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A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: No anticipated changes
Comments:A new RO was appointed - Hamish McLure
Action for next year: No anticipated changes

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes/No [delete as applicable]
Action from last year: To implement and fully operationalise a new appraisal system
Comments: The contract was awarded to SARD and replaced PReP on the 6th April 2021
Action for next year: No anticipated changes

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Role out the new system and processes
Comments: The contract was awarded to SARD and replaced PReP on the 6th April 2021
Action for next year: :Develop the system further to make it interoperable with ESR

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: No further action due
Comments:
Action for next year: Revalidation policy is due for renewal in 2022

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: Validate our processes and align to new appraisal system, set up a peer review with Darlington Comments: Peer review was not undertaken due to COVID Action for next year: Contacted Darlington to set up a peer review, awaiting confirmation of meeting date

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Continue to improve these processes Comments: Continue to work with CSUs to improve these processes Action for next year: Continue to improve these processes

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Action from last year: No action Comments: COVID deferrals contributed towards a lower completion rate of 70% Encouraged the completion of the mag 20 form probably had a positive effect on the whole process Action for next year: Continue to encourage MAG20 discussions and support doctors with the new appraisal system to increase completion rates

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Comments: Action for next year:

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: No updates required Comments: Action for next year: Due to be reviewed in 2022

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: To carry out an annual recruitment process Comments: One Session was held during COVID via teams, 4 sessions are arranged for Sep/Oct 21 Action for next year: To hold more sessions continuing to use teams. To review the training materials and bring them up to date for a virtual audience

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: To continue to hold more sessions via Microsoft teams and to introduce more interactive breakout sessions, technology permitting Comments:8 sessions held in 20/21 Action for next year: Hold monthly sessions via teams and include ASPAT tool using the new appraisal system

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

Action from last year: To conduct the annual audit as usual and continue to audit first 3 appraisals conducted by new appraisers

Comments :Introduction of a new system and COVID halted the annual audit

Action for next year To undertake annual audit and implement new audit process using new appraisal system

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2021	1590
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	1105
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	467
Total number of agreed exceptions	18

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: No action

Comments: The recommendations to the GMC are made on GMC connect aprox. 2 weeks before revalidation date, the exceptions to this is where we are chasing doctors for missing information i.e. feedback – 360 feedback has now been moved to year 3 of the revalidation cycle to further reduce our deferral rate. No late recommendations made to GMC, 83 positive recommendations and 3 deferrals made to GMC in 20/21

Action for next year: Robust process to ensure recommendations made on time

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the

recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: No action

Comments: Following on from the appraisal deferral in March 2020 and all those doctors subsequently put under notice by the GMC, have now all been checked for revalidation readiness and revalidated where able to. Only 3 deferrals in this period, due to suspension of appraisals, all doctors were contacted with an action plan. The deferral rate for 20/21 already exceeds any previous years totals with the majority of these due to non completion of feedback. This is due to COVID, implementation of new appraisal system and Drs getting used to the new system and the online patient feedback functionality. Feedback reminders are on the appraisal system to remind doctors to complete feedback in year 3 to help reduce deferrals

Action for next year: Continue to drive completion of feedback, supporting drs with new system where necessary and reduce deferrals

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: We have procured a new appraisal system and hope to mandate this with the roll out of the system next year

Comments: Assurance and performance in this area are reported through the Quality Assurance Committee to our Trust Board, overseen by the Chief Medical Officer (CMO) and Chief Nurse. Key aspects of clinical governance for the RO at LTHT are the collection and use of clinical information and systems to assist clinicians in their annual appraisal and more rarely to trigger the raising of concerns about a doctor's practice from our clinical risk management systems.

The RO gave a briefing to the Trust Board on their responsibilities around medical governance and revalidation. There is a designated Non-Executive Director with responsibility for medical revalidation.

Progress in implementing a high-quality system for revalidation is overseen by the Revalidation and Appraisal Steering Group. A working group, lead appraiser group and a number of other groups contribute to this overview. The Steering Group is chaired by the Chief Medical Officer (CMO) and Responsible Officer (RO) and its membership includes the Medical Appraisal Lead, clinical leaders, professional development and medical workforce, as well as 'front-line' clinicians who have volunteered to help the Group with its work. The Group reports to the board through this annual report. The Lead clinician form, now called Appraisee declaration is integrated in to the SARD system for completion

Action for next year: Drive increased completion of Appraisee declaration

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Same as this year

Comments: The approach taken in LTHT is to use existing routine systems to monitor the fitness to practise of all doctors. This includes

- Mortality and morbidity reviews
- Clinical governance forums and meetings in specialties
- Participation in national and local audits
- Quality Improvement Activity
- Whistleblowing systems
- Never Events

Clinical Directors hold responsibility for identifying and managing concerns about all aspects of all performance, escalating them where it is felt that they may be serious.

Action for next year: As outlined above triangulation of information from these listed sources will be fed into the appraisal process via the Appraisee Assurance form. We will develop processes for collating this information with Trust governance systems

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: : We will continue to follow our agreed policies and procedures

Comments: The Trust's approach to identifying and responding to concerns is covered by the Principles for Responding to Concerns and the Guidance and Principles for Remediation

Action for next year: We will continue to follow our agreed policies and procedures

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and

outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: To continue with trust processes

Comments: The table below contains data regarding the numbers of doctors at risk during 2020/21 that required formal action by the GMC, or by the Trust internally, where there was an outcome other than "case closed with no further action".

	Low Risk	Moderate Risk	High Risk	**Totals**
Conduct	9	7	0	**16**
Capability	2	1	0	**3**
Health	0	1	0	**1**
Totals	11	9	0	**20**

Action for next year: To continue with trust processes

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: Continue to monitor compliance

Comments: External requests for information are subject to initial review by the appraisal and revalidation administration team, and the relevant Clinical Director is contacted for information about involvement in incidents, complaints and investigations. The request is reviewed by the RO before signature and release.

The RO contacts the relevant RO with any concerns over practice that may impact on that organisation

For doctors connected elsewhere, including doctors in training, initial contact and exchange of relevant information is arranged as needed.

Transfer of Information Requests are no longer provided as routine – trainees entering the organisation are now being requested to provide the last ARCP outcome form for assurance purposes

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action for next year: Continue to monitor compliance

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: No action

Comments: All processes for responding to concerns are managed according to our Trust Policy (Disciplinary and Capability Procedures for Medical and Dental Staff) which is consistent with MHPS. We have trained Case Investigators and Case Managers to ensure appropriate processes. Issues around potential bias and discrimination are considered by our Senior Team before any formal process is commenced

Action for next year: No action

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Continue to monitor compliance

Comments: All doctors employed by LTHT are subject to the NHS mandatory pre-employment recruitment checks prior to appointment, including locum doctors which are carried out on the Trust on-boarding system.

In April 2014, a new category of fitness to practise impairment 'not having the necessary knowledge of English' was introduced by the GMC, requiring Trusts to ensure that doctors have sufficient knowledge of the English language necessary for their work to be performed in a safe and competent manner. The pre-employment checks carried out on all doctors provide this assurance at LTHT.

Action for next year: We will continue to monitor compliance

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- General review of actions since last Board report
- Actions still outstanding
- Current Issues
- New Actions:

Overall conclusion:

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

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