Revalidation Support Team

A review of integrated clinical governance in the context of medical revalidation

Organisational Readiness Self Assessment (ORSA) Report for the Health Sector in England as at 31 March 2011

September 2011

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Organisational Readiness Self Assessment (ORSA) Report

Foreword

This report sets out, for the first time, a snapshot of the comprehensiveness of clinical governance and appraisal systems in the context of revalidation, for the health sector in England at 31 March 2011. The tool developed to capture this data, the Organisation Readiness Self Assessment (ORSA) tool, was developed by the NHS Revalidation Support Team (RST) and distributed to 562 bodies designated under the Medical Profession (Responsible Officers) Regulations 2010. 507 bodies completed ORSA returns, providing a 90% response rate.

Completion of the ORSA exercise is one of several initiatives that are being undertaken to prepare the health sector for the introduction of medical revalidation in late 2012 and will form a baseline against which progress can be measured to ensure appropriate maturity of clinical governance and appraisal systems for doctors.

As it is the first time such an extensive exercise has been undertaken, there are inevitable flaws in some of the data, as well as gaps in the returns from some parts of the health sector – most notably locum agencies. These will be addressed in the coming months with support from the RST.

This is not just a bureaucratic exercise. Appraisal underpins both clinical governance and revalidation. It is the key opportunity for organisations to talk to their doctors individually about how they can together improve the quality of care they offer. It should be objective, constructive and supportive. The process is vital for engaging doctors, promoting continuous professional development and clinical quality improvement and identifying early potential problems with clinical service delivery. It facilitates personal and organisational development.

The quality of clinical service offered by organisations is an aggregate of different clinical service lines, staffed by different clinical teams. The NHS is itself an aggregate of multiple clinical organisations and the process of appraisal of doctors is fundamental to improving quality of care throughout the NHS and the wider health care sector.

Whilst the report shows that systems of clinical governance and appraisal have improved over the last two years, I have a sense from the report that not all organisations grasp the importance and benefits of this process either for their staff or for the organisation.

Therefore, I expect all NHS boards and their equivalents in the independent sector to monitor their own organisation's progress in these areas.

I am pleased that all ten Strategic Health Authorities have already commissioned action plans from their designated bodies to address the shortfalls that have been identified through this process.

These will form the basis of monitoring further progress. A further England-wide ORSA exercise will be undertaken in March 2012, with two interim measurements between now and then to maintain oversight of progress. Ensuring that the key components to underpin medical revalidation are in place forms part of the NHS Operating Framework for England 2011/12.

Clinical leadership is pivotal to bringing about improvements in health outcomes, so responsible officers should continue to support doctors in improving care and ensuring their fitness to practise. Clinical governance and outcome data should be collected, shared and used in a way that supports continuous improvement.

I would like to commend the progress made by designated bodies and responsible officers thus far, but also re-iterate that having effective systems of governance and appraisal for all doctors is vital to maintaining and improving quality of patient care. As such, I expect these issues to be championed and addressed at board level in every clinical organisation in England.

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Gateway reference number: 16586

Executive summary

Introduction

Background and context

A commitment was made in October 2010 by the UK health departments and the General Medical Council (GMC) that, subject to an assessment of readiness, medical revalidation will start to be implemented across the UK in late 2012[1].

A great deal of progress has been made since that commitment was given last year and the national focus is now on preparing for the implementation of revalidation. A number of key guidance documents are in place such as the GMC's 'Good Medical Practice Framework for Appraisal and Revalidation'[2] and 'Supporting Information for Appraisal and Revalidation'[3]. These, together with further guidance from the NHS Revalidation Support Team (RST) and its partners, will help organisations and doctors prepare for the implementation of revalidation.

On 1 January 2011, new regulations (The Medical Profession (Responsible Officers) Regulations, 2010) came into force requiring designated organisations that employ or contract with doctors to nominate or appoint a 'responsible officer' (a senior doctor, usually the Medical Director). This is a key role with statutory duties relating to the evaluation of doctors' fitness to practise and the monitoring of conduct and performance. In England, the regulations give responsible officers a further range of duties relating to clinical governance. These functions will help doctors improve the quality of care they provide through enhanced systems of clinical governance and appraisal and will underpin revalidation. Such systems are and will continue to be subject to external scrutiny through appropriate regulators. This baseline assessment is a snapshot of organisational readiness at 31 March 2011 only three months after the statutory role of responsible officer came into force. Much progress has been made since this review was performed including the introductory training for responsible officers which commenced in April 2011 and support for the evolving local responsible officer networks. The result of these advances should be apparent in a planned progress review in October 2011.

[1] GMC, Revalidation: a statement of intent , October 2010, http://www.gmc-uk.org/Revalidation_A_Statement_of_Intent_October_2010__Final_version___web_version_.pdf_35982397.pdf

[2] GMC, Good Medical Practice Framework for appraisal and revalidation,, March 2011, http://www.gmc-uk.org/doctors/revalidation/revalidation_gmp_framework.asp

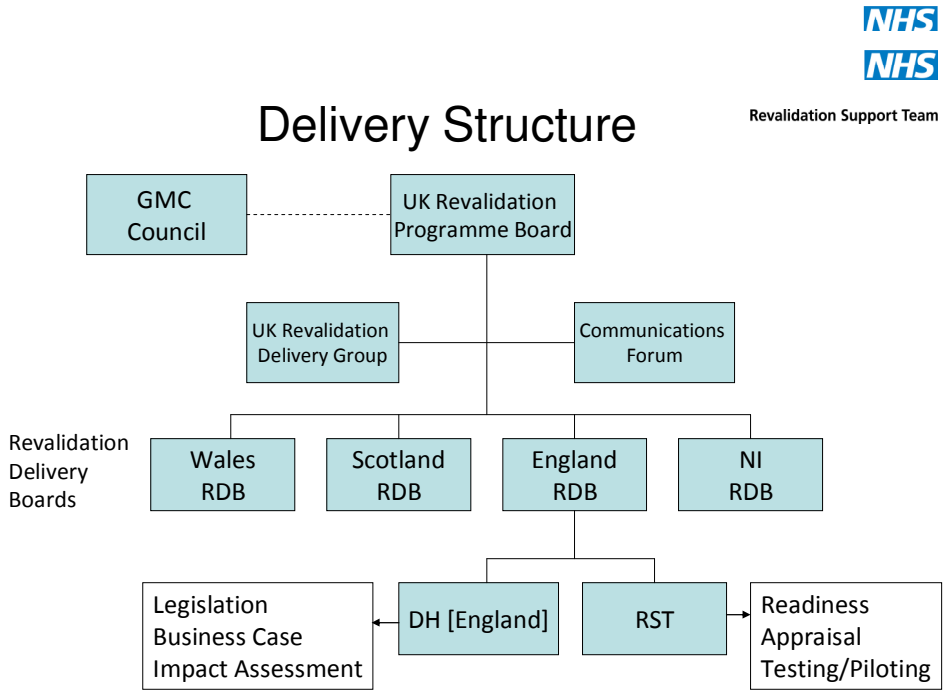
[3] GMC, Supporting information for appraisal and revalidation, March 2011, http://www.gmc-uk.org/doctors/revalidation/9226.asp

In summary:

- Revalidation will start in late 2012, subject to an assessment of readiness;
- Revalidation aims to provide assurance for patients, the profession and employers that licensed doctors are practising to appropriate professional standards and systems of appraisal and clinical governance are consistent across the country;
- Healthcare organisations and doctors have made progress in improving systems of clinical governance in the last decade, revalidation is simply the next step in this continuum; and
- Organisations in the NHS and the independent sector will need to have the right systems in place locally to support the appraisal and revalidation of their doctors.

Governance arrangements

Medical revalidation represents a large and complex project and has a commensurately robust system of programme management to assure its delivery. Ultimately the Secretary of State must be assured that revalidation is fit for purpose based on robust evidence of the practicalities, costs and benefits determined from the testing and piloting. As the regulator, the GMC must also be assured and the following diagram illustrates how governance for the UK revalidation programme is structured in order to provide this assurance.



Organisational Readiness Self Assessment

The Organisational Readiness Self Assessment (ORSA) exercise is designed to ensure designated bodies in England understand what will be needed when revalidation starts and to help them identify and prioritise areas for development. Over the next year, it will also evaluate the level of organisational readiness for the introduction of medical revalidation.

This report covers the baseline findings of the ORSA exercise for the year ending 31 March 2011. It provides a useful snapshot of the state of readiness in England on 31 March 2011 and shows steady progress has been made since a similar exercise was performed in 2009.

The Responsible Officer Regulations were in force for only three months of the reporting period. The report of the ORSA exercise shows:

- There was a high level of engagement with 90% of known designated bodies responding (507/562);
- 97.8% of responding designated bodies had appointed a responsible officer by 31 March 2011, the rate was higher in the NHS with only 2 out of 400 NHS organisations having not appointed a responsible officer by the reporting date; and
- It is estimated that around 85-90% of doctors working in England were covered by the responses.

These figures are reassuring against a background of structural change though it should be noted that this is a self-assessment exercise and organisations may have overstated or understated their position. The need for independent validation and calibration of the self-assessments is under review and the RST will produce a series of options for discussion and testing.

Designated Bodies

It is understandable at this early stage in the implementation of the Responsible Officer Regulations that some inaccuracies will be present in the data collected. For instance, some designated bodies may not yet realise they are designated by the Regulations and others have not yet identified themselves to the Strategic Health Authority (SHA) responsible officer (for example, there was a low response rate from designated locum agencies). It is important that responsible officers are linked to their SHA so they are included in the introductory training programme, responsible officer networks and are linked into essential communications. Pending the appropriate approval it is anticipated that future ORSA exercises will give an increasingly accurate picture as greater numbers of designated bodies participate.

Data provided by designated bodies on the number of doctors they are responsible for is also subject to potential inaccuracies. Predictably, some doctors, especially those outside NHS settings, have not yet identified their designated body. Some designated bodies may not have included all doctors with whom they have a prescribed connection and others have clearly included doctors who have a prescribed connection elsewhere (e.g. trainees and GPs included in hospital trust figures). Some designated bodies, for instance locum agencies and faculties may not yet have systems set up to identify the doctors to whom they have a connection.

Responsible Officers

Almost all designated bodies had a responsible officer in place to complete the questionnaire. Responsible officer training and networks have been set up in all SHA areas and this is reflected in the finding that 87.8% of responsible officers and 94.4% of NHS responsible officers agreed that local support was available. The introductory responsible officer training programme did not start until after the ORSA exercise and the figure of 50.9% of respondees who agreed that appropriate responsible officer training was undertaken may reflect this. It is anticipated that this percentage will increase substantially when the exercise is repeated in 2012 as the introductory responsible officer training programme will be completed by December 2011.

It was reported by 67.7% of responsible officers that sufficient funds and other resources have been provided to enable them to discharge their responsibilities under the Regulations'. This showed notable differences between organisational types, with 74.5% of primary care trusts (PCTs) responding positively compared with 49.7% of hospital trusts. This is an important finding and may require further exploration, but it is a snapshot of the situation as at 31 March 2011. As knowledge and understanding of the statutory role of responsible officer increases and as organisations adapt, appropriate resources should be redistributed or applied more effectively to meet the requirements set out in the legislation.

Appraisal systems

Good quality appraisal is essential for the responsible officer to be assured that each doctor is up to date and fit to practise. Appraisal must also provide a safe environment for personal development needs to be discussed and agreed. A good appraisal system is dependent on effective leadership and management and with responsible officers now in post, this can be expected to provide a strong stimulus for further development. Appraisal is also dependent on the quality of supporting information and the quality and professionalism of the appraisers. New guidance on supporting information was published by the GMC in April 2011. The RST

will produce further advice on how appraisal can continue to improve and develop in support of revalidation during 2011.

Against this evolving background, and bearing in mind the variation in the way appraisal has developed in each sector since its introduction, across designated bodies that responded, 73.7% of doctors had a completed appraisal between 1 April 2010 and 31 March 2011. These figures exclude deaneries and trainees as different processes apply. The number of completed appraisals in PCTs was 85.2% compared with 55.7% in hospital trusts. For hospital doctors, 65% of consultants and 31.4% of SAS and Staff Grade doctors had a completed appraisal. There are a number of potential reasons for these differences:

- Appraisal system issues - the numbers of completed appraisals may not be recorded accurately or collated centrally within the designated body, this would provide a falsely low number of completed appraisals;
- Definition of completed appraisal - the need for a definition has been demonstrated in previous pilots which showed that some organisations do not have a sign off process for completed appraisals and some appraisals did not have agreed personal development plans or summaries. Organisations which have not monitored the sign off and outputs of appraisal may be disadvantaged by the precise definition of a completed annual appraisal given in ORSA. According to this definition, an appraisal that is signed off more than 28 days after the appraisal meeting does not count towards the total;
- Need for annual appraisal - it is possible that some designated bodies have allowed doctors to leave longer periods between appraisals meaning that some doctors may not have an appraisal every year; and
- Doctors on temporary or short-term contracts have not required appraisal in the past whereas the submission includes all doctors with a prescribed connection.

The details of each indicator are shown in the main body of the report and the results show that 65.1% of the designated bodies reported that they had a sufficient number of trained appraisers to meet the needs of the organisation. PCTs (87.6%) provided more positive responses than hospital trusts (52.2%). It is also worth noting that:

- In total, designated bodies reported that 87.8% appraisers had received appraiser training at some point, though this percentage was lower in hospital trusts (82.4%); and
- 71.8% of designated bodies reported that their medical appraisers were supported in the role through access to leadership and peer support and this was answered positively in 98% of PCTs and 52% of hospital trusts.

Governance systems

This section reports on the organisational systems and processes which ensure accountability for the quality and safety of all services commissioned or provided on behalf of the designated body. The details of each indicator are shown in the main body of the report and the results show that 91.5% of designated bodies have a governance structure in place. This rate is generally higher in NHS organisations. 86.8% of designated bodies reported that their governance systems are subject to external or independent review. Hospital trusts (97.5%) provided more positive responses than PCTs (74.5%), which may relate to uncertainty about models of external governance review where the national system regulators are not involved (for example, locum agencies, faculties and some other designated bodies).

69.2% of designated bodies reported that they have a system for monitoring conduct and performance of medical practitioners. 100% of mental health trusts and 95.5% of hospital trusts stated that they have medical or clinical audit activity which covers the areas recommended in national guidance. This figure was lower for PCTs (43.8%) where national audit recommendations are less clearly defined.

Other results from the governance section showed:

- 42.4% of designated bodies have a system to obtain essential information about new doctors from the doctors' previous responsible officer. The positive response rate was higher in PCTs (67.3%) than in hospital trusts (22.9%) or mental health trusts (16%). This low rate is thought to be due to the short period of time since the Responsible Officer Regulations commenced and is anticipated to show a significant increase when the exercise is repeated in 2012;
- 83.2% of designated bodies reported that they had established a process for investigating performance, conduct, health and fitness to practise concerns. The RST will produce new advice on this area in November 2011;
- 30.2% had a policy for re-skilling, rehabilitation, remediation and targeted support in place which reflects the responsibilities of the Responsible Officer Regulations. This low response rate is thought to be due to the short period of time since the Responsible Officer Regulations commenced. New guidance from the RST will be developed by November 2011 and it is anticipated that there will be a significant increase when the exercise is repeated in 2012; and
- 88.2% of designated bodies reported that relevant appraisal and human resource policies are fair and non discriminatory. The positive response rate was higher for hospital trusts (97.5%) and mental health trusts (96%) than PCTs (77.1%).

Progress since 2009

There have been a number of notable improvements since a similar exercise was performed in the NHS in 2009. A direct comparison is not possible due to differences in the wording and definition of indicators, but where broad comparisons are possible, the number of positive responses showed an increase in the percentage of organisations stating that:

- They had sufficient resources available to support appraisal and revalidation (from 31.1% to 67.7%);
- They provided appraisers with feedback on performance (23.3% to 46.2%);
- They provided appraisers with support in the role (from 46.2% to 71.8%);
- Their systems are fair and non-discriminatory (from 70.1% to 91.5%);
- Their systems for monitoring performance, conduct and fitness to practise (from 41.6% to 69.2%); and
- They had a process in place for investigating fitness to practise concerns (from 67% to 83.2%).

Improving the ORSA tool and process

Evaluation of the ORSA tool and process showed the exercise was well received by SHAs and participating designated bodies. It was found to be very helpful in assessing the readiness of appraisal and governance systems. The process was not found to be cumbersome with a modal time of 2 hours to complete the tool. The explanations and annexes were generally found to be very useful and information supporting the assessment was easy to obtain. Based on their feedback, further refinements of the process and the tool are planned, including additional explanatory notes and further advice and examples.

Next Steps

Whilst designated bodies in England have made progress in some areas there remain areas for improvement in organisational systems and whilst many of these can be explained, the systems will need to be strengthened. This work will be the responsibility of each designated body and responsible officers, and they have been encouraged to produce action plans to strengthen their systems. Support for responsible officers for this work will be available through the SHA and local responsible officer networks supported and assisted by the RST as well as, where appropriate, the GMC, DH, employers and the National Clinical Assessment Service (NCAS).

Conclusion

In October 2010, as part of the GMC consultation response on the revalidation of doctors, a joint statement of intent from the four UK administrations and the GMC was published, setting

out a timetable for assessing readiness for revalidation and the intention for revalidation to commence in late 2012, subject to a test of readiness. It is recognised that designated bodies are at different stages of preparation for revalidation and that some organisations have more work to do than others. Revalidation can provide all designated bodies with the necessary imperative to speed up actions which improve patient safety and quality of care.

This self-assessment exercise for the year ending 31 March 2012 shows there is an increasingly strong foundation to build on and a number of improvements have been achieved since a similar exercise in 2009. Some organisational systems will need to be strengthened and this is to be expected: a 'no' answer in the survey does not mean the absence of systems; it will usually mean the present systems need additional features which can be put in place without difficulty.

Designated bodies in England, by their own declaration, still have work to do to and their action plans backed by local, regional and national support will aim to address development needs and ensure the service is ready to commence revalidation on time.

Organisational Readiness Self Assessment (ORSA) Report

Introduction

The purpose of revalidation is to ensure that doctors remain up to date and continue to be fit to practise. It aims to support doctors in their professional development, to contribute to improving patient safety and quality of care and to sustain and improve public confidence in the medical profession. It also seeks to facilitate the identification of the small number of doctors who are unable to remedy significant shortfalls in their standards of practice. To achieve these aims, the General Medical Council (GMC) will require assurance that local systems of medical appraisal and clinical governance function effectively and fairly in distinguishing between satisfactory and unsatisfactory performance and that responsible officers are making correct and valid recommendations.

Background

The Organisational Readiness Self Assessment (ORSA) exercise was designed by the NHS Revalidation Support Team (RST) to help designated bodies in England as defined in The Medical Profession (Responsible Officers) Regulations 2010, develop their systems and processes in preparation for the implementation of revalidation. The exercise is a two-stage process approved by the England Revalidation Delivery Board (ERDB) in February 2011.

- The first stage, completed by designated bodies in April/May 2011 (for the year ending 31 March 2011) gives an indication of the current state of preparation for revalidation and to help prioritise development needs.
- The second stage repeats the exercise in April/May 2012 (for the year ending 31 March 2012) to inform the Secretary of State's decision regarding commencement of revalidation.

The exercise utilises a self-assessment questionnaire (see Annex 1) which is based on the statutory responsibilities contained in the Regulations and Guidance and additional organisational criteria proposed by the GMC. ORSA annexes give more detailed information with samples and details of core content. Some changes are likely to be made during 2011/12 after initial evaluation and as new information and guidance becomes available.

The exercise is coordinated by the Strategic Health Authorities (SHAs) in England and they have also been asked by the ERDB to provide quarterly reports on progress towards readiness between the annual ORSA self-assessments. The RST will be facilitating this through two further interim reports measuring agreed key metrics:

- At 6 months (30 September 2011) - reported in October 2011; and

- At 9 months (31 December 2011) - reported in January 2012.

The RST has produced a shorter version of the ORSA questionnaire for this purpose providing the agreed key metrics.

The responsible officer is responsible for completing the self-assessment form on behalf of the designated body, though this can be appropriately delegated. Input can also be provided from medical workforce/HR teams, appraisal leads and clinical governance teams amongst others. As the ORSA submissions will be made on behalf of the designated body, it is recommended that responsible officers should present the report, together with an action plan, to the organisation's board or to an appropriate governance or executive group to ensure there is a corporate understanding of the current state of readiness and the statutory responsibilities. Organisations should consider including ORSA reports and action plans in their quality accounts and the reports should be publicly available.

The objectives of the ORSA exercise are to:

- Ensure designated bodies understand what will be needed when revalidation starts;
- Identify and prioritise areas for development;
- Inform the ERDB and the GMC regarding progress towards readiness in England and where possible, improvements since the previous exercise in 2009 which used self-assessment tools from the Assuring the Quality of Medical Appraisal for Revalidation document (AQMAR); and
- Inform the Department of Health's business case which supports the Secretary of State's assessment of readiness for revalidation in 2012.

In the future, the ORSA questionnaire may also be used:

- To enable individual designated bodies to provide assurance to the GMC, the Care Quality Commission as well as the public, the profession and other interested bodies, that they are fulfilling their statutory obligations;
- To demonstrate their systems are ready for the responsible officer to begin making recommendations;
- To contribute to the process for approval of new designated bodies; and
- By the responsible officer in their appraisal/revalidation portfolio as supporting information for the role.

The evaluation of the process will also explore the effectiveness of the ORSA tool and the experience of completing the process. This in turn will contribute towards the development of the tool itself and refinement of the process

This report is divided into three main parts. Part one provides a summary of the responses to the ORSA questionnaire. Part two provides a high level comparison where possible between the AQMAR 2009 exercise and the ORSA 2011 exercise. Part three provides a summary of the feedback received from the SHAs and designated bodies on their experience of using the ORSA tool. Finally, conclusions are drawn.

Part One

Responses to ORSA Questionnaire

Method

Each SHA invited known designated bodies to complete and submit the ORSA questionnaire for the year ending 31 March 2011, during the period 1 April - 31 May 2011. In preparation, regional meetings were held in seven of the SHAs, with a total of approximately 300 attendees. In addition, there was a conference call with 15 responsible officers in the East Midlands SHA area as well as meetings with a total of 30 independent sector responsible officers. During the reporting period, support was available to organisations from the central RST organisational readiness team and from SHA project managers covering each of the 10 SHAs to answer queries and to assist them in completing and submitting their forms.

An electronic reporting process was commissioned to allow organisations to make their submissions automatically. An electronic version of the ORSA form was completed and submitted to a remote server where the results were automatically downloaded on to a central database. This database was then updated each day with any new submissions being added to the existing numbers. SHA project managers were informed regularly of the organisations which had completed the exercise so they could target their efforts to optimise the number of submissions. In order to provide the best possible opportunity for designated bodies to submit their ORSA form and in view of the deadline falling in a Bank Holiday week a decision was made to extend the original deadline by a week to 7 June.

The results of each individual designated body were collected and put into a Microsoft® Access Database. These figures were then exported into the statistical package for social sciences (SPSS) and Excel spreadsheets for statistical analysis. The evaluation reports on each indicator in ORSA. The data is presented as total yes or no answers shown by SHA area or by organisational type. Numerical data is presented by organisational type or by doctor type.

It should be noted that this is a self-assessment exercise and there has been no external validation of the findings. It is possible that the indicators have been interpreted differently by organisations and some trusts may have overstated or understated their position. Efforts have been made to ensure that participating trusts give an accurate picture of their current status. This includes guidance on who should be involved in completing the self-assessment. RST has also provided assurance that the responses would be shared only with the relevant SHA and that anonymised information would be used for reporting. Each SHA responsible officer has received the responses from the designated bodies in their area and national comparators. The need for independent validation and calibration of these self-assessments is under review and RST will produce a series of options for discussion and testing.

The ORSA questionnaire was completed for the year ending 31 March 2011 by designated bodies across all 10 SHAs. Submissions were accepted from 1 April 2011 until 7 June 2011.

Details of Designated Body

Section one of the ORSA tool contains details of the designated body, including the organisation type, the relevant SHA and the number and type of doctors who have a prescribed connection with the designated body. Of the 562 designated bodies known to SHAs, 507 returned completed ORSA responses, this equates to a 90% response rate (see Table 1.1).

Table 1.1: ORSA response rates

SHA	Number of returns received	Number of known designated bodies	Percentage responses
East Midlands	33	33	100%
East of England	45	45	100%
London	114	145	79%
North East	23	25	92%
North West	69	75	92%
South Central	41	41	100%
South East Coast	47	49	96%
South West	46	47	98%
West Midlands	48	50	96%
Yorkshire and Humber	41	52	79%
Total	**507**	**562**	**90%**

SHAs have made significant efforts to identify designated bodies in their area by contacting all the organisations registered with the Care Quality Commission [CQC] and providing them with relevant information and advice. The RST provides support for any issues and questions arising. A number of additional submissions have been received since the closure of the reporting period and as at 10th August 2011 the total received was 536. SHAs have contacted non responders to ascertain their reasons. In some cases the reason for not responding is not having appointed or nominated an responsible officer, in others it is being unprepared and for a very small minority of foundation trusts and independent healthcare providers it appears to be a reluctance to engage with the SHA.

The lower response rates in two SHAs were due to some designated bodies being identified close to the submission deadline, designated bodies with no responsible officer, and the large number of independent sector and non NHS designated bodies in London SHA.

The numbers and types of organisations completing the self-assessment exercise and the numbers in each SHA area are presented in Table 1.2.

Table 1.2: ORSA responses by SHA and organisational type

SHA	**Hospital trusts**	**Primary care trusts**	**Mental health trusts**	**Other NHS trusts**	**Faculties**	**Hospices, Charity, Voluntary Sector**	**Independent healthcare providers**	**Locum agencies**	**Other Independent Non NHS**	**Deaneries**	**Total**
East Midlands	9	10	4	4	0	1	4	1	0	0	**33**
East of England	17	13	6	5	0	0	3	0	0	1	**45**
London	29	31	9	4	3	5	29	2	1	1	**114**
North East	7	12	2	1	0	0	1	0	0	0	**23**
North West	29	23	6	2	0	4	3	0	0	2	**69**
South Central	9	9	2	4	0	5	8	0	2	2	**41**
South East Coast	12	7	3	3	0	9	9	1	2	1	**47**
South West	14	15	6	5	0	2	3	0	0	1	**46**
West Midlands	17	18	7	2	0	3	1	0	0	0	**48**
Yorkshire/Humber	14	15	5	3	0	0	2	1	0	1	**41**
Totals	**157**	**153**	**50**	**33**	**3**	**29**	**63**	**5**	**5**	**9**	**507**

The reported number of designated bodies in the SHA area is the number that have currently made themselves known to each SHA. It is important that responsible officers are linked to their SHA so they are included in the introductory training programme, responsible officer networks and are also linked for essential communications. These numbers are the best current estimate of designated bodies but a number of potential inaccuracies may occur in these figures:

- Some designated bodies have not yet identified themselves to their SHA; and

- Some designated bodies may not yet realise they are designated under the Regulations.

As can be seen in Table 1.1, not all known designated bodies have submitted returns. Previous estimates of the expected number of designated bodies in England came to a suggested figure of 900. The responsible officer Impact Assessment (responsible officer Impact Assessment. DH. 2010) stated: '*There are 151,070 doctors on 'head count' basis currently practising in England (source: OECD Health Data 2009, figures for 2007, available at http://www.oecd.org) that will be overseen by around 900 responsible officers (estimated from the types of organisations referenced in the regulations). Out of the total, we estimate that 49% of all responsible officers will be in the public sector and 51% in the private sector.*'

Designated bodies may share responsible officers which may account for some of the apparent deficit, but it is very likely that the current number of known designated bodies is an underestimate of the true total. Locum agencies have a particularly low response rate with only 5 of 55 locum agencies on the OGC Buying Solutions Framework responding. RST will provide targeted communications through the relevant channels to this group and to other groups of designated bodies (e.g. very small independent healthcare providers and wholly independent practitioners). It is anticipated that these group may also require additional support with organisational systems. Future self-assessment exercises will give an increasingly accurate picture as designated bodies begin to understand their statutory responsibilities and make themselves known to their SHA.

Number of doctors

Section one of the ORSA tool also contains details of the number and type of doctors who have a prescribed connection with the designated body. The following table (Table 1.3 see next page) shows the number of doctors with whom the designated body has a prescribed connection as at 31 March 2011 covering different organisational types.

Table 1.3: Number of doctors by organisational type

Organisational Type	Total Designated bodies	Consultant	Staff Grade/ SAS	GP	Trainee	Practising privileges	Other	Total doctors
Hospital trusts	157	33974	12524	78	5194	0	1571	53341
Primary care trusts	153	293	191	43689	996	0	583	45752
Mental health trusts	50	3808	1508	10	805	0	233	6364
Other NHS Trusts/Organisations	33	962	502	20	5	29	187	1705
Deaneries	9	0	0	0	38520	0	7	38527
Independent/Non NHS Total Comprising (below):		1149	1144	109	168	2515	1561	6646
Faculties	3	36	11	0	0	0	850	
Hospices, Charity, Voluntary	29	58	79	13	11	11	47	
Independent healthcare providers	63	574	503	96	7	2004	255	
Locum agency	5	463	544	0	150	500	8	
Other Non NHS	5	18	7	0	0	0	401	
Total doctors		40186	15869	43906	45688	2544	4142	152335

These figures show some errors in data entry or potential misconceptions about prescribed connections. Trainees would normally have a prescribed connection with a deanery rather than their clinical placement. GPs are linked to the PCT where they are on the Performers List even if they work in another setting. Doctors with practising privileges would usually only be linked to independent healthcare providers. Doctors in deaneries other than trainees would usually be connected to their SHA rather than the deanery. These inaccuracies are relatively minor but would result in some double counting of doctors and this highlights the need for clear and unambiguous guidance for doctors and responsible officers regarding prescribed connections.

There are extensive figures available on the number of employed doctors and those working in general practice from a variety of sources and we also know the number of doctors currently registered and licensed to practise. However these do not readily provide a complete picture of those licensed doctors practising in England. Current estimates are:

- 151,070 practising in England (source: OECD Health Data 2009, figures for 2007)
- 173,054 doctors with a licence to practise who have a registered address in England (source: GMC)

The reported numbers in Table 1.3 are the current figures or estimates by designated bodies of doctors with whom they have a prescribed connection, but a number of potential inaccuracies may occur in these figures:

- Some designated bodies may not have included all doctors with whom they have a prescribed connection. This may be due to the doctors not yet identifying themselves to their designated body (e.g. doctors who are unaware of the prescribed connections described in the regulations), or the reported figures relying on inaccurate internal estimates (e.g. not including some doctors with honorary contracts, temporary contracts, etc)
- Some designated bodies may have included doctors who have a prescribed connection elsewhere (e.g. trainees and GPs included in hospital trust figures)
- Some designated bodies have not previously needed to record this information and their systems may not yet be ready (e.g. in the case of locum agencies, faculties, etc)

It is understandable that at this early stage in the implementation of the Responsible Officer Regulations that individual doctors may not know the designated body with which they have a prescribed connection. It is also likely that many responsible officers did not have sufficiently detailed knowledge of prescribed connections as this exercise was carried out before the responsible officer introductory training programme was commenced. It is therefore not yet possible to evaluate the validity of these figures and future self-assessments will give an increasingly accurate picture.

There are no detailed figures for the number of doctors currently working in England. A total of 39037 NHS consultants, 43797 GPs and 36520 trainees (not including those trainees reported by trusts) are covered by this ORSA exercise. The ORSA process will provide increasingly accurate figures as knowledge and expertise increases.

Responsible Officer

Section 2 of the ORSA questionnaire covers the responsible officer role. These detailed indicators are shown in Table 1.4.

Table 1.4: ORSA section 2 indicators

Section Number	Indicator
2.1	Responsible officer has been nominated/appointed in compliance with the Regulations
2.2	Appropriate responsible officer training is undertaken
2.3	Local/regional support is available to the responsible officer
2.4	Provision of funding and resource from the designated body is sufficient to undertake the responsibilities of the role
2.5	A second responsible officer is nominated/appointed where a conflict of interest or appearance of bias exists between the person to be nominated/appointed and a medical practitioner with whom the designated body has a prescribed connection

Table 1.5 breaks down the total number of yes and no responses for each of the questions above by sector. It shows that overall 97.8% of designated bodies had a nominated responsible officer in accordance with the regulations. The rate was higher in NHS organisations with only 2 out of a total of 400 responses from NHS designated bodies having failed to appoint a responsible officer by 31 March 2011.

50.9% of responses felt appropriate responsible officer training was being undertaken. There may have been some difficulty with interpretation of this indicator as it was referring to the year ending 31 March 2011. Two of the SHAs had commenced their introductory responsible officer training programme in April and May 2011 and the responses to this question were slightly higher in these areas and may have been influenced by this training. It is anticipated that this percentage will have increased substantially when the exercise is repeated as the introductory responsible officer training programme should be complete by December 2011.

Responsible officer networks have been set up in all SHA areas and this is reflected in the finding that overall 87.8% of responsible officers and 94.4% of NHS responsible officers were aware that they had local support available.

67.7% of responsible officers felt that they had sufficient funding and resource to discharge their responsibilities of the responsible officer role. This showed notable differences between organisational types, with 74.5% of PCTs responding positively compared with 49.7% of hospital trusts. This is an important finding and may need further exploration. However the

ORSA return is a snapshot of the situation as at 31 March 2011 and as knowledge and understanding of the role increases, a need for additional or differently applied resources may become apparent.

25.2% of designated bodies had appointed a second responsible officer where a conflict of interest or appearance of bias exists. Further support will be available from RST through responsible officer networks to support this process. It is not currently possible to estimate how many designated bodies will need to nominate or appoint a second responsible officer.

Table 1.5: Total number and percentages for each indicator in ORSA Section 2 by organisational type

Organisational Type	**2.1 Responsible officer nominated appointed**		**2.2 Responsible officer training undertaken**		**2.3 Local support available**		**2.4 Sufficient funding for responsible officer**		**2.5 Second responsible officer nominated appointed**		
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**N/A**
Primary care trusts	**153 (100%)**	0	**84 (54.9%)**	69 (45.1%)	**145 (94.8%)**	8 (5.2%)	**114 (74.5%)**	39 (25.5%)	58 (37.9%)	**66 (43.1%)**	29 (19%)
Hospital trusts	**157 (100%)**	0	**84 (53.5%)**	73 (46.5%)	**148 (94.3%)**	9 (5.7%)	78 (49.7%)	**79 (50.3%)**	41 (26.1%)	**69 (43.9%)**	47 (29.9%)
Mental health trusts	**49 (98%)**	1 (2%)	**31 (62%)**	19 (38%)	**47 (94%)**	3 (6%)	**32 (64%)**	18 (36%)	12 (24%)	16 (32%)	**22 (44%)**
Other NHS trusts organisations	**32 (97%)**	1 (3%)	**22 (66.7%)**	11 (33.3%)	**31 (93.9%)**	2 (6.1%)	**30 (90.9%)**	3 (9.1%)	2 (6.1%)	10 (30.3%)	**21 (63.6%)**
Deanery	**9 (100%)**	0	2 (22.2%)	**7 (77.8%)**	**7 (77.8%)**	2 (22.2%)	1 (11.1%)	**8 (88.9%)**	3 (33.3%)	3 (33.3%)	3 (33.3%)
Faculty	**3 (100%)**	0	**2 (66.7%)**	1 (33.3%)	1 (33.3%)	**2 (66.7%)**	**2 (66.7%)**	1 (33.3%)	0	2 (6.7%)	**1 (33.3%)**
Locum agency	**5 (100%)**	0	2 (40%)	**3 (60%)**	**3 (60%)**	2 (40%)	2 (40%)	**3 (60%)**	0	**4 (80%)**	1 (20%)
Independent healthcare provider	**59 (93.7%)**	4 (6.3%)	22 (34.9%)	**41 (65.1%)**	**42 (66.7%)**	21 (33.3%)	**61 (96.8%)**	2 (3.2%)	9 (14.3%)	26 (41.3%)	**28 (44.4%)**
Hospices, Charity/Voluntary	**24 (82.8%)**	5 (17.2%)	9 (31%)	**20 (69%)**	**18 (62.1%)**	11 (37.9%)	**18 (62.1%)**	11 (37.9%)	2 (6.9%)	10 (34.5%)	**17 (58.6%)**
Other	**5 (100%)**	0	0	**5 (100%)**	**3 (60%)**	2 (40%)	**5 (100%)**	0	1 (20%)	1 (20%)	**3 (60%)**
Total	**496 (97.8%)**	**11 (2.2%)**	**258 (50.9%)**	**249 (49.1%)**	**445 (87.8%)**	**62 (12.2%)**	**343 (67.7%)**	**164 (32.3%)**	**128 (25.2%)**	**207 (40.8%)**	**172 (33.9%)**

Appraisal System

In section 3 of the ORSA tool, designated bodies are asked to provide details of their appraisal systems. Good quality appraisal is essential for the responsible officer to be assured that each doctor is up to date and fit to practise. Appraisal must also provide a safe environment for personal development needs to be discussed and agreed. A good appraisal system is dependent on effective leadership and management, the quality of supporting information and the quality and professionalism of the appraisers. New guidance was published by the GMC in March 2011 and the RST will produce further advice on how changes to appraisal can be put into operation during 2011. The indicators are described in Table 1.6.

Table 1.6: ORSA Section 3 Indicators

Section Number	Indicator
3.1	A medical appraisal policy with core content is in place
3.2	Numbers of doctors with whom the designated body has a prescribed connection who have a completed appraisal between 1 April 2010 and 31 March 2011
3.3	An exception audit has been performed to determine reasons for all missed or incomplete appraisals
3.4	The number of trained medical appraisers is sufficient for the needs of the organisation
3.4.1	Number of active medical appraisers at 31 March 2011
3.4.2	Number of active medical appraisers who have attended an appraiser training course at any time in the past
3.5	Medical appraisers are supported in the role through access to leadership and peer support
3.6	Medical appraisers receive feedback on their performance in the role which includes feedback from appraisees or feedback on the quality of appraisal outputs [e.g. PDPs, appraisal summaries]

Results

Overall 51.7% designated bodies reported that they did have a medical appraisal policy with core content in place. The breakdown by organisation type can be seen in Table 1.7 and this shows higher levels of positive responses from PCTs. The ORSA tool

showed an example of core content for an appraisal policy as an annex and it is likely that this is an area where a suitable policy can be generated and shared within local responsible officer networks.

Table 1.7: Organisations with medical appraisal policy in place

Organisation type	**Medical appraisal policy in place**	
	Yes	**No**
Primary care trusts	105 (68.6%)	48 (31.4%)
Hospital trusts	68 (43.4%)	89 (56.7%)
Mental health trusts	18 (36%)	32 (64%)
Other NHS trusts/Organisations	10 (30.3%)	23 (69.7%)
Deaneries	5 (55.6%)	4 (44.4%)
Independent/Non NHS	56 (53.3%)	49 (46.7%)
Total	262 (51.7%)	245 (48.3%)

Tables 1.8 and 1.9 break down the number of completed appraisals by doctor type and organisational type. Deaneries appear to have had difficulty interpreting this indicator providing responses of either 0% or 100%. This is understandable as the Annual Review of Competence Progression (ARCP) process is not directly comparable with appraisal for trained doctors. For the purposes of analysis and in view of the double counting of trainees already mentioned, trainees and deaneries have been removed from the following analysis. Across the remaining designated bodies which responded, 73.7% of doctors had a completed appraisal between 1 April 2010 and 31 March 2011.

A completed appraisal was defined for the purpose of ORSA as '*one where the appraisal meeting has taken place within the appraisal year and the summary of appraisal discussion/PDP have been signed off by appraiser and appraisee within 28 days of the appraisal meeting'*. For the purposes of ORSA the organisational appraisal year runs from 1 April until 31 March.

Table 1.8: Number of completed appraisals by doctor type

Doctor type*	Total number of doctors	Total number of completed appraisals	Percentage
Consultant	40186	25762	64.1%
Staff Grade	15869	5656	35.6%
General Practitioner	43906	34633	78.9%
Practising privileges	2544	345	13.6%
Other	4142	1123	27.1%
Total	**104647**	**77146**	**73.7%**

*Trainees omitted from this table due to inconsistent interpretation of this indicator by deaneries and double counting of trainees

Table 1.9: Number of completed appraisals by organisation type (adjusted for trainees)

Organisation type*	Total doctors	Total trainees	Adjusted total doctors	Total completed appraisals	Trainees completed appraisals	Adjusted total completed appraisals	Percentage
Primary care trusts	45752	996	44756	38629	491	38138	85.2%
Hospital trusts	53341	5194	48147	29057	2260	26797	55.7%
Mental health trusts	6364	805	5559	4313	301	4012	72.2%
Other NHS trusts/Organisations	1705	5	1700	604	3	601	35.4%
Independent/Non NHS	6646	167	6479	2038	12	2026	31.3%

*Deaneries omitted from this table due to inconsistent interpretation of this indicator by deaneries and double counting of trainees

The number of completed appraisals in PCTs was 85.2% compared with 55.7% in hospital trusts. Many independent sector and non NHS organisations are starting from a low baseline and they have not needed to provide appraisal for their doctors in the past. A further analysis of hospital trust doctors shows that 65% of consultants and 31.4% of SAS and Staff Grade doctors had a completed appraisal between 1 April 2010 and 31 March 2011. The breakdown is shown in Table 1.10.

Table 1.10: Number of completed appraisals in hospital trust doctors by doctor type

Hospital doctor type	Total number of doctors	Total number of completed appraisals	Percentage
Consultant	33974	22069	65.0%
SAS/Staff Grade	12524	3931	31.4%
General Practitioner	78	16	20.5%
Other	1571	178	11.3%
Total	48147	26797	55.7%

The number of completed appraisals in hospital trust doctors is lower than in PCTs and mental health trusts. There are a number of potential reasons for this:

- Appraisal system issues - the numbers of completed appraisals may not be recorded accurately or collated centrally within the designated body; this would provide a falsely low number of completed appraisals;
- Definition of completed appraisal - a completed appraisal has not previously been defined. The need for a definition has been demonstrated in previous pilots which showed that some organisations do not have a formal sign off process for completed appraisals and some appraisals do not have agreed personal development plans or summaries. This was noted in the First Stage Mersey Pilot where a PDP was agreed by appraisers in 88% and by appraisees in 84% of appraisals (Mersey Appraisal Pilot in Secondary Care. RCP. 2010). Organisations which have not monitored the sign off and outputs of appraisal may have been disadvantaged by a clear definition;
- Appraisals completed outside the time limit in the definition - an appraisal that is signed off more than 28 days after the appraisal meeting would not be counted towards the total. Some organisational systems may not have worked to this timescale in the past;
- Need for appraisal to be every year - it is also likely that appraisal systems have allowed doctors to leave periods of longer than 12 months between appraisals meaning that some doctors may not have had an appraisal within the defined ‘appraisal year’. The GMC now require all doctors to have an annual appraisal, some organisational systems may not have provided an appraisal every year;
- A number of GPs are included in the submissions from hospital trusts which are likely to have been included in error; and

- A number of doctors in hospital trusts may not previously have required appraisal. This includes quite large numbers of doctors on temporary or short-term contracts**.**

There also a number of other possible reasons for a doctor needing to have an extended period between appraisals including sickness absence, maternity leave, etc. The findings from the ORSA exercise are broadly consistent with those from a survey performed by the British Medical Association in November 2010 which found that 92.4% of GPs and 86.4% of consultants had participated in an appraisal between April 2009 and November 2010 (a period of 19 months). Gearing the appraisal system to deliver an annual appraisal for every doctor is an important part of the preparation for revalidation.

It appears that deaneries may have had difficulty in interpreting some of the indicators in this section as there was wide variation in their responses. Additional work is needed to clarify how the Responsible Officer Regulations apply to deaneries and the RST is addressing this in a pilot with all deaneries during 2011.

Where appraisals had not been completed or missed 45% of designated bodies had performed an audit to understand the reasons (see table 1.11). The breakdown for organisational type shows 79.1% of PCTs performed an exception audit compared with 31.8% of hospital trusts.

Table 1.11: Number of organisations performing an exception audit on reasons for missed/incomplete appraisals by organisational type

Organisation type	**Yes**	**No**
Primary care trusts	**79.1%**	20.9%
Hospital trusts	31.8%	**68.2%**
Mental health trusts	42%	**58%**
Other NHS trusts/Organisations	18.2%	**81.8%**
Deanery	11.1%	**88.9%**
Independent/Non NHS	27.6%	**72.4%**
Total	**45%**	**55%**

65.1% of the designated bodies reported that they had a sufficient number of trained appraisers to meet the needs of the organisations (Table 1.12). 87.6% of PCTs had

sufficient numbers of trained appraisers compared with 52.2% of hospital trusts. This difference may be explained by the need for annual appraisals for all doctors including those who have not previously been included in the appraisal system (doctors on temporary or short-term contracts).

Table 1.12: Number of organisations with sufficient number of trained appraisers

Organisation type	**Yes**	**No**
Primary care trusts	**87.6%**	12.4%
Hospital trusts	**52.2%**	47.8%
Mental health trusts	**74%**	26%
Other NHS trusts/Organisations	**54.5%**	45.5%
Deanery	**55.6%**	44.4%
Independent/Non NHS	**51.4%**	48.6%
Total	**65.1%**	34.9%

87.8% of the total number of active appraisers had received appraiser training at some stage. The highest rates of trained appraisers were in primary care (97.7%) and 17.6% of appraisers in hospital trusts had not received training (see Table 1.13).

Table 1.13: Total numbers of active appraisers by training and organisational type

Organisation type	**Total number of active appraisers**	**Total number of active appraisers trained (%)**
Primary care trusts	3487	3406 (97.7%)
Hospital trusts	5445	4487 (82.4%)
Mental health trusts	993	942 (94.9%)
Other NHS trusts/Organisations	161	119 (73.9%)
Deanery	2937	2484 (84.6%)
Independent/Non NHS	461	398 (86.3%)
Total	13484	11836 (87.8%)

71.8% of designated bodies reported that their medical appraisers were supported in the role through access to leadership and peer support (see Table 1.14). This was

answered positively in 98% of PCTs and 52% of hospital trusts. 46.4% of designated bodies stated that their medical appraisers received feedback on their performance, including feedback form appraisees or feedback on the quality of appraisal outputs. The role of appraiser is central to the quality of appraisal and all appraisers require training and support. The RST is developing guidance to ensure appraisers are properly selected, trained and supported.

Table 1.14: Number of organisations with supported medical appraisers

Organisation type	**Yes**	**No**
Primary care trusts	**150 (98%)**	3 (1.9%)
Hospital trusts	**93 (59.2%)**	64 (40.8%)
Mental health trusts	**36 (72%)**	14 (28%)
Other NHS trusts/Organisations	**19 (57.6%)**	14 (42.4%)
Deanery	**5 (55.6%)**	4 (44.4%)
Independent/Non NHS	**61 (58.1%)**	44 (41.9%)
Total	**364 (71.8%)**	143 (28.2%)

This apparent variation between sectors in appraisal systems reflects differences in the way appraisal has developed in each sector since it was introduced.

Organisational Governance

All designated bodies involved in commissioning or providing healthcare have a responsibility for the quality of the care provided on their behalf. For most designated bodies the process by which this is achieved will be described in a board-approved governance strategy (which includes clinical governance or clinical quality assurance). Some designated bodies, especially non NHS organisations, may not have a board and some do not directly deliver clinical care and so the equivalent in these settings would be the structures and arrangements for assuring the quality of contractors/members or the quality of services provided.

Section 4 of the ORSA tool asks each designated organisation to provide details around their organisational governance. This includes the following indicators;

Table 1.15: ORSA section 4 indicators

Section Number	Indicator
4.1	A governance structure or strategy is in place [including clinical governance where appropriate]
4.2	The governance systems [including clinical governance where appropriate] are subject to external/independent review and are not the subject of improvement notices or formal action plans
4.3	There is a system for monitoring the conduct and performance of medical practitioners with whom the designated body has a prescribed connection
4.4	There is a system for obtaining and collating patient and colleague feedback for all doctors which complies with GMC requirements
4.5	The designated body's medical or clinical audit activity covers the areas recommended in national guidance
4.7	There is a process in place for the responsible officer to ensure that key information [for example specified complaints, SUIs /significant events, outlying performance/clinical outcomes] is included in the appraisal portfolio and has been discussed in the appraisal so that development needs are identified
4.8	Information relating to all new doctors is obtained from the doctor's previous responsible officer and/or employing or contracting organisation
4.10	A process is established for the investigation of performance, conduct, health and fitness to practise concerns
4.11	A policy [with core content] for re-skilling, rehabilitation, remediation and targeted support is in place
4.12	Where a medical practitioner is subject to conditions imposed by, or undertakings agreed with, the GMC, the responsible officer monitors compliance with those conditions or undertakings
4.13	A description of the support available from the designated body for medical practitioners to keep their knowledge and skills up to date is in place
4.14	Relevant appraisal, revalidation and human resources policies are fair and non-discriminatory

Results from the ORSA analysis showed that 91.5% of designated organisations have a governance structure in place; this rate is generally higher in NHS organisations (see Table 1.16). 86.8% reported that their governance systems are subject to external or independent review and are not the subject of improvement notices or formal action plans. Hospital trusts (97.5%) provided more positive responses than PCTs (74.5%).

This may relate to uncertainty about models of external governance review where the national system regulators are not involved (e.g. for PCTs, locum agencies, faculties and some other designated bodies).

69.2% of designated bodies reported that they have a system for monitoring conduct and performance of medical practitioners. 35.7% had a system for obtaining and collating patient and colleague feedback which complies with the GMC requirements. The rates of positive response for this indicator were higher in hospital and mental health trusts than in PCTs, but the figures may be subject to inaccuracy as the questionnaire relates to the year ending 31 March 2011 and the GMC requirements for patient and colleague feedback questionnaires were approved by GMC Council on 7 April 2011. 100% of mental health trusts and 95.5% of hospital trusts stated that they had a medical or clinical audit activity which covers the areas recommended in national guidance, this figure was lower for PCTs (43.8%) where national audit recommendations are less clearly defined.

Table 1.16: Total number and percentages for each indicator in section 4 by organisational type (Questions 4.1 to 4.5)

Organisational type	**4.1 Governance structure in place**		**4.2 Governance system externally reviewed**		**4.3 System for monitoring conduct and performance**		**4.4 System for obtaining patient and colleague feedback**		**4.5 Audit activity in line with national guidance**		
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	N/A
Primary care trusts	**137 (89.5%)**	16 (10.5%	**114 (74.5%)**	39 (25.5%)	**116 (75.8%)**	37 (24.2%)	25 (16.3%)	**128 (83.7%)**	**67 (43.8%)**	50 (32.7%)	36 (23.5%)
Hospital trusts	**149 (94.9%)**	8 (5.1%)	**153 (97.5%)**	4 (2.5%)	**99 (63.1%)**	58 (36.9%)	68 (43.3%)	**89 (56.7%)**	**150 (95.5%)**	6 (3.8%)	1 (0.6%)
Mental health trusts	**47 (97%)**	3 (6%)	**48 (96%)**	2 (4%)	**26 (52%)**	24 (48%)	**30 (60%)**	20 (40%)	**50 (100%)**	0	0
Other NHS trusts	**31 (93.9%)**	2 (6.1%)	**29 (87.9%)**	4 (12.1%)	**21 (63.6%)**	12 (36.4%)	9 (27.3%)	**24 (72.7%)**	**25 (75.8%)**	2 (6.1%)	6 (18.2%)
Deanery	3 (33.3%)	**6 (66.7%)**	**5 (55.6%0**	4 (44.4%)	4 (44.4%)	**5 (55.6%)**	2 (22.2%)	**7 (77.8%)**	0	1 (11.1%)	**8 (88.9%)**
Independent/Non NHS	**97 (92.4%)**	8 (7.6%)	**91 (86.7%)**	14 (2.8%)	**85 (81%)**	29 (19%)	47 (44.8%)	**58 (55.2%)**	71	17	17
Total	**464 (91.5%)**	**43 (8.5%)**	**440 (86.8%)**	**67 (13.2%)**	**351 (69.2%)**	**156 (30.8)**	**181 (35.7%)**	**326 (64.3%)**	**363 (71.6%)**	**76 (15%)**	**68 (13.4%)**

37.5% of designated bodies reported that there was a process in place for the responsible officer to ensure that key information is included in the appraisal portfolio and has been discussed in the appraisal so that development needs are identified (see

Table 1.17). The positive response rate for this indicator was higher in the independent/non NHS sector than in the NHS. 42.4% of designated bodies stated that they had a system to obtain information relating to all new doctors from the previous designated body. The positive response rate was higher in PCTs (67.3%) than in hospital trusts (22.9%) or mental health trusts (16%). This low rate is thought to be due to the short period of time since the Responsible Officer Regulations commenced and is anticipated to show a significant increase when the exercise is repeated in 2012.

83.2% of designated bodies reported that they had established a process for investigating performance, conduct, health and fitness to practise concerns and 30.2% had a policy for re-skilling, rehabilitation, remediation and targeted support in place. This low response rate is thought to be due to the short period of time since the Responsible Officer Regulations commenced. New guidance on these areas from the RST will be developed during 2011 and it is anticipated that there will be a significant increase when the exercise is repeated in 2012.

Table 1.17: Total number and percentages for each indicator in section 4 by organisational type (Questions 4.7 to 4.11)

Organisational type	**4.7 Process in place to ensure key information in portfolio**		**4.8 Process to ensure Information obtained from previous responsible officer**		**4.10 Process established to investigate performance concerns**		**4.11 A policy in place for re-skilling etc**	
	Yes	No	Yes	No	Yes	No	Yes	No
Primary care trusts	54 (35.3%)	**99 (64.7%)**	**103 (67.3%)**	50 (32.7%)	**144 (94.1%)**	9 (5.9%)	51 (33.3%)	**102 (66.7%)**
Hospital trusts	48 (30.6%)	**109 (69.4%)**	36 (22.9%)	**121 (77.1%)**	**144 (91.7%)**	13 (8.3%)	54 (34.4%)	**103 (65.6%)**
Mental health trusts	17 (34%)	**33 (66%)**	8 (16%)	**42 (84%)**	**47 (94%)**	3 (6%)	10 (20%)	**40 (80%)**
Other NHS trusts	15 (45.5%)	**18 (54.5%)**	12 (36.4%)	**21 (63.6%)**	**23 (69.7%)**	10 (30.3%)	9 (27.3%)	**24 (72.7%)**
Deanery	1 (11.1%)	**8 (88.9%)**	0	**9 (100%)**	**6 (66.7%)**	3 (33.3%)	**6 (66.7%)**	3 (33.3%)
Independent	**55 (52.4%)**	50 (47.9%)	**56 (53.3%)**	49 (46.7%)	**58 (55.2%)**	47 (44.8%)	23 (21.9%)	**82 (78.1%)**
Total	**190 (37.5%)**	**317 (62.5%)**	**215 (42.4%)**	**292 (57.6%)**	**422 (83.2%)**	**85 (16.8%)**	**153 (30.2%)**	**354 (69.8%)**

78.5% of the designated bodies stated that they had a system in place in which the responsible officer would monitor compliance when a medical practitioner is subject to conditions imposed by, or undertaking agreed with the GMC (see Table 1.18). 71.8% of

the designated bodies reported that they had a description of support available for the medical practitioners to keep their knowledge and skills up to date. 88.2% of designated bodies reported that all relevant appraisal, revalidation and human resource policies are fair and non-discriminatory. The positive response rate was higher for hospital trusts (97.5%) and mental health trusts (96%) than PCTs (77.1%)

Table 1.18: Total number and percentages for each indicator in section 4 by organisational type (Questions 4.12 to 4.14)

SHA	**Question number**					
	4.12 Responsible officer monitors compliance to GMC outcome		**4.13 Description of support available for doctor**		**4.14 Relevant policies are fair and non-discriminatory**	
	Yes	No	Yes	No	Yes	No
Primary care trusts	**130 (85%)**	23 (15%)	**105 (68.6%)**	48 (31.4%)	**118 (77.1%)**	35 (22.9%)
Hospital trusts	**134 (85.4%)**	23 (14.6%)	**119 (75.8%)**	38 (24.2%)	**153 (97.5%)**	4 (2.5%)
Mental health trusts	**39 (78%)**	11 (22%)	**37 (74%)**	13 (26%)	**48 (96%)**	2 (4%)
Other NHS trusts	**24 (72.7%)**	9 (27.3%)	**26 (78.8%)**	7 (21.2%)	**33 (100%0**	0
Deanery	**7 (77.8%)**	2 (22.2%)	**6 (66.7%)**	3 (33.3%)	**8 (88.9%)**	1 (11.1%)
Independent	**64 (61%)**	41 (39%)	**71 (67.6%)**	34 (32.4%)	**87 (82.9%)**	18 (17.1%)
Total	**398 (78.5%)**	**109 (21.5)**	**364 (71.8%)**	**143 (28.2%)**	**447 (88.2%)**	**60 (11.8%)**

Part Two

Progress since 2009

Progress since 2009

Introduction

One of the objectives of the ORSA exercise is to show, where possible, any improvements since the previous exercise in 2009 which used the self-assessment tools in Assuring the Quality of Medical Appraisal for Revalidation (AQMAR). Due to differences in methodology, structure and in the wording of the indicators between the two exercises it is not possible to give direct comparisons. The AQMAR tools used a traffic light system of Red, Amber and Green and feedback on the AQMAR exercise showed that the tools were helpful in identifying development needs but were considered cumbersome, some indicators were open to interpretation and the tools took a long time to complete.

Following this feedback the self-assessment tool has been completely redesigned for the ORSA exercise. Many of the indicators in ORSA have been more carefully defined as they relate to the role outlined in the Responsible Officer Regulations. As ORSA aims to give a clear picture of what is required for organisational readiness it has been designed with binary 'yes/no' responses.

Background

The AQMAR document was structured around four high level indicators.

Box 2.1: AQMAR high level indicators

High Level Indicator 1: Organisational Ethos

There is unequivocal commitment from the highest levels of the responsible organisation to deliver a quality assured system of appraisal, in support of revalidation, that is fully integrated with local clinical governance systems.

High Level Indicator 2: Appraiser Selection, Skills and Training

The responsible organisation has a process for selection of appraisers. Appraisers undertake initial training and their skills are reviewed and developed

High Level Indicator 3: The Appraisal Discussion

The appraisal is informed by a portfolio of verifiable supporting information that reflects the whole breadth of the doctor's practice and informs objective evaluation of its quality. The discussion includes challenge, encourages reflection and generates a Personal Development Plan (PDP) for the year ahead.

High Level Indicator 4: Systems and Infrastructure

The management of the appraisal system is effective and ensures that all doctors linked to the responsible organisation are appraised annually.

The appraisal self-assessment tool contained indicators under each of these headings. The clinical governance self-assessment tool contained 8 sections, these were:

1. Organisational clinical governance systems;
2. Information management systems;
3. Clinical risk management/patient safety systems;
4. Clinical audit systems;
5. Reporting and managing performance concerns;
6. Complaints management systems;
7. Continuing professional development (CPD) systems; and
8. Service development, workforce development, human resource management.

In contrast, the ORSA document is broken down into 4 section areas, these are:

1. Details of designated body;
2. Responsible officer;
3. Appraisal system; and
4. Organisational governance.

Results

The ORSA exercise was completed by a wider range of organisational types than the AQMAR tool and so for the purposes of comparison this report will look only at the scores for the NHS sectors that were involved (hospital trusts, primary care trusts and mental health trusts). The total number of these designated bodies who reported in each SHA area is presented in table 1. A larger number of NHS trusts have been engaged in the ORSA exercise than the AQMAR exercise (360 against 251), though further AQMAR and ORSA responses were received after the respective reporting windows closed.

Table 2.1: Total number of trusts responding to AQMAR and ORSA within each SHA area

SHA	**Hospital trusts**		**Primary care trusts**		**Mental health trusts**	
	AQMAR	**ORSA**	**AQMAR**	**ORSA**	**AQMAR**	**ORSA**
East Midlands	8	9	*	10	5	4
East of England	6	17	2	13	0	6
London	29	29	30	31	10	9
North East	8	7	5	12	2	2
North West	12	29	*	23	*	6

South Central	5	9	*	9	4	2
South East Coast	12	12	8	7	4	3
South West	16	14	14	15	5	6
West Midlands	11	17	12	18	4	7
Yorkshire/Humber	16	14	14	15	9	5
Total	**123**	**157**	**85**	**153**	**43**	**50**

* Incomplete at the time of evaluation

The AQMAR utilised a traffic light system for the self-assessment.

- Red: indicator not achieved
- Amber: indicator partially achieved
- Green: indicator achieved

The ORSA uses yes/no or not applicable responses. For this comparison 'Green' AQMAR responses will be compared to 'Yes' ORSA responses and 'Red/Amber' AQMAR responses will be compared with 'No' ORSA responses.

The comparisons were divided into two areas, appraisal system responses (Table 2.2) and clinical governance responses (Table 2.3). Of all the indicators close comparisons can be made in 10 indicators. In each of these the percentage of ORSA 'yes' responses is increased when compared with AQMAR 'green' responses. The graphs below illustrate the comparisons between ORSA and AQMAR responses.

Appraisal Comparisons

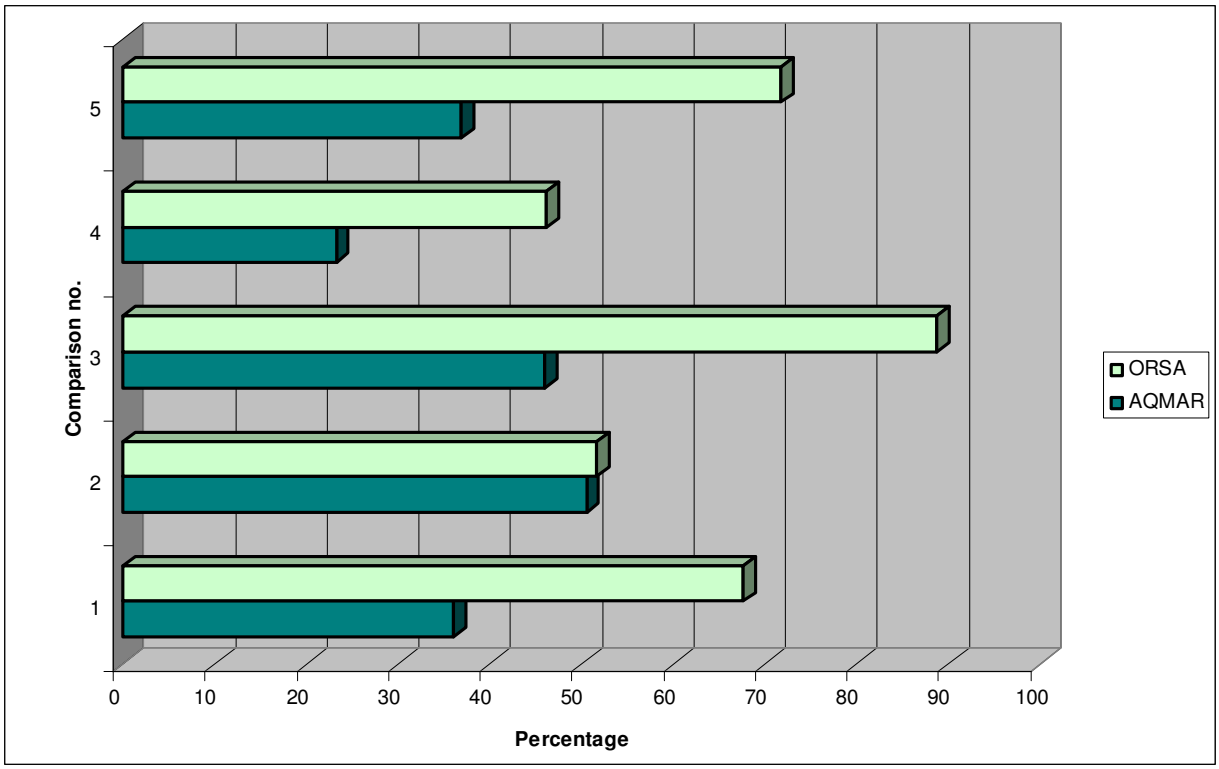
Table 2.2 and graph 2.1 show the comparisons made between the AQMAR and ORSA responses. Comparison 1 shows the number of organisations with sufficient funding to support appraisal and revalidation, compared with the number of organisations with sufficient funding for the responsible officer role increased by 31.6%. Comparison 2 shows that there was a 36 % increase in the number of organisations who reported not having a written description/ appraisal policy in place. In comparison 3, there was 42.8% increase in the number of organisations who reported that their appraisal, revalidation and HR policies were fair and non discriminatory. In comparison 4 there was 22.9% increase in the number of organisations who stated that they had a process in place in which appraisers received feedback on their performance. Comparison 5 illustrates a 34.9% increase in the number of organisations which

reported that their medical appraisers were supported in their role through access to leadership and peer support.

Table 2.2: Appraisal comparisons between AQMAR and ORSA

Comparison no.	**AQMAR**		**ORSA**	
1	1.1.5: The organisation has identified financial resources to support appraisal and revalidation for doctors		2.4: Provision of funding and resource from the designated body is sufficient to undertake the responsibilities of the role	
	Red % (+amber %)	**Green %**	No %	**Yes %**
	18.3% (64%)	**36.1%**	32.3%	**67.7%**
2	1.1.6: There is a written description of the organisations annual appraisal process		3.1: A medical appraisal policy is in place covering the core content	
	Red % (+amber %)	**Green %**	No %	**Yes %**
	12.3% (49.4%)	**50.6%**	48.3%	**51.7%**
3	1.1.7: The appraisal system is free from unfair discrimination		4.14: Relevant appraisal, revalidation, HR policies are fair and non discriminatory	
	Red % (+amber %)	**Green %**	No %	**Yes %**
	8% (54%)	**46%**	11.8%	**88.8%**
4	2.3.1: There is a regular review of performance which includes annual feedback on their performance in the role and periodic evaluation of knowledge and skills		3.6: Medical appraisers receive feedback on their performance in the role, which includes feedback from appraisees or feedback on the quality of appraisal outputs	
	Red % (+amber %)	**Green %**	No %	**Yes %**
	46.6% (77%)	**23.3%**	53.8%	**46.2%**
5	2.3.2:There are clear arrangements to support appraisers with structured ongoing training and opportunities for peer support		3.5: Medical appraisers are supported in the role through access to leadership and peer support	
	Red % (+amber %)	**Green %**	No %	**Yes %**
	27% (63.1%)	**36.9%**	28.2%	**71.8%**

Graph 2.1: Illustration of AQMAR ‘green’ and ORSA ‘yes’ comparisons



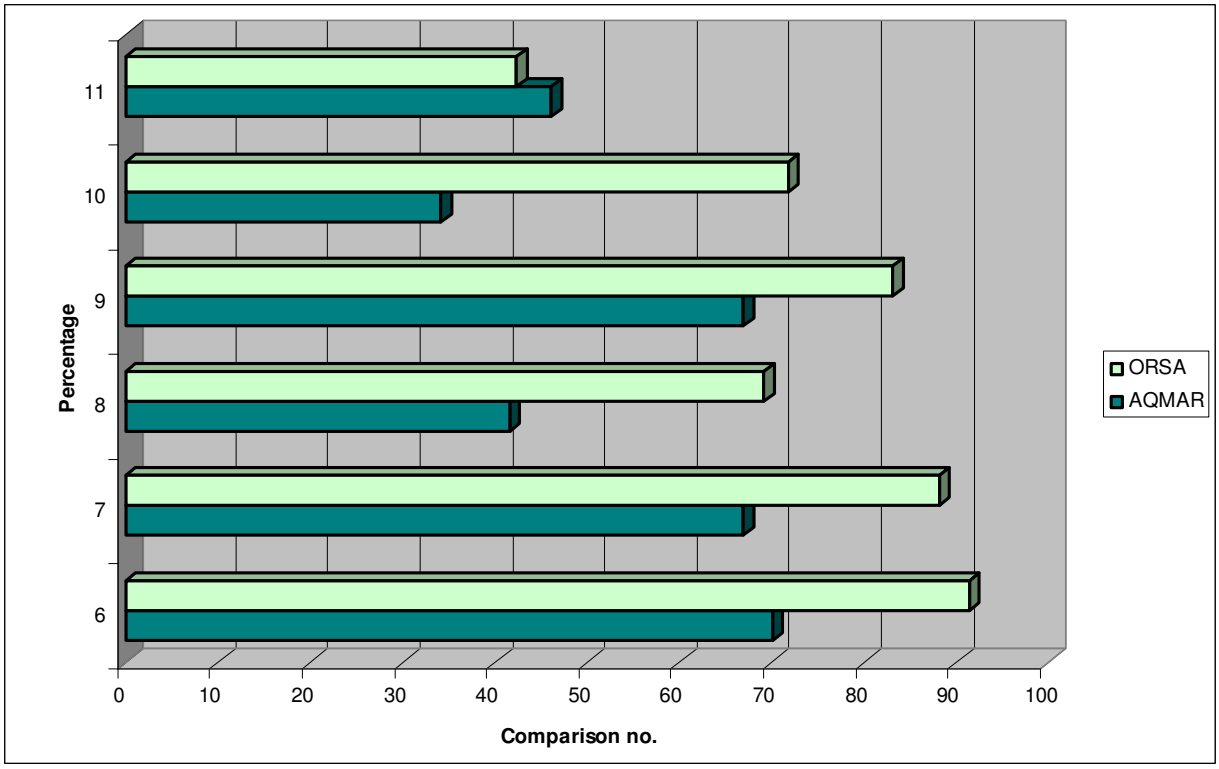
Clinical governance comparisons

In comparison 6, 21.4% more organisations reported that they had a clinical governance structure or strategy in place. Comparison 7 shows that 21.2% more organisations stated that the relevant appraisal, revalidation HR policies in pace were fair and non discriminatory. In comparison 8 there was a 27.6% increase in the number of organisations who stated that they had a system for monitoring the conduct and performance of medical practitioners. As illustrated in comparison 10, there was a 37.6% increase in the number of organisations reporting that a strategy for CPD is in place, now compared to a description of support for doctors to keep knowledge and skills up to date. As illustrated in comparison 11, the number of organisations who stated that a system was in place for responsible officer to receive information about new doctors form the previous responsible officer/organisation showed a 3.8% decrease but this may be explained by a specific set of information which should be transferred and a 3 month timescale for information transfer being described in the ORSA tool.

Table 2.3: Clinical governance comparisons between AQMAR and ORSA

Comparison number	**AQMAR**		**ORSA**	
6	1A: a clinical governance strategy agreed by the board is in place		4.1: A governance structure or strategy is in place	
	Red % (+amber %)	**Green %**	No %	**Yes %**
	4.7 (29.9)	**70.1**	8.5	**91.5**
7	1C: there are monitoring and reporting processes in place which provide assurance about the fairness in relation to equality and diversity of clinical governance systems		4.14: Relevant appraisal, revalidation, HR policies are fair and non discriminatory	
	Red % (+amber %)	**Green %**	No %	**Yes %**
	6.1 (32.9)	67	11.8	88.2
8	2B: Information relating to the performance of doctors and teams is used to identify good practice and emerging poor performance		4.3: There is a system for monitoring the conduct and performance of medical practitioners	
	Red % (+amber %)	**Green %**	No %	**Yes %**
	7.4 (58.4)	41.6	30.8	69.2
9	5A: There is a written description of the process for the identification and investigations of potential impaired clinical performance, including proactive identification of emerging performance		4.10: A process is established for the investigation of performance, conduct, health and fitness to practise concerns	
	Red % (+amber %)	**Green %**	No %	**Yes %**
	8.6 (33)	67	16.8	83.2
10	7A: A CPD strategy agreed by the board is in place		4.13: A description of the support available from the designated body for medical practitioners to keep their knowledge and skills up to date is in place	
	Red % (+amber %)	**Green %**	No %	**Yes %**
	34.7 (65.8)	34.2	28.2	71.8
11	8B: Information relating to all new medical appointees is obtained from the doctors previous organisation		4.8: Information relating to all new doctors is obtained from the doctors previous responsible officer/ employing organisation	
	Red % (+amber %)	**Green %**	No %	**Yes %**
	13.3 (53.8)	46.2	**57.6**	42.4

Graph 2.3: Clinical governance AQMAR ‘green’ and ORSA ‘yes’ comparisons



Part Three

Feedback on ORSA process and ORSA tool

Method

Two feedback forms were sent to the SHAs. One was for the SHA to complete, and the second form was to be sent to the designated bodies which had participated in the ORSA exercise. The forms were written using Survey Monkey and an electronic link was provided to allow the respondent to complete and submit the feedback. Results were collated using Survey Monkey.

The following part is divided into two section, the first is feedback collected from each SHA and the section part is feedback collected from the designated organisations.

Feedback from Strategic Health Authorities

Participants

Responses were collected from all ten SHA's (100% response rate) after completion of the ORSA exercise.

Results

SHAs were asked to compare their experience of completing the ORSA tool with the 2009 AQMAR exercise. Comments on this were:

- The "AQMAR tool was very time consuming";
- ORSA "information did not need to be collected manually";
- ORSA "made more sense";
- ORSA was "shorter and less complicated";
- "The questions [in ORSA] were less ambiguous";
- ORSA "provided constructive information and allowed easy monitoring of progress";
- ORSA was straightforward and [it was] easy to formulate any actions that needed to be taken as a result";
- "examples were set out well [in ORSA] and there is much more knowledge about what is required from revalidation"; and
- ORSA was "clearer and simpler".

70% (7) of SHAs felt that the ORSA exercise was either easy or very easy to run and organise compared to 14% for AQMAR.

Each SHA was asked to rate a series of listed benefits of the information collected under the ORSA exercise on a scale of 1 (not well) to 5 (very well). The majority of SHAs stated that the information collected in the ORSA tool helped them (well or very well) to identify the priorities for development (70%), increase awareness of needs for revalidation (70%) and prepare the organisation for revalidation (90%) (see table 3.1).

Table 3.1: Benefits of ORSA information

How well did the information collected from the ORSA tool…	**Not well** ← → **Very well**					**Average Score (max 5)**
	1	2	3	4	5	

Identify priorities for development in your SHA?	1(10%)	0 (0%)	2 (20%)	**6 (60%)**	1(10%)	3.60
Increase awareness of needs for revalidation in the SHA?	0(0%)	0(0%)	3 (30%)	3(30%)	**4(40%)**	4.10
Prepare organisations for revalidation?	0(0%)	0(0%)	1(10%)	**6(60%)**	3(30%)	4.20

The ORSA tool was sent to SHAs on 17th February 2011. Distribution of the ORSA tool to designated bodies varied from SHA to SHA, from 18th February to 21st April 2011. When asked how each SHA ensured the response form their designated bodies the responses were:

- making the responsible officer aware;
- making the SHA delivery board aware;
- one to one meetings;
- email and telephone reminders;
- revalidation lead meetings;
- forums;
- ORSA preparation workshops;
- responsible officer network meetings.

SHAs reported the following aims for the completion of the ORSA exercise:

- "a sense of organisational readiness in the SHA region."
- "raising awareness and profile of revalidation"
- "greater focus on priorities"
- "engaging responsible officer's and maintaining relationships"
- "beginning actions and planning development"
- "providing guidance to organisations"
- "to increase pressure on trusts lagging in developing systems"
- "compliance"
- "establishing a benchmark – a useful source of comparative information"
- "identifying common ORSA needs across the patch"

Of the aims listed above 70% (7) of SHA's reported that they had achieved their aims.

SHAs reported the following difficulties during the completion of the ORSA tool with ensuring responses from the relevant responsible officers, and errors or problems with the submission. One SHA suggested that “for the interim reporting [we] would prefer that we adopt the workaround email method so that responsible officers send their response to me and then I can forward on. This way [we] can monitor who has submitted the report and who needs a gentle reminder”. Some organisations found that certain areas of the ORSA did not apply. There was agreement that the RST provided “well organised and timely” support. One SHA suggested that future versions of the ORSA tool could be organised by the SHA.

SHAs reported that the main advantage to the ORSA tool was that it provided a clear focus and overview of the current position and helped to prioritise and identify areas of support and development across the SHA region.

Additional feedback covered areas such as the need to validate the responses, consideration of a scale as opposed to yes no answers, providing areas for comments in the tool and ensuring the IT systems were properly tested.

Feedback from Designated Bodies

Respondents

Overall 204 designated bodies, covering all ten SHA areas, had completed the feedback from by 12 July 2011. Table 3.2 shows the breakdown of organisation responses by health care sector.

Table 3.2: Organisation feedback responses by organisational type

Organisational type	Feedback responses received	Feedback received as percentage of participants in each organisational type
Primary care trusts	56	36.6
Hospital trusts/Secondary care	74	47.1
Mental health trusts	24	48
Other NHS trust/Organisation	10	30.3
Deanery	4	44.4
Independent/Non NHS Sector	36	34.3
Total number of responses	**204**	**40.2**

Results

64% of the organisations had completed the 2009 AQMAR exercise. Of these, 75% stated that ORSA was either easier or much easier to complete than AQMAR. Reasons for this were that the ORSA tool was “sensibly laid out with clear line of questioning”. It was felt to be more streamlined than its predecessor with clearer and less ambiguous questions. It took less time to complete as it was “less complex”, “more user friendly, more intuitive” and “much briefer”.

Each organisation was asked to list the key people involved in completing the ORSA tool (see table 3.3). The primary role was the medical director (21.8%)

Table 3.3: Key people involved in ORSA completion

Role	Frequency	%
Medical director	100	21.8
Deputy/Associate medical director	56	12.2

Manager	56	12.2
Responsible officer	43	9.4
Administrative	40	8.7
Lead	36	7.8
HR	33	7.2
Director	31	6.8
Head	20	4.4
Other	14	3.1
Officer/Project manager	10	2.2
Consultant	5	1.1
Executive board/team	3	0.7
Dean	2	0.4
Chief executive	1	0.2
Chairman	1	0.2
CMO	1	0.2
Deputy responsible officer	1	0.2
IT	1	0.2
Steering group	1	0.2
Missing data	4	0.9
Total	459	100

The mean amount of time across all roles for completing the ORSA tool was 4.85 hours (range = 0.25 - 40), the mode time spent in 18% of responses was 2 hours.

Designated bodies were asked to rate how well the ORSA tool assessed the following criteria; details of the designated body, responsible officer, appraisal system and organisational governance. Table 3.4 breaks down the responses to these statements on a scale of 1 (not well) to 5 (very well)

Table 3.4: Usefulness of ORSA in assessing the listed areas

ORSA section	Not well ← → Very well					Average Score (max 5)
	1	2	3	4	5	
Details of designated body	44 (22%)	29 (15%)	**57 (29%)**	49 (25%)	19 (10%)	2.85
Responsible officer	19 (10%)	29 (15%)	**58 (30%)**	56 (29%)	34 (17%)	3.29
Appraisal System	10 (5%)	13 (7%)	43 (22%)	**83 (42%)**	50 (25%)	3.75
Organisational Governance	9 (5%)	16 (8%)	55 (28%)	**80 (41%))**	37 (19%)	3.61
Total number of responses: 199						

Designated bodies were also asked to rate the usefulness of the ORSA annexes on a scale of 1(not useful) to 5(very useful). For each annex the mean score was 3.9 to 4 (useful). The breakdown of this can be found in table 3.5.

Table 3.5: Usefulness of ORSA annexes

ORSA Annex	Not well ← → Very well					Average Score (max 5)
	1	2	3	4	5	
Annex 1	10 (5%)	13 (7%)	38 (19%)	57 (29%)	**78 (39%)**	3.86
Annex 2	3 (2%)	11 (6%)	40 (20%)	**64 (32%)**	5 (3%)	3.93
Annex 3	6 (3%)	3 (2%)	32 (16%)	74 (37%)	**81 (41%)**	4.09
Annex 3a	4 (2%)	11 (6%)	44 (22%)	**73 (37%)**	83 (32%)	3.86
Annex 3b	4 (2%)	11 (6%)	43 (22%)	**61 (31%)**	5 (3%)	3.82
Annex 4	6 (3%)	14 (7%)	43 (22%)	61 (31%)	**72 (36%)**	3.84
Annex 5	8 (4%)	18 (9%)	42 (21%)	58 (29%)	**65 (33%)**	3.64

Additional information to be included in the annexes were requests for person specifications for managers, guidance around engagement, future funding and appraiser training and clarity over approved systems and expectations once revalidation has been implemented.

Suggestions for improving the form were to include:

- an indication on the form for areas awaiting guidance;
- an "outline of upcoming revalidation requirements to allow future planning"; and
- "details of appraisal scheme to be implemented so that [we are] not filling this form in isolation"

Other responses requested information on the "recommended procedure for dealing with poorly performing doctors and remediation policy".

In 11 of the 13 sections designated bodies found collecting evidence to be very easy (see table 3.6).

Table 3.6: Ease of collecting evidence for ORSA

	Not easy ← → Very easy					**Unable to find evidence**	**Average Score**
ORSA section	**1**	**2**	**3**	**4**	**5**		
Number of doctors with a prescribed connection	17 (9%)	25 (13%)	43 (22%)	49 (25%)	**61 (31%)**	3 (2%)	3.61
Appropriate responsible officer training undertaken	2 (1%)	8 (4%)	19 (10%)	48 (24%)	**110 (56%)**	11 (6%)	4.46
Local/regional support available	8 (4%)	9 (5%)	40 (20%)	66 (33%)	**72 (36%)**	4 (2%)	3.99
Sufficient funding/resource to undertake the role	35 (18%)	30 (15%)	40 (20%)	**44 (22%)**	38 (19%)	11 (6%)	3.27
Medical appraisal policy in place	2 (2%)	12 (6%)	35 (18%)	46 (23%)	**93 (47%)**	7 (4%)	4.18
Numbers of doctors who have completed appraisal	17 (9%)	28 (14%)	36 (18%)	50 (25%)	**65 (33%)**	4 (2%)	3.65
Exception audit on missed/incomplete appraisals	23 (12%)	28 (14%)	34 (17%)	41 (21%)	**49 (25%)**	22 (11%)	3.66
Number of trained medical appraisers is sufficient	17 (9%)	19 (10%)	39 (20%)	41 (21%)	**77 (39%)**	7 (4%)	3.82
Appraisers receive feedback on their performance	16 (8%)	26 (13%)	33 (17%)	35 (18%)	**62 (31%)**	26 (13%)	3.90
Governance structure or	3	17	46	55	**75**	3 (2%)	3.96

strategy is in place	(2%)	(9%)	(23%)	(28%)	**(38%)**		
System for monitoring conduct and performance	4 (2%)	14 (7%)	44 (22%)	52 (26%)	**78 (39%)**	6 (3%)	4.03
Process for the investigation of concerns	1 (1%)	11 (6%)	39 (20%)	55 (28%)	**89 (45%)**	5 (3%)	4.17
Policy for re-skilling, rehabilitation, remediation and support	17 (9%)	37 (19%)	**41 (21%)**	40 (20%)	38 (19%)	25 (13%)	3.61

The main benefits of applying the ORSA tool were around a raised awareness of expectations ("Start of a journey!") with helpful guidance to help address the gaps identified through the process. 55% of designated organisations reported ORSA to be useful or very useful in identifying good practice.

- "[It is a] very good way to identify the gap between where we are and where we need to be."
- "It made clear what the requirements/ expectations were."
- "Increased awareness at board level of resource implications and importance of revalidation process."
- "Good benchmarking exercise and provides useful practical guidance in identifying and addressing gaps."
- "I know there is a lot of work for my organisation to do, but completing the ORSA helped enormously to focus on what was already in place, but needed extending and what is simply not in existence at all."

The reasons for difficulties identified in completing the ORSA can be broken down into two categories, problems identified within the organisations and difficulties encountered with the ORSA tool.

Organisational difficulties with completing the ORSA tool included "difficulty in obtaining an accurate figures" and baseline data; lack of awareness on a organisation level also presented challenges.

- "[There is a] lack of staff with sufficient awareness and knowledge."
- "Revalidation is not widely known outside of the medical field as such I repeatedly had to explain what is was and how it has come about to a range of staff across the trust who would impact on our ability to provide the data required."

Some organisations reported difficulty with fragmented process and policies and with strategies in place but not necessarily written down. Organisations restructuring made completing the ORSA tool more difficult.

- “[The] PCT [is] in [a] state of flux and personnel changes.”
- “[The exercise was] made difficult by recent PCT clustering process and systems [are] only just beginning to bed down.”

Deaneries and smaller non-NHS organisations encountered more difficulties with the tool.

- “The deanery has a different structure and relationship to our trainees as compared to a trust and its employees. There was some lack of clarity as to how this may affect the details of implementation of revalidation.”
- “[The] questions have strong NHS assumptions, so hard to translate to independent.”
- “Being a non-NHS organisation it has required some interpretation.”

Difficulties with completing ORSA tool included problems around submission, and yes/no answers with no option for free text.

- “The definitions for each category were very clear, which was useful in that a yes/no answer was easy to arrive at. However this skewed the overall result somewhat as there was little room to accommodate alternative systems and practices that may achieve the required end but did not conform with the defined processes.”

Conclusion

In October 2010, as part of the GMC consultation response on the revalidation of doctors, a joint statement of intent from the four UK administrations and the GMC was published, setting out a timetable for assessing readiness for revalidation and the intention for revalidation to commence in late 2012. It is recognised that designated bodies are at different stages of preparation for revalidation and that some organisations have more work to do than others as they have not required systems to manage and support their doctors in the past. Revalidation can provide all designated bodies with the necessary imperative to speed up actions which improve patient safety and quality of care.

This self-assessment exercise for the year ending 31 March 2012 shows there is an increasingly strong foundation to build on and a number of improvements have been achieved since a similar exercise in 2009. Some organisational systems will need to be strengthened and this is to be expected: a 'no' answer in the survey does not mean the absence of systems; it will usually mean the present systems need additional features which can be put in place without difficulty.

Whilst designated bodies in England have made progress in some areas there remain some weaknesses and inconsistencies in organisational systems and, whilst many of these can be explained, the systems will need to be strengthened if revalidation is to fulfil its primary aims. This work will be the responsibility of each designated body and responsible officer, and they have been encouraged to produce action plans to strengthen their systems. Support for responsible officers for this work will be available through the SHA and local responsible officer networks supported and assisted nationally by the RST as well as, where appropriate, the GMC, DH, employers and NCAS.

Designated bodies in England, by their own declaration, still have work to do to and their action plans backed by local, regional and national support will aim to address development needs and ensure the service is ready to commence revalidation on time.

Glossary of terms

Appearance of bias	An apparent predisposition, prejudice or preconceived opinion that may prevent an impartial or objective evaluation.
Annual appraisal	The process of preparation, collation and reflection on information, followed by a discussion with an appraiser at a formal, confidential meeting. The appraisal meeting between the appraisee and appraiser should take place every year. An appraisal is considered to be completed when the summary of the appraisal discussion and personal development plan (PDP) have been signed off by appraiser and appraisee within 28 days of the appraisal meeting.
AQMAR	Assuring the Quality of Medical Appraisal for Revalidation (AQMAR) was the precursor to ORSA (see below).
Business case	A business case captures the reason for initiating a project or task. The Department of Health (England) is currently developing the business case for revalidation. This will evaluate the costs and benefits of appraisal, assessing that the proposed model is proportionate and right for doctors, employers, patients and the public. It will be informed by the RST's testing and piloting programme and overall assessment of organisational readiness of the health sector to introduce revalidation.
Clinical audit	The National Institute for Clinical Excellence (NICE) defines clinical audit as: *'a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery.'* [4]

[4] National Institute for Clinical Excellence, Principles for best practice in clinical audit, Radcliffe Medical Press, 2002

Conflict of interest	A situation in which the responsible officer has competing professional or personal duties, loyalties, obligations or interests that would either make it difficult to fulfil their duties fairly, or would create an appearance of impropriety or a loss of impartiality that could undermine public confidence.
Deanery	A deanery, within healthcare in the UK, is responsible for the organisation and management of postgraduate medical and dental training.
Designated body	An organisation that employs or contracts with doctors and is designated in The Medical Profession (Responsible Officer) Regulations 2010. http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents
England Revalidation Delivery Board	The England Revalidation Delivery Board (ERDB) is the governance body established to provide assurance to the Department of Health in England that the introduction of revalidation is being managed appropriately.
Good Medical Practice	Good Medical Practice sets out the principles and values on which good practice is founded; these principles together describe medical professionalism in action. The guidance is addressed to doctors, but it it also intended to let the public know what they can expect from doctors. http://www.gmc-uk.org/guidance/good_medical_practice.asp
GMP framework for appraisal and revalidation	The *Good Medical Practice* Framework for appraisal and revalidation sets out the broad areas which should be covered in medical appraisal. The Framework will form the basis of a standard approach for all appraisals, in which licensed doctors must take part in order to revalidate. http://www.gmc-uk.org/doctors/revalidation/revalidation_gmp_framework.asp

Licence to practise	To practise medicine in the UK all doctors are required, by law, to be both registered and hold a licence to practise. This applies to practising full time, part time, as a locum, privately or in the NHS, or employed or self-employed. Licences are issued, renewed and withdrawn by the GMC.
OGC Buying Solutions Framework	Formerly known as OGC Buying Solutions, the Government Procurement Service is an executive agency of the Cabinet Office. Its priority is to provide procurement savings for the UK Public Sector as a whole and specifically to deliver centralised procurement for Central Government Departments. Government Procurement Services negotiates framework agreements, which are a set of pre-tendered contracts with a range of preferred suppliers from which public sector customers can purchase goods and services.
ORSA	ORSA (Organisational Readiness Self-Assessment) is a self-assessment tool designed to help designated bodies in England determine whether they are ready for revalidation.
Peer review	Peer review is the process of having a piece of work or data/information reviewed by colleagues in the same field to ensure its validity and relevance.
Personal Development Plan (PDP)	The personal development plan (PDP) is an agreement, between the appraisee and appraiser, on the learning and development needs of the appraisee, identified at the appraisal interview, with an outcome-based learning plan for the subsequent year.
Practising privileges	The agreement between an independent healthcare organisation and the doctor, allowing the doctor to practise within that organisation.
Prescribed connection	The prescribed connection is the formal link between a doctor and their designated body. It is the route by which doctors are able to find their responsible officer. Regulation 10 and 12 in The Medical Profession (Responsible Officer) Regulations 2010 set out the “prescribed connection” between designated bodies and doctors and these are explained in more detail in the responsible officer guidance.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117861

Remediation

The overall process agreed with a practitioner to redress identified aspects of under performance. Remediation is a broad concept varying from informal agreements to carry out some re-skilling, to more formal supervised programmes of remediation or rehabilitation.

Responsible officer

A licensed doctor with at least 5 years experience who has been nominated or appointed by a designated body.

Responsible officer networks

Responsible officer networks are regional networks of responsible officers organised by the SHA responsible officers, providing development, peer support and advice.

RST

The NHS Revalidation Support Team (RST) works in partnership with the Department of Health, the GMC and designated bodies to deliver an effective system of revalidation for doctors in England. This includes:

- supporting healthcare organisations and responsible officers in preparing for medical revalidation
- producing clear and effective guidance for annual medical appraisal, and
- providing evidence of the costs, benefits and practicalities of implementation, to ensure that revalidation supports high quality care and is cost-effective and efficient.

For more information, please visit: www.revalidationsupport.nhs.uk

RST Pathfinder Pilots

The NHS Revalidation Support Team (RST) Pathfinder Pilot project ran from 1 January 2010 to 31 March 2011. Over 3,000 doctors from primary and secondary NHS healthcare settings participated across ten pilot sites in England.

The aim of the RST Pathfinder Pilots was to test whether the proposed components of medical revalidation, such as strengthened medical appraisal, are as practical and as efficient as possible, whilst supporting high quality care and providing confidence to the public.

The RST Pathfinder Pilots were phase two of a three phase piloting process. Phase one included preliminary small scales pilots. A third and final phase of piloting is taking place in 2011-12, testing specific components of the revalidation process and the Medical Appraisal Guide on doctors in a variety of healthcare settings and organisations.

Second responsible officer

Designated bodies must nominate or appoint a second responsible officer where there is a significant conflict of interest or an appearance of bias. Where a second responsible officer has been appointed, that individual has the responsibilities specified in the legislation.

Statement of Intent

Revalidation: A Statement of Intent was published by the GMC in October 2010, following the GMC's consultation in early 2010 and the announcement by the Secretary of State to introduce an added year of testing and piloting.

It was agreed by the General Medical Council, the Chief Medical Officers for England, Northern Ireland and Wales, the Deputy Chief Medical Officer for Scotland and the Medical Director of the NHS in England and sets out the GMC and our partners' commitment to change the way doctors are regulated in the UK.

Targeted support

In the context of the spectrum of intervention, targeted support could be seen as a mid-range process, short of formal remediation but beyond the scope of the standard PDP agreed between the doctor and his/her appraiser.

Organisational Readiness Self Assessment Tool

End of Year Report for 2010-2011

Organisational Readiness Self Assessment: End of Year Report 2010-2011

The purpose of revalidation is to ensure that doctors remain up to date and continue to be fit to practise. It aims to support doctors in their professional development, to contribute to improving patient safety and quality of care and to sustain and improve public confidence in the medical profession. It also seeks to facilitate the identification of the small proportion of doctors who are unable to remedy significant shortfalls in their standards of practice. To achieve these aims the General Medical Council will require assurance that local systems of medical appraisal and clinical governance function effectively and fairly in distinguishing between satisfactory and poor performance and that Responsible Officers are making correct and valid recommendations.

This self assessment exercise is designed to help designated bodies [as defined in The Medical Profession (Responsible Officers) Regulations 2010] in England develop their systems and processes in preparation for the implementation of revalidation. The self assessment will be a two-stage process:

1. the first stage will be completed by designated bodies in April/May 2011 [for the year ending 31.3.11] to give an indication of the current state of preparation for revalidation and to help prioritise development needs; and
2. the second stage will repeat the exercise in April/May 2012 [for the year ending 31.3.12] to inform the Secretary of State's decision regarding commencement of the revalidation.

The aims of the self assessment are therefore to:

- ensure designated bodies understand what will be needed when revalidation starts;
- identify and prioritise areas for development;
- inform the England Revalidation Delivery Board and the GMC regarding progress towards readiness in England; and
- contribute towards the Secretary of State's assessment of readiness for revalidation in 2012.

The overall timetable for revalidation, as described in '*Revalidation: A statement of Intent, GMC, October 2010*', suggests that revalidation will be launched in late 2012 and most Designated Bodies will begin making revalidation recommendations during the following year [2013/14]. For the NHS the importance of preparing local systems in readiness for revalidation is highlighted in the Operating Framework ["NHS organisations will need to ensure they have in place the key components to underpin medical revalidation, in advance of an assessment of readiness in early 2012/13 to help doctors remain up to date

and fit to practise throughout their career"]. Some important new statutory responsibilities are described and due to widely differing starting points, preparations may take longer for some designated bodies. It is important that action plans are produced which provide assurance that the designated body is progressing towards readiness in a timeframe agreed with the SHA Responsible Officer. The information from the first stage self assessments will be collected by the NHS Revalidation Support Team and forwarded with national comparators to the responsible officer at the relevant SHA. A report using collated, anonymised information will be presented to the England Revalidation Delivery Board and published on the RST website. No information about individual designated bodies will be included in this report.

In the future, the self assessment process will enable individual designated bodies to provide assurance to the General Medical Council [as well as the public, the profession and other interested bodies] that they are fulfilling their statutory obligations and their systems are ready for the Responsible Officers to begin making recommendations. Further information about the process for commencement of revalidation recommendations in individual Designated Bodies will be available as we move towards implementation. It is anticipated that in the future the content of this end of year report will be a public document. It may form part of an NHS organisation's Quality Account but it could also be presented at a public board meeting or be published on a designated body's website. It should be made available to the GMC, SHA Responsible Officer, CQC and other interested bodies. The content of the report may also be used by the responsible officer in their appraisal/revalidation portfolio as supporting information for the role of responsible officer.

How to use this document

The questionnaire is based on the Responsible Officer Regulations and Guidance and additional criteria from the General Medical Council. A small number of additional areas are included for 2012/13 to show what may be needed as new information becomes available in the future. Annexes give more detailed information with samples and details of core content. Some changes are likely to be made during 2011/12 as new information and guidance becomes available.

The responsible officer is responsible for completing the self assessment form on behalf of the designated body, though this responsibility can be appropriately delegated. Input can also be provided from medical workforce/HR teams, appraisal leads and clinical governance teams amongst others. Final submissions will be made on behalf of the designated body and responsible officers should consider whether the report should be presented to the board or an appropriate governance or decision making structure to ensure there is an understanding of the corporate and legislative responsibilities.

The self assessment tool is divided into four sections:

Section 1: Details of designated body

Section 2: Responsible officer

Section 3: Appraisal System

Section 4: Organisational Governance

Sections in BLACK are areas necessary for initial organisational readiness. Some of these are new responsibilities and will not be in place for the end of 2010/11 but the current situation should be reported [for instance, it is not possible for a patient and colleague feedback system compliant with GMC requirements to be in place by end of 2010/11 as these have not yet been published]. Designated bodies should plan how these areas will be covered.

Sections in GREY are areas which will be necessary to maintain readiness in subsequent years. If the designated body wishes to provide an answer for 2010/11 then it should do so. Designated bodies should plan how these areas can be covered by the end of 2012/13.

An electronic version of the form will be available which should be completed by the responsible officer for each designated body in April/May 2011 for the year ending 31st March. The deadline for completion is 31st May 2011. The information and guidance for submitting the electronic form will be sent out at the end of March 2011. Following completion of the self assessment an action plan with timescales for reaching readiness should be developed.

References:

This document should be read in conjunction with the Responsible Officer Regulations and the responsible officer Guidance. References to these documents are given in each section where appropriate. All referenced documents are available on the RST website: www.revalidationsupport.nhs.uk

- 'Regulations' refers to: The Medical Profession (Responsible Officers) Regulations. DH. 2010.
- 'Guidance' refers to: The role of the Responsible Officer: Closing the gap in medical regulation – responsible officer Guidance. DH. 2010.

The following documents are also referenced:

- Good Medical Practice Framework for Appraisal and Assessment. GMC. 2010.
- Assuring the Quality of Medical Appraisal for Revalidation [AQMAR]. RST. 2009.

- Assuring the Quality of Training for Medical Appraisers [AQTMA]. CGST. 2007.
- Appraisal Guidance for Consultants. DH. 2001.
- Appraisal Guidance for General Practitioners. DH. 2004.
- A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties. A report to the Secretary of State for Education and Skills. Professor Sir Brian Follett and Michael Paulson-Ellis. September 2001.
- Joint University and NHS Appraisal Scheme for Clinical Academic Staff. UCEA. 2002.
- Guide to independent sector appraisal for doctors employed by the NHS and who have practising privileges at independent hospitals: Whole Practice Appraisal. BMA and Independent Healthcare Forum. October 2004.
- Revalidation: A Statement of Intent. GMC, DH, HSSG, WAG, DHSSPSNI. October 2010.

1.	**Section 1: Details of designated body** This section contains contact details along with information describing the designated body to facilitate reporting and allow benchmarking between similar organisations. The names and contact details do not need to be included in a public report.				
	1.1	**Name of trust/Designated body:**			
		Address Website [if relevant]			
		Name of responsible officer		GMC Number	
		Email		Phone	
		Name of Chief Executive [if relevant]		GMC Number [if relevant]	
		Email		Phone	
	1.2	**Health Sector:** [tick one]	Primary care trusts		
			Hospital trusts/Secondary care		
			Mental health trusts		
			Other NHS trust/Organisation [Community trusts, Ambulance trusts, Blood Transfusion Service, etc]		
			Deanery		
			Independent/Non-NHS sector [tick one]	Independent healthcare provider	
				Locum agency	
				Faculty/Professional body [FPH, FOM, FPM, IDF]	
				Academic or Research Organisation	
				Civil Service	
				Armed Forces	
				Hospices, Charity/Voluntary Sector	
				Other non-NHS [please enter type e.g. pharmaceutical]	

	1.3	**SHA area of Trust/Designated body:** [tick one]	North East	
			North West	
			Yorkshire and Humber	
			East Midlands	
			West Midlands	
			East of England	
			London	
			South East Coast	
			South Central	
			South West	
	1.4	**Number of doctors with whom the designated body has a prescribed connection as at 31st March 2011** The Responsible officer should keep an accurate record of all doctors with whom the designated body has a prescribed connection under The Medical Profession (Responsible Officers) Regulations 2010 [Guidance, 4.5]. The prescribed connection is defined in detail in the regulations and the responsible officer must be satisfied that the doctor has correctly identified their designated body. The number of individual doctors in each broad category should be entered. The categories relate to current roles and job titles rather than qualifications or previous roles. A large number of doctors [including research, civil service, locums, other employed or contracted doctors, doctors in wholly independent practice, etc] may not be included in these categories and should be entered under 'Other'. Academics with honorary clinical contracts will usually have their responsible officer in the NHS Trust where they perform their clinical work. Trainees have a prescribed connection to the deanery. Secondary care locums may have a prescribed connection to a locum agency or another designated body. Practising privileges for an independent healthcare provider will only define a prescribed connection where the doctor does not have an employment contract with another organisation. Detailed advice on establishing whether a prescribed connection exists is contained in the Regulations and Guidance.		
		1.4.1	**Consultant** [including honorary contract holders]	
		1.4.2	**Staff Grade, Associate Specialist, Specialty doctor, Trust doctor**	

		1.4.3	**General Practitioner** [for primary care trusts only, doctors on a General Practitioner Performers List]	
		1.4.4	**Trainee: Doctors in postgraduate training scheme** [for deaneries only, doctors on national training programmes]	
		1.4.5	**Doctors with practising privileges** [for independent healthcare providers only]	
		1.4.6	**Other** [including management/leadership roles, research, civil service, secondary care locums, other employed or contracted doctors, doctors in wholly independent practice, etc]	

2.	**Section 2: Responsible officer** The Medical Profession (Responsible Officers) Regulations 2010 came into force on 1.1.11. These define the role and the statutory responsibilities of the responsible officer and should be read in conjunction with the Guidance [The role of the Responsible Officer: Closing the gap in medical regulation – responsible officer Guidance. DH, 2010]. The contractual arrangements and job description for the responsible officer will depend on the type of designated body and the other responsibilities the post holder has [for instance performing the role of Medical Director]. Annex 1 contains suggested core content for a responsible officer job description and includes the main responsibilities from the Responsible Officer Regulations and Guidance.		
	2.1	**Responsible officer has been nominated/appointed in compliance with the Regulations [Regulations, 7]**	Yes/No
		To answer 'Yes': • The responsible officer has been a medical practitioner fully registered under the Act throughout the previous 5 years and continues to be fully registered under the Act whilst undertaking the role of Responsible Officer.	
	2.2	**Appropriate responsible officer training is undertaken [Guidance, 4.48, 4.49]** A minimum standard cannot be set for this important area as every responsible officer will have different training and development needs depending on their experience and the type of designated body they work in. A short general programme of initial training for Responsible Officers in England will be delivered regionally by SHAs during 2011. The responsible officer's appraisal should help to prioritise their own development needs in the role and these should be agreed and included in their PDP.	Yes/No
		To answer 'Yes': • Appropriate initial training has been undertaken • Appropriate ongoing training and development is undertaken • PDP items relating to the role of responsible officer have been identified	
	2.3	**Local/regional support is available to the responsible officer** Regional 'Responsible officer support networks' are being set up to facilitate the ongoing development and support of responsible officers. These will encourage the development of local/regional protocols for responding to concerns, managing conflicts of interest, information sharing, thresholds for intervention, etc.	Yes/No
		To answer 'Yes': • The responsible officer has made themselves known to their responsible officer at the SHA [Guidance, 2.6]	

		• The responsible officer has access to support from:
		  ○ The SHA Responsible Officer[Guidance, 4.50]
		  ○ A peer group [e.g. the responsible officer Support Network] [Guidance, 4.50]
		  ○ GMC Employer Liaison Adviser [Guidance, 4.27]
		  ○ NCAS [Regulations, 18b]
		  ○ Medical Royal Colleges and Faculties for guidance and advice regarding a doctor's specialist practice [Guidance, 4.7]	

	2.4	**Provision of funding and resource from the designated body is sufficient to undertake the responsibilities of the role [Regulations, 14, 19]** Each designated body must provide the responsible officer with sufficient funding and other resources necessary to enable the officer to discharge their responsibilities. This might include administrative/management support, information management, training, etc	Yes/No
		To answer 'Yes': • In the opinion of the responsible officer, sufficient funds and other resources have been provided to enable them to discharge their responsibilities under the regulations	
	2.5	**A second responsible officer is nominated/appointed where a conflict of interest or appearance of bias exists between the person to be nominated/appointed and a medical practitioner with whom the designated body has a prescribed connection [Regulations, 6]** It is assumed that each designated body will have one responsible officer but the regulations allow for a second responsible officer to be nominated or appointed where a conflict of interest or appearance of bias exists. It is anticipated that this will cover the uncommon situations where close family or business relationships exist. In order to ensure a consistent approach to this, each potential conflict of interest or appearance of bias situation should be agreed by the SHA Responsible Officer. Additional responsible officers should be nominated or appointed in agreement with the SHA responsible officer and will require training and support in the same way as the main responsible officer.	Yes/No
		To answer 'Yes': • The potential conflict of interest or appearance of bias situations must be agreed with the SHA responsible officer and local processes should be followed	

		• In agreement with the SHA Responsible Officer, the designated body must nominate/appoint a second responsible officer where there is a conflict of interest or appearance of bias between the person to be nominated or appointed and a medical practitioner. • Sections 2.1 – 2.5 above also apply to this appointment/nomination.	
	2.6	**End of 2012/13: Numbers of positive revalidation recommendations made between 1st April 2012 and 31st March 2013** It is expected that some revalidation recommendations will be made in the later part of the year 2012/13. Further information will be available during 2011/12 on the process for this and the phasing of recommendations over the first revalidation cycle. The purpose of this question is to highlight the need for monitoring progress to completing the process on 100% of doctors within agreed timescales.	

3.	**Section 3: Appraisal System** The appraisal system is one of the cornerstones of revalidation and high quality appraisal is essential for the responsible officer to be assured that each medical practitioner is up to date and fit to practise. Appraisal must also provide a safe environment for personal development needs to be discussed and agreed. A good appraisal system is dependent on effective leadership and management, the quality of the supporting information and the quality and professionalism of the appraisers. Guidance on a strengthened model of medical appraisal including the essential supporting information for revalidation, the process of appraiser judgement, the specialty aspects of appraisal and the outputs of appraisal [e.g. PDP, summary of appraisal discussion, appraiser/appraisee statements] is to be agreed and published during 2011/12. Current agreements between NHS Trusts and Universities for joint appraisal arrangements for clinical academics, governed by the Follett principles, are unaffected by this guidance and should remain in place. The principles of Whole Practice Appraisal [ensuring information from a doctors other roles and organisations is available at appraisal] are essential for revalidation to be successful. The appraisal system needs to deliver annual appraisal for all the doctors in the designated body [Revalidation: A Statement of Intent. October 2010]. Current appraisal systems vary considerably in quality and consistency and it is likely that a number of doctors in every designated body, even those for whom it is currently a contractual obligation, have missed their appraisal or the appraisal is incomplete. There is evidence for instance, from early piloting that in the past some appraisals have been regarded as complete without an agreed PDP or 'sign off'. In order to ensure all doctors have an annual appraisal it will be necessary for the Responsible Officers to investigate the reasons for all missed or incomplete appraisals to satisfy themselves that the appraisal system is functioning effectively and also that doctors are fulfilling their professional obligations. The responsible officer is responsible for the quality and effectiveness of the appraisal system even if this has been commissioned from a provider organisation. For the purposes of this guidance the organisational appraisal year runs from 1st April until 31st March. Defining the appraisal year in this way is to assist the management and monitoring the appraisal system and to allow comparators and benchmarking between organisations and sectors. A completed appraisal is one where the appraisal meeting has taken place within the appraisal year and the summary of appraisal discussion/PDP have been signed off by appraiser and appraisee within 28 days of the appraisal meeting. It is not suggested that these definitions, required for managing an effective organisational system, should be applied in the future to revalidation recommendations for individual doctors. The exception audit will give a detailed understanding of what has happened in all missed or incomplete appraisals and judgement can be used by the responsible officer on a case by case basis if an appraisal falls outside the appraisal year for acceptable reasons. In exceptional circumstances the designated body may wish to agree a different 'appraisal year' with the SHA responsible officer but the principle remains that every doctor should have an appraisal within the appraisal year.

	The role of medical appraiser is an important professional role and effective selection processes and structured initial training programmes are needed. Ongoing performance review, development and support of appraisers will also be necessary to maintain the skills of the appraiser and to assure the quality and consistency of appraisal. New guidance on appraiser selection, training, performance review and support will be available during 2011.		
	3.1	**A medical appraisal policy with core content is in place**	Yes/No
		To answer 'Yes': • A medical appraisal policy is in place covering the core content described in Annex 3	
	3.2	**Numbers of doctors with whom the designated body has a prescribed connection who have a completed appraisal between 1st April 2010 and 31st March 2011 [Guidance, 3.10]** For the purposes of this guidance, completed appraisal is one where the appraisal meeting has taken place within the appraisal year [between 1st April 2010 and 31st March 2011] and the summary of appraisal discussion/PDP have been signed off by appraiser and appraisee within 28 days of the appraisal meeting. Some organisations may require additional sign off from medical line managers, clinical directors or medical directors. These additional processes should be described in the organisation's appraisal policy with any necessary deadlines but the principle that should apply in all situations is that the appraiser and appraisee should sign the agreed outputs within 28 days. In most circumstances the final sign off of the appraisal should occur within a week or so of the appraisal meeting. The 28 day period is to allow for holidays and other absences and should be sufficient for agreement and sign off in almost all circumstances. For example an appraisal meeting taking place on 31st March would need to be signed off on 27th April for it to be included in the year. An appraisal that has not been signed off within this period should be regarded as incomplete and included in the audit of missed/incomplete appraisals so the reason for the delay can be explored. In completing this self assessment it is important to distinguish between the responsible officer's responsibility to manage the quality and effectiveness of the appraisal system and their responsibility to make recommendations on individual doctors. To manage the system the responsible officer needs to know that every doctor is being effectively appraised and the sign off has been completed. In making recommendations on individual doctors the responsible officer can use their judgement to allow flexibility for appraisals delayed by holidays, sickness absence, study leave, etc. There is no suggestion that an individual appraisal will be 'invalidated' by delays, but in managing the appraisal system the organisation needs to set a reasonable expectation, track what's happening and understand the reasons for any delay. It would be unusual for a designated body to have appraised all of the doctors for whom it has responsibility within the current	

		year. There are many potential reasons for this. Some groups of doctors employed in NHS Trusts do not have a contractual obligation for appraisal and this also applies to many doctors employed or contracted outside the NHS. The main purpose of this section is to help the designated body establish how many of the connected medical practitioners currently have an appraisal so that any additional capacity and appraiser training can be planned. The same categories of doctors in section 1.4 are used in this section to identify those doctors who have had a completed appraisal in the year 2010/11. Comparing the numbers in sections 1.4 and 3.1 will give an indication of the additional organisational capacity and training required over the next 2-3 years.		
		3.2.1	**Consultant** [including honorary contract holders]	
		3.2.2	**Staff Grade, Associate Specialist, Specialty Doctor, Trust Doctor**	
		3.2.3	**General Practitioner** [for primary care trusts only, doctors on a General Practitioner Performers List]	
		3.2.4	**Trainee: Doctors in postgraduate training scheme** [for deaneries only, doctors on national training programmes]	
		3.2.5	**Doctors with practising privileges** [for independent healthcare providers only]	
		3.2.6	**Other** [including management/leadership roles, research, civil service, secondary care locums, other employed or contracted doctors, doctors in wholly independent practice, etc]	
	3.3	**An exception audit has been performed to determine reasons for all missed or incomplete appraisals [Guidance, 3.10]** A missed or incomplete appraisal is an important occurrence which could indicate a problem with the appraisal system or a potential issue with an individual doctor which needs to be addressed. Missed appraisals are those which were due within the appraisal year but not performed. Incomplete appraisals are those where, for instance, the appraisal discussion has not been completed or where the PDP or summary of appraisal discussion have not been signed off within 28 days of the appraisal meeting.		Yes/No
		To answer 'Yes': • An audit of all missed or incomplete appraisals has been performed at the end of the appraisal year [See Annex 2 for a suggested format of the exception audit] • Recommendations and improvements are enacted		
	3.4	**The number of trained medical appraisers is sufficient for the needs of the organisation [Guidance, 3.9, 3.10]** It is important that the designated body's appraiser capacity is sufficient for the number of appraisals. This assessment may depend on geographical spread, speciality spread, as well as on numbers recruited and trained. To ensure appraisal is of a sufficient		Yes/No

		standard to inform revalidation, appraisers should participate in an initial training programme before starting to perform appraisals. Further guidance and recommendations on training for medical appraisers will be developed during 2011 to incorporate the new requirements of revalidation. Until this is produced it is advised that the guidance in '*Assuring the Quality of Medical Appraisal for Revalidation'* and '*Assuring the Quality of Training for Medical Appraisers'* is followed. It is expected that not all appraisers need to have received 'revalidation ready' training for a Designated Body to be ready to commence revalidation. We would suggest that new appraisers receive full 'revalidation ready' training from 2012/13 and a proportion of current appraisers [for example 50%] should receive 'top-up' training in the same year. We suggest that all medical appraisers should receive full 'revalidation ready' training by the end of 2013/14.		
		To answer 'Yes': • All medical appraisers have attended an appraiser training programme • In the opinion of the responsible officer, the number of trained medical appraisers is sufficient for the designated body's needs • The initial training for medical appraisers should cover the competencies and skills required for the organisation's appraisal process but to inform revalidation should include: ○ Understanding the purpose of appraisal and revalidation and the links between these processes and other systems for improving the quality of medical practice in the organisation and the wider health system ○ Competency in assessing supporting information that informs the appraisal and revalidation process, specialty aspects of appraisal ○ Skills to conduct an effective appraisal discussion, including all the elements necessary for revalidation ○ Ability to produce consistently high quality appraisal documentation, sufficient to inform the revalidation recommendation as well as inform personal development		
		3.4.1	**Number of active medical appraisers at 31st March 2011 [Guidance, 3.9]** Active appraisers are those who have performed at least one appraisal in the appraisal year	
		3.4.2	**Number of active medical appraisers who have attended an appraiser training course at any time in the past [Guidance, 3.10]** The training history and current training status of all appraisers needs to be understood by the responsible officer so that	

			plans can be made to update their training.	
		3.4.3	**End of 2012/13: Number of appraisers who have received 'revalidation ready' training/top up training [Guidance, 3.10]** As revalidation commences the number of appraisers who have received full 'revalidation ready' training should increase to eventually match the required capacity. A proportion of appraisers will need to have completed the training by the end of 2012/13 and as suggested above all appraisers will need to have completed this training by the end of 2013/14.	
	3.5	**Medical appraisers are supported in the role through access to leadership and peer support** Support for appraisers may include: • Access to leadership and advice on all aspects of the appraisal process from a named individual [e.g. Appraisal Lead] • Periodic review of performance in the role of appraiser including suggestions for inclusion in their PDP which address their development needs • Access to training and professional development resources to develop appraiser skills • Provision of peer support, specialty support [if required] and discussion of difficult areas of appraisal and significant events in an anonymised and confidential environment • Some appraisers may need access to external peer support because of their role within the organisation [e.g. the medical director or appraisal lead] and/or their relationship to the other appraisers • Organisations may choose to satisfy these requirements in different ways, but there is evidence that a well structured Appraiser Support Group led by a suitably skilled Appraisal Lead or facilitator can meet these needs.	Yes/No
		To answer 'Yes': • As a minimum, support arrangements for appraisers should include: ○ Access to leadership and advice on all aspects of the appraisal process from a named individual [e.g. Appraisal Lead] ○ Provision of peer support, specialty support [if required] and discussion of difficult areas of appraisal and significant events in an anonymised and confidential environment	
	3.6	**Medical appraisers receive feedback on their performance in the role which includes feedback from appraisees or feedback on the quality of appraisal outputs [e.g. PDPs, appraisal summaries]** Completion of training is not a guarantee of competence in the role or that knowledge and skills have been assimilated and	Yes/No

		performance review is included as a means of quality assuring the competence of appraisers. Performance Review may include: • Assessment/evaluation after training or after a probationary period • Feedback from appraisees on the appraiser's performance in the role [for sample questionnaire see Annex 4] • Review of outcomes of completed appraisals [e.g. PDPs, summaries of appraisal discussion] • Review of any complaints or significant events relating to the appraiser • Periodic structured evaluation of specific areas of knowledge, skills and attributes [e.g. handling of patient safety issues arising in appraisal, portfolio evaluation, specialty aspects of appraisal, communication]. More details on the methods of review and assessment will be produced by RST in 2011. It must be recognised that some appraisers may fail to maintain the necessary knowledge, skills and attributes to be an effective appraiser and if appropriate remedial processes fail those individuals should not continue in this important professional role.	

		To answer 'Yes':
		• The process of performance review should include at least one of these methods:
		  ○ Feedback from appraisees on the appraiser's performance in the role
		  ○ Review of the outcomes of completed appraisals [e.g. PDPs, summaries of appraisal discussion]
		• Before the end of 2012/13:
		  ○ The process of performance review should include both of these methods:
		  ▪ Feedback from appraisees on the appraiser's performance in the role
		  ▪ Review of the outcomes of completed appraisals [e.g. PDPs, summaries of appraisal discussion]
		  ○ All medical appraisers undergo an assessment after their initial training or after a probationary period [for example after the first three appraisals] to ensure the appraisals they undertake are quality assured.	

4.	**Section 4: Organisational Governance** The responsible officer in all designated bodies is responsible for ensuring those medical practitioners with whom it has a prescribed connection are up to date and fit to practise. Those designated bodies involved in commissioning or providing healthcare have in addition, a statutory responsibility for the quality of the care provided on their behalf. This section deals with the governance and accountability arrangements required to fulfil this responsibility.		
	4.1	**A governance structure or strategy is in place [including clinical governance where appropriate]** All designated bodies involved in commissioning or providing healthcare have a statutory responsibility for the quality of the care provided on their behalf. For most designated bodies the process by which this is achieved will be described in a board approved governance strategy [which includes clinical governance or clinical quality assurance]. Some designated bodies do not have a board and some do not directly deliver clinical care and so the equivalent in these settings may be a description of the structures and arrangements for assuring quality of services provided or the quality of contractors. This should include reporting and accountability arrangements and the methods of internal and external quality assurance. Systems and processes for the management, storage and sharing of information and the handling of complaints, significant untoward incidents [SUIs]/significant events, patient safety issues, clinical outcomes and routine performance and quality data should be described. If the designated body is an agency the description should include the means of assuring the quality of those who are delivering services through the agency. The document will need to be approved by the Executive Team, Management Team, Council or an equivalent internal governance or management structure.	Yes/No
		To answer 'Yes': • An approved governance structure or strategy is in place with written description/policies of: ○ Reporting and accountability arrangements for quality of services ○ Processes for internal and external quality assurance ○ Management, storage and sharing of information relating to individuals [Guidance, 4.32] ○ Management of clinical outcomes, complaints, SUIs/significant events, patient safety issues and routine performance and quality data ○ Assuring the fitness to practise of medical practitioners who have a prescribed connection with the Designated Body	

	4.2	**The governance systems [including clinical governance where appropriate] are subject to external/independent review and are not the subject of improvement notices or formal action plans** For designated bodies which provide healthcare this will be carried out by the national healthcare regulator [for England, the Care Quality Commission] which has responsibility for assuring compliance with national standards. Some designated bodies will not be regulated by an external regulator and an alternative external or independent review process should be agreed with the SHA Responsible Officer. The process should be described including the frequency and the methodology. A potential solution in these circumstances could be the publication of annual reports demonstrating compliance with key criteria with periodic external review of this report through a local group or a peer group. Further guidance on this will be available during 2011.	Yes/No
		To answer 'Yes': • For designated bodies subject to regulation by the Care Quality Commission, the relevant systems are not the subject of improvement notices or formal action plans • For designated bodies not subject to regulation by the Care Quality Commission, there is a description of the process of external review which has been agreed by the SHA responsible officer and the relevant systems are not the subject of improvement notices or formal action plans	
	4.3	**There is a system for monitoring the conduct and performance of medical practitioners with whom the designated body has a prescribed connection [Regulations 16(3)(a)]** The types of information available will be dependent on the setting and the role of the doctor. Conduct and performance should be monitored through clinical outcomes, performance data, activity data, quality indicators, complaints, feedback, SUIs/significant events and audit. In primary care this information is not always available from GP practices and new arrangements may need to be put in place to request relevant information from practices where appropriate. In order to monitor the conduct and performance of trainees, arrangements will need to be agreed between the deanery responsible officer and the trainee's clinical attachments to ensure relevant information is available to both. Where information relating to the individual is not available or not possible, team based information should be monitored. An explanation is essential where an indication of outlying performance or quality is discovered. The information/data used for this needs to be kept under review so that the correct information is collected and the quality of the data [for instance coding accuracy] is improved. Appropriate records should be maintained.	Yes/No
		To answer 'Yes':	

		• Information [including clinical outcomes] is routinely collected to monitor the quality of individual and team performance • An explanation is sought and recorded when outlying performance, activity or quality is discovered • The quality of the data used to monitor individual and team performance is reviewed [Guidance, 5.16] • Relevant information about the practitioner from other roles and organisations is available [Guidance, 5.17] • All routinely available information produced and collected by the organisation for monitoring should be shared with the doctor for inclusion in their portfolio • Appropriate records are maintained by the responsible officer of assessments [Regulation 11(2)(f)]	
	4.4	**There is a system for obtaining and collating patient and colleague feedback for all doctors which complies with GMC requirements [Guidance, 3.5, 5.18]** A patient and colleague feedback exercise using structured feedback questionnaires will need to be carried out for most doctors at least once in each five year revalidation cycle. Draft GMC guidance is currently available [see *'Revalidation: The Way Ahead. Annex 3 – GMC Principles, Criteria and Key Indicators for Colleague and Patient Questionnaires in Revalidation'* GMC, 2010] and it is anticipated that final guidance for this process will be agreed in 2011. Patient feedback will not apply to medical practitioners who have no direct patient contact but others may provide feedback in these circumstances [e.g. carers, parents, students, clients, customers, etc]. It will be important to track which doctors have received feedback on their patient and colleague questionnaires to ensure all doctors complete the exercise in each revalidation cycle. The system needs to be set up during 2011/12 and needs to be functioning before the end of 2012/13 to track those doctors who have completed the exercise. Feedback received from sources other than structured questionnaires should also be collated and shared with the doctor for inclusion in their portfolio.	Yes/No
		To answer 'Yes': • The designated body has a system in place for obtaining and collating patient and colleague feedback which complies with agreed GMC guidance • Before the end of 2012/13: numbers of doctors who have completed structured patient and colleague feedback exercise which is compliant with GMC guidance in last 5 years	
	4.5	**The designated body's medical or clinical audit activity covers the areas recommended in national guidance** This may not apply to all designated bodies but the majority will need to ensure their audit activity is appropriate and complies	Yes/No

		with national guidance relevant to their areas of medical work. The results of these audits should contribute to the monitoring of quality and performance and should be shared with the doctor for inclusion in their portfolio.	
		To answer 'Yes': • The audits performed by the designated body cover areas recommended in national guidance [for example from NCAAG, National Audits, NICE Guidance, etc] [Guidance, 4.25]	
	4.6	**End of 2012/13: The organisation monitors contributions to national clinical registries and patient safety reporting systems [including disease registries, surgical registries, drug reactions,]** This may not apply to every designated body but the majority of healthcare providers will need to address this area. Contributing to these registries and systems is a major means of improving patient safety and of improving knowledge and understanding of certain conditions. This is an organisational responsibility as well as an individual professional responsibility.	Yes/No
		To answer 'Yes': • Before the end of 2012/13, the designated body has a means of encouraging and monitoring reporting to the relevant registries and patient safety systems.	
	4.7	**There is a process in place for the responsible officer to ensure that key information [for example specified complaints, SUIs/significant events, outlying performance/clinical outcomes] is included in the appraisal portfolio and has been discussed in the appraisal so that development needs are identified [Regulations 11(3)]** It is important that issues and concerns about performance or conduct are addressed at the time they arise. Appraisal is usually not the most appropriate setting for dealing with concerns and in most cases these are dealt with outside the appraisal process in a clinical governance setting. Learning by individuals from such events is an important part of resolving concerns and whilst learning should be included in the clinical governance discussion, the appraisal meeting may be the appropriate setting to ensure this has occurred. The responsible officer may therefore wish to place an obligation on the doctor to include certain key items of supporting information in their portfolio and discuss specific issues or events with their appraiser so that development needs are identified and addressed. The responsible officer will also need to be able to check that this has happened, for instance by checking the PDP and summary of appraisal discussion to ensure the issue has been discussed and development needs have been identified.	Yes/No
		To answer 'Yes':	

		• There is a written description within the appraisal policy, of the process for placing an obligation on a doctor to include certain key items of supporting information in their portfolio • Medical practitioners are aware of the process and aware of their responsibility to include certain key items of supporting information in their portfolio • responsible officer has a system for checking after the appraisal that this has happened	
	4.8	**Information relating to all new doctors is obtained from the doctor's previous responsible officer and/or employing or contracting organisation [Regulations, 16(2)]** A system for obtaining information from each doctor's previous responsible officer and/or employing or contracting organisation will need to be in place and all new medical appointments will need to be included during 2011/12. The information will fall into two main categories: • 'Pre-employment information' or 'information regarding suitability for role'. This needs to be available to the responsible officer before the doctor starts work. This category includes references, qualifications and experience, current Responsible Officer, revalidation due date, GMC conditions or restrictions, etc. • 'responsible officer information' or 'fitness to practise information'. This information needs to be available to the responsible officer within 3 months of the doctor's starting date. This category includes records of appraisals, relevant performance monitoring information, records of all investigations, disciplinary procedures, conditions/restrictions and unresolved concerns.	Yes/No

		To answer 'Yes':
		• 'Pre-employment information' or 'information regarding suitability for role' needs to be available to the responsible officer for all new doctors before the doctor starts work. This category includes:
		  ○ References [Regulations 16(2)(b)]
		  ○ Qualifications and experience [Regulations 16(2)(a)]
		  ○ Verification of identity [Regulations 16(2)(c)]
		  ○ Gender and ethnicity data [to ensure fairness and equality] [Guidance 4.47, 6.9]
		  ○ Details of current responsible officer and Designated Body
		  ○ Revalidation due date and date of last appraisal	

		○ GMC conditions or restrictions [Regulations, 13(2)(d)] ○ Criminal Records Bureau checks [these fall in to this category but delays may prevent these being available to the responsible officer before the starting date in every case] • 'responsible officer information' or 'fitness to practise information' needs to be available to the responsible officer for all new doctors within 3 months of the doctor's starting date. This category includes: ○ Records of appraisals [Regulations, 11(f)] ○ Relevant performance monitoring information [Regulations, 16(3)(a)] ○ Records of patient and colleague feedback ○ Records of fitness to practise investigations, disciplinary procedures, conditions/restrictions and unresolved concerns [Regulations, 11(f)] • For primary care trusts, admission to the performers list is managed in accordance with the relevant regulations [Regulations 16(2)(d)] • Accurate records are maintained of all steps taken [Regulations 16(2)(e)]	
	4.9	**End of 2012/13: Exit reports for locums and temporary appointments are completed by the supervising consultant, doctor or another senior member of clinical staff for all doctors who have worked more than one week in the organisation** It is important that the clinical care locum doctors provide on behalf of the employing/contracting organisation is quality assured. Locum doctors may also need supervision. The organisation in which the care is delivered may ensure this is happening by completing exit reports. Exit reports from clinical attachments are also an important source of information for the locum's responsible officer who has a duty to monitor the performance and quality of their doctors. It is also important that locums have sufficient information relating to their clinical practice for their appraisal and revalidation portfolios. For GP locums, practices employing locums should be advised that their locums will be expecting to receive these reports and completing them will helpfully contribute towards the doctor's revalidation portfolio and also towards improving patient safety. GP locums should be encouraged to report if the practice does not comply with this advice.	Yes/No
		To answer 'Yes': • Before the end of 2012/13: ○ Information regarding the locum's responsible officer and designated body is obtained before they start work	

		○ An exit report [see Annex 5 for a sample report] is completed for all locums who have worked for the organisation for 5 days or more during the year. ○ The exit report is forwarded at the end of the attachment to both the locum and their responsible officer	
	4.10	**A process is established for the investigation of performance, conduct, health and fitness to practise concerns [Regulations, 11(2)(b)]** It is the responsibility of the responsible officer to respond appropriately when unacceptable variation in individual performance is identified or when concerns exist about the fitness to practise of medical practitioners with whom the designated body has a prescribed connection. The designated body should establish a procedure for initiating and managing investigations and appropriate records should be maintained.	Yes/No
		To answer 'Yes': • A description of this process is in place covering the following: ○ NCAS advice on good practice in investigation [Regulations, 18(b)] ○ Initiating, managing and concluding an investigation ○ Ensuring investigators are appropriately qualified [Regulations, 16(4)(a)] ○ Ensuring all relevant information is taken into account and that factors relating to performance, conduct, health and fitness to practise are considered [Regulations, 16(4)(c)] ○ Where appropriate, ensuring advice is taken from NCAS, GMC Employment Liaison Advisers, local expert resources, specialty and Royal College advisers, deaneries, etc [Guidance, 3.10] ○ Where appropriate, making a recommendation to the designated body that the medical practitioner should be suspended or have conditions or restrictions placed on their practice [Regulations, 16(4)(g)] ○ Where appropriate, taking any steps necessary to protect patients [Regulations, 16(4)(g)] ○ Ensuring that a medical practitioner who is subject to these procedures is kept informed about progress and that the medical practitioner's comments are taken into account where appropriate [Regulations, 16(4)(e)(f)] ○ Appropriate records are maintained by the responsible officer of all fitness to practise information [Regulation 13(2)(f)]	
	4.11	**A policy [with core content] for re-skilling, rehabilitation, remediation and targeted support is in place [Regulations, 16(4)(h)]**	Yes/No

		Guidance for Responsible Officers on the processes of rehabilitation, targeted support and remediation will be produced in 2011. The Responsible Officer Regulations outline the following responsibilities:
		• Ensuring that appropriate measures are taken to address concerns, including but not limited to:
		  ○ Requiring the medical practitioner to undergo training or retraining [Regulations, 16(4)(h)(i)]
		  ○ Offering rehabilitation services [Regulations, 16(4)(h)(ii)]
		  ○ Providing opportunities to increase the medical practitioner's work experience [Regulations, 16(4)(h) (iii)]
		  ○ Addressing any systemic issues within the Designated Body which may contribute to the concerns identified [Regulations, 16(4)(h)(iv)]
		• Ensuring that any necessary further monitoring of the practitioner's conduct, performance or fitness to practise is carried out [Regulations, 16(4)(d)]	

		To answer 'Yes': • A policy for remediation, rehabilitation and targeted support is in place which complies with the agreed guidance.	
	4.12	**Where a medical practitioner is subject to conditions imposed by, or undertakings agreed with, the GMC, the responsible officer monitors compliance with those conditions or undertakings [Regulations, 13(2)(d)]**	Yes/No
		To answer 'Yes': • A system is established which ensures compliance with GMC conditions or undertakings	
	4.13	**A description of the support available from the designated body for medical practitioners to keep their knowledge and skills up to date is in place** The doctor has the primary responsibility for keeping their knowledge and skills up to date. The Medical Royal Colleges and Faculties have responsibility for setting specialty standards for Continuing Professional Development. Designated bodies will have different levels of responsibility in this area, for instance designated bodies who directly employ their medical staff will have higher levels of responsibility than those where the relationship is one of contractor or agency. The principle is that the responsible officer should ensure that doctors are supported by the organisation in their efforts to keep their knowledge and skills up to date and to improve their performance and the quality of care they provide to patients [Guidance 4.15]. This may be part of a wider Education and Training strategy and involve providing study leave, mandatory training and access to learning and development but as a minimum should involve provision of information about relevant learning and development opportunities	Yes/No

		[many of which are available at postgraduate centres or can be negotiated at reduced or no cost] and provision of relevant training opportunities at minimum cost to participants where common development needs are found [for example training in resuscitation or child protection]	

		To answer 'Yes':
		• A written description of the support available from the designated body for medical practitioners to keep their knowledge and skills up to date is in place [this may be part of a wider Education and Training strategy] which includes:
		  ○ Provision of information about relevant learning and development opportunities
		  ○ Provision of opportunities for relevant essential training at low cost to doctors with whom the Designated Body has a prescribed connection where common development needs are found [for example training in resuscitation or child protection]	

	4.14	**Relevant appraisal, revalidation and human resources policies are fair and non-discriminatory [Guidance 4.47, 6.9]**	Yes/No
		To answer 'Yes': • Gender and ethnicity data is collected for all doctors for whom the designated body has a prescribed connection • Before the end of 2012/13: Equality Impact Assessment is performed for relevant policies in accordance with regulatory requirements	

Annex 1: Core elements of a job description for a responsible officer

The term 'medical practitioner' in this description refers to doctors with whom the designated body has a 'prescribed connection' under the Act.

The Job Description of the postholder includes the following core elements in relation to the responsible officer role:		
1	In relation to monitoring medical practitioners' conduct and performance, the responsible officer:	
	a	Reviews regularly the general performance and quality information held by the designated body including • routine performance data, activity data, quality indicators • complaints • significant events/significant untoward incidents [SUIs] • audit
	b	Ensures relevant information relating to all the medical practitioner's roles is available for monitoring fitness to practise and appraisal
	c	Maintains records of all fitness to practise evaluations, including appraisals, investigations and assessments
	d	Establishes a system for collating patient and colleague feedback for all doctors which complies with GMC requirements
2	In relation to appraisal, the responsible officer:	
	a	Ensures that the designated body maintains an appraisal system which complies with national guidance and requirements
	b	Ensures that medical practitioners undertake annual appraisals
	c	Ensures that appraisals take account of relevant information relating to all the medical practitioner's roles
3	In relation to responding to concerns, the responsible officer:	
	a	Responds appropriately when variation in individual performance is identified

	b	Takes any steps necessary to protect patients
	c	Establishes procedures to investigate concerns about the conduct, performance or fitness to practise of a medical practitioner
	d	Initiates investigations with appropriately qualified investigators and ensures that all relevant information is considered
	e	Recommends to the designated body where appropriate that the medical practitioner should be suspended or have conditions or restrictions placed on their practice
	f	Ensures that appropriate measures are taken to address concerns, including but not limited to: • requiring the medical practitioner to undergo training or retraining • offering rehabilitation services • providing opportunities to increase the medical practitioner's work experience • addressing any systemic issues within the Designated Body which may contribute to the concerns identified
	g	Ensures that any necessary further monitoring of the practitioner's conduct, performance or fitness to practise is carried out
	h	Ensures that a medical practitioner who is subject to these procedures is kept informed about progress and that the medical practitioner's comments are taken into account where appropriate
4	In relation to contracts of employment or contracts for the provision of services with medical practitioners, the responsible officer:	
	a	Ensures that medical practitioners have qualifications and experience appropriate for the work to be performed
	b	Ensures that appropriate references are obtained and checked
	c	Takes any steps necessary to verify the identity of medical practitioners
	d	Where the Designated Body is a primary care trust, manages admission to the Performers List in accordance with the regulations

	e	Maintains accurate records of all steps taken
	f	Transfers relevant information and records to a new responsible officer in a timely manner
5	In relation to communicating with the GMC, the responsible officer:	
	a	Co-operates with the GMC in carrying out its responsibilities
	b	Makes recommendations to the GMC about medical practitioners' fitness to practise taking all relevant information into account
	c	Where appropriate, refers concerns about the medical practitioner to the GMC
	d	Monitors a medical practitioner's compliance with conditions imposed by or undertakings agreed with the GMC
6	General	
	a	Governance and reporting responsibilities
	b	Indemnity arrangements for Responsible Officer

Annex 2: Suggested format of exception audit to identify reasons for all missed or incomplete appraisals

Results of exception audit to identify reasons for all missed or incomplete appraisals			**Numbers**
1	**Appraisee factors:**		
	a	Absence of appraisee at the end of the appraisal year [so not possible to rearrange within year] e.g. maternity/sickness leave	
	b	Incomplete portfolio or supporting information [GMC Guidance will be available in 2011]	
	c	PDP/Summary not signed by appraisee within 28 days of the appraisal meeting	
	d	Factors relating to lack of time of appraisee	
	e	Lack of engagement of appraisee	
	f	Other appraisee factors [description]	
2	**Appraiser factors:**		
	a	Unforeseen absence of appraiser at the end of the appraisal year [so not possible to rearrange within year]	
	b	PDP/Summary not signed by appraiser within 28 days of the appraisal meeting	
	c	Factors relating to lack of time of appraiser	
	d	Other appraiser factors [description]	
3	**Organisational factors:**		
	a	Administrative/management factors	
	b	Factors relating to function or failure of electronic portfolio or information system	

	c	Insufficient numbers of trained appraisers	
	d	Other organisational factors [description]	
4	**Recommendations:**		

Annex 3: Core content of medical appraisal policy

The medical appraisal policy covers the following:

- Objectives of medical appraisal [to include professional development, revalidation and where relevant, organisational development needs]
- Accountability, management, quality assurance and reporting arrangements for the appraisal system [to ensure accountability and enable consistent quality assurance processes, the responsible officer ensures that appraisals are carried out by the designated body [Regulations 13(3)]
- Description of appraisal process including timescales and deadlines
- The appraisal system must incorporate the standards in the GMC's Good Medical Practice Framework for Appraisal and Assessment and where appropriate comply with current official DH Appraisal Guidance
- Description of integration with quality improvement, clinical governance and performance monitoring systems [to include the transfer and sharing of information between these systems]. To include how collated development needs are used to inform organisational development activity
- Description of the relationship of appraisal to the job planning process [if appropriate]
- Arrangements [if appropriate] for Whole Practice Appraisal and Joint Appraisal for clinical academics with honorary contracts to comply with the Follett principles [see references]
- Principles of equality and fairness
- Responsibilities of:
    - Designated body
    - Responsible officer
    - Appraiser [and Appraisal Lead if appropriate]
    - Appraisee
- End of 2011/12: Description of essential supporting information requirements
- Confidentiality, security and access arrangements; electronic portfolio support [if appropriate]
- Feedback from participants about the appraisal system
- How specific situations will be dealt with:
    - Illness, secondment, absence, suspension
    - Missed or incomplete appraisals

  - Description of the process allowing the responsible officer to ensure that key information [for example specified complaints, SUIs/significant events, outlying performance/clinical outcomes] is included in the appraisal portfolio and has been discussed in the appraisal so that development needs are identified
  - Conflict of Interest, where appropriate ensuring common situations where a conflict may exist are covered, for example:
    - Personal or family relationships;
    - An appraiser and appraisee sharing close business or financial interests;
    - Reciprocal appraisal - where 2 doctors appraise each other;
    - An appraiser appraising a doctor who acts as their line manager in the same or a different organisation;
    - A responsible officer or a doctor's direct employer acting as their appraiser;
    - An appraiser receiving direct payment from an appraisee for performing the appraisal.
  - Risk of collusion/complacency between appraiser and appraisee [this can be minimised through appraiser training, ensuring two appraisers within the revalidation cycle, periodic joint appraisal, qualitative evaluation of appraisal outputs, etc]
  - Complaints about the appraiser or appraisal system
  - Significant concerns or patient safety issues arising within appraisal
- Selection, training and support of medical appraisers [see AQMAR, AQTMA]
  - Description of the selection process for appraisers
    - Required competencies
    - Probationary period or early review of skills [if applicable]
    - Person Specification contains the core elements described in Annex 3a
    - Job Description contains the core elements described in Annex 3b
  - Description of the training and development of appraisers
    - Description of initial training
    - Arrangements for access to leadership, support and ongoing development
    - Arrangements for performance review including feedback on performance in the role
- Description of indemnity arrangements for appraisers

Annex 3a: Medical appraisal policy: Core elements of a person specification for medical appraiser

The role of appraiser may be a stand-alone role or an integral part of a broader medical management role (e.g. clinical director, head of service). To ensure quality and consistency the person specification of medical appraisers should include core elements relating to the role of appraiser. The following is an example.

Core elements of a person specification for medical appraiser	
No distinction has been made between 'essential' and 'desirable' as the importance of each of these qualities should be determined in relation to the local context Probationary periods or provisional appointment subject to satisfactory completion of training and/or demonstration of competence should be described in the job description	
Qualifications	Medical Degree (plus any Postgraduate qualification required) GMC License to Practice Where appropriate, entry on GMC Specialist or General Practitioner Register For General Practitioners, entry on a Performers List
	Completion of Appraisal Training (this may not be a requirement prior to appointment but would need to be completed before appraisals are performed)
Experience	Has been subject to a minimum of 3 medical appraisals, not including those in training grades. (There may be unusual situations where this is not possible for example where medical appraisal has not occurred in the past in that organisation)
	Experience of managing own time to ensure deadlines are met
	Experience of applying principles of adult education or quality improvement
Knowledge	Knowledge of the role of appraiser

	Knowledge of the appraisal purpose and process and its links to revalidation Knowledge of educational techniques which are relevant to appraisal
	Knowledge of responsibilities of doctors as set out in Good Medical Practice Knowledge of relevant Royal College speciality standards and CPD guidance Understanding of equality and diversity, and data protection and confidentiality legislation and guidance
	Knowledge of the health sector [e.g. primary care, Secondary Care, Mental Health] in which appraisal duties are to be performed Knowledge of local and national healthcare context Knowledge of Evidence Based Medicine and clinical effectiveness
	Excellent integrity, personal effectiveness and self-awareness, with an ability to adapt behaviour to meet the needs of an appraisee Excellent oral communication skills – including active listening skills, the ability to understand and summarise a discussion, ask appropriate questions, provide constructive challenge and give effective feedback
Expertise, Skills and Aptitudes	Excellent written communication skills – including the ability to summarise a discussion clearly and accurately
	Objective evaluation skills
	Commitment to ongoing personal education and development
	Good working relationships with professional colleagues and stakeholders Ability to work effectively in a team
	Motivating, influencing and negotiating skills
	Adequate IT skills for the role

Annex 3b: Medical appraisal policy: Core elements of a job description for a medical appraiser

The role of appraiser may be a stand-alone role or an integral part of a broader medical management role (e.g. clinical director, head of service). To ensure quality and consistency the job description of medical appraisers should include core elements relating to the role of appraiser. The following is an example.

The job description of the postholder includes the following core elements in relation to the appraiser role:	
1	Description of key accountabilities for the role which include accountability to the responsible officer
2	Description of role and key responsibilities of appraiser
3	Undertake pre appraisal preparation and appraisal discussion in line with current local and national guidance and quality standards
4	Complete post appraisal documentation in line with current local and national guidance and quality standards
5	Duration of appointment as an appraiser (for example, description of arrangements for re-appointment or formal extension of contract every 3-5 years)
6	Maximum and minimum numbers of appraisals expected per year
7	Description of probationary period or provisional appointment subject to satisfactory evaluation/assessment after initial training
8	Requirement to attend initial training
9	Requirement to participate in ongoing training and support to address development needs in the role of appraiser
10	Requirement to participate in performance review in the role of appraiser
11	Requirement to participate in the management and administration of the appraisal system
12	Requirement to participate in arrangements for quality assurance of the appraisal system
13	Description of confidentiality of appraisal process and specific circumstances in which confidentiality should be breached

14	Indemnity arrangements for appraisers

Annex 4: Sample appraisee feedback questionnaire

Name of Organisation/Trust						
Name of appraisee		**Date of appraisal**				
Name of appraiser		**Duration of appraisal meeting**				
		Poor	**Borderline**	**Average**	**Good**	**Very good**
The organisation		1	2	3	4	5
The management of the appraisal system						
The access to the necessary supporting information						
Comments to help the organisation improve the process						
The appraiser						
Their preparation for my appraisal						
Their skill in conducting my appraisal						
Their skill in reviewing progress against last year's PDP						
Their skill in providing challenge to help me review my practice						
Comments to help your appraiser improve their skills						
The appraisal discussion						
The new PDP reflects my main priorities for development						
The appraisal was useful for my professional development						
The appraisal was useful in preparation for revalidation						
Comments to help improve the appraisal discussion						

Annex 5: Exit reports for locum appointments

Exit report for locum appointments. The completed report should be forwarded to the locum doctor and their Responsible Officer.		
1	**Details of locum doctor:**	Name GMC Number Contact details [email/phone]
2	**Details of locum agency [if appropriate]:**	Name of agency Contact details [email/phone]
3	**Details of the locum's responsible officer:**	Name Contact details [email/phone]
4	**Details of locum role performed:**	Title/grade/Specialty Dates Description of duties [if not standard for the role] Name/address of the trust/organisation
5	**Details of person completing the report:**	Name GMC Number [if appropriate] Title/Role Contact details [email/phone]
6	**The doctor's performance was:**	Unsatisfactory Borderline Satisfactory Good Excellent Please describe issues or concerns
7	**The doctor's conduct/behaviour was:**	Unsatisfactory Borderline Satisfactory Good Excellent Please describe issues or concerns
8	**Would you be happy for this doctor to be employed in the same role in the future:**	Yes/No If no, please describe reasons
Additional optional information:		

9	GMC Domain 1: Knowledge skills and performance	Unsatisfactory	Borderline	Satisfactory	Good	Excellent
10	GMC Domain 2: Safety and quality	Unsatisfactory	Borderline	Satisfactory	Good	Excellent
11	GMC Domain 3: Communication partnership and teamwork	Unsatisfactory	Borderline	Satisfactory	Good	Excellent
12	GMC Domain 4: Maintaining trust	Unsatisfactory	Borderline	Satisfactory	Good	Excellent