



A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement



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Annex D – Annual Board Report and Statement of Compliance.

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Contents

Introduction:	3
Designated Body Annual Board Report	5
Section 1 – General	5
Section 2 – Effective Appraisal	7
Section 3 – Recommendations to the GMC.....	8
Section 4 – Medical governance.....	9
Section 5 – Employment Checks	10
Section 6 – Summary of comments, and overall conclusion.....	10
Section 7 – Statement of Compliance.....	11

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance¹. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

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

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

- a) help the designated body in its pursuit of quality improvement,
- b) provide the necessary assurance to the higher-level responsible officer, and
- c) act as evidence for CQC inspections.

- **Statement of Compliance:**

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

Designated Body Annual Board Report

Section 1 – General:

The Medical Director and Executive management team of Liverpool Heart & Chest Hospital NHSFT can confirm that

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: 8th May 2019

Action from last year: Nil

Comments: Clarifications from Revalidation team with responses –

Do doctors within your organisation have a set appraisal month? The appraisal window is September to December each year with most being completed by end of October. The trust doctors however have their appraisals at the end of their attachment either six months or twelve months so quite variable. Some of the six month attachments may have had an appraisal within the previous twelve months but don't necessarily declare this until reminders have been issued. If so, were reminders timely? There are automatic reminders on the Allocate system and there is a weekly report of incomplete appraisals to myself and the Associate Medical Directors so prompting can take place.

Did the organisation instigate formal non participation policy? Not required. If, yes what action was taken? If no, what prompted participation? Reminders and prompting as above. Has there been a significant event review to explore why the programme did not prompt the doctors participation? No – not required.

Was there a trend amongst staff grade? (if numbers allow) Trust doctors as above due to timing.

Have all doctors since participated with appraisal? All doctors scheduled within the appraisal window have participated – in fact no individual has missed an appraisal completely. Some trust doctors awaiting end of attachment.

Action for next year: Address recording and timeliness

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

Action from last year: Nil

Comments: Yes

Action for next year: Nil

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

Yes

Action from last year: Nil

Comments: Time in job plans for appraisers. Good HR support. Funding of Allocate appraisal software and licences.

Action for next year: Nil

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

Action from last year: Nil

Comments: The RO reviews GMC Connect weekly. The lists are submitted to GMC Connect and updated regularly. All appraisal data is online with the Allocate system and is visible to the RO and relevant HR staff. Other data (including previous MAG forms) is held by HR and available on demand to the RO.

Action for next year: Nil

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

Action from last year: Nil

Comments: Yes. HR support team review at appropriate time in three year cycle and bring through various assurance committees including the LNC.

Action for next year: Nil

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: MIAA to audit appraisal and revalidation

Comments: Audit carried out in summer 2018 and report released in March 2019. Two areas for improvement noted. Appraisal training records incomplete and depth of narrative in the appraisal document variable. Refresher training now completed for all appraisers and records held in HR. This included appraiser guidance on extending the richness of narrative of PDP and summary. Guidance has been circulated to all staff undergoing appraisal to note the depth of narrative issues for next round of appraisal.

Action for next year: Review quality of appraisals internally

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another

organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Nil

Comments: All short term doctors (trainees, trust doctors and trust appointed locums) are assigned an educational supervisor who then determines their appraisal needs. All are entered on the appraisal system and where required appraisal carried out toward the end of attachment. Those who revalidate during their period attached to this DB go through the same process as full time staff.

Action for next year: Continue

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: Nil

Comments: Yes. All roles including work in other organisations are covered. Performance, complaints and significant events are described and discussed.

Action for next year: Nil

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

Action from last year: Nil

Comments: N/A

Action for next year: Nil

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

Action from last year: Nil

Comments: Yes – updated and reviewed September 2018

Action for next year: Nil

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

Action from last year: Nil

Comments: 34 appraisers for 123 doctors

Action for next year:

5. Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers² or equivalent).

Action from last year: Update training and training records

Comments: Update training delivered 26th April 2019. Two new appraisers going on new appraiser course. Feedback requested routinely and given to appraisers when obtained.

Action for next year: Nil

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

Action from last year: MIAA audit

Comments: Yes audit shared through assurance committee to Board of Directors

Action for next year: Nil

Section 3 – Recommendations to the GMC

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

Action from last year: Nil

Comments: Yes

Action for next year: Nil

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Nil

Comments: Yes. Very few deferrals other than some new appointees or if personal circumstances delay appraisal process.

Action for next year: Nil

² <http://www.england.nhs.uk/revalidation/ro/app-syst/>

² Doctors with a prescribed connection to the designated body on the date of reporting.

Section 4 – Medical governance

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

Action from last year: Nil

Comments: Yes

Action for next year: Nil

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

Action from last year: Nil

Comments: Yes. Local and national performance data – monitoring of outcomes/performance. Peer and patient 360 feedback. Teaching feedback, educational appraisal, CPD monitoring. Full scope of practice appraised. Strong trust support for FTSU, HALT and SOS. Complaints and observations are discussed at appraisal with appropriate reflection requested.

Action for next year: Nil

3. There is a process established for responding to concerns about any licensed medical practitioner's¹ fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Nil

Comments: Yes, Local policies and MHPS. Regular communication with GMC ELA.

Action for next year: Nil

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors³.

Action from last year: Nil

⁴This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

Comments: Yes. Monthly report to Board of Directors of any performance issues or disciplinary processes.

Action for next year: Nil

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation⁴.

Action from last year: Nil

Comments: Yes. MPIT forms completed. Significant information shared with new organisations as appropriate.

Action for next year: Nil

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

Action from last year: Nil

Comments: Equality and Inclusion policy supports an open culture and focusses on reducing bias. BAME group for all staff meets regularly chaired by an associate specialist doctor. Organisation rapidly responds to reports of discrimination and bias.

Action for next year: Continue work to reduce bias

Section 5 – Employment Checks

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

Action from last year: Nil

Comments: Comprehensive HR process of background checks

Action for next year: Nil

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

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

The actions from last year related to the MIAA external audit of appraisal and revalidation. Actions have been carried out including appraiser training and improving the quality of appraisals.

Overall conclusion: A robust process is in place to manage appraisal and revalidation. Reporting and governance is a strength.

Section 7 – Statement of Compliance:

The Medical Director and Executive management team of Liverpool Heart & Chest Hospital NHSFT has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Chief Executive

Official name of designated body: LHCH NHSFT

Name: Ms Jane Tomkinson

Role: CEO

Date: 6th August 2019

Signed: 