The Leeds Teaching Hospitals NHS Trust

Medical Revalidation Annual Report
Public Board
30th September 2021

Presented for:	Approval/ Information
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Previous Committees:	Revalidation and Appraisal Steering Group

Trust Goals	
The best for patient safety, quality and experience	✓
The best place to work	✓
A centre for excellence for research, education and innovation	✓
Seamless integrated care across organisational boundaries	
Financial sustainability	

Risk Appetite Framework				
Level 1 Risk	(✓)	**Level 2 Risks**	**(Risk Appetite Scale)**	**Risk**
Workforce Risk	✓	Workforce Performance Risk - We will deliver safe and effective patient care through having the right systems and processes in place to manage performance of our workforce.	Cautious	↔ (same)
Operational Risk			Choose an item	
Clinical Risk	✓	Patient Safety & Outcomes Risk - We will provide high quality services to patients and manage risks that could limit the ability to achieve safe and effective care for our patients.	Minimal	↔ (same)
Financial Risk			Choose an item	
External Risk	✓	Regulatory Risk - We will comply with or exceed all regulations, retain its CQC registration and always operate within the law.	Averse	↔ (same)

Key points	
1. To note the progress, compliance with national policy and legal requirements and our improvement plan	Information
2. Approve the Board assurance statement relevant to this report	Approval

Summary

This is the Trust Responsible Officer's Annual Report covering the 2020/21 appraisal year. This report is a required item of assurance, and also the assurance statement we are required to submit to NHSE.

1. Background

The General Medical Council's (GMC) aims for medical revalidation are that it:

- is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.
- supports doctors in their professional development, contributes to improving patient safety and quality of care, and sustains and improves public confidence in the medical profession.
- facilitates the identification of the small proportion of doctors who are unable to remedy significant shortfalls in their standards of practice and remove them from the register of doctors.

To achieve these aims, the GMC requires that all doctors identify the Designated Body (usually their employer) that monitors and assures their practice. LTHT is a Designated Body for over 1590 doctors.

Revalidation is overseen in England by NHSE through annual audits. In the recent past, the Trust's medical appraisal and revalidation processes have also been peer reviewed by County Durham and Darlington NHS Foundations Trust. However, no peer review occurred in 2020 as the demands of the COVID pandemic suspended appraisal activity. This external peer review will re-commence once the pandemic activity has settled.

Over the last 12 months, our focus has been adjusting to the changes to the appraisal system as a consequence of the COVID pandemic and also implementing the new appraisal toolkit.

Significant staff changes in this year have included Dr Hamish McLure taking on the role of Responsible Officer (RO), and Mr Chris Mannion becoming the Trust Medical Appraisal Lead.

2. Equality Impact Assessment

An Equality Impact Assessment was completed in September 2019 as part of the renewal of the revalidation policy. It will be repeated in 2022.

3. Publication Under Freedom of Information Act

This paper is available under the Freedom of Information Act

4. Supporting Information

The following papers make up this report:

- Medical Revalidation Responsible Officers Report is presented in Appendix 1
- Appendix D Annual Board report and statement of compliance Appendix 2

5. Recommendation

- Note the assurance provided on medical appraisal and revalidation
- Note the continued good progress being made in this area
- Confirm commitment to supporting the progress of this work

Dr Hamish McLure

Medical Director (Professional Standards & Workforce Development) and Responsible Officer for Leeds Teaching Hospitals NHS Trust, St Gemma's Hospice & Martin House Hospice

September 2021

Appendix 1 - Medical Revalidation Responsible Officer Report

1. SUMMARY

In the appraisal year 2020/21, LTHT was the Designated Body for 1590 doctors. In addition to these doctors, LTHT also provided appraisal support for 81 dentists from the Leeds Dental Institute.

In the appraisal year 2020/21, 70% of doctors and dentists completed their appraisal. This is significantly lower than the 97% achieved in the previous year and is a consequence of the impact of the COVID-19 pandemic.

When the COVID-19 pandemic started, the GMC suspended appraisals in order to allow doctors to prepare for an expected surge of critically ill patients. In addition, all doctors who were due to be revalidated in the 2020/21 appraisal year had their revalidation date deferred for a year. The deferral of revalidation dates had the potential to cause significant administrative difficulties for revalidation teams the following year as there would be twice as many doctors required to go through the process. In addition, the deferral caused frustration for doctors who were already prepared and, in a position, to be recommended. To allow flexibility and enable organisations to 'decompress' the system, all of those doctors who had been deferred were put under notice by the GMC, meaning that if they had sufficient evidence, then their Responsible Officer could have recommended them for revalidation. In LTHT, revalidation panels, where we review doctor's readiness for revalidation, were re-started in July 2020.

As the first surge of COVID-19 patients started to diminish in the summer of 2020, the GMC suggested that appraisals re-start at the end of September. However, the precise timing of the restart remained at the discretion of the Responsible Officer. At LTHT, we followed GMC guidance and re-started appraisals at the beginning of October. However, we were tolerant of clinicians who were still extremely busy dealing with the pandemic and recognised that some were still unable to complete their appraisal. In April, at the start of the 2021/22 appraisal year, appraisal returned to being a mandatory requirement.

Guidance to help Responsible Officers to re-start appraisal was developed in collaboration between the General Medical Council (GMC), British Medical Association (BMA), Academy of Medical Royal Colleges (AoMRC) and NHS England & NHS Improvement (NHSE&I). The guidance, called the Medical Appraisal Guide 2020 (MAG 2020), described how appraisal should be carried out considerately and effectively in the context of the pandemic. It emphasised the established functions of appraisal, but also offered doctors an opportunity to de-brief on their experience of the pandemic and gave them a chance to reflect on their health and wellbeing. In addition, the MAG 2020 aimed to minimise the administrative burden of preparation for an appraisal, reducing diversion from patient care by focussing on the verbal discussion as evidence rather than doctors having to provide written supporting information to their appraiser. This approach was a change from asking doctors to prove 'beyond all reasonable doubt' that they are working in line with the principles of Good Medical Practice (GMP), and instead used the balance of probability with the collation of both written and verbal supporting information within the appraisal discussion with an emphasis on 'bring what you can'.

In addition to the change in focus of the appraisal and in order to undertake appraisal in a way that encouraged social distancing, the use of IT platforms such as Microsoft Teams or Zoom was adopted.

The changes in the appraisal and revalidation process affected the majority of the doctors at LTHT, which generated significant work for the appraisal team. In addition to the pandemic related work, the team were also managing a procurement then launch for the new appraisal toolkit. At LTHT we had used an online appraisal toolkit called PReP, provided by Premier IT, since 2012. The appraisal admin team had significant ongoing contact with Premier IT to troubleshoot various issues and that contact wasn't always smooth. The contract for PReP was due for renewal in 2021 at which point we had the option of moving to a better system. We decided to survey users, so an online questionnaire was distributed to doctors asking for their experiences of using PReP. Of the 176 respondents, 33% reported that PReP was difficult/very difficult to use. They commented that the system wasn't intuitive, was overly complex, repetitive, slow and required multiple steps to upload and view pieces of supporting information. There were also some positive comments and several doctors asked to stay with the same system, but usually because it had been so difficult to become familiar with it in the first place. It's clear that there were poor experiences amongst appraisees and the appraisal administration team. As a consequence, the appraisal team made a decision to explore alternative appraisal toolkits. After a detailed review process which included appraises, appraisers and CSU lead appraisers, a new appraisal toolkit called SARD was chosen. The SARD team worked with our appraisal team during 2020/21 and the new toolkit was launched successfully at the beginning of the 2021/22 appraisal year. We plan to survey doctors using the system after the first year.

When appraisal was first launched, there was an emphasis on appraisees choosing topics for discussion at their appraisal. If they'd had a significant event, then they could choose not to discuss it and the appraiser might not be aware. This represented a missed opportunity to provide support and avoid a similar occurrence in the future. In order to ensure appraisers had sight of all of the important events in a doctor's past year, the Lead Clinician form was introduced. This form was meant to be completed by the appraisee, giving details of significant events and allowing the Lead Clinician to add any issues they thought were relevant to an appraisal discussion. It was meant to be signed off by the Lead Clinician and returned to the appraisee who would upload it as a piece of supporting information. Unfortunately, it was never fully embedded as appraisees were suspicious that it was part of a performance management process and there was confusion around who should complete the form, often leaving busy Lead Clinicians to fill in details for everyone in their department. In 2020/21, the form was re-launched, but badged as the Appraisee Declaration, shifting responsibility for completing the form back to the appraisee. It's now embedded in the new toolkit and the process should be easier for appraises to complete.

2. PURPOSE OF THE PAPER

To update on progress and improvement plans for medical revalidation.

3. BACKGROUND

Designated Bodies have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that their 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 and

- ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to the required standards.

4. GOVERNANCE ARRANGEMENTS

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.

5. MEDICAL APPRAISAL DATA

5.1 Appraisal Figures 2020/2021

	2016-17	2017-18	2018-19	2019-20	2020-21
Total Completed	1193 (96%)	1242 (94%)	1285 (94%)	1436 (97%)	1105 (70%)
Special Circumstances	25 (2%)	32 (3%)	36 (3%)	24 (2%)	18 (1%)
No Appraisal	29 (2%)	44 (3%)	51 (3%)	15 (1%)	467 (29%)

The 'No Appraisal' figure represents all appraisals that were not undertaken due to the suspension of appraisals during the COVID pandemic and were marked as approved missed on the appraisal system. Unapproved missed appraisals, where doctors fail to engage with the appraisal process are always of particular concern. However, we are unable to report numbers of doctors in this category for 2020/21 as appraisals were formally suspended from March to October, and the GMC permitted doctors who were still busy due to the pandemic to miss their appraisal until the end of the appraisal year.

5.2 Appraisers

There are currently 211 medical appraisers at LTHT. All are required to attend two update workshops every three years in order to maintain their knowledge and skills. Appraiser attendance at these sessions is monitored and individuals who do not attend a sufficient number are contacted with dates of future sessions. LTHT ran seven appraisal update

sessions using a remote format in 2020/21. Feedback from these sessions was good with excellent interaction and contributions from the attendees.

In addition to appraiser update sessions, we delivered new appraiser training sessions using a remote format and have planned a further four sessions in September and October 2021.

Historically, appraisees have been able to choose their appraiser. Although popular with appraisees, this is open to abuse and can lead to conflicts of interests NHSE recommends that appraisers are allocated for doctors to avoid conflicts of interest. During 2020/21, a new process for allocation of appraisers was developed and has been launched with the new appraisal system. Allocation of appraisers now involves the appraisal admin team and the CSU Appraisal Leads who has local knowledge of suitable pairings and can avoid potential conflicts. This has allowed us to allocate more appraisees to appraisers who only appraise one or two colleagues, and reduce the number of appraisals for colleagues who had a very heavy workload. This should improve the overall quality of the process (see below section on QA) and hopefully reduce the burden on some colleagues.

5.3 New Starters

All new doctors for whom LTHT is their designated body are sent a welcome email and an invitation to attend a new starter learning burst. These sessions explain the process of appraisal and revalidation, and are an opportunity to answer questions and signpost sources of support. Alongside the pause in appraisal, these sessions stopped in March 2020 then re-started in October using a remote format. New starters were given the contact details for the appraisal admin team and encouraged to get in touch if they had questions.

In order to obtain relevant history, doctors are asked to complete a new starter form which asks for details of previous appraisals, feedback exercises, disciplinary action, GMC investigations and restrictions in clinical activity. Additional significant details are also available from Transfer of Information forms which are completed by Responsible Officers in other organisations.

5.4 Strengthening CSU responsibilities

We continue to work with the CSUs by providing them with real time data on numbers of completed appraisals and contacting them with any issues about specific doctors. The role of CSU Appraisal Lead has become more significant as we need them to allocate appraisers. In addition, they are required to quality assure a proportion of appraisals every year using a standardised QA tool, and are helping with training by running new starter appraisal sessions.

5.5 Quality Assurance

NHSE requires organisations to quality assure the appraisal process. At LTHT this is done in a number of ways. Firstly, all appraisers are trained and regularly updated. Update sessions include a feedback exercise where appraisers collectively review their appraisal output forms. This gives them an opportunity to calibrate themselves and learn from others. In addition, appraisal documentation is reviewed at monthly revalidation panels and if there are issues with appraisal quality, then appraisers are contacted, issues discussed, and support provided. Finally, a national standard tool, the Appraisal Summary and PDP Audit Tool (ASPAT) is used to assess 10-20% of appraisal documentation. The ASPAT tool is now

used as a training aid for appraiser update and new appraiser training sessions as it helps guide appraisers to include elements that score highly in terms of quality.

5.7 Clinical Governance

Assurance and performance in this area are reported elsewhere, overseen by the Chief Medical Officer (CMO) and Chief Nurse. Key aspects of clinical governance for the Responsible Officer 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. Detailed discussions with the informatics team have identified the potential and the barriers to the provision of this information and work is on-going.

6. MEDICAL REVALIDATION

6.1 Revalidation Recommendations

The monthly revalidation panels include the CMO, RO Medical Appraisal Lead, LNC representative and HR. This group assesses doctors for readiness for revalidation. Where they have sufficient evidence, a positive recommendation is made to the GMC. The revalidation panel has made 2048 recommendations to the GMC since revalidation started in 2012. In the 2020/21 appraisal year, LTHT made 113 positive recommendations for revalidation to the GMC.

If the doctor doesn't have sufficient evidence and needs more time to collect that evidence, then their recommendation may be deferred. In addition, in 2020/21 there were 313 deferrals due to the pandemic.

On rare occasions, doctors do not engage with the appraisal process despite multiple interventions from the appraisal and departmental teams. In these cases, a non-engagement notification is made to the GMC. During the 2020/21 appraisal year, there were no doctors requiring a non-engagement submission.

6.2 Policy and guidance

The medical revalidation policy is due for review by May 2022.

7. RECRUITMENT AND ENGAGEMENT BACKGROUND CHECKS

All doctors employed by LTHT are subject to the NHS mandatory pre-employment recruitment checks prior to appointment, including locum doctors.

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.

8. MONITORING PERFORMANCE

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.

9. RESPONDING TO CONCERNS AND REMEDIATION

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

10. RISKS AND ISSUES

There are no risks or issues that need to be escalated for the Board's attention.

11. RECOMMENDATIONS

Board Members are asked to:

Note the assurance provided on medical appraisal and revalidation

- Note the continued progress being made in this area
- Confirm commitment to supporting the progress of this work

Dr Hamish McLure

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