South Eastern Health and Social Care Trust

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Trust Board Date	30 March 2022
Title	Annual Report – Medical Appraisal and Revalidation
Lead Director	Mr C J Martyn – Medical Director / Responsible Officer

Contents

1.0 Purpose

The purpose of this report is to provide assurance to the Trust Board that the arrangements for Medical Appraisal and Revalidation have been operating effectively. This report forms part of the Medical Director's duties as a Responsible Officer (RO) and covers the calendar years January to December 2019 and 2020 respectively. The appraisal cycle covering the calendar year for 2021 is ongoing.

2.0 Background

Medical Revalidation was launched by the General Medical Council (GMC) in 2012 to strengthen the way doctors are regulated, with the aim of improving the quality of patient care, patient safety and increasing public trust and confidence in the medical profession. The process involves a 5 year cycle of annual appraisals, with both patient and peer feedback, to support the Responsible Officer, Mr Charlie Martyn, in making a recommendation to the GMC in relation to an individual's fitness to retain a license to practice. The appraisal itself is a summative and formative review of a doctor's clinical and professional development. It helps encourage doctors to plan and ensure continued professional development through an agreed personal development plan. All non-training doctors with a licence to practice are required to participate in the process and the GMC allocates each doctor to a designated body which oversees the local appraisal process. Currently, the South Eastern H&SC Trust as a designated body has 450 doctors attached to it.

3.0 The impact of Covid-19 and the Trust Response

On 17 March 2020, the GMC suspended the revalidation process for the period 17 March 2020 to 30 September 2020. All doctors who were due to revalidate during this period had their revalidation date deferred for 1 year. This decision recognised the impact of the pandemic on some doctor's ability to prepare for their appraisal and revalidation. The suspension was further extended in June 2020 to cover the period until 16 March 2021. This impacted 91 doctors in the Trust who had their revalidation date moved forward by 12 months. Notwithstanding this, the Trust did revalidate 35 doctors during the early part of 2020.

On 10 April 2020, the Chief Medical Officer suspended appraisals for the 2019 year within Northern Ireland until further notice. The initial approach from this Trust was to encourage doctors to complete their 2019 appraisal where possible, but no later than 30 December 2020. However this date remained under review and was subsequently extended until 31 March 2021.

The GMC formally restarted the appraisal process on 1 October 2020 with an altered format where the emphasis moved away from providing documentary evidence to a more narrative and reflective approach with the focus on support and the wellbeing of the doctor. The Trust subsequently informed doctors that the date for completion

of the 2019 and 2020 appraisals was adjusted to 31 March 2021 and 30 June 2021 respectively.

4.0 SET – Internal Appraisal Process

All appraisals are conducted by a trained appraiser in accordance with GMC requirements. During the 2019 and 2020 cycles, there were 54 and 56 trained appraisers respectively who actively supported the process. While the Trust recommends that each appraiser should carry out between 6 and 8 appraisals each year, this continues to present a challenge in some specialties. In 2020 there were 10 appraisers who exceeded the recommended quota.

For quality assurance purposes, following consultation with the relevant Clinical Director, a doctor is allocated to their appraiser centrally by the Office of the Medical Director and they are also required to change their appraiser at least once in every 5 year cycle.

The doctor gathers evidence regarding their whole practice and reflects on this according to the format specified by the GMC. This has 4 domains: knowledge, skills and performance; safety and quality; communication, partnership and teamwork and maintaining trust. The OMD have provided guidance documents to inform doctors in the regards to the supporting information which they should include within their appraisal, which includes a detailed explanation of their CPD and once in every 5 year cycle, the doctor must also include multi-source feedback from patients and colleagues. This is a standardised process which is facilitated by the HSC Leadership Centre.

Trained appraisers have responsibility for ensuring that sufficient information has been provided for an informed appraisal to take place, to challenge and support the reflection of the doctor, to assess progress against the Personal Development Plan (PDP) set in their previous year's appraisal, and to agree a prospective PDP for the following year.

Each Appraiser is required to declare the following:

I. An appraisal has taken place which reflects the whole of the doctor's scope of work and addresses the values and principles set out in Good Medical Practice.
II. Appropriate supporting information has been presented in accordance with Good Medical Practice to support the nature and scope of the doctor's work.
III. A review that represents progress against last year's PDP.
IV. An agreement has been reached in regards to a prospective PDP.
V. No information has been presented or discussed in the appraisal which raised a concern regarding the fitness to practice of the doctor.

4.1 Appraisal Completion Rates

Table 1 and 2 outline the Trust appraisal completion rates for the periods 2019 and 2020 respectively. Although the Trust has performed highly, there has been an increase in the number of unapproved or missed appraisals (see table 2). While the

pandemic and the resulting extension of the appraisal deadline has undoubtedly contributed towards this, measures have been taken to ensure all outstanding appraisals are completed as a priority.

Table 1: Appraisal Period – January to December 2019

	Number of Prescribed Connections	Completed Appraisals	Approved Incomplete or Missed	Unapproved Incomplete or Missed
Consultants	247	245	2	0
SAS Doctors	96	95	1	0
Other Doctors	3	3	0	0
TOTAL	**346**	**343 (99%)**	**3 (1%)**	**0**

Table 2: Appraisal Period January to December 2020

	Number of Prescribed Connections	Completed Appraisals	Approved Incomplete or Missed	Unapproved Incomplete or Missed
Consultants	272	261	4	7
SAS Doctors	101	94	4	3
Other Doctors	5	3	1	1
TOTAL	**378**	**358 (94.7)**	**9 (2.4%)**	**11 (2.9%)**

5.0 SET – Internal Revalidation Process

Each doctor is contacted by the Office of the Medical Director approximately 12 months prior to their next revalidation. At this stage, the doctor is advised that they must meet with their Clinical Director at no later than 4 months before their revalidation date. The purpose of this meeting is to conduct a final review of their revalidation portfolio and ensure that it meets all of the necessary requirements for revalidation as outlined by the GMC. If gaps are identified, an action plan is agreed. If concerns arise which have not previously been highlighted, the RO will be informed immediately and the case may be discussed with the GMC Employment Liaison Adviser where appropriate.

One week prior to a doctor's revalidation date, the RO will make a recommendation to the GMC and inform the doctor accordingly. The recommendation will be one of the following:

I. Revalidate.

II. Defer revalidation – this recommendation is made when some further steps need to be taken to complete satisfactory appraisal, or when the doctor is

unable to progress at the present time due to, for example, maternity leave. *In circumstance where it has been deemed that a doctor's deferral was avoidable, they will be invited to a meeting with the Head of the Office of the Medical Director and the Associate Medical Director. The purpose of this meeting is to agree an action plan.*

III. Record non-engagement – this recommendation may lead to the suspension of the doctor from the GMC register.

Failure to revalidate will ultimately result in removal of the doctor from the GMC Medical Register.

5.1 SET – Revalidation Recommendations

The table below provides a summary of revalidation recommendations for the Trust.

Table 3: Summary of Revalidation Recommendations

	2019	2020	2021
Revalidated	89 (92.71%)	35 (100%)	89 (89.9%)
Deferral Requested	7 (7.29%)	0	10 (10.1%)
Non-Engagement Indicated	0	0	0
Recommendations Remaining in Year	0	0	0
TOTAL	**96**	**35**	**99**

SET deferral rates are generally consistent with regional and national patterns. It is recognised that there has been an increase over the last 24 months in regards to the deferral rates and anecdotal evidence from the GMC also suggests that was a result of the pandemic. The GMC are keen to point out that a deferral should not automatically be viewed negatively. Notwithstanding this, the Trust does not want to encourage a culture of unnecessary deferrals. Therefore, in circumstances where it has been deemed that a doctor's deferral is avoidable, they are now invited to a meeting with the Head of the Office of the Medical Director and the Associate Medical Director. The purpose of this meeting is to agree an action plan.

6.0 Quality Assurance

The OMD continues to oversee the quality control of the medical appraisal process. Records of appraisals are tracked and where documentation has been submitted which appears to be incomplete, these are returned for completion. The introduction of the electronic Regional Appraisal System has facilitated this.

Regular contact is maintained with the local GMC Employment Liaison Adviser and a formal meeting is held quarterly. In addition, the Trust RO attends the regional and national RO Forums.

An Associate Medical Director (AMD) is employed with responsibility for Service and Governance Reform. The primary function of this role will be to provide the OMD with clinical expertise on appraisal and revalidation.

Systems have been implemented to track new and former employees and share information between organisations in regards to appraisal and revalidation. Again, this has been further facilitated by the introduction of the electronic Regional Appraisal system.

The OMD reviews the allocation of appraisers to ensure these are rotated at least once in every 5 year cycle. Training for new appraisers needs to continue to decrease the ratio of appraiser to appraisee.

The OMD has a dedicated portal on the Trust I-connect site. This is regularly updated to provide useful contacts, guidance documents and where appropriate links to external sites.

7.0 Challenges

7.1 Engagement

Loss of engagement with the appraisal process: Due to the suspension of appraisal during the pandemic, there has been some loss of habit of an annual review. Doctors can feel threatened by the process and view it as a critical system rather than the safe place for reflection and development which it is intended to be. This needs to be closely managed to ensure ongoing compliance with the process.

7.2 Appraiser Capacity and Resource

The largest risk to the appraisal process remains the difficulty in recruiting and retaining appraisers. There are significant barriers to undertaking this role, with lack of time in job plans and budgetary restrictions making it difficult to fulfil the role.

(BMA estimates that for GPs alone "the time demands of revalidation were equal to 390,000 days of patient appointments. The Department of Health's own impact assessment from 2012 predicted the costs conservatively at £1 billion over 10 years. 300,000 Doctors in the UK (47% female 53% male), 63,000 (GP 55% female. 45% male), 80,000 specialists (37.5% Female, 62.5% Male). 157,000 are doctors in training. (65% of doctors working in UK qualified following undergraduate training in the UK, current aim is to increase from 9000 to 14000 students per annum).

7.3 Qualitative Assurance of the Process

The resources of the OMD (both administratively and clinically) are currently limited, and will need to be further developed in order to meet the growing context in which it operates. It should be noted that Trusts often have a dedicated team which oversees the process. In particular, the statutory requirement to have enhanced quality assurance mechanisms in place necessitates this development.

8.0 Future Focus and Aims

8.1 Move from compliance to commitment

The Kings Fund has endorsed the concept of moving appraisal from compliance to commitment and from quantitative to qualitative. In the lead-up to the formal introduction of revalidation, resources were targeted on the establishment of and support for the RO role and on encouraging Designated Bodies to strengthen processes and systems, to enable them to capture better clinical governance data and, where necessary, to improve their existing appraisal systems.

However, moving revalidation from compliance to commitment will bring greater benefits (safety) to patient care and ultimately lead to sustainability of the process. Moving revalidation from compliance to commitment will require action by leaders at all levels within Trust.

To facilitate this, it will be necessary for the need to commit the necessary resources to maintain, refine and evaluate the process and its impact against aims. This would unlock the potential for quality improvement, particularly in Designated Bodies employing locums, recognising the contribution they make to delivering patient care in primary, secondary and mental health settings.

8.2 Encourage a learning culture where high quality is recognised and where lessons are learned from mistakes.

Through Appraisal it is important to support doctors in benchmarking themselves against comparable organisations and specialisms by investing in and evaluating the accuracy of current data systems. Currently appraisal is largely quantitative our aim is change this emphasis towards a qualitative assessment. Job planning should be the forum for quantitative discussion. This will be facilitated by encouraging all doctors to identify and participate in relevant quality-driven audits, QI work, participation in trials and research where possible. This needs to be undertaken in a supportive, safe space and compassionate learning culture.

It is essential that as an organisation we therefore ensure current mechanisms for patient and peer feedback into both appraisal and revalidation are honest, valued and acted on.

In doing so we must

1. Support any corrective actions emerging from appraisal, (learning and development, and service improvements).
2. Have a strategy and funding to enable appropriate support for the appraisal process.

Our view is that medical revalidation, with the right conditions, can be a valuable driver of behaviours and cultures that support sustained quality improvement. The time to develop those conditions and create this culture following the hiatus of covid is now.