Medical Appraisal/Revalidation

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Executive Summary

Trust Board paper P

Context

This annual report provides information to the Board on how UHL has fulfilled its statutory duties as Designated Body for medical practitioners employed by the Trust for the year 2014/15.

Questions

1. Is the Board in a position to approve the 'statement of compliance' confirming that UHL, as a Designated Body, is in compliance with the regulations?
2. Is the Board assured that appropriate systems and processes for appraisal and revalidation in place, and that they properly monitored?
3. Is performance on appraisal and revalidation satisfactory, and are appropriate measures taken to deal with cases of non-compliance and of concerns?

Conclusion

1. The Responsible Officer (RO) believes that UHL is in compliance with the regulations.
2. Revalidation is properly supported and resourced by the Trust. The RO monitors frequency and quality of appraisals: there are adequate numbers of trained appraisers and appropriate systems, including for patient input. The Trust now allocates appraisers.
3. There are effective systems in place for dealing with conduct and performance of doctors. Some changes to the relevant policies are being made.
4. Over 95% of doctors completed their appraisal for the year 14/15. Each case of missed appraisal was considered individually by the Medical Conduct Committee and further action has been taken in 11 cases.

Input Sought

We would welcome the board's input regarding acceptance of the report, approval of the statement of compliance, and continued support for the executive in providing resource to ensure the Trust continues to meet its obligations as Designated Body.

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	Yes
Effective, integrated emergency care	Not applicable
Consistently meeting national access standards	Not applicable
Integrated care in partnership with others	Not applicable
Enhanced delivery in research, innovation & ed'	Not applicable
A caring, professional, engaged workforce	Yes
Clinically sustainable services with excellent facilities	Yes
Financially sustainable NHS organisation	Yes
Enabled by excellent IM&T	Yes

2. This matter relates to the following governance initiatives:

Organisational Risk Register	No
Board Assurance Framework	No

3. Related Patient and Public Involvement actions taken, or to be taken:
   Patient feedback forms part of evidence for revalidation, and the Trust has systems for obtaining feedback on individual doctors for consideration at appraisal.

4. Results of any Equality Impact Assessment, relating to this matter: N/A

5. Scheduled date for the next paper on this topic:	One year (annual report). July 2016.
6. Executive Summaries should not exceed 1 page.	My paper does comply
7. Papers should not exceed 7 pages.	My paper does not comply – based on the NHS England template. Apologies.

Medical Appraisal and Revalidation at UHL

Report for Trust Board on the appraisal year April 2014- March 2015

1. Purpose of the Paper

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] . NHS England has reaffirmed the expectation that provider boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations
- checking there are effective systems in place for monitoring the conduct and performance of their doctors
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

The purpose of this document is to inform the Trust Board about work in relation to the duties of the University Hospitals of Leicester (UHL) in its role as a Designated Body for the majority of its medical employees. It covers the appraisal year from 1st April 2014 to 31st March 2015, including steps taken after the end of the appraisal year in respect of doctors who did not complete an appraisal within that year. The information contained is needed to satisfy members of the Board that the Trust is appropriately discharging its statutory duties in this area, and that it can continue to do so in the coming year.

2. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. UHL was in a strong position to implement the reforms, because the Trust had been one of a small number of pilot sites prior to the introduction of revalidation. The Trust's revalidation lead, Professor Furness, had experience of leading on revalidation for the Academy of Medical Royal Colleges during the development of the new processes and was therefore very familiar with what would be required.

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

Previous Annual Reports to Trust Board have set out how mechanisms were put in place to deliver the requirements of medical appraisal and revalidation within UHL. Changes in 2014-15 were comparatively minor. Consequently this report (which is based on a template provided by NHS England) will only summarise existing appraisal and revalidation mechanisms. It will concentrate on describing events, changes and results in 2014-15. A copy of last year's report is available on request.

Towards the end of 2014-15 the statutory role of Responsible Officer was passed from the then Medical Director, Dr Kevin Harris, to the Deputy Medical Director, Dr Peter Rabey. The Revalidation Lead (Professor Peter Furness) and the Revalidation Manager (Ms Tracey Hammond) remained the same. No other individuals are directly employed to deliver medical revalidation at UHL; this has caused some workload problems for Ms Hammond which are discussed below. Part-time support for Ms Hammond is planned to address this.

3. Governance Arrangements

Policy and Guidance

UHL's Medical Appraisal and Revalidation Policy, and its associated Guidance document, were approved in 2012. An important change was agreed in 2013-14 and implemented in 2014-15, as discussed below, to clarify the processes to be followed in respect of doctors who fail to deliver an annual appraisal. This change has been approved by the Local Negotiating Committee and the Policy and Guidance Committee. All doctors whose Designated Body is UHL were informed of this change by email in November 2014.

A further change has been agreed and implemented on 1st April 2015, whereby appraisers are now allocated to appraisees rather than being chosen by appraisees from a list of approved appraisers. This change was made principally because of concerns generated by our quality assurance processes, suggesting that some appraisals were being conducted as quick 'tick-box' exercises by appraisers whose aim was to help colleagues satisfy the demands of the Trust and the GMC rather than to conduct a thorough appraisal. We also wished to address excessive variation in the workloads of our trained appraisers

All doctors whose Designated Body is UHL were consulted on this change in November 2014; 52 responses were received, the majority of which were supportive. Doctors were informed of the decision to implement this change on 27th January 2015, and the change was implemented with the assistance of Premier IT at the start of the new appraisal year in April.

Seven appraisers responded to this decision by stating that they no longer wished to act as appraisers under such a system, several explicitly stating that they had only

agreed to be an appraiser in order to help their colleagues through the system. These resignations were politely (indeed, gratefully) accepted.

Medical appraisal software

We have continued to use the 'PReP' online system from Premier IT for documentation of medical appraisals. We regard some form of support of this type as being essential for an organisation of the size of UHL. Personal experience and discussion with colleagues from other institutions leads us to believe that it remains one of the best systems available. The initial 3-year contract for its use expires in June 2015 but a further 3-year contract has been negotiated without increase in price, at a rate considerably below the advertised cost.

A significant recent improvement has been implemented as the PReP system now integrates with the GMC website in respect of each doctor's revalidation record.

Process for maintaining accurate list of prescribed connections

At the level of the GMC, if a doctor modifies the GMC's record of his/her Designated Body, UHL's Revalidation Manager (Tracey Hammond) is automatically informed. She then contacts the doctor to confirm the connection and to obtain the necessary information to set up the doctor with an account on our online medical revalidation system (PReP).

At the level of the Trust, Trust's HR department informs UHL's Revalidation Manager of any new medical employees who are not in formal training posts (trainees are monitored by and revalidate through the Deanery). She follows the same procedure and also ensures that the GMC's records correctly reflect the doctor's new Designated Body.

All new medical employees receive a short summary of UHL's medical appraisal and revalidation processes, including how to find more detailed information online (including a suite of revalidation guidance pages on UHL's intranet) and how to contact UHL's Revalidation Manager.

We have again had a small number of doctors where this three-level process did not work; usually in respect of non-consultant clinical academic doctors or non-consultant doctors who are in posts where there is close supervision and in practice some training is given, but the post is not recognised by the Deanery as a training post. These have come to light by various means, usually as a result of the doctor receiving some communication that reminds them about revalidation, such as messages from the GMC. We have had to ask the GMC for deferral of the revalidation date in some such cases, to allow the doctor time to collect the necessary information to justify revalidation; but no doctor's revalidation has been jeopardised.

4. Medical Appraisal

Appraisal and Revalidation Performance Data

The system for reminding doctors about the need to organise an appraisal is set out in the Trust policy and guidance. In brief, each doctor is allocated an appraisal 'due by' date. Email reminders are sent two months, one month and one week before an appraisal is due. If a completed appraisal is not recorded using the online medical appraisal software ('PReP'), a further reminder is sent 2 weeks after the appraisal due date.

NHS England has issued guidance including a definition of a late or missed appraisal which is not identical to that used within UHL. It includes appraisals conducted more than 2 months before or more than 2 months after the appraisal due date. The 'PReP' medical appraisal software we use currently does not allow us to use this new definition. We therefore continued to define a missed appraisal simply as one which did not occur within the appraisal year. This simpler definition is arguably less stringent for doctors with a revalidation date early in the year, but more stringent for those with a revalidation date in February or March; this has generated a few complaints from doctors with appraisal due dates in March. We have discussed this with Premier IT, the supplier of PReP, and we have received assurances that they are working on an update of their software that will implement the new definition.

At the end of the appraisal year (31st March 2015) UHL was the Designated Body for 751 doctors (an increase from the 678 doctors described in last year's report). Of these, 660 completed an appraisal within the appraisal year and another 55 completed an appraisal slightly late (in April 2015); most of these had appraisal due dates in February or March, as discussed above.

36 doctors therefore did not complete an appraisal by May 2015. Of these, 9 had justification for missing an appraisal that was known in advance (usually maternity leave or long term sick leave).

All of these missed appraisals have been analysed.

Action on missed appraisals

The very varied circumstances which lead doctors to miss appraisals were discussed in the 2013-14 report. There is a broad spectrum, from sound justification (such as prolonged sick leave) to complete and unjustifiable disengagement with the process. For this reason, it was agreed that the circumstances of each doctor who missed an appraisal would be considered at a meeting of the Medical Conduct Committee, with a view to deciding what sanctions, if any, would be appropriate in each case.

A meeting on 3rd June considered the circumstances of 47 doctors, with the benefit of notes on each compiled by Ms Hammond and Professor Furness. The doctors concerned had previously been contacted, with a warning that they had missed an appraisal, an explanation of the process set out in Trust policy, and an invitation to

provide any mitigating circumstances. Responses to these invitations were included in the consideration. The outcome of the meeting was:

- In three cases it was decided that the circumstances did not justify further action.
- In four cases the doctor concerned had left UHL and it was decided that their new Responsible Officer should be informed of the situation.
- In one case, unusual circumstances justified a discussion with the local Employment Liaison Officer of the GMC to plan appropriate action.
- In 28 cases action was limited to a letter from the Medical Director, setting out the importance of adhering to the appraisal process and the serious consequences that would follow in the future if this was not done.
- In 11 cases it was decided that further action was justified.

Further action in these 11 cases consisted of a letter to each informing them that:

- Pay progression for 2014-15 would be withheld (resulting in a permanent 12 month delay in pay progression for any doctor not already at the top of the pay scale)
- Any application for a local Clinical Excellence Award would not be accepted this year
- The Trust would refuse to support any application for a national Clinical Excellence Award
- If an appraisal was not delivered within three months, disciplinary action would be initiated
- Their situation would be discussed with the local representative of the GMC, who would consider whether the GMC wishes to take action for failure to engage with the revalidation process
- They should inform any other employers (including the management of private sector hospitals) that this notification and warning had been received.

Quality Assurance of Appraisals

After each appraisal, the appraisee is automatically asked to complete a short questionnaire on the quality of the process. This questionnaire has proved very disappointing as a tool to assess the quality of appraisals, because for each appraiser the number of respondents is too small to allow the 'Likert scale' approach of the questionnaire to generate valid numeric results. Free text comments are invited, but in practice are rarely delivered. We have used the information generated to target appraisers who appear to be 'outliers' for review in the audit, described below, but it is not appropriate to use the results for feedback to individual appraisers.

The quality of individual appraisal portfolios is audited by two separate but similar processes.

1. A selection of individual appraisal portfolios was audited by an experienced office manager who has received specific training for the purpose. We did not audit every appraisal in this way, but NHS England's expectation is that a sample (of unspecified size) will be examined. The selection of cases for this audit was designed to include at least one appraisal by each of UHL's approved appraisers.
   In practice, despite using a proforma designed by NHS England for this purpose, many of the supposedly objective questions are difficult to answer with a simple 'Yes' or 'No'; for example '*Is there evidence that the appraisee was challenged?*'. Consequently, in practice the audit resulted in any portfolios where there are grounds for concern being referred to Professor Furness for review.
2. When a doctor's revalidation date approaches (i.e. every 5 years) the doctor's appraisal portfolio is checked by UHL's Revalidation Manager. This is primarily to identify any problems with the documentation of which the Responsible Officer should be aware before considering a revalidation recommendation, ideally with time for the doctor to correct those problems. But she also considers the quality of each portfolio in a similar way to that taken in the audit described above. This process covers at least 20% of UHL's appraisals each year and in practice was found to be more informative than the process described in (1) above.

These two processes have identified a number of common problems, mainly around the level of detail of documentation and the appropriate use of the PReP software. The latter has informed the subsequent content of top-up training for appraisers, discussed below.

As a result of issues identified in this way Professor Furness or Dr Rabey had confidential conversations with several appraisers about problems of variable severity. Regrettably, and despite attempts at a tactful approach, the majority of these conversations led to the appraiser resigning rather than agreeing to improve performance. We were driven to the conclusion that in most cases we were identifying appraisers whose resignation should probably be welcomed.

In several cases there was concern that the appraiser was delivering a short, 'tick-box' appraisal merely with the intention of satisfying the GMC's requirements for revalidation. This was often evident from extremely brief or inconsistent documentation. In one case an appraiser was clearly using 'cut and paste' to insert the same text into every appraisal output report, in another it appeared that the report had actually been completed by the appraisee.

These problems, together with the very variable workload of individual appraisers, led us to move to a system of allocating appraisers to appraisees, as discussed below.

Appraisers are offered support in relation to general issues or individual cases from a group of Senior Appraisers (one per CMG) and the Revalidation Lead. Update training is offered as explained below.

Progress and problems in the delivery of medical appraisal and revalidation are discussed at meetings of the Medical Revalidation Support Network; minutes are available on request. The major issues discussed are considered in other parts of this report.

Allocation of appraisers to appraisees

Up to April 2015, doctors were invited to choose any appraiser from the list of approved UHL medical appraisers (all of whom have completed the appropriate training, as discussed below). This is an approach that was initially recommended by the Revalidation Support Team, but we are aware of many organisations which allocate a named appraiser to each appraisee – notably NHS England in respect of all general practitioners. We decided to move to an allocation system, largely as a result of quality assurance information discussed above.

This change would be disruptive if not applied at the start of a new appraisal year, and even so it would cause problems for doctors who had failed to deliver an appraisal on time. All doctors were therefore warned of the change in a bulk email sent in January 2015, along with a warning that they must complete their 2014-15 appraisal before the change was made on 1st April.

Appraiser allocation was planned using an Excel spreadsheet prepared by Professor Furness. Every doctor was allocated a new appraiser. Wherever possible, the appraiser was from the same or a similar specialty to the appraisee. However, each appraiser was allocated a similar number of appraisees and a mis-match between the number of appraisers and the number of appraisees in some specialties meant that some doctors were allocated an appraiser from a different specialty. This is entirely compatible with national guidance. All doctors were informed of their new appraiser by bulk email, with an invitation to flag any allocations that generated a conflict of interest or other significant problems. Approximately twenty reallocations were made as a result.

Premier IT altered the configuration of the software to allow appraiser allocation by the system administrator at the start of April, as planned. However, it proved possible for Premier IT to avoid reallocating the appraiser in those cases where the 2014-15 appraisal had not been completed, allowing most of those concerned to complete their appraisal with the appraiser planned for 2014-15.

A small number of appraisers have resigned as a result of this change, as discussed above. A precise number cannot be given because several who were concerned that they did not wish to appraise someone from a different specialty agreed to ‘give it a try’.

Hence the switch to allocating appraisers has been completed successfully, although at the ongoing cost of considerable administrative staff time.

Appraiser training

The events described above resulted in the loss of a number of UHL's trained appraisers, although we already had more appraisers than the minimum requirement. As a result of appraiser allocation most appraisers have just seven appraisees and none has more than eight. This is well within national guidance (the recommended maximum is 10). However, the change to appraiser allocation has made it more obvious that some specialties have an insufficient number of trained appraisers. The relevant CMG Leads were contacted by Dr Rabey with an invitation to identify colleagues in the specialty who might wish to undergo appraiser training.

The in-house full appraiser training course, developed in 2012-13, was run again in October 2014, training 20 new appraisers. Feedback from participants was collected at the end of the course and was almost entirely positive. Those who have completed the course are required to undertake and document a 'mock' appraisal of another trainee appraiser before their names are added to the list of UHL appraisers. The documentation of this appraisal is reviewed by Professor Furness before approval is granted.

To ensure that a sufficient number of trained appraisers is maintained we plan to run this course again in the winter of 2015-16, probably twice if a sufficient number of recruits can be obtained.

In addition, three half-day 'top-up training' sessions for approved appraisers were run in 2014-15, one at each of UHL's hospitals. Attendance registers have been kept; similar sessions will be delivered in 2015-16 and it is anticipated that attendance at at least one top-up session will be made mandatory by the end of 2015-16.

Administrative support for medical appraisal

Previous Annual Reports have complimented the performance of our Medical Revalidation Manager, Tracey Hammond, but also noted that she is single-handed, she has a very considerable workload and we would have a problem with succession planning if she was to leave. The implementation of allocation of appraisers, discussed above, has imposed a considerable extra workload on her. Consequently it has been agreed that a part-time assistant will be employed. The post has now been advertised and interviews are planned for 16th July 2015.

Access, security and confidentiality

This is provided by the mandatory use of the secure 'PReP' online medical appraisal software, which is provided by Premier IT and is designed for the purpose. We have continued to enjoy a good service from Premier IT in relation to technical support, problem solving and further product development.

Outline of data for appraisal.

All appraisers and appraisees should be aware of the GMC's requirements on supporting information for appraisal. The provision of appropriate information is primarily the appraisee doctors' responsibility; it should be checked by the appraiser and it is subject to audit as set out above.

To deliver the required colleague feedback and patient feedback informs that comply with GMC requirements, UHL offers the system provided for that purpose by Edgecumbe. Its use is not mandatory, but a GMC-compliant system is required and UHL will not fund any other system.

The provision of information on quality improvement, clinical audit, clinical incidents and outcome measures is the responsibility of the appraisee doctor. Availability will vary between different specialties and appraisers are encouraged to demand compliance with the guidance of the relevant medical Royal College.

We have investigated the automated provision of information on clinical incidents using the Datix system, but that system was not designed for this purpose. Therefore appraisers have been informed that they are entitled to ask about clinical incidents on Datix that are associated with their appraisee's name.

The relevance of outcome data in appraisal varies between specialties. In those specialties where outcome data is recommended by the relevant Royal College we would expect it to be provided; it is the responsibility of the individual appraisee to ensure that this information is delivered and discussed with their appraiser. We have investigated providing such information automatically using the Trust's data collection and clinical governance systems, but we have not yet identified a solution that is not excessively complicated. However exploration of this area will continue.

Doctors are told that their record of statutory and mandatory training must be discussed at appraisal. Appraisers have been told that any deficiencies should at minimum become items on the Personal Development Plan, for urgent attention, and may if critical be reported to the relevant UHL manager. The Trust's online system for managing such training does not interface directly with the PReP system for appraisal, but a summary of training can readily be downloaded or printed and provided as an item of supporting information for review.

5. Revalidation Recommendations

Number of recommendations falling due in 2014/15	311
Number of positive recommendations	264
Number of deferral requests	47
Number of non-engagement notifications made at revalidation date	0

Number of non-engagement reports made before revalidation date 0

6. Recruitment and engagement background checks

The UHL Recruitment Services is a centralised recruitment function and conducts the recruitment of all posts into the organisation to ensure full compliance with all of the NHS Employers 'Employment Check Standards'. A dedicated team for doctors conducts the recruitment of all non-trainee (and trainee) Doctors in line with these standards which consist of the following checks:

Verification of Identity Check
Right to Work in the UK Check
Professional Registration and Qualifications Check e.g. GMC Registration
Employment History and References Check
Criminal Record and Barring Check
Workplace Health Assessment Check

Robust audit and monitoring processes are in place for these checks including the NHSLA and Home Office immigration controls to give assurance that these checks are carried out in accordance with legislation and best practice.

For further information follow the link http://www.nhsemployers.org/your-workforce/recruit/employment-checks/nhs-employment-check-standardshttp://www.nhsemployers.org/your-workforce/recruit/employment-checks/nhs-employment-check-standards

7. Monitoring Performance

Approaches include:

- Medical appraisal, as discussed above
- Analysis of outcome data, as provided by Dr Foster / HED / Specialist societies
- Action on clinical incidents, reported through DATIX
- Action on complaints received
- Reports from CMG leads
- Reports from other doctors following the GMC requirement to act to protect patient safety
- Following up on concerns from any source

8. Responding to Concerns and Remediation

UHL manages all medical cases relating to conduct, capability and health in line with the national Maintaining High Professional Standards (MHPS) document. The Trust's "concerns policy" is the "The Conduct, Capability ,Ill Health and Appeals

Policy for Medical Practitioners", and is based on MHPS.

The Medical Conduct Committee meets monthly with representation from the Medical Director, Responsible Officer, Director of Human Resources, and Occupational Health, to consider all "live" cases, and to ensure that an appropriate approach is being taken.

The Medical Director and Responsible Officer meet regularly with the GMC's employment liaison officer to discuss cases as appropriate with the GMC, and review those cases relevant to the Trust which are currently subject to a GMC process.

A Remediation Policy is under development, based on the National Clinical Advisory Service "Back on Track" guidance. It is also proposed that the concerns policy should be amended to include formal guidance on handling doctors with outcome outlier alerts, and simplified flowcharts demonstrating on how concerns about doctors from any source should be addressed.

9. Risk and Issues

Appraisal quality. Our methods for monitoring appraisal quality are described above, together with an explanation of the switch to appraiser allocation which has been implemented as a result.

Inadequate numbers of appraisers. We have sufficient appraisers at present, but have lost some this year. We are aware that we cannot force doctors to act as appraisers and we find that any criticism of the performance of an appraiser tends to result in resignation rather than improvement. Hence there is a risk of having insufficient numbers to be able to discharge the statutory duties of the Responsible Officer. To date this has not been an issue and our training programme is described above.

Funding. UHL, as a Designated Body, has a statutory duty to provide sufficient resources to allow the Responsible Officer to deliver his/her responsibilities. This duty has so far been delivered, but there are foreseeable cost pressures on the horizon. The imminent employment of a part-time assistant for the Medical Revalidation manager is discussed above. NHS England has strongly recommended that organisations undertake external review of the quality of their medical appraisal and revalidation processes. This is not yet mandatory but may become so. We have not yet commissioned such a review and the medical appraisal budget currently does not include funds to support such a review.

10. Corrective Actions, Improvement Plan and Next Steps

We have implemented action on missed appraisals and changed to a system of appraiser allocation, as discussed above. Plans for 2015-16 include:

- Continue the programme of training for new appraisers and updates for existing appraisers, making it mandatory that appraisers attend an update session by the end of 2015-16.
- Continue to challenge appraisers whose performance, identified through ongoing audit, raises cause for concern, while anticipating that any such challenge will probably result in the appraiser ceasing to act as an appraiser rather than re-training
- Attempt to improve the delivery of outcome data and information about clinical incidents to the appraisal process
- Implement NHS England's new definition of missed or late appraisals (dependent on software updates promised by Premier IT).
- Consider the possibility of commissioning an external audit (depending on the availability of funds)

11. Recommendations

- To accept this report (noting that it will be shared, along with the annual audit, with the higher level Responsible Officer)
- To approve the 'statement of compliance' confirming that UHL, as a designated body, is in compliance with the regulations.
- To continue to provide support for funding as reasonably justified and agreed by the Executive to allow UHL to discharge its responsibilities as a Designated Body.