To:	**Trust Board**
From:	**Medical Director**
Date:	**20 December 2012**
CQC regulation:	**ALL**

Trust Board paper U

Title:	**Medical Appraisal and Revalidation at UHL**
Author/Responsible Director:	Professor Peter Furness, UHL Revalidation Lead Dr Kevin Harris, Medical Director
Purpose of the Report: To update the Trust Board on Medical Appraisal and Revalidation at UHL.	

The Report is provided to the Board for:

Decision		Discussion	
Assurance	√	Endorsement	√

Summary / Key Points:

- The report provides the Board with an interim report on progress in respect of Medical Appraisal and Revalidation at UHL.

Recommendations:
The Trust Board is invited to receive and note the interim update report.

Strategic Risk Register N/A	**Performance KPIs year to date** N/A
Resource Implications (eg Financial, HR) N/A	
Assurance Implications Yes	
Patient and Public Involvement (PPI) Implications N/A	
Equality Impact N/A	
Information exempt from Disclosure N/A	
Requirement for further review ? Yes	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **20 DECEMBER 2012**

REPORT BY: **MEDICAL DIRECTOR**

SUBJECT: **MEDICAL APPRAISAL AND REVALIDATION AT UHL**

Background

Annual appraisal of doctors has been a requirement for all medical staff for several years, but this has been implemented and enforced very variably across the NHS. The impetus for doctors to undertake annual appraisals has been greatly enhanced by the General Medical Council's plans for medical revalidation, which are based around a requirement for annual appraisal to standards that are acceptable to the GMC.

Ministerial Regulations have been passed which identify UHL as the 'Designated Body' for the purpose of revalidation in respect of most of the doctors that it employs, other than those in formal training posts (who will revalidate through the Postgraduate Deanery). The Responsible Officer is the organisation's Medical Director, Kevin Harris, and UHL has a statutory duty to support the Responsible Officer in discharging his functions.

The Secretary of State has now agreed that revalidation will start on 3rd December 2012. A small group of doctors (all responsible Officers and some senior medical managers) will be given revalidation dates between then and 1st April 2013. The GMC will give revalidation dates within the first full year (April 2013-march 2014) to 20% of doctors. Dates in the second full year will be given to 40% of doctors and the rest in the third year. The GMC will start to inform doctors (and their Responsible Officers) of those dates in December 2012.

The use of annual appraisal to justify revalidation means that appraisal for doctors, unlike other NHS employees, has as its main focus the needs of the patient rather than the needs of the employer. The appraisal must cover everything that the doctor does as a doctor, not just the work for one employer. The needs of the employer are not irrelevant and in most respects these needs will closely overlap, but this distinction is nevertheless important. For example, one of the consequences is that medical appraisal and job planning must be kept separate.

UHL is in the fortunate position in having participated in the programme of DH-funded 'pathfinder pilots' between 2009 and 2011. This means that we have a cohort of appraisers and doctors who are broadly familiar with the requirements of medical appraisal as demanded by the GMC.

Appraisal year 2011-12

The Pathfinder pilot funding ended in 2011.In December 2011 UHL appointed a revalidation lead and Assistant Medical Director (Professor Furness). Under his supervision by the end of March 2012, over 95% of doctors with entries on the UHL medical appraisal system had completed an appraisal. Those doctors appearing on the UHL appraisal system were mainly consultants (the pathfinder project only involved consultants) and work has been taken forward to capture non-consultant staff in non-training grade posts.

The majority of UHL's doctors undertook their appraisal towards the end of the appraisal year and this generated a number of problems, including a considerable work overload for UHL's trained appraisers. This problem was addressed in 2012-13, as discussed below.

A new Medical Appraisal policy has been approved (available at http://moss.xuhl-tr.nhs.uk/together/Documents/Medical%20Staff%20Appraisal%20Guidance/UHL%20Medical%20Appraisal%20%20Revalidation%20Policy.pdf).

Administrative support

A medical appraisal budget was agreed for 2012-13 and a Medical Revalidation Support Manager has been appointed. By comparison, it should be noted that the system for appraisal and revalidation of doctors in primary care in Leicestershire covers a similar number of doctors and employs almost 3 WTE support staff. Never the less UHL is currently satisfying its statutory duty to support the Responsible Officer in respect of his duty to deliver medical appraisal for revalidation.

Software support

For an organisation as large as UHL it is absolutely essential that there is a system to maintain the rigour of medical appraisal, to ensure that appraisals take place and to inform the Responsible Officer about progress and problems. During the Pathfinder Pilot, UHL had been alone in producing its own in-house software to deliver these functions. The 'UHL senior medical appraisal system' was not universally popular, but it undoubtedly out-performed the software purchased for the other pilot sites by the Revalidation Support Team.
However, experience from the Pathfinder Pilots resulted in numerous changes in how medical revalidation would be run in the future and a number of alterations to the UHL software would have been essential if it was to remain fit for purpose.

In recognition that any large organisation that employs doctors would need a similar system a number of market in software solutions to support medical revalidation had become available. Therefore rather than continuing with the development of its own system, UHL elected to procure a commercially available revalidation software system. The 'PReP' system from Premier IT was procured and implemented. The contract included systems (which are now mandatory) for gathering feedback from colleagues and patients in a format approved by the GMC, through a collaboration with Edgecumbe 360. The contract runs for three years.

Identifying doctors with a 'Prescribed Connection' to UHL

To populate the new appraisal support system a list of doctors employed by UHL in non-training posts, was used. This approach captured large number of non consultant non training grade doctors previously not included in UHL's medical appraisal system. In September the GMC provided us with a list of doctors that the GMC believed had a connection with UHL for revalidation purposes; as anticipated there were a number of discrepancies between our list and that of the GMC's and work is being undertaken to eliminated by April 2013.

The task of keeping our list of doctors with a Prescribed Connection to UHL up to date as doctors join UHL, leave, or move from training to substantive posts will remain, and close working relationships with Human Resources have been established to meet this. Use of our revalidation system is now a specific topic in the induction process for all doctors who start work at UHL with new starters encouraged to check that their revalidation requirements are being delivered, and if not to contact the revalidation office.

Staff training

The GMC has continually updated their information about revalidation to all doctors; no-one with a licence to practise should be unaware of what is happening, what will be expected of doctors, and how to obtain more information.

To assist UHL staff in the use of the online appraisal support system a total of seven one-hour training sessions, spread across all 3 hospital sites have been delivered by Professor Furness. For those who were unable to attend any of these sessions, online training material has been made available through INsite.

A suite of web pages to explain how revalidation and appraisal will affect medical staff at UHL is also available at http://insite.xuhl-tr.nhs.uk/homepage/clinical/medical-revalidation (UHL network only).

All medical staff have been regularly updated by email. The PReP appraisal support software also generates automatic email reminders when appraisals are becoming due.

Appraiser training

UHL is fortunate to have a large cohort of appraisers who were trained during the Pathfinder Pilot. However, the DH Revalidation Support Team (RST) made it clear that all appraisers should receive 'top-up' training to ensure that they are familiar with the new requirements of medical appraisal for revalidation. Courses were offered free of charge, through the SHA. The availability and in some instance the quality of those top up courses was limited and they were specifically aimed at those who have already acquired basic appraiser skills .UHL therefore elected to develop and to deliver in-house appraiser training.

Peter Furness attended a 'Train the Trainer' course delivered by the RST, and collaborated with UHL staff who deliver appraiser training for non-medical appraisers. A training video specifically aimed at training medical appraisers was developed and UHL now runs a one day course for new appraisers. The morning covers generic aspects of appraisal skills; the afternoon covers issues specific to medical appraisal, and in so doing it constitutes 'top-up' training for established appraisers, to RST requirements. This course was run for the first time on 17th October 2012; 20 new appraisers attended and were joined for the afternoon session by another 35 current appraisers. Formal participant feedback indicated a high level of satisfaction. This course will be repeated this course on 8th January 2013 and there is a high level of confidence that UHL will continue to have a sufficient number and spread of trained appraisers. In time the course may also be offered to other organisations.

Appraiser support

The 'top-up'- training for medical appraisers stresses the importance of seeking support and advice if in any doubt about how (or whether) to proceed with an appraisal. UHL's appraisers are supported by four Senior Appraisers the Assistant Medical Director for Revalidation and the Responsible Officer. There are quarterly meetings of the Revalidation Support Network to discuss any problems arising and their resolution.

Collaboration with the University of Leicester

The GMC has indicated that the introduction of revalidation does not alter the principles of the Follett report on joint appraisal for clinical academics. We have enjoyed close collaboration with the University of Leicester, and no new problems are foreseen. The PReP appraisal support system includes specific provision for the requirements of clinical academics.

Collaboration with the private sector

Medical appraisal for revalidation has to cover a doctor's whole practice, not just work done for the NHS. This demands collaboration with other local providers of healthcare, including agreement on the transfer of relevant information about the performance of doctors. Agreements have been reached with the Medical Staff Committees at both the main private hospitals in Leicester.

DH oversight

At the start of the 2012-13 year a contract was agreed with DH to provide additional scrutiny of and feedback on the implementation of revalidation-ready appraisals in Leicester. UHL has complied with all the requirements of this contract, although the number of completed appraisals in the first two quarters has been lower than requested, for reasons discussed below.
We are required to submit regular returns to DH on the organisation's readiness for revalidation. These have all been submitted on time and have since early 2012 indicated that UHL is 'revalidation ready'.

Quality assurance

The GMC has set out minimum criteria for quality assurance of the medical appraisal system. UHL complies with these. All structural requirements relating to the delivery of a sufficient number of appraisals by an adequate number of trained appraisers are in place, as are all necessary policies. All appraisees are asked to complete a feedback questionnaire after their appraisal is competed; these will be scrutinised at the end of the appraisal year to identify appraisers whose skills may need improvement. Appraisers are also expected to deliver this feedback as part of the supporting information for their own appraisal. We are also required to undertake random sampling of appraisal output forms; this will be undertaken towards the end of the appraisal year.
We anticipate that the GMC may make further demands in relation to quality assurance as systems become more mature.

Appraisals in 2012-13

As the new appraisal support system was not live until mid 2012, no appraisals could be undertaken using the system during April and May.

To avoid a repeat of the rush to complete appraisals at the end of March, the dates for appraisal were spread throughout the year. The few doctors who had not completed an appraisal in 2011-12 were given a date of 31st July. As a result, one third of UHL's doctors were allocated appraisal due dates in August to November inclusive and two thirds in December to March inclusive. This approach has generated some discussion from a minority of doctors, who have maintained that neither the GMC nor their NHS contract obliges them to have more than one appraisal within 12 months. However, this is required to ensure appraisal dates are spread evenly throughout the year. In addition to the automated email reminders from the PReP system (which mention GMC and NHS contractual requirements), personal letters have been sent to all doctors who haven't undertaken their appraisal by their due date, asking them as a very minimum to identify on the system a firm date on which an appraisal will occur.

The GMC has stated that in December it will start to send letters to all doctors informing them of their revalidation date. It is anticipated that this is likely to encourage compliance.

The imposition of a completely new medical appraisal support software system has generally been accepted. All software problems have been rapidly resoled by the Assistant Medical Director for Revalidation and overall the system seems to be 'bedding down'. The response of Premier IT's staff and the speed with which they acknowledge and address problems has been good.

Future issues

- Despite efforts to spread appraisal dates around the year, there will still be an excess of appraisals taking place in late March. However, we are already in a better position than this time last year and this will continue to improve year on year.
- A small number of non consultant doctors remain under the impression that appraisal and revalidation applies only to consultant staff. Although it is unlikely that any of them will be given a revalidation date in the first year, concerted efforts are being made to communicate the needsof revalidation to this group.
- A system for the delivery of colleague and patient feedback has been available since September 2012. However it remains likely that some doctors who receive revalidation dates soon after April 2013 will not have completed an appraisal that includes these elements by that date. These doctors will be encouraged to deliver the feedback then have an additional appraisal so that the Responsible Officer has sufficient information with which to make a recommendation.
- It is recognised that personal feedback systems sometimes result in critical or even spiteful statements being made about those who have requested feedback. Whether justified or not, such comments can generate considerable distress, even to the point of being incapacitating. For this reason, it is widely recommended that such feedback should be delivered by specifically trained facilitators. In common with many NHS organisations, UHL does not have a sufficient number of such facilitators and the Edgecumbe system expects appraisers to deliver this feedback. UHL's appraisers have been specifically informed of this, and have been advised to seek advice and assistance if they find they are expected to deliver feedback that may cause distress.
- Many organisations are expressing considerable concern that revalidation will result in increased demands for the remediation of doctors and they are unclear how this will be achieved (or where the resources will come from). How this impacts on UHL remains to be determined, but the impact is likely to be far lower on organisations with good clinical governance systems, where problems with the performance of doctors are already being identified and addressed by other means. UHL's early experience of implementing 'revalidation-ready' appraisals suggests that this is not likely to be a major problem. We are nevertheless collaborating with work across the East Midlands to harmonise approaches and share expertise and resources in this area.
- It remains possible that a small number of doctors may express an unwillingness to cooperate with the new requirements for medical appraisal for revalidation. This could impact on UHL's ability to deliver its service requirements through the loss of otherwise competent doctors. This concern has been recently mitigated because the GMC has recently clarified its proposed processes to deal with 'non-engagement'. In brief, where the Responsible Officer has such concerns about a doctor, he will be encouraged to contact the GMC (through its Employment Liaison Officer) long before revalidation is due. If the concern is justified, the GMC will then issue a formal letter of warning to that doctor, and may bring forward his/her revalidation date. This will be a more effective deterrent than the previous approach of threats to block annual pay progression and Clinical Excellence awards. This approach will allow us to avoid problems with doctors delaying their engagement and compliance with the GMC's requirements.