

Report to Trust Board

Date 27 July 2011

Agenda item no 8.2

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| <p>Title</p> <p>Author</p> <p>Responsible Director</p> <p>Purpose</p> | <p>Report from Medical Director- Revalidation</p> <p>Mr E J Neale Medical Director</p> <p>Mr E J Neale Medical Director</p> <p>For approval</p> |
| <p>Action required</p> | <ul style="list-style-type: none"> ➤ To endorse the progress so far and acknowledge the further work that needs to be undertaken. ➤ To consider whether the Board wishes to charge doctors who do not have a connection to the hospital but who wish to make use of the services of the Responsible Officer for Revalidation in order to cover our costs. This is likely to only affect retired Consultants. ➤ To understand there may be cost implications yet to be determined. |
| <p>Relevant CQC standard/ NHS Constitution pledge</p> | <p>Outcome</p> <p>12</p> |
| <p>Link to strategy/plans</p> | |
| <p>Impact assessment:</p> <ul style="list-style-type: none"> - quality - financial/business - equality/diversity - risk - legal/statutory - sustainability | <p>Part of national drive to improve quality.</p> <p>The organisation is legally obliged to provide the Responsible Officer with the resources to discharge their duties.</p> <p>Nil</p> <p>Nil</p> <p>Responsible Officer regulations enacted by Parliament November 2010.</p> |
| <p>Previous consultation/decision/ discussion/</p> | <p>Update on previous reports.</p> |

Date: 7th June 2011

Update on Medical Revalidation

The Responsible Officer (RO) Legislation came into force in November 2010. Under this the Trust is a “designated body” and obliged to ensure resources are available to support the Responsible Officer in their role delivering Revalidation. The General Medical Council (GMC), the Department of Health Revalidation Support Team (RST) and the National Clinical Assessment Service (NCAS) have developed a training programme which is being rolled out across each of the regions of the U.K. Last month I joined the rest of the East of England ROs and underwent the first of these training sessions to be delivered. The purpose of this paper is to provide an update on the current position regarding Revalidation both nationally and locally.

Key Principles of Revalidation

The key themes throughout the national documents are that Revalidation is designed to improve quality and safety of patient care and strengthen professional development. A secondary theme is to improve systems for the identification and support of doctors requiring it.

Revalidation should be based on effective systems of appraisal, governance and quality assurance, but should be seen as a by-product of these strengthened systems.

Timetable

During 2011 and 2012 there will be additional testing, piloting and preparation of systems across the country. Each organisation has been required to complete and submit an organisational readiness survey (Appendix 1 shows the results for our own organisation) which will be repeated to assess progress and readiness on the 31st March 2012. It is anticipated that the Secretary of State will make an assessment of national readiness in the summer of 2012 with a decision to “go live” late 2012. The first recommendations for Revalidation by ROs will then be made at the end of 2012 or early 2013 with 2013/14 being the first full year. It is anticipated that between 2013 and 2016 the whole process will be rolled out across the U.K., although whether this will be by organisation or doctor is, as yet, unclear.

The key milestones for system readiness are the appointment of an RO, a robust system of annual appraisal for all doctors based on the elements of the GMC framework Good Medical Practice and agreed core information to support this. A process is also required for ROs to deliver recommendations to the GMC (which has not yet been decided) as well as clear processes for remediation, the need for which may increase, certainly in the initial phases.

Prescribed Connections

Under the regulations each doctor should have a prescribed connection to a designated body and hence an RO. Although this system is potentially very complex for locums etc., within the hospital environment it is very straight forward. Every doctor who has a permanent or fixed term contract with us (but not a locum contract) is the responsibility of the organisation and the organisation’s RO. As doctors can only have one RO, those who have more than one NHS contract will be connected to the organisation that holds the contract for the majority of their time. Those who have a single contract but work in more than one place, the connection will be to the contract holder.

The Responsible Officer’s Role

Each designated body is required to appoint an RO (which we have done) but also should have access to a second RO for those instances where there may be a conflict of interest or

appearance of bias. I have had preliminary discussions with John McNamara regarding this, but he will need to access the training, hopefully, at one of the nearby regions in order to reduce the cost. The legislation, however, allows for a designated body to appoint an RO from another organisation so this could be covered within local networks.

The key messages that came out of the training in terms of the RO are that the designated body is obliged to resource the RO to carry out the role, but the resource required will depend on what is currently in place. In addition it is clear that the RO will need professional support externally by means of a local RO network in order to deliver their obligations. The RO them self will be accountable currently to the regional RO, however, how this may change with the reorganisation of the NHS is not yet clear.

Clinical Governance

The regulations are written on the assumption that a strong clinical governance process exists within each organisation. It is assumed that those governance systems will not only drive high standards of care but also provide data to support individual revalidation. For Consultants we have data which reflects the activity of the team they lead more than their individual practice. For non Consultant staff the data is much less readily available. Exactly what core data will be required by each doctor has not yet been finalised but, without a doubt, more than is currently available will be required, particularly in respect of patient outcomes. In addition regular reports in respect of complaints and litigation will need to be produced.

Appraisal System

The cornerstone of Revalidation will be enhanced appraisal. In essence this will cover all aspects of a doctor's job (such as NHS work, private practice, management, or even supporting a local sport's team) and will need to be designed so that all aspects of the GMC document, *Good Medical Practice*, are assessed over each five year period. Supporting information will include data on continuing professional development (which will probably be led by the Medical Royal Colleges), quality improvement activity, significant events and incidents that the doctor has been involved in, feedback from colleagues, feedback from patients and review of complaints and compliments, including lessons learnt and actions that have been taken as a result. Final detail is due to be published later this year by the RST and our system (which is currently inadequate) will need to be updated and flexible enough to meet any changes as they come in.

Who should undertake the appraisal is currently open to debate. Our current system is that the doctor can choose their appraiser. The original advice of the RST was that the appraisal should be undertaken by a doctor in the same or a related specialty, however, the latest advice suggests that the same appraiser should not be used more than two years in succession. In addition, although we currently have 19 trained appraisers in the organisation, all appraisers will have to undergo training to deliver enhanced appraisal to the new standards required to support Revalidation, and as a number of our appraisers are approaching retirement, an expanded pool is therefore likely to be needed. This training is likely to be cascaded on a regional level, but the details are currently not available.

Also awaited are details on how the appraisal and clinical governance systems themselves will need to be quality assured within each organisation, but appraiser review and appraiser support mechanisms are almost certainly going to be required, as well as a review of the outputs to ensure that not only is the system well managed, but that the correct information is available for the appraisal and the quality of the personal development plan that is produced reaches a significantly high standard.

Enhanced Appraisal and Revalidation

A lot of concern was expressed at the training regarding the detail of the process of Revalidation which is as yet unavailable. It was the view of the Department of Health that a simple decision to recommend Revalidation or not was all that will be required of the RO. The GMC on the other hand suggested that there would be four options, namely recommend Revalidation, recommend referral to the GMC, recommend immediate ceasing of practice, or a realisation that there was insufficient evidence currently available and the deferring of any decision for a set period of time. The RO/Medical Directors were very concerned about the lack of clarity about the point in time of Revalidation. However, it is very clear to me that the requirements over a five year period to make a recommendation to revalidate an individual should highlight those with problems well in advance so that remedial action can be taken prior to the time when the recommendation is required. My main concern is what different processes may be put in place for the period of transition and that first recommendation.

Conclusion and Actions

It was the general feeling of all RO who underwent the training that far more questions were asked than answers provided and certainly we seem to be at the very early stages of a process which is gathering a momentum without clear detail of the final process. The lack of clarity prompted the ROs from acute organisations across the region to meet separately and agree a plan to pool current systems and resources and produce a series of documents for local adaptation in order that we can all use a very similar process on the grounds of safety in numbers! To that end we have agreed to produce a draft appraisal policy and supporting documentation before the end of July. We have also (potentially) identified monies to support the beginning of appraiser training which we will, hopefully, be able to put in place by September. (A summary of the requirements of the role of the RO is given in Appendix 2).

Actions I will be undertaking locally are:

- Identify all doctors for whom I am Responsible Officer.
- Ensure adequate appraisers have been appointed in anticipation of training such that no appraiser undertakes appraisal for more than 6-10 doctors per year at an average of 4 hours each.
- Identify a suitable package for both colleague and patient 360° and a suitable timeframe. The legislation suggests a minimum of 1 per 5 years. I believe it should be more frequent than that, though perhaps not annually as we currently do.
- Identify true cost and resources for Revalidation including time in job plans and administrative support.
- To review available appraisal documentation once the regional policy is complete and identify the most suitable to our needs.

Appendix 3 is taken from “The Role of the Responsible Officer” (DoH) shows the responsibilities of the organisation.

E J NEALE FRCOG
Medical Director