

Trust Board Meeting: Thursday 6 September 2012
 TB2012.78

Title	Medical Revalidation Update
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Status	For information
History	

Board Lead(s)	Professor Edward Baker			
Key purpose	Strategy	Assurance	Policy	Performance

Summary

1	Medical Revalidation is being formally introduced on December 4 th 2012 and during this financial year, the Trust's Responsible Officer, (the Medical Director) will be revalidated. In 2013-14, 20% of the Trust's doctors will revalidate, with the remaining 80% revalidating in the two years thereafter.
2	The Trust is making good progress to meet all the requirements for revalidation including improved information flows to and from doctors, improving the quality of medical appraisal and the assurance processes surrounding it, and having a fully compliant set of relevant policies and procedures.
3	Progress to date includes the assembly of comprehensive medical staff databases, a centralised system for tracking appraisals and a greater standardisation, audit of missed appraisal, and "revalidation-ready" appraiser training.
4	Moving forwards, there are significant demands on human resource within the Medical Director's office that must be met in order to ensure the Trust is able to run a process by which all its 797 doctors with a prescribed connection are able to present validated evidence in a quality-assured appraisal that leads to a positive recommendation on revalidation, while ensuring that appropriate action is taken for any who are not on trajectory.
5	Recommendation: The Board is asked to note progress to date

Medical Revalidation Update

Introduction

1. The stated purpose of Medical Revalidation is to assure patients and the public that doctors involved in their care are up to date and fit to practice. It also offers a key opportunity to ensure that doctors are supported in their development and are engaged in assuring and improving the quality of services.
2. The road to Medical Revalidation has taken over a decade to navigate, a fact that has attracted the attention of the Parliamentary Health (Select) Committee. However plans are now finalised and advancing at pace, with the Secretary of State due to sign off the final national business case for revalidation within the next few months.
3. Every doctor with a License to Practice must revalidate. Although the “steady state” arrangement will see each doctor revalidate every five years, for the introduction of revalidation a transitional timetable has been set out that will see 20% of doctors revalidate in 2013-14, 40% of doctors revalidate in 2014-15, and 40% revalidate in 2015-16.
4. Revalidation is undertaken by the General Medical Council following the recommendation of a senior doctor known as a Responsible Officer (RO). Every doctor has a Prescribed Connection to a Designated Body, usually an NHS Trust or PCT, each of which has a Responsible Officer who makes the recommendation to the GMC that a doctor should revalidate. When PCTs are abolished, doctors with prescribed connections to them will have new prescribed connections to the NHS Commissioning Board, but this does not concern the OUH Trust. Arrangements in secondary care are unaffected by the current health reforms.
5. The Responsible Officer for the OUH NHS Trust is Professor Edward Baker, the Medical Director. The Revalidation Lead, accountable to him for implementation, is Dr Tony Berendt, the Deputy Medical Director.
6. Responsible Officers will revalidate during 2012-13; there is a hierarchical process by which the “Responsible Officer’s Responsible Officer” is determined.
7. Medical Appraisal is the essential gateway to Medical Revalidation. Every doctor must undergo an annual appraisal, provided by his/her Designated Body, through a process overseen by the RO of the Designated Body. The RO will use the outputs of appraisal, undertaken through a process set out by the Revalidation Support Team and the GMC, along with any other information available about the doctor such as concerns regarding fitness to practice, to make one of a small number of recommendations:
 - 7.1. Recommended for revalidation
 - 7.2. Revalidation should be deferred to allow for the collection of more evidence (this may be for entirely explicable reasons such as prolonged absence through sickness)
 - 7.3. Failure to engage with revalidation.

8. If a doctor is reported as failing to engage, the GMC will contact them to remind them of the need to revalidate to maintain their License to Practice and may amend their revalidation date accordingly. Should a doctor continue to fail to engage the GMC is likely to carry out “administrative removal” of their License to Practice, without which they cannot be on the Specialist Register or undertake clinical work.
9. It should be noted that there is not an option for the RO to make a recommendation that an individual should **not** be revalidated. This is because:
 - 9.1. It is for the GMC to take that decision
 - 9.2. At any point at which the RO deems that there are substantive concerns about the fitness to practice of a doctor for whom s/he is responsible, that doctor must enter a local remediation process or be referred to the GMC.
10. There is significant external scrutiny in place seeking to ensure that the Trust, along with all other Designated Bodies, has a comprehensive and robust, quality-assured system for medical appraisal, the management of concerns, and the generation of information flows to support revalidation, all in place prior to the relevant legislation coming into force on 4th December 2012.
11. The SHA continues to be involved in the oversight and performance management of the implementation of revalidation. Their activities include running a programme office and a network for RO s to gain greater understanding, expertise and peer support. The Trust is reporting monthly and sharing action plans with the SHA.

Local Arrangements

12. The Trust has established the Medical Revalidation Implementation Group (MRIG) as a subgroup of the Workforce Committee accountable to Trust Management Executive (TME). MRIG has representation from the Divisions, LNC and MSC, relevant corporate departments, and a mixture of consultant and SAS doctors involved. It meets monthly to review progress and agree policy.
13. A new Medical Appraisal and Revalidation Policy, compliant with revalidation requirements, was approved earlier in the year and is now in place.
14. For 2011-12 the annual appraisal process was recommenced in December 2011 following a pause during which changes to the appraisal policy were initiated, new documentation was adopted, and appraisers were allocated to consultants by the Divisions and Directorates, rather than being self-selected as previously.
15. In addition, appraisal documentation was required to be submitted to the Medical Director’s Office to allow tracking of appraisal numbers and subsequently to carry out the quality assurance processes that will become standard procedures in future years.
16. Reporting on rates of medical appraisal has a degree of complexity because the Trust is responsible for appraising all doctors working within it with the exception of:
 - 16.1. Trainees in Deanery programmes (for whom the Postgraduate Dean is the Responsible Officer and the Deanery the Designated Body). These doctors have numbered training posts, or are by agreement “out of programme” (usually on

- research fellowships but sometimes working elsewhere), or are in their “grace period” between completing training and securing a consultant job.
- 16.2. Doctors on the Performers List of the PCT (a Designated Body), i.e. practising GPs.
 - 16.3. Doctors in substantive employment in another NHS Trust.
17. Specifically, the Trust **is** responsible for appraising:
 - 17.1. Consultants
 - 17.2. SAS doctors
 - 17.3. Training grade doctors in non-Deanery posts, for example Trust Clinical Fellows, or research fellows out of training programmes
 - 17.4. Clinical academics and other doctors with an honorary contract with the Trust.
 18. There has been a very substantial amount of work done, from a challenging starting position, to provide an up-to-date list of the doctors who are active in the Trust, and of any others, with whom the OUH has a Prescribed Connection.
 19. The initial database extracted from the electronic staff record listed some 1300 doctors. This list was extensively “cleansed” by colleagues in HR and was then validated by the Clinical and Divisional Directors, and by representation from the University Division of Medical Sciences. It became clear that a significant number of the initial list of doctors had left the organisation, retired, or were working substantively for another NHS Trust which was therefore responsible for their appraisal.
 20. Based on this work, the database currently shows 797 doctors with a prescribed connection to the Trust. This figure is likely to increase as groups such as clinical academics, who may not have had appraisals in the past, align themselves to a Designated Body for the purposes of revalidation. There are a significant number of other doctors with Prescribed Connections to the Postgraduate Deanery or to other NHS Trusts, for whose appraisal the OUH is not responsible.
 21. As reported to TME at the end of June, the number of appraisals received by the Medical Directors Office for 2011-12 is 638.
 22. Following agreement at TME, unless appraisal documentation for 2011-12 was submitted by May 11th, the appraisal was logged as “missed”. The Medical Director’s Office (MDO) has been auditing the reasons for missed appraisals and will report these to MRIG in September, and thence to Workforce Committee and TME.
 23. The Responsible Officer will consider the reason for a missed appraisal alongside other evidence when making recommendations for an individual’s revalidation.
 24. Now that accurate data for the numbers of doctors with a Prescribed Connection are available, we are able to calculate the percentage appraisal rate for medical staff for 2011-12. Prior to this, it was only possible to make a crude estimate based on the number of doctors with a submitted job plan and the number of doctors who had submitted an appraisal.

25. Eighty percent (80.1%) of all doctors with a prescribed connection have submitted appraisal documentation for 2011-12.
26. The Medical Director's Office has written to all doctors who missed appraisal during 2011-12 to ask them to clarify their revalidation plans.
27. Based on the responses the major themes underlying missed appraisals have been :
 - 27.1. Some doctors had indeed had an appraisal but the documentation had not been submitted to the MDO, either by the doctor or by the appraiser.
 - 27.2. Some doctors were on long term sickness or maternity leave, but this fact was not notified to the MDO by the Clinical Directorate in question
 - 27.3. Some doctors genuinely missed their appraisal despite the best attempts of the MDO and the Divisions (and the University) to publicise the issue.
28. Doctors who have missed appraisal are being required to undertake an appraisal with a "top-up trained" appraiser (see below) who will be allocated by the MDO, and using the latest version of the Medical Appraisal Guide (MAG) electronic documentation devised by the GMC.
29. Work continues to build quality assurance structures around the appraisal process and the performance of appraisers including an online survey of all doctors who submitted an appraisal for 2011/12 to understand their experiences of the process, the appraiser, and the appraisal.
30. The Trust's approved appraiser list has been overhauled. All appraisers have been contacted to make them aware of the need to attend "top up" training sessions to ensure they are able to undertake "revalidation-ready" appraisals for the period 2012/13. Training sessions have taken place within the Trust, supported by the Strategic Health Authority. For those who were unable to attend any of these events, the Trust is planning more local sessions as part of the ongoing programme of activities to foster an appraiser network within the Trust. A process for inviting, training and supporting new appraisers has been drafted and is awaiting discussion with the LNC.
31. Based on an expectation that appraisers should carry out 8-10 appraisals each per year and an existing total of 797 doctors with a prescribed connection to the Trust, we expect to need 80 - 100 appraisers. This range may still need adjusting; there remain a significant number of doctors (c500) whose Designated Body is uncertain and while the vast majority are likely to have a prescribed connection with the Oxford Deanery or another NHS Trust, some may ultimately be connected to the OUH and so require appraisal by the Trust.
32. The time required to carry out appraisal to the appropriate standard should not be underestimated. Appraisers will need to have update training in any changes in the regulations and to participate in a network group to ensure common standards and consistent appraisal behaviours. They will also need to be involved in providing face to face input into 360 feedback to satisfy the requirements of revalidation. We anticipate that the quality of appraisal will gain a very significantly sharper focus when the Francis Report into the events at Mid Staffordshire NHS FT is finally

published and action is triggered as a result. At present the MDO estimates 3-4 hours per appraisal will be necessary.

33. The Trust's Revalidation and Appraisal Policy sets out the way in which appraisal informs the revalidation recommendation process. It is appended to this report for information. This has been approved by MRIG, LNC, MSC and Workforce Committee.

Next steps for revalidation and appraisal

34. For the 20% of staff who will revalidate in 2013/14, the Trust will need to provide names to the GMC for each of the four quarters of that year, by 14th September 2012. The GMC will then allocate the actual revalidation date. For subsequent years, the Trust will be able to nominate only which doctors should be revalidated in each year, but not set their date.
35. A business case for the establishment of a Revalidation Office and ultimately the purchase of Revalidation Management Software is currently being prepared in conjunction with the Human Resources team. This will enable the Trust to comply with the GMCs timetable in Years 0 and 1 of the revalidation implementation phase whilst simultaneously installing appropriate software using a rigorous implementation and testing programme. This will ensure that as many systems as possible are operating in a joined up environment, using accurate and validated data, and have been fully stress-tested to ensure value for money and fitness for purpose.
36. To make a recommendation for revalidation during this so-called "transition period" from 2012 to 2016, a doctor must be in good standing with the Trust, have no unresolved concerns arising from previous appraisals or other information, and have completed at least one revalidation-ready appraisal with a "top-up trained" appraiser. The revalidation-ready appraisal(s) must consider all the supporting information stipulated by the GMC. This information in aggregate must meet the requirements for an entire revalidation cycle (i.e. must have at least one piece of supporting information for each of the six GMC domains in each area of the doctor's clinical practice).
37. Doctors assigned a revalidation "slot" in the first quarter of 2013-14 will be notified of their revalidation date in December 2013 by the GMC and will need their final revalidation ready appraisal between October 2012 and the end of March 2013. Since it is not yet clear how far in advance of the GMC's decision the Responsible Officer will have to make the recommendation, the appraisal for a Q1-revalidating doctor may need to be completed sooner in the October-March window, rather than later.
38. The Medical Director's Office will work with the Medical Revalidation Implementation group to support doctors nominated for revalidation during 2013-14, especially early in the year.
39. A review of the commercial products available to support appraisal and revalidation has concluded that providers still have some way to go to ensure their offerings fully reflect guidance available from the Revalidation Support Team (RST) and GMC. The leading provider aims to have their product fully functional by the end of August

2012. However, taking into account the issues with data quality that have been experienced to date, the likelihood of delays in complex software development programmes and the current resources available to manage such a project, it will not be possible to have any web based system up and running for the 2012-13 round of appraisals.

40. Fortunately the feedback from the use of the RST's Medical Appraisal Guide (MAG) Model Appraisal Form, an interactive PDF document into which up to 10MB of supporting information can be uploaded, has been overwhelmingly positive from all areas of the Trust. A further version of this, modified slightly in response to feedback from the final Revalidation pilots, is available from the RST and will be used as the Trust's sole appraisal documentation for 2012/13.
41. To comply with the requirement to revalidate 20% of the medical workforce in 2013-14 using the output from the 2012-13 appraisal round, it will therefore be necessary to set up an in-house revalidation office to track and manage the substantial administrative processes surrounding revalidation. Current resource (partly provided by the medical director's office business manager and partly by a human resources manager) is insufficient to accommodate this additional requirement.

GMC Connect

42. The GMC opened its *GMC Connect* portal at the end of June 2012 which is the mechanism by which all revalidation matters, including formal recommendations, will be managed. The Responsible Officer will be the first member of the Trust to be revalidated by the end of the financial year 2012/13.
43. The MDO is in the process of allocating, via GMC Connect, ALL consultants and other doctors for who the Trust is the Designated Body, and who were in post as of 20th July 2012 to revalidate during a specific quarter in 2013-14 or during a specific year for 2015 or 2016. This allocation activity must be completed by 14th September 2012. The GMC will then issue specific revalidation dates for each doctor based on these allocations. A process for allocation of doctors was agreed by MRIG, and it has involved clinical leaders (NHS and University), forming the bulk of the first year's cohort. Other than this decision, all doctors have been allocated to a specific quarter within 2013-14, or one of the two following years, using a random number selection system.

Appraisal systems

44. The Trust continues to support appraisers to undertake the necessary top up training provided by the SHA to enable them to conduct revalidation ready appraisals for 2012-13. However it is likely that further in house sessions will need to be provided to facilitate training for those who were prevented from attending by clinical commitments. Additional appraiser recruitment is also likely to be necessary. The numbers of appraisers trained for each Division, and required by the Trust, has been calculated and communicated to the Divisions.

Additional data flows

45. In order to comply with the GMC's standards for both appraisal and fitness to practice in relation to revalidation a significant amount of data will need to be collected, monitored and stored by the Trust. Information flows broadly fall into 5 categories:
- 45.1. Information provided to a doctor by the Trust to enable them to complete the necessary reviews at appraisal. This includes clinical governance data on significant events, complaints and compliments and the provision of a multi source feedback tool to enable the collection, analysis and review of patient and colleague feedback. It should be noted that as a doctor's appraisal is required to cover all aspects of their practice the Trust will be responsible for providing this information to all doctors, not just those with whom they have a prescribed connection.
 - 45.2. Information requested from / required by another Designated Body. Although a doctor is broadly responsible for collating their own data to illustrate compliance across all areas of their practice, Trusts may need to validate this data independently as part of their assurance processes. Guidance on information flows between Designated Bodies has been issued by the RST to ensure compliance with the Data Protection Act and similar legislation.
 - 45.3. Information requested by the Deanery. Deaneries are responsible for the revalidation of doctors in training. As it is likely that trainees will have worked at several different sites during each 5 year cycle, Deaneries will need to collect information on each trainee's performance and conduct from each institution for whom they have worked.
 - 45.4. Information exchanged between the RO and HR. A key area of revalidation focuses on a doctor's fitness to practice. This requires the RO to take into account any previous or current performance, conduct, probity or other fitness to practice issues when a revalidation recommendation is made. The Trust is currently strengthening its HR processes in this area to ensure sufficient assurance can be given to the RO in this regard.
 - 45.5. Information exchanged between the RO and the doctor. In order to manage the revalidation process efficiently and to comply with the statutory obligations placed on the RO, the Trust will need to track and manage each doctor's revalidation cycle individually. This includes collection of appraisal data, fitness to practice data and any involvement with the GMC across the full remit of the doctor's practice for each doctor the Trust is responsible for revalidating.
46. It can therefore be seen that the implementation of revalidation will place a significant administrative burden on the Trust. However it also represents an opportunity to improve the quality of data management and reporting relating to medical staffing and to improve efficiency and working practices between departments within the Trust.

Further implications

47. The Medical Director's Office will be bringing a definitive business case to resource:
- 47.1. A revalidation office that ensures the Trust is able to meet its legal obligations with respect to the revalidation of its doctors
 - 47.2. Software to ensure reliable and more cost-effective tracking of the process in the future
 - 47.3. Multi-source feedback according to GMC standards; while there may be a cost-effective way to develop this in house in the future, in the short term the only way to have assurance of a standardised and robust process is to procure individual licences for a commercial web-based product for those doctors revalidating in 2013-14 who do not have an existing MSF from patients and colleagues.
48. A risk register has been produced which is held in the Medical Director's Office and is reviewed by MRIG.

Conclusion

49. The decision to proceed with medical revalidation from 4th December 2012 has been taken.
50. The Trust has a statutory obligation to implement revalidation and to ensure adequate resources are available to the RO to do so. S14 of The Medical Profession (Responsible Officers) Regulations 2010 states that "(1) Subject to paragraph (2), each designated body must provide the responsible officer nominated or appointed for that body with sufficient funds and other resources necessary to enable the officer to discharge their responsibilities for that body under regulations 11 and 13."
51. The Trust has made substantial headway in preparing for the implementation of revalidation with relatively little resource, but there will be significant resourcing implications going forward.

Recommendations

52. The Board is asked to note the contents of this update, particularly the resource implications of the practical implementation and ongoing management of revalidation.

Professor Edward Baker, Medical Director

Dr Tony Berendt, Deputy Medical Director

August 2012