

Clinical Audit in Appraisal and Revalidation

In the time since revalidation for doctors was first discussed, the proposed process has been subject to refinement and simplification, but throughout the whole period, the role of clinical audit as an essential source of evidence of a doctor's professional competence has remained constant. It is a vital source of supporting information for both appraisal **and** revalidation.

In 2009 HQIP submitted a report on how audit should be used by doctors as part of revalidation, which was developed from workshops involving Royal College leads and submitted through the Academy of Medical Royal Colleges (AoMRC). This document is attached [HERE](#).

This proposed a model of how involvement in clinical audit should be treated in **revalidation**, but it is equally appropriate to **appraisal**.

The HQIP report is clear that because many doctors only participate in clinical audit of team activity, in most cases it is possible able to determine the effect of their individual practice on healthcare outcomes. Instead the key definitional principles in assessing quality of involvement by an individual doctor in clinical audit are in relation to **participation, reflection on findings and taking appropriate action**.

The document defines clearly how work in audit can be assessed and evidenced for quality. To use audit as information for appraisal and revalidation, doctors need to show they have significantly participated in the processes or leadership of audit, and actively reflected on findings and taken action to bring practice back in line with guidance. Only in specific situations where clinical audit data could be used to evidence the specific impact of an individual doctor on health outcomes would evidencing outcomes in audit become possible, and hence offering outcomes from audit should not be a requirement for all doctors.

In the latest GMC versions of the information to support appraisal, (which are still potentially open to change as of date of writing, July 2011, and found at: http://www.gmc-uk.org/doctors/revalidation/supporting_information.asp), clinical audit is cited as an essential source of appropriate information, where the doctor is involved in clinical practice. In setting out criteria for the use of audit, the latest version draws from the HQIP/AoMRC report in stating that a doctor must **participate in clinical audit and respond constructively**. Therefore the criteria used in the HQIP/Academy report that define what 'participation, reflection and taking action' mean, given that they are substantively the same as the GMC definition, remain valid for use in interpreting audit information for the purposes of appraisal currently and revalidation, when it starts.

Therefore individual doctors and their appraisers should read the HQIP/AoMRC report when using clinical audit evidence or information for these processes. Individual doctors should be able to evidence that in their work in audit they meet the criteria set out in the report. Appraisers should use the document to assess whether the work of the doctor in audit that has been submitted is of

good quality. It remains the essential guidance for judging the quality of audit work used as a source of information in these processes.

Individual doctors can get help from a variety of sources to help ensure their audit work is of good quality. They should do this anyway throughout their professional work, but they should certainly do so when offering audit as a source of information for these processes. The first of these are the resources on this site, including the definition of [‘Criteria and indicators of best practice in clinical audit’](#) and the revalidation principles themselves in the AoMRC report. By comparing your audit work against these standards, you should be able to see how and where it is adequate or deficient, and self-review accordingly.

A doctor can also use services provided by their individual college, including resources such as the Royal College of Pathologists’ audit quality assurance process and the Royal College of Physicians PCAT self-appraisal software (in development, but shortly to be available on the RCP website, and derived from HQIP’s work).

Appraisers can also use the guidance HQIP and colleges provide to ensure their knowledge of what constitutes good practice in audit is. They can also quality assure the evidence/information submitted, by asking the doctor whether they have used any of these quality assurance tools. It is the responsibility of the submitting doctor to ensure they can evidence the quality of their work, but the appraiser will be aided in their role if they direct their appraisees to assure quality using agreed and validated guidance. Appraisers can be assured that where these have been used, the audit submitted to them is likely to be of a higher level of quality and constitute a suitable source of information to make a judgement.

Responsible officers should also be aware of the support available.

Organisations can ensure they also encourage individual doctors as part of these processes to use available support. Organisational readiness for appraisal and revalidation is essential to ensure these processes are used effectively. Signposting doctors who work for you to these sources of help and setting organisational expectations that individual doctors use these sources of help is useful in driving up quality.

Although clinical audit remains the best method for assessing clinical work, doctors can use other quality improvement examples, especially where they do not do clinical work of suitable type, or do not provide clinical work at the present time.