Trust Board Paper S

To:	**Trust Board**
From:	Medical Director
Date:	29th August 2013
CQC regulation:	Outcomes – 12, 14 and 16

Title:	Medical Appraisal and Revalidation at UHL

Author/Responsible Director:
Professor Peter Furness/Dr Kevin Harris

Purpose of the Report:
Provide the Board with an update on progress to date following the formal introduction of revalidation in December 2012

The Report is provided to the Board for:

Decision		Discussion	x
Assurance	x	Endorsement	

Summary / Key Points:

- UHL is the 'Designated Body' for the purpose of revalidation in respect of most of the doctors that it employs with the Medical Director being the "Responsible Officer". The exception is "doctors in training"
- GMC has given revalidation dates within the first full year (April 2013-March 2014) to 20% of doctors. Dates in the second full year have been given to 40% of doctors; the rest are in the third year.
- Annual appraisal is the main mechanism to justify revalidation and appraisal for doctors, unlike other NHS employees, has as its main focus the needs of the patient rather than the needs of the employer.
- UHL has introduced a robust electronic system for capturing data from appraisals and monitoring progress. This has allowed recommendations to the GMC to be made in accordance with UHL's statutory obligations.
- To date no UHL doctor has been referred to the GMC for non engagement
- Key to the long term sustainability of the process is maintaining an adequate number of trained and accredited appraisers.
- The report describes the steps UHL is taking to ensure the quality of its appraisal process and in recruiting, training and retaining appraisers

Recommendations:

- The Board is asked to note the progress made to date
- The Board is asked to support the actions being undertaken to make the system of enhanced appraisal sustainable in order to allow UHL to continue to full fill its statutory obligations under the RO regulations.

Previously considered at another corporate UHL Committee?
Executive Team

Strategic Risk Register:	**Performance KPIs year to date:** Outlined in the paper - UHL remains on track to make

	recommendations to the GMC on the 20% of its doctors with revalidation dates in 13/14.
Resource Implications (eg Financial, HR): Statutory responsibility to provide resources to the RO to undertake the role are being met	
Assurance Implications:	
Patient and Public Involvement (PPI) Implications:	
Stakeholder Engagement Implications: Performance reported to GMC and Revalidation Support Team	
Equality Impact:	
Information exempt from Disclosure:	
Requirement for further review? Annual Report	

Medical appraisal and revalidation at UHL

Report for Trust Board on progress to date

Professor Peter Furness, Revalidation Lead

July 2013

This report builds on and expands the Interim Report provided for UHL Trust Board dated 11th November 2012.

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.

Revalidation formally started on 3rd December 2012. A small group of doctors (all Responsible Officers and some senior medical managers) were given revalidation dates between then and 1st April 2013. UHL's responsible Officer, Dr Harris, achieved revalidation before that date.

The GMC has given revalidation dates within the first full year (April 2013-March 2014) to 20% of doctors. Dates in the second full year have been given to 40% of doctors; the rest are in the third year. Following advice from UHL, the GMC gave revalidation dates within the first year to all of UHL's more senior medical managers and to all its trained medical appraisers. These individuals were deemed to be more likely to be aware of the requirements for revalidation and their total number approximated to 20% of the relevant medical staff.

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 had ended in the previous year and many of the staff who had supported that pilot on temporary contracts were no longer in post. Professor Furness was appointed as Assistant MD with responsibility for revalidation in December 2011. The completed appraisal rate at that time was <5% but by the end of March 2012, over 95% of doctors registered with the UHL medical appraisal system had completed an appraisal. The majority of staff on the UHL appraisal register were consultants (the pilot projects had only focused on consultant appraisal) and it was recognised that the system needed to expand to include all non-consultant staff in non-training grade posts since UHL was the designated body for this group as well as consultants. Only two doctors were identified as having potential problems in respect of providing the necessary evidence to support a recommendation for revalidation, both of whom had their problems resolved internally.

The fact that the majority of UHL's doctors undertook their appraisal towards the end of the appraisal year generated a number of problems, including a considerable demand on the time of UHL's trained appraisers. Some doctors who could not complete an appraisal complained, with some justification, that they could not find an appraiser who was willing to deliver an appraisal in time. Plans to address that that problem have been put in place for 2012-13.

The Trust has approved a new Medical Appraisal Policy (available at http://moss.xuhl-tr.nhs.uk/together/Documents/Medical%20Staff%20Appraisal%20Guidance/UHL%20Medical%20Appraisal%20%20Revalidation%20Policy.pdf), together with related guidance on the conduct of medical appraisals. A modification is currently under discussion to define more clearly the steps that will be taken to remind doctors of their responsibility to complete an appraisal, prior to reporting the doctor to the GMC for an apparent failure to engage with the revalidation process.

Administrative support

A medical appraisal budget was agreed for 2012-13 and on that basis Ms Tracey Hammond was engaged as Medical Revalidation Support Manager and she has been integral to the success of delivering appraisal and revalidation within UHL. As a result UHL is currently satisfying its statutory duty to support the Responsible Officer in respect of his duty to deliver medical appraisal for revalidation (in contrast 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).

Software support

For an organisation as large as UHL it was essential that there was 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 produced its own in-house software to deliver these functions. Although the 'UHL senior medical appraisal system' was not universally popular, it out-performed the software purchased for the other pilot sites by the Revalidation Support Team.

The experience from the Pathfinder Pilots resulted in numerous changes in how medical revalidation would be run in the future. It was recognised that in the long term UHL's IT department did not have the resources to adapt UHL's "in-house" system to the changing requirements.

In the meantime, the fact that any large organisation that employs doctors would need a similar system had generated a market in software to support medical revalidation. UHL therefore produced a specification (with assistance from the DH Revalidation Support team) and tendered for bids. We formally evaluated three bids and on the basis of best value for money the 'PReP' system from Premier IT was purchased. The contract also includes at no extra cost 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, supplied by Human Resources was used. This allowed doctors not included in the previous medical appraisal system to be included. In September 2012 the GMC provided us with a list of doctors that the GMC believed had a connection with UHL for revalidation purposes. A reconciliation exercise was undertaken and discrepancies resolved. However, an audit taken after the end of the revalidation year still revealed 66 doctors on our medical appraisal system who were not recognised by the GMC as having UHL as their Designated Body. For some of these the reason was obvious (recent departure from UHL employment or simultaneous work as a GP, in which case the Designated Body is the NHS England). For reasons of confidentiality the GMC website does not allow us to identify whether another organisation has accepted the responsibility of being Designated Body for these doctors. Therefore they have all been written to, explaining that UHL will not accept responsibility as their Designated Body for revalidation purposes unless they explicitly ask us to do so and also inform the GMC that its records should be corrected.

Keeping our list of doctors with a Prescribed Connection to UHL up to date remains a challenge as doctors join UHL, leave, or move from training to substantive posts. Communication with Human Resources is being improved to resolve this.

Revalidation is now specifically included in the induction process for all doctors who start work at UHL. This encourages them to check that their revalidation requirements are being delivered, and to contact Ms Hammond or Professor Furness if they identify a problem.

Staff training

The GMC has provided a steady stream of information about revalidation to all doctors; no-one with a licence to practise medicine can claim to 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 Professor Furness has delivered a total of seven one-hour training sessions, spread across all 3 hospital sites. For those who nevertheless could attend none 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 has been made available at http://insite.xuhl-tr.nhs.uk/homepage/clinical/medical-revalidation (UHL network only).

Medical Staff are also provided with frequent email updates and the PReP appraisal support software also generates automatic email reminders when appraisals are becoming due.

Appraiser training in 2012-13

UHL is fortunate to have a large cohort of appraisers who were trained during the Pathfinder Pilot. However, the DH Revalidation Support Team (RST) requires 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. Early courses were of variable quality and were specifically aimed at those who had already acquired basic appraiser skills.

UHL therefore developed and now delivers its own in-house appraiser training to the standards required by the RST. A training video specifically aimed at training medical appraisers has been produced. UHL has run two, whole day courses to provide appraisal training which provides both training for new appraisers and top up training. 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. After the course the participants are asked to conduct mock appraisals of each other, use an interactive PDF form supplied by the RST to document the appraisal and send the documentation for review, before they are accepted onto the list of approved appraisers. By this means UHL has had a sufficient number and spread of trained appraisers for 2012-13. However, the need for further appraiser training is discussed below.

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 made aware that they can seek such advice from four Senior Appraisers, from Professor Furness me, or from the Responsible Officer. There are quarterly meetings of the Revalidation Support Network to discuss any problems arising and their resolution and open meetings of appraisers are planned.

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. UHL has worked with the Medical Staff Committees at both the main private hospitals in Leicester and obtained agreement in these areas. Concern was expressed about the possible transfer of commercially sensitive information between the organisations. This appears to have been resolved by the inclusion of a section on confidentiality in UHL's new Medical Appraisal policy.

DH oversight

At the start of the 2012-13 year UHL agreed a contract with DH to provide additional scrutiny of and feedback on the implementation of revalidation-ready appraisals in Leicester. We have complied with all the requirements of this contract.

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'.

Appraisals in 2012-13

Scheduling appraisals

In March 2012 there was pressure on many of UHL's trained medical appraisers as a large proportion of UHL's doctors attempted to complete an appraisal just before the end of the appraisal year. A number of appraisers felt overstretched at this time and were threatening to refuse to undertake the role in the future.

To avoid a repeat of the rush to complete appraisals at the end of March appraisal dates were spreadaround the year. As a surrogate for true randomisation of dates, each doctor's date of birth was used as the next 'revalidation due' date. Although this generated some adverse feedback from a few doctors (neither the GMC nor their NHS contract obliges them to have more than one appraisal within 12 months) this approach has resulted in a more even spread of appraisals through the year although more work needs to be done.

Non-engagement

The PReP appraisal software automatically sends email reminders to doctors at two months, one month and two weeks before their appraisal due date. If an appraisal is not completed a further reminder is sent two weeks after the due date. The reminders mention that completion of an annual appraisal is a GMC requirement in addition to being an NHS contractual requirement. In addition to these automated email reminders from the PReP system, personal letters have been sent to doctors when an appraisal was more than 4 weeks overdue asking them as a minimum to identify on the system a firm date on which an appraisal will occur. Two weeks before the end of the appraisal year (31st March 2013) a further letter was sent to all doctors who had not by that time completed an appraisal, pointing out that we would be providing to the GMC a list of all doctors who had not completed an appraisal by the end of the year.

UHL submitted a formal ('ORSA') response to DH at the end of April 2013 stating that of 692 non-trainee doctors employed by the Trust, 598 (86.4%) had completed a revalidation-ready appraisal in the 2012-13 appraisal year. A small number of doctors completed an appraisal late, in April 2013. Further investigation of the doctors who had not completed an appraisal revealed that 66 of them, despite apparently having a contract of employment with UHL, were not identified on the GMC's records as having UHL as the Designated Body. (As noted above, the identity of the Designated Body can be difficult to ascertain if a doctor does not respond to emails or letters).

By the time we met with the GMC's local Employment Liaison Advisor, we had been able to confirm that only 11 (1.5%) doctors who the GMC agreed had UHL as their designated body and, had not completed an annual appraisal for 2012-13. The majority of these had not responded to any of our communications relating to revalidation. The majority were non-Consultant grade doctors. We supplied details of these doctors to the GMC and the GMC sent letters to them, warning them that they are placing their licence to practise at risk

unless they responded promptly. As a result of this pro-active management, to date UHL has not had to make any formal referrals to the GMC for non-engagement in the revalidation process.

Remediation

Many organisations have expressed concern that revalidation will result in increased demands for the remediation of doctors and they are unclear how this will be delivered. UHL's early experience of implementing 'revalidation-ready' appraisals correctly suggested that this was not likely to be a major problem here. So far, the only problems identified relating to the performance of doctors are ones where the existence of a problem was already known.

Revalidation recommendations

The GMC provides the Responsible Officer with a constantly updated online list of doctors whose revalidation recommendations are due in the coming weeks. We have established a pattern of monthly meetings of Dr Harris (as Responsible Officer), Ms Hammond and Professor Furness to review these doctors in time for problems to be identified and corrected. This is working well, although it is time-consuming to check that all the necessary information is in place (see 'Quality assurance of appraisals' below). There has been a relatively high proportion of those with early revalidation dates for whom it has been necessary to ask the GMC to defer the revalidation date for a few months, to allow time for all the necessary information to be collected. Given this is the first year of revalidation this was to be expected and the request for a deferral has no adverse implications for the individuals as long as the necessary information is presented within the time allowed. We anticipate that the number of doctors needing a deferral will decrease over time, as doctors become more familiar with the requirements of the revalidation process and have the time to assemble the information required.

Quality assurance of appraisals

The GMC has set out minimum criteria for quality assurance of the medical appraisal system. We believe that we comply 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. We have taken three approaches to assessing the quality of appraisals and their documentation.

1. The PReP appraisal support system requires each appraisee to complete a short questionnaire after an appraisal is completed. This includes questions on the performance of the appraiser, with Likert scales to give numeric scores. Unfortunately, in practice this has been less informative than we had hoped, because many of the appraisers have relatively few appraisees and individual appraisees clearly take different approaches to the scoring system.

2. Checking of appraisal records prior to a revalidation recommendation.

3. Random selection of appraisal records for review against a checklist. We aim initially to check at least one set of appraisal documentation from each appraiser each year, with further assessments if any serious problems are found. This work is being supervised by Professor Furness, but it is laborious and it is as not yet complete for 2012-13.

Approaches (2) and (3) have demonstrated variations in the quality of appraisal documentation despite the extensive programme of appraiser training; in particular some appraisers are completing the documentation too briefly, instead of giving a thorough account of the topics discussed.

The conclusion of the appraisal process requires appraisers to answer 'Yes' or 'No' to five formal 'statements to the responsible officer'. In particular the appraiser is asked to confirm that "*Appropriate supporting information has been presented in accordance with the Good Medical Practice Framework for Appraisal and Revalidation and this reflects the nature and scope of the doctor's work."* It is apparent that there is not a consistent approach to what constitutes "appropriate supporting information" and therefore rather than relying on the appraisers statements the Responsible Officer ensures that the appraisal record of every doctor approaching a revalidation date (as in (2) above). This issue is being addressed through the UHL training package for appraisers.

Appraiser recruitment, retention, motivation and training

The Department of Health's Revalidation Support Team (RST) has indicated that medical appraisers should receive 'top-up training' every 2 years; but most appraisers received such training in the last 12 months and the RST has not yet provided national guidance on what the content for the next round of training should be. Despite this, our experience with quality assurance so far indicates that further training is urgently needed.

UHL plans to hold three 'appraiser support' meetings (one at each hospital site) in September 2013. These will include a presentation on the problems identified by the quality assurance of appraisals, emphasising what is expected. They will also include the opportunity for appraisers to explain the problems they face and to suggest solutions and improvements. Appraisers who are unable to meet the standards required will not be allowed to continue in that role.

There are however difficulties in recruiting appraisers in secondary care because of competing demands on their time. Time for appraisers to undertake the role is notionally within their SPA allowance in their job plan and it is essential that individuals undertaking this role have their essential contribution to UHL appropriately recognised.

On-going development of appraisers with the appropriate time and skills to undertake this role remains a priority for UHL in 2013 in order to ensure we can continue to deliver our statutory responsibilities under the RO regulations.

31st July 2013