	3	3	3	3
TOTAL RN	26	2	23	23	25	29	32	6	27	27	38	31	31	
MEAN RN	2.6	0.2	2.3	2.3	2.5	2.9	2.7	3	2.7	3	3.8	3.1	3.1	
Army 1	2	0	2	2	2	2	3	0	2	2	3	2	2	2
Army 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Army 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Army 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Army 5	2	0	2	2	2	3	3	0	2	2	3	2	2	2
Army 6	2	0	2	2	2	2	3	0	2	2	3	2	2	2
Army 7	1	0	1	2	2	2	2	0	2	2	2	2	2	2
Army 8	2	2	1	1	2	2	2	0	2	2	2	2	1	1
Army 9	2	0	2	2	2	2	2	0	2	2	2	2	1	1
Army 10	2	0	2	2	2	2	2	0	2	2	2	2	2	2
Army 11	2	0	2	2	2	2	3	0	2	2	3	2	2	2
Army 12	2	0	2	2	2	2	2	0	2	2	2	2	2	2
Army 13	1	2	1	2	2	2	2	0	1	2	2	2	1	1
Army 14	1	2	1	1	1	1	3	0	1	1	2	2	1	1
Army 15	2	0	1	1	1	2	3	0	2	2	2	2	2	2
Army 16	2	0	2	2	2	2	2	0	2	2	3	2	2	2
Army 17	2	0	2	2	2	2	0	3	2	3	3	2	2	2
Army 18	1	0	1	1	1	2	2	0	1	2	3	2	1	1
Army 19	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Army 20	2	0	2	2	2	2	3	0	2	2	2	2	2	2
TOTAL ARMY	15	2	14	15	16	17	20	0	16	16	20	14	14	
MEAN ARMY	0.9	0.1	1.2	0.9	1.3	1.4	2	0	1.3	1	1.8	1.2	1.2	
RAF1	2	0	2	2	2	2	0	3	2	2	2	2	2	2
RAF2	2	0	2	2	3	2	0	3	2	2	3	2	2	2
RAF3	2	0	2	2	2	3	0	3	2	2	3	2	2	2
RAF4	0	0	0	0	0	0	0	0	0	0	0	0	0	0
RAF5	2	0	2	2	2	2	3	0	2	2	3	2	2	2
RAF6	2	0	2	2	2	2	3	0	2	2	3	2	2	2
RAF7	1	0	1	1	1	1	2	0	1	1	2	2	1	1
RAF8	2	0	2	2	2	2	2	0	2	2	2	2	2	2
RAF9	2	0	2	2	2	2	2	0	2	2	2	2	2	2
RAF10	2	0	2	2	2	3	0	4	2	2	3	2	2	2
RAF11	2	0	2	2	2	2	2	0	2	2	2	2	2	2
RAF12	0	0	0	0	0	0	0	0	0	0	0	0	0	0
RAF13	0	0	0	0	0	0	0	0	0	0	0	0	0	0
RAF14	1	0	1	1	2	2	2	0	1	1	2	2	1	1
RAF15	0	0	0	0	0	0	0	0	0	0	0	0	0	0
RAF16	0	0	0	0	0	0	0	0	0	0	0	0	0	0
RAF17	2	0	2	2	2	2	2	0	2	2	2	2	2	2
RAF18	0	0	0	0	0	0	0	0	0	0	0	0	0	0
RAF19	1	0	2	2	2	2	2	0	2	2	2	2	1	1
RAF20	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL RAF	23	0	24	24	26	27	20	13	24	24	31	23	23	
MEAN RAF	1.9	0	1.8	2	2.2	2.1	2.3	3.3	1.8	2	2.4	1.8	1.8	
FCO1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FCO2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FCO3	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL FCO	0	0	0	0	0	0	0	0	0	0	0	0	0	
MEAN FCO	0	0	0	0	0	0	0	0	0	0	0	0	0	
Participant						Domain								
MEAN RN	2.6	0.2	2.3	2.3	2.5	2.9	2.7	3	2.7	3	3.8	3.1	3.1	31.1
MEAN ARMY	0.9	0.1	1.2	0.9	1.3	1.4	2	0	1.3	1	1.8	1.2	1.2	13.1
MEAN RAF	1.9	0	1.8	2	2.2	2.1	2.3	3.3	1.8	2	2.4	1.8	1.8	23.6
TOTAL DMS	5.4	0.3	5.3	2.9	6	6.4	7	6.3	5.8	6	8	6.1	6.1	65.5
MEAN DMS	1.8	0.1	1.8	1	2	2.1	2.3	2.1	1.9	2	2.7	2	2.2	22
TOTAL FCO	0	0	0	0	0	0	0	0	0	0	0	0	0	0

