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Medical Practitioners Assurance Framework
Registered Managers Training - Leeds

Hashtag: #MPAFLEEDS

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www.ihpn.org.uk

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Context of the MPAF - 2018

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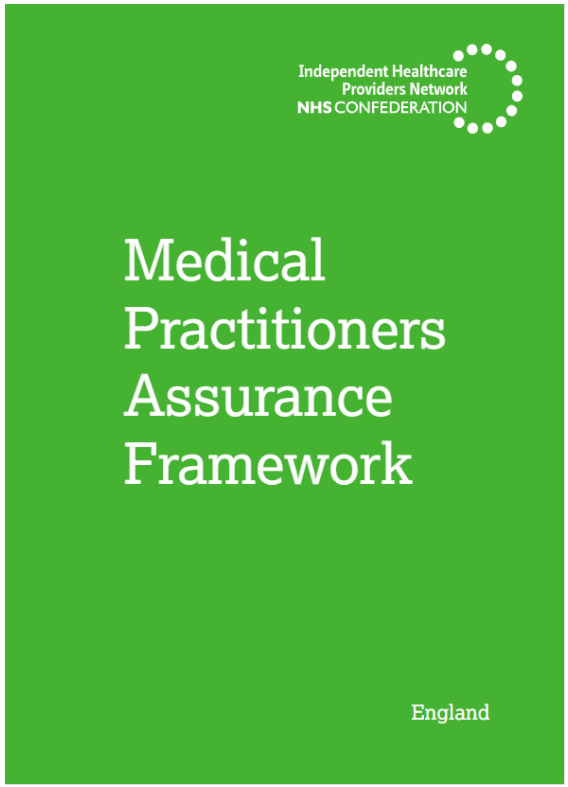
Ambition of the MPAF

- Seeks to drive patient safety and quality through the Kings Fund's Three Lines of Defence approach.
- Recognises the need to work together as a joined up "whole healthcare system" – interdependencies exist.
- Asks "What is the problem we're trying to solve?" in each section.
- Sets out responsibilities for medical practitioners and providers.



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Scope of the MPAF

The MPAF applies to all medical practitioners working in independent healthcare settings through practising privileges or on an employed basis.

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Application of the MPAF

"One size will not fit all" and the MPAF recognises that organisations have different structures.

Providers should be able to demonstrate how their individual systems and processes meet the expectations of the MPAF. The framework does not require providers to replace structures.

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Regulatory Alignment

- MPAF is designed to fit with existing legal and regulatory frameworks, notably:

  - GMC's Good Medical Practice
  - Responsible Officer Regulations
  - CQC's Well led Key Line of Enquiry

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CQC's response to the MPAF

- When launched, CQC formally welcomed the MPAF:

"This framework is a welcome development and an important step forward in addressing the need for stronger medical governance across the independent sector.

While sign up to the framework is not mandatory or something CQC has the power to enforce, where providers can demonstrate effective and robust implementation of its principles, this will be considered as evidence of good governance and will inform the judgement we make about how well led services being provided by that organisation are."

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The Ian Paterson Inquiry report

Bishop James described the "wickedness" and "callousness" faced by Paterson's victims

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What the Paterson report says about the MPAF

"…our view is that, while [the MPAF] is welcome, much of it appears to be voluntary and is currently untested."

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CQC's response to the Paterson Report

CQC's response to the Paterson Inquiry report:

"[The MPAF] is one clear way that independent hospitals can demonstrate the robust governance processes we expect to see when we inspect and will help improve information exchange between private and NHS services. Our wider engagement with the sector has also set clear expectations for quality and safety."

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Government's response to the Paterson Report

Department of Health & Social Care

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IHPN Medical Practitioners Assurance Framework (MPAF)
Video Input from Sir Bruce Keogh

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Creating an effective clinical governance structure for medical practitioners
Section 1

#MPAFLEEDS

Spire Healthcare

Medical Practitioners Assurance Framework

27th February 2020

Andy Eadsforth
Hospital Director
Spire Manchester Hospital

Three questions to start…

1. Who has read the Paterson report?
2. Who has read the MPAF?
3. Who is completely confident that their systems of governance would prevent another Paterson?

Exercising Consultant Oversight with imperfect systems!

The questions I wrestle with when I start somewhere new…

- How many Responsible Officers do your doctors have connections with?
- Do your local Trusts know which of their doctors do private practice? How?
- Who reads your consultants' appraisals? What do they look for? How do you assure yourself that it has been a 'full practice' appraisal?
- When did you last meet the RO for the trusts with whom you share doctors? What did you discuss?
- How do you know that your doctors are only doing things they are trained / experienced to do?
- Do you know which doctors would not be chosen by your own teams for their treatment?
- Does your hospital / organisation have a culture of sharing soft intelligence – how do you know?

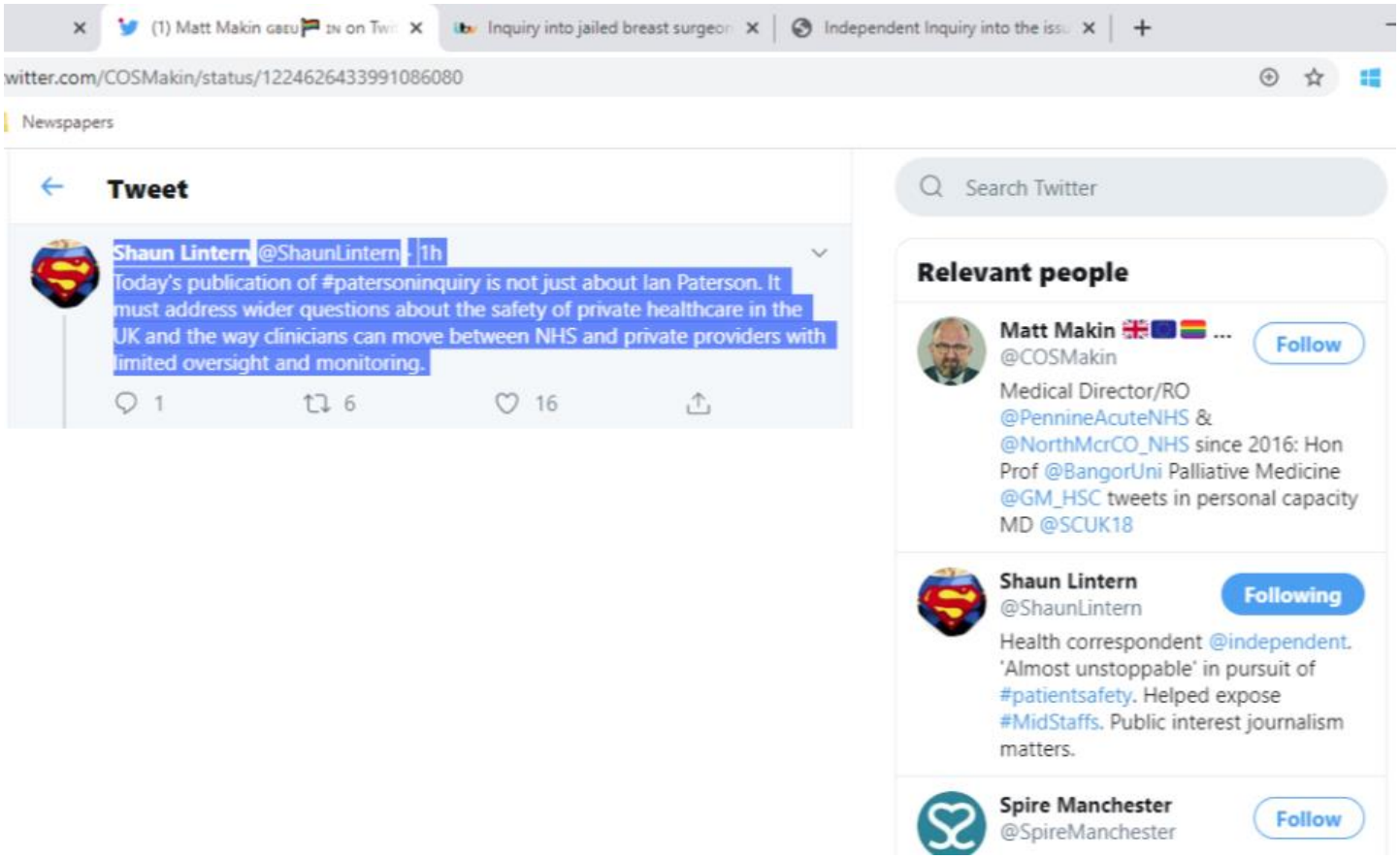
Some simple tips for improving oversight (1)

- I ask colleagues who they wouldn't be treated by and why? Particularly if you're new to the organisation.
- Amended our PP spreadsheet to capture every doctor's RO.
- Provide a list of all doctors with PP's to each Responsible Officer on a quarterly basis.
- Develop an info sharing arrangement with those NHS Trusts with whom you share consultants. Communicate this to all the Medical Society for clarity and legitimacy.
- Consultant inductions which make clear:
  - Their appraisal **must** mention Private Practice and if not it will be rejected and PP's suspended and the appraisal must be shared in sufficient detail for us to to confirm this
  - If they want to do anything that they don't do in the NHS they must speak to us first, failure to do so will result in suspension of PP's
  - Information will be shared openly and freely if we feel it's necessary to do so (the 'information of note' threshold)

Some simple tips for improving oversight (2)

- Either HD or Matron read every appraisal and sign to say we've read it. If there's something we know about which is not in there then we reject it
- Don't underestimate soft intelligence to identify a problem – and make sure that you feed back to your staff to perpetuate the behaviour
- Cultivate a climate in which people ask questions and spot unusual requests
- Consultant concerns are discussed openly and on a named basis at the MAC meetings and a redacted version of the minutes detailing the concern but removing the PID are circulated to all the Medical Society.

We have had some success in our processes being recognised…



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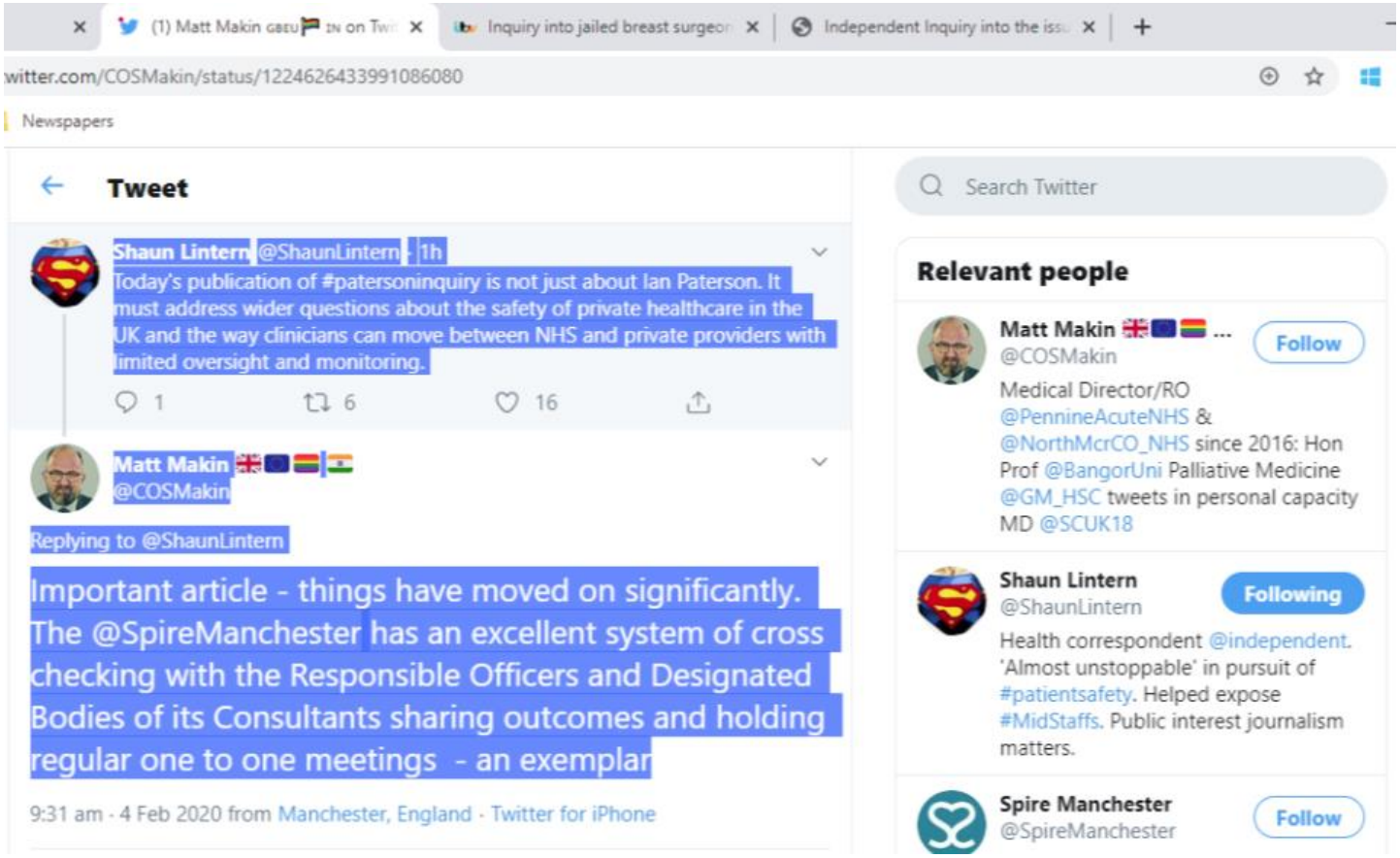

CQC Feedback…

"the hospital had been invited to attend a neighbouring trusts Medical Oversight Group which was established by the responsible officers of the local NHS trust. *This supported a joined up approach to working between the two hospitals."*

"The hospital medical advisory committee liaised with the responsible officer for the local NHS trust regarding consultants working under practicing privileges. *The information shared with the responsible officer was considered during the revalidation and appraisal process."*

"The medical advisory committee reviewed each consultant that held practising privileges every year to ensure that their private work conducted at the hospital has been discussed with their NHS responsible officer. The hospital director also had links to the responsible officers of the consultants holding practising privileges."

Spire Manchester CQC Report, 2019

Some interesting reflections on Paterson…

1. People are reluctant to disbelieve the highly trained. These specialists have undergone years of training. Questioning them would require more knowledge than most of us have.
2. A confident, crowd-pleasing manner goes a long way. But pay attention if those charming types turn nasty when challenged.
3. When problems start to appear, it is tempting to avoid seeing them rather than taking action. Managers do not always interrogate data well, but instead seem to look for patterns which reassure rather than disturb.
4. The responsibility for connecting the dots and taking action rests with those at the top. When problems emerge, they need to ask questions. One of the most striking elements of the Paterson case was the lack of curiosity by those in charge.

Opinion Piece, Financial Times, 11th February 2020

So what are the answers?

- Connectivity…across the system to help spot problems emerging early
- Inquisitiveness and curiosity…right throughout the organisation
- Transparency and openness…with the consultants, with the MAC, with the RO's and with other healthcare organisations (NHS and independent).
- A healthy skepticism…
- Confidence to grasp the nettle early and nudge the bar a little higher than it is perhaps at present

Support from the MAC

Tim Justin

Consultant General / Colorectal Surgeon & Chairman of MAC

Requirements for Medical Advisory Committees

No statutory role

Can be chosen as part of governance structure to access medical advice on professional and clinical issues. Attended by ED and DCS

To help provide a safe and secure clinical environment in the hospital, to maximise the prospects of successful clinical outcomes for all patients

Composed of individual consultants representing their subspecialties, with Chair appointed by ED. Voluntary position.

In my hospital the Chair is also “Responsible Clinician” who take responsibility for supporting clinical governance and sits on hospital Clinical Governance Committee

To communicate with Consultants any relevant information, including key clinical policies and procedures and decisions from committee meetings. Also seek view of colleagues on matters of concern or interest to them and report to MAC

For the avoidance of doubt, the ED of the hospital is not bound to follow the recommendations of the committee

History

Private Practice was seen as environment when could escape perceived NHS interference, providing optimal clinical care with adequate time, less restriction on resources and private providers role was to facilitate this care

MAC's had "Gentleman's club ethos" but "governance" existed at local level

Practitioners were not identified as a problem

But times change

History

- Finished my first 4 year stint as MAC Chair in 2015
- During Annual Dinner I made comment that, of specialties represented on that MAC during my period in office, one third of the consultants had undergone GMC investigations of some sort.
- I don't believe this was as a result of significant drop in clinical standards – frequently other non-clinical agendas in play

MAC and Hospital Director

- Probably over-investigate events in private sector
- Almost certainly don't have a Paterson
- Issue is demonstrating this to external regulators and "sleeping peacefully at night"
- Don't require more regulation "hiding in plain sight"
- Likely clinical governance structures are sufficient but are you using the MAC to answer specific issues?
- MAC provides insight into local medical politics
- Is MAC Chair involved in communication with local providers?

- Get MAC specialty rep to check scope of practice of all their consultants – incorporate into MAC meeting – annually?
- Get speciality reps to present consultant data from any national databases for review at MAC meeting
- MDT working
  - – check histology lab "cancer diagnoses" and ensure get monthly report to check referral to appropriate MDT's
  - Do same for radiology – "code for cancers"

Key to MAC Chair Relationship

Ensure you can work together

Provide vital medical knowledge

(nurses and doctors use different approaches to issues!)

Ability to challenge

Not subject to corporate agenda

Lack personal agenda

NHS management experience helpful

Ensure they identify their role

Colleague credibility

Pitfalls

- Personal agenda
  - Biggest earners – increased likelihood
  - Protection
- No ultimate responsibility
- Voluntary role in many cases ?help or hinderance
- Increasing surveillance linked to often deficient data systems and mistakes appear common!

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Table Discussions – Section 1

- What are your biggest challenges around clinical governance structures for medical practitioners and how do you think the MPAF will help you deal with them?
- Areas to consider:
- Practising privileges
- Scope of practice
- New procedures and treatments
- Medical Advisory Committees

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Raising and Responding to concerns
Section 4

#MPAFLEEDS

What NHS Resolution can do for you

Independent Healthcare Providers Network

MPAF Registered Manager Training

Vicky Voller, Director of Advice & Appeals

Objectives

- Role of NHS Resolution
- Learning from our experience
- Relevance to the independent sector
- Case study

A bit about us…

The genesis of NHS Resolution

- **Formerly the NHS Litigation Authority** (NHS LA) – joined by the National Clinical Assessment Service and the Family Health Services Appeal Unit, functions brought together by successive arm's length body reviews.
- **Established in 1995** to bring expertise and economies of scale to the management of compensation claims against the NHS in England and to pool the risk of such claims.
- **Changed our name in 2017** and brought together functions under a shared purpose and strategy.

NHS Resolution

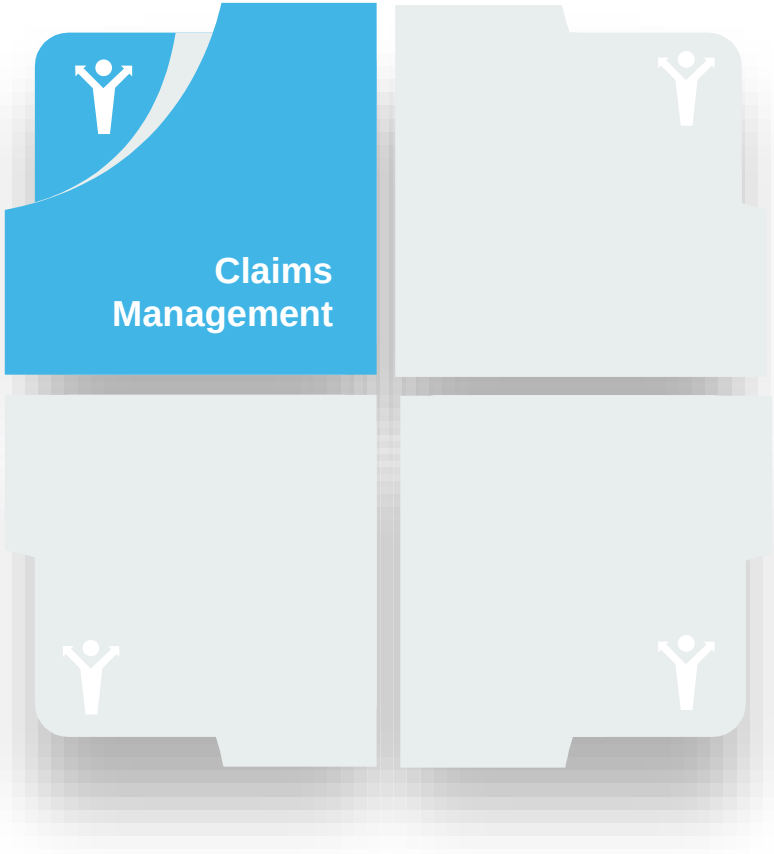
Primary Care Appeals

Ensures the prompt and fair resolution of appeals and disputes between primary care contractors and NHS England. Primary care contractors include GPs, dentists, opticians and pharmacists.

Pharmacy/dispensing appeals
GP, Dental and Ophthalmic contract disputes;
Payments to GPs and Dentists whilst suspended;
Withdrawal from the National Performers List;
Sale of Goodwill; and
Trainee GP Salary Assessments

Claims Management

Providing indemnity schemes to the NHS in England and resolving claims for compensation fairly



Clinical
Clinical negligence scheme for trusts (CNST)
Clinical negligence scheme for general practice (CNSGP)
Existing liabilities schemes (DHSC)

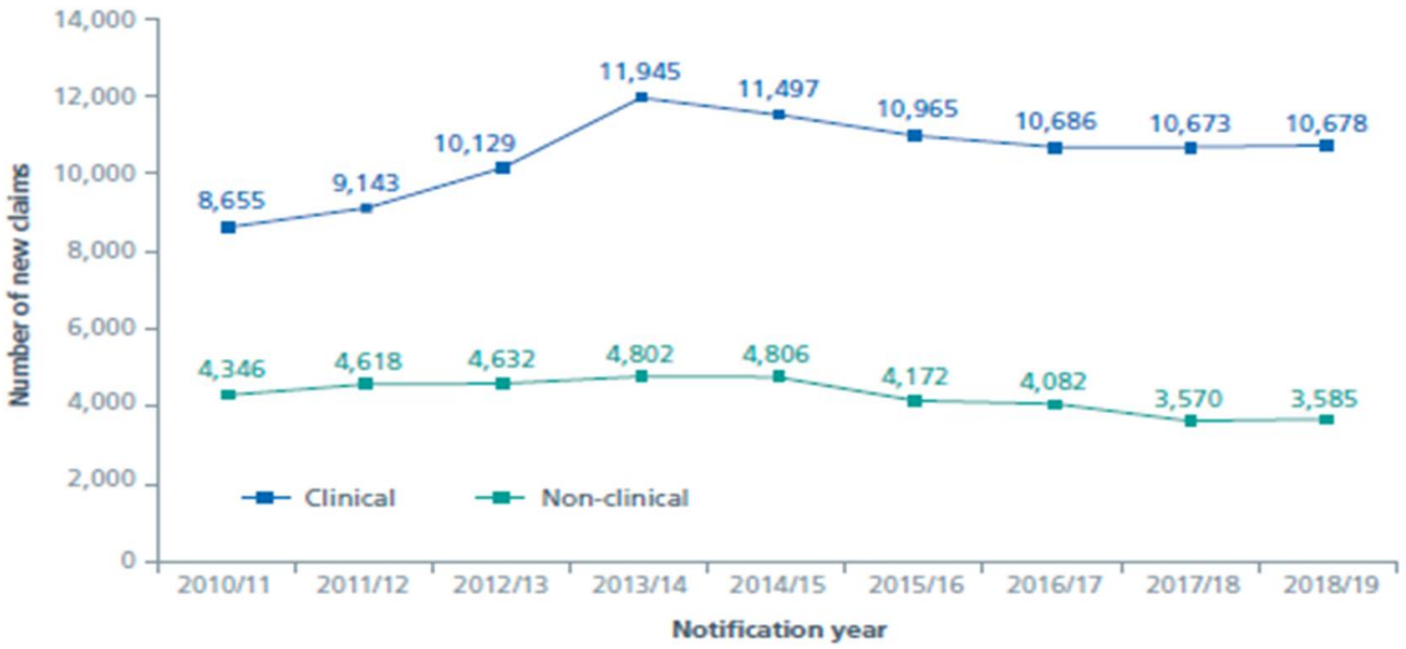
Non Clinical
Property expenses schemes (PES)
Liabilities to third parties scheme (LTPS) .

Claims Management

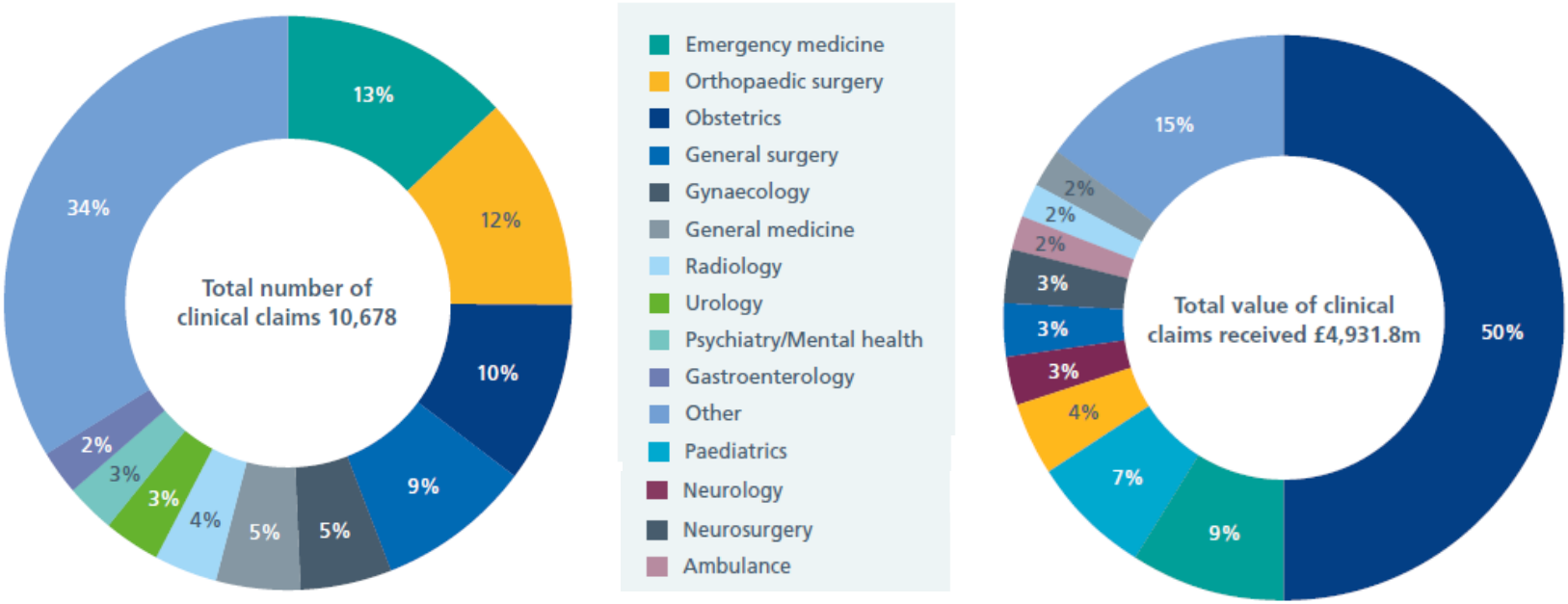
- NHS Resolution claims database
  - 100% claimant derived data on harm
- Significant human cost, to patients, staff and public
- Additional costs to the NHS system and to society
- £2.4 billion NHS funding 2018/19
  - spent as a result of harm
- Liabilities of £83 billion in 2019

Claims in England

Figure 2: The number of new clinical and non-clinical claims reported in each financial year from 2010/11 to 2018/19



Claims volume and value in 2018/19

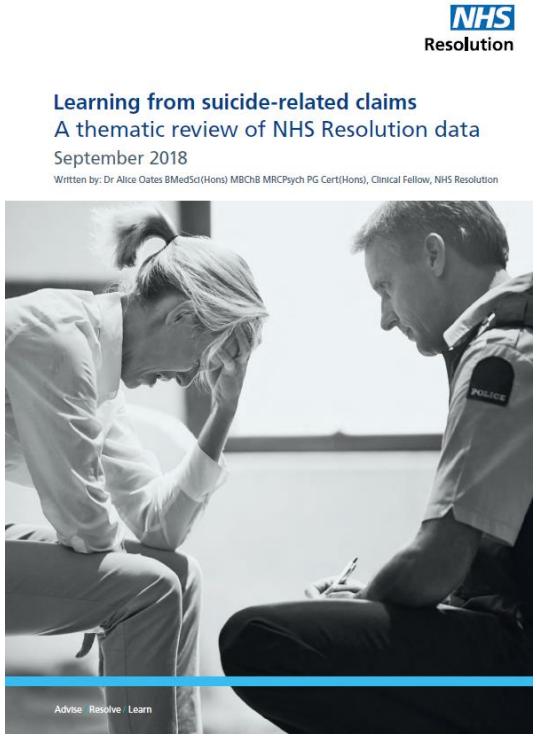


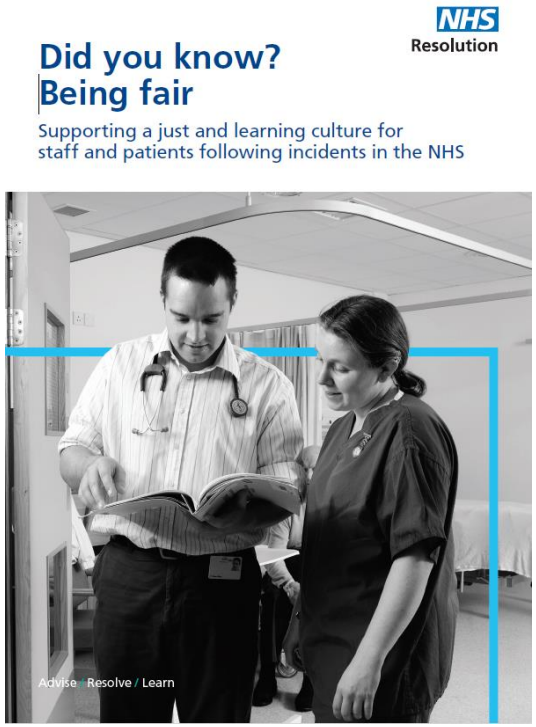
Safety and Learning

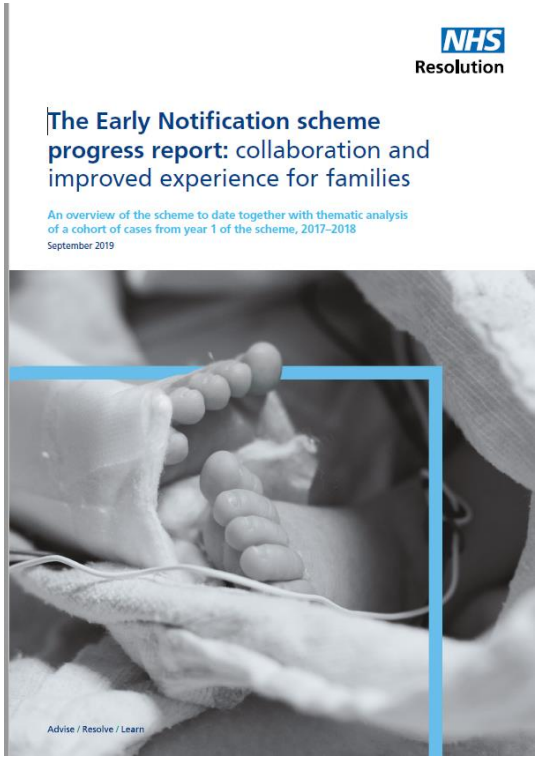
Learning lessons in maternity
Early notification scheme
Insights from assault cases
Being fair
Learning from suicide related claims

Supports our Claims Management service members to better understand their claims risk profiles to target their safety activity while sharing learning across the system

Our publications







Scorecards

- Quality improvement tool
- Ten years of claims data
- Open and closed claims
- Updated annually
- Supports thematic analysis

Scorecard guide **www.tinyurl.com/ybz6s5jk**

Practitioner Performance Advice

Advice

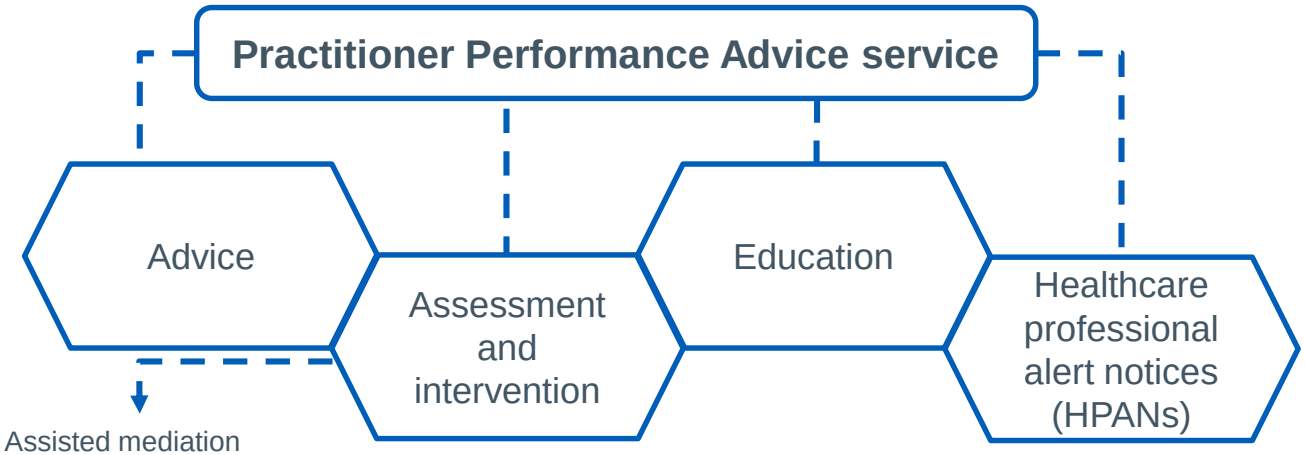
Assessment and intervention

Education

Healthcare professional alert notices (HPANs)

Supporting the resolution of performance concerns of individual doctors, dentists and pharmacists

How we support resolution of concerns



Assisted mediation
Behavioural assessments
Clinical performance assessments
Professional support and remediation
Team reviews

www.resolution.nhs.uk/services/practitioner-performance-advice/

Advice

- Free to NHS bodies and no threshold to contacting us
- Around 1000 requests a year
- Adviser team are senior staff with backgrounds in clinical, human resources and legal professions
- Advisers are aligned to specific healthcare organisations and NHS regions across England, Northern Ireland and Wales

www.resolution.nhs.uk/practitioner-performance-advisers/

When to call Advice

- Whenever you want advice
- If you have to – i.e. if you are considering capability proceedings under *Maintaining High Professional Standards in the modern NHS* (MHPS)
- If you are considering exclusion
- If you are requesting a HPAN

HPANS

A system where notices are issued by NHS Resolution at the request of employers, to inform NHS bodies of health professionals (or individuals posing as a health professional) who:

- Poses a significant risk of harm to patients, staff or the public;
- May continue to work or seek additional or other work in the NHS as a healthcare professional.

(National Health Service Litigation Authority (Amendment) Directions 2019)

HPANS

- England only and applies to all registered healthcare professionals
- Usually interim action pending regulator decision
- Used as a pre-employment check (you can still employ but knowing there has been an issue)
- Employer or contracting body notifies us, decision making group decide and cascade
- Reviewed at least every three months
- Around 20 active at any time

How do you request an HPAN?

- Go to our website: www.resolution.nhs.uk/services/practitioner-performance-advice/hpans/
- Download and complete the HPAN checklist and confirm the healthcare professional:
  - Poses a significant risk of harm to patients, staff or the public; and
  - May continue to work or seek additional or other work in the NHS as a healthcare professional; and
  - That there is a pressing need to issue an alert notice.
- Ensure you have made a referral to the Regulator
- Email the completed form to: hpan@resolution.nhs.uk
- Note: we may contact requester for additional information before making decision

How do you check a HPAN?

- NHS Resolution Performers Lists Regulations and HPAN web check service
- Email: hpan@resolution.nhs.uk

Education

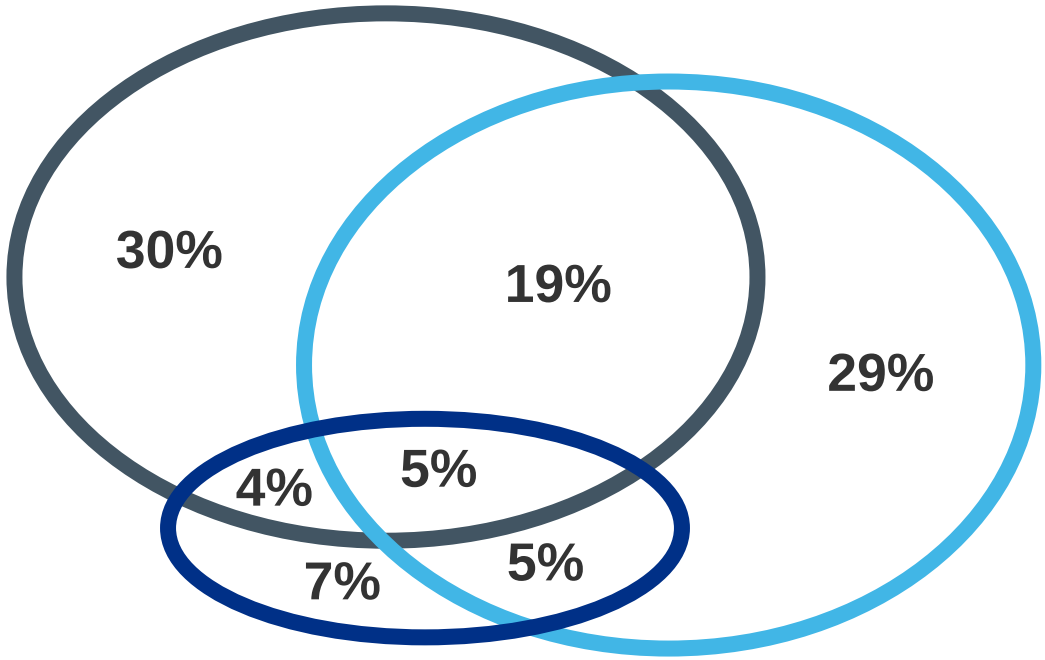
- Case investigator training: two-day workshop
- Case manager training: one-day workshop
- Half-day MHPS overview
- Bespoke workshops
- Safety and Learning events
- Contributors to events
- Action learning circles for case managers and case investigators
- Public dates, prices and booking form available on the NHS Resolution website

What have we learnt?

Where do concerns come from?

Categorisation of concerns

58% categorised as behaviour /misconduct

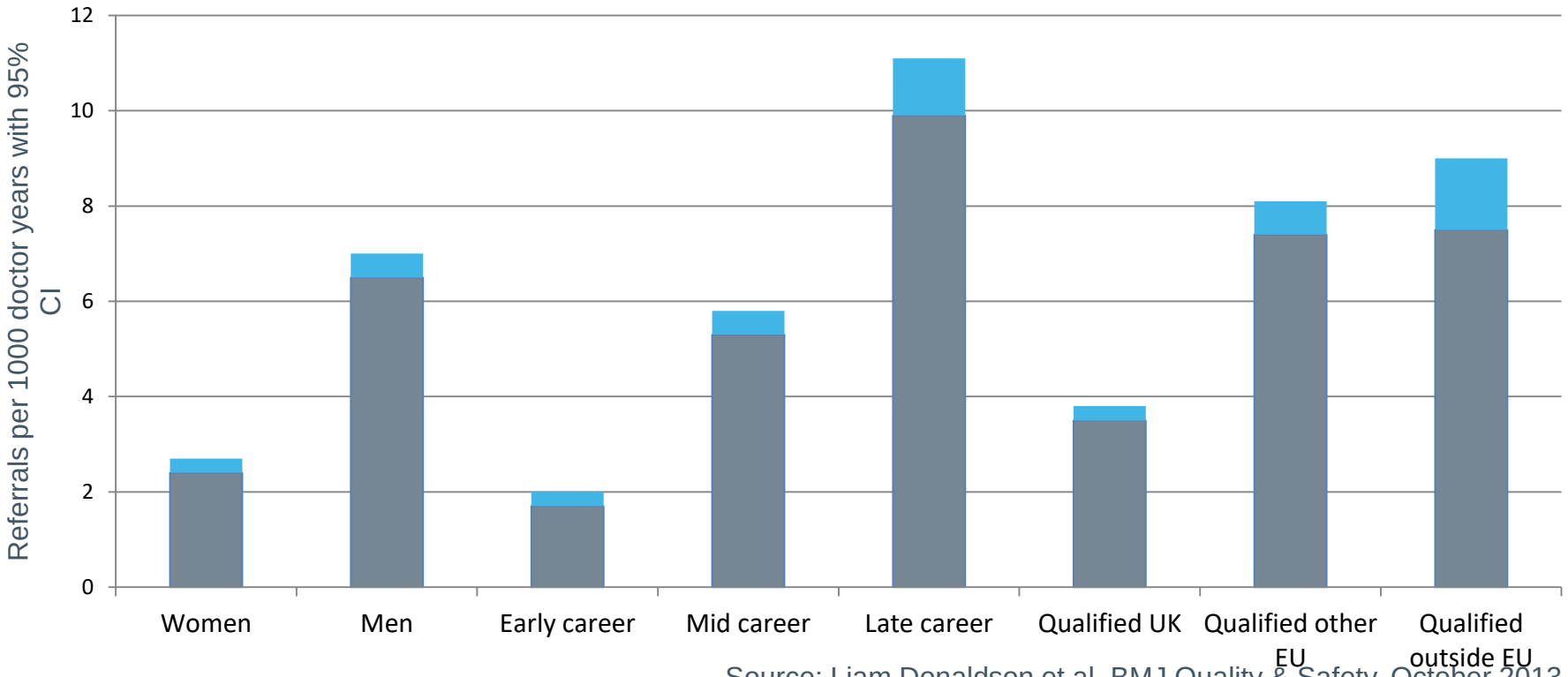


58% categorised as clinical including governance/ safety

21% categorised as health concerns

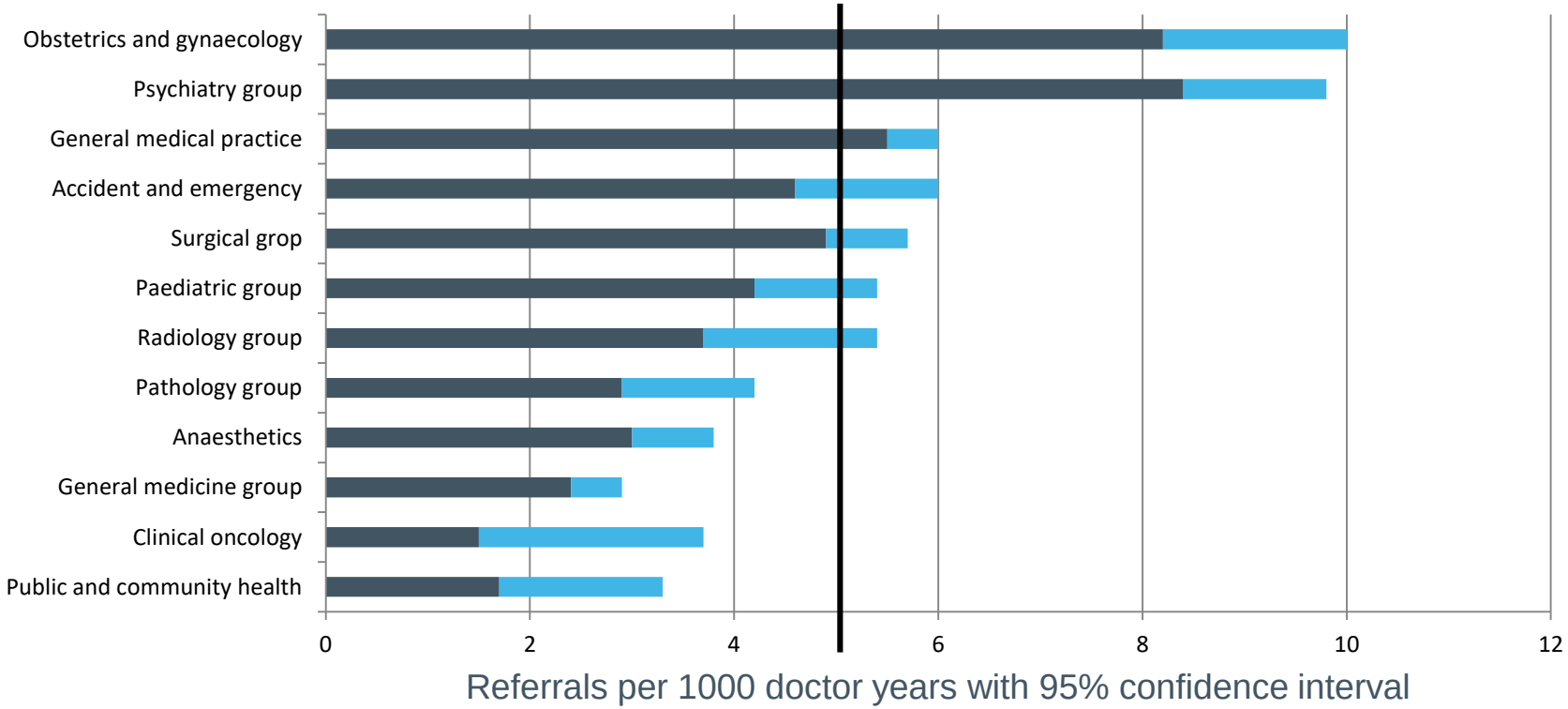
5634 cases requested for advice and support to us Dec 2007 – Sept 2013

Requests for advice and/or support



Source: Liam Donaldson et al, BMJ Quality & Safety, October 2013

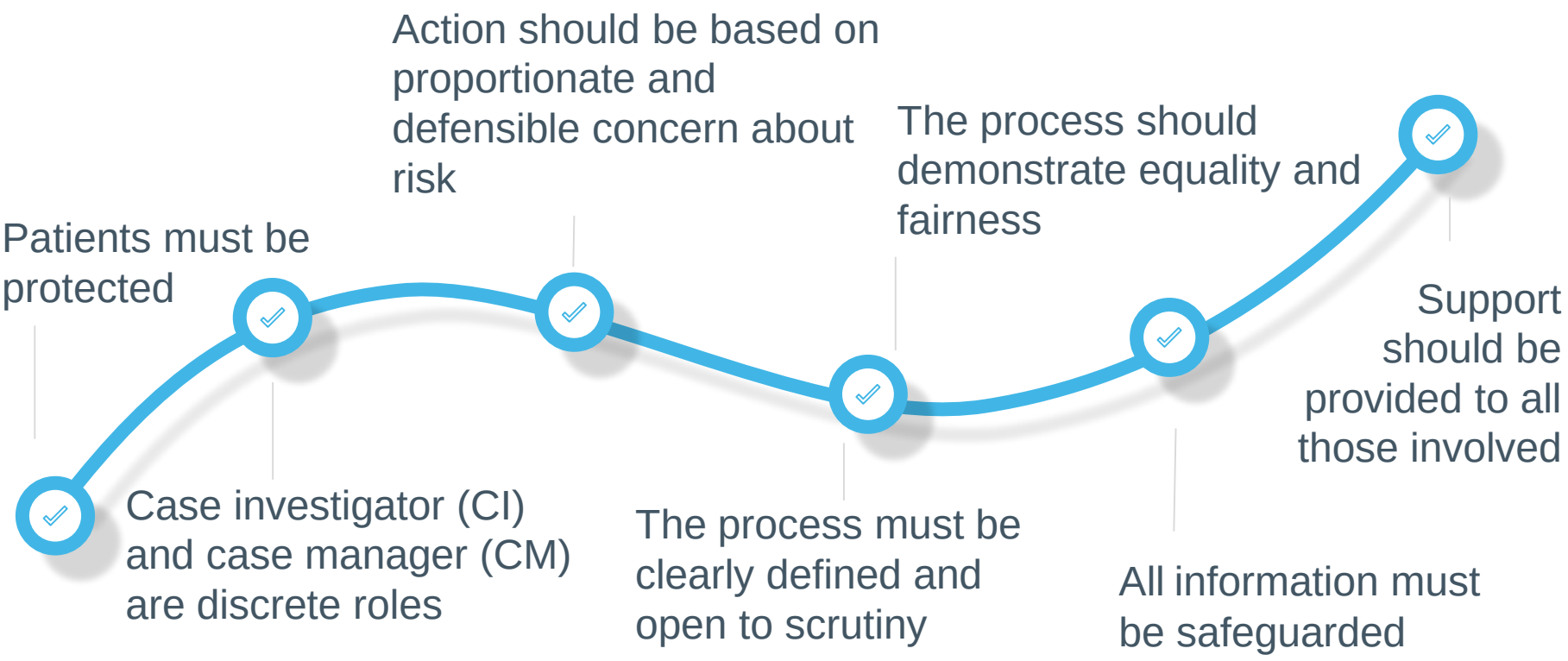
Requests for advice and/or support



Referrals per 1000 doctor years with 95% confidence interval

Source: Liam Donaldson et al, BMJ Quality & Safety, October 2013

Framework common principles



Key question

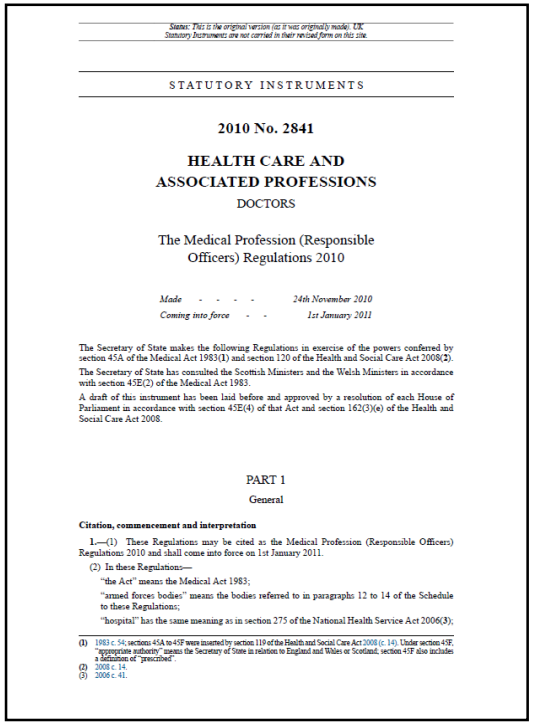
If there are concerns raised about a doctor, how can you distinguish between:

- A doctor in difficulty
- A doctor with difficulties
- A difficult doctor

How is the independent sector different?

- Sitting outside NHS governance arrangements
- Often not the primary employer
- Unsighted on activity/concerns/actions elsewhere
- Outsourced support functions

What helps?



Status: This is the original version (as it was originally made). UK Statutory Instruments are not carried in their revised form on this site.

STATUTORY INSTRUMENTS

2010 No. 2841

HEALTH CARE AND ASSOCIATED PROFESSIONS

DOCTORS

The Medical Profession (Responsible Officers) Regulations 2010

Made - - - - 24th November 2010
Coming into force - - 1st January 2011

The Secretary of State makes the following Regulations in exercise of the powers conferred by section 45A of the Medical Act 1983(1) and section 120 of the Health and Social Care Act 2008(2).

The Secretary of State has consulted the Scottish Ministers and the Welsh Ministers in accordance with section 45E(2) of the Medical Act 1983.

A draft of this instrument has been laid before and approved by a resolution of each House of Parliament in accordance with section 45E(4) of that Act and section 162(3)(e) of the Health and Social Care Act 2008.

PART 1

General

Citation, commencement and interpretation

1.—(1) These Regulations may be cited as the Medical Profession (Responsible Officers) Regulations 2010 and shall come into force on 1st January 2011.

(2) In these Regulations—

"the Act" means the Medical Act 1983;

"armed forces bodies" means the bodies referred to in paragraphs 12 to 14 of the Schedule to these Regulations;

"hospital" has the same meaning as in section 275 of the National Health Service Act 2006(3);

(1) 1983 c. 54; sections 45A to 45F were inserted by section 119 of the Health and Social Care Act 2008 (c. 14). Under section 45F, "appropriate authority" means the Secretary of State in relation to England and Wales or Scotland; section 45F also includes a definition of "prescribed".
(2) 2008 c. 14.
(3) 2006 c. 41.

The Acute Data Alignment Programme (ADAPt)

Aims to integrate data on privately funded healthcare into NHS systems and standards for the first time

What can we learn from Paterson?

- Patient safety is the priority
- Use a process
- Know which process you are in
- Understand and record your rationale for all decisions
- Review the case and your decisions regularly, preferably through a decision making group
- Different people may need a different approach but not a different process

Contact Practitioner Performance Advice

020 7811 2600

advice@resolution.nhs.uk

NHS Resolution
2nd Floor,
151 Buckingham Palace Road, London,
SW1W 9SZ

Events team:

020 7811 2801

events@resolution.nhs.uk

@NHSResolution

www.resolution.nhs.uk

Case study

Mr Violet

- At your tables…

- What actions do you think the RO should take in response to the information from Mr Green?
- Do you think the appraisal was satisfactory?

- *One person from each table to feed back after 15minutes*

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Monitoring patient safety, clinical quality and encouraging continuous improvement Section 2

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Objectives of a Consultant Information Sharing System

- To establish where consultants are working – both NHS and independent sector
- Set out a self-declared Scope of Practice visible to all providers where the consultant works
- Improve RO to RO communication across and within sectors re consultants PP status and NHS employment status
- Make PP administration more streamlined and efficient for consultants and providers

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What the Paterson Inquiry recommends

"We recommend that there should be a single repository of the whole practice of consultants across England, setting out their practising privileges and other critical consultant performance data, for example, how many times a consultant has performed a particular procedure and how recently. This should be accessible and understandable to the public. It should be mandated for use by managers and healthcare professionals in both the NHS and independent sector."

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Sector wide Data Transparency and Alignment

GIRFT
GETTING IT RIGHT FIRST TIME

HQIP
Healthcare Quality Improvement Partnership

PHIN + NHS Digital =

The Acute Data Alignment Programme (ADAPt)

Independent Healthcare Providers Network
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Table Discussion – Section 2

What are the main ways you assure yourself that consultants are engaging in continuous quality improvement?

- Areas to consider:
- Peer review
- MDT working
- Submissions to audits and registries
- Duty of candour

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Supporting whole practice appraisal
Section 3

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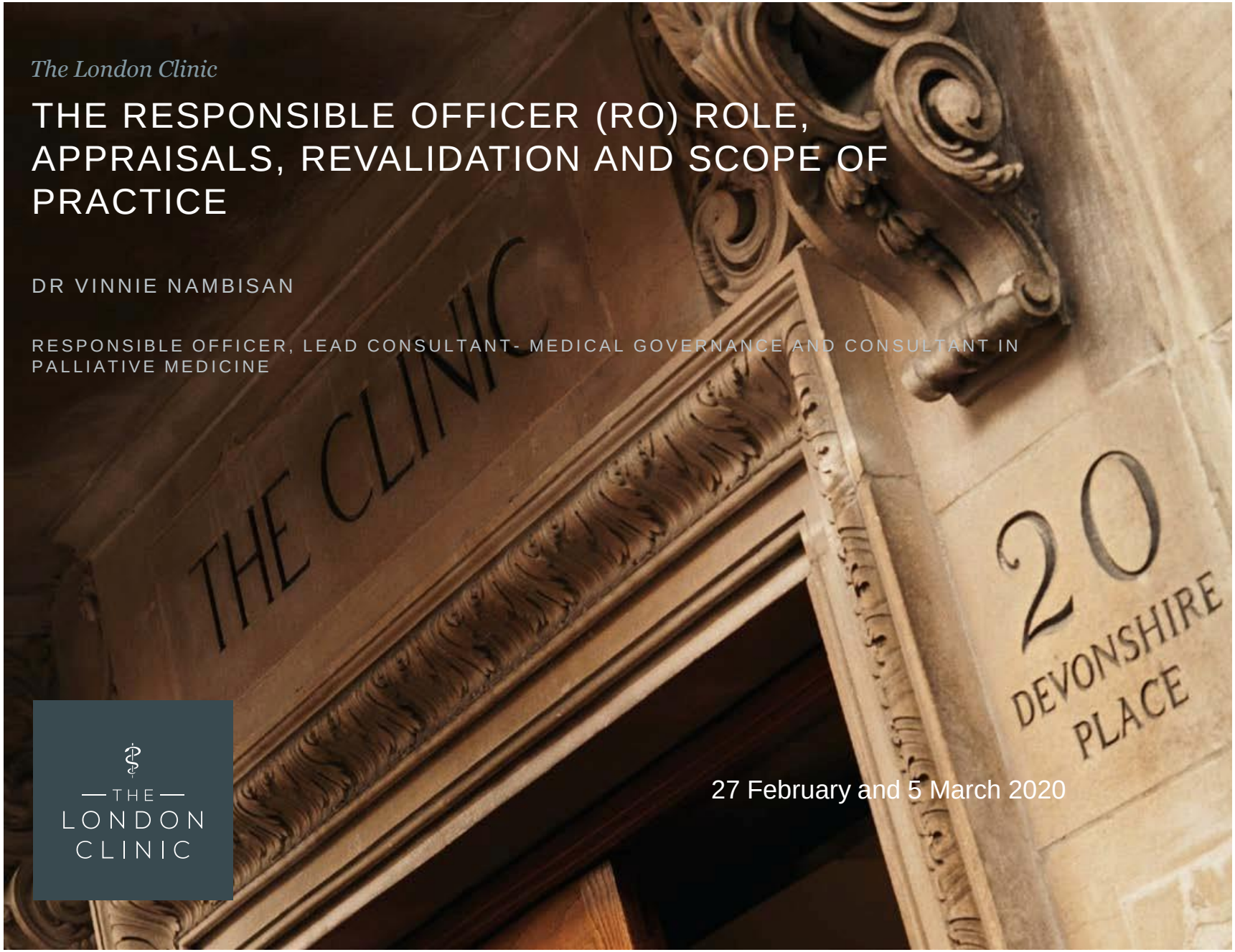


The London Clinic

THE RESPONSIBLE OFFICER (RO) ROLE, APPRAISALS, REVALIDATION AND SCOPE OF PRACTICE

DR VINNIE NAMBISAN

RESPONSIBLE OFFICER, LEAD CONSULTANT- MEDICAL GOVERNANCE AND CONSULTANT IN PALLIATIVE MEDICINE

THE LONDON CLINIC

27 February and 5 March 2020

CONTENTS

BACKGROUND- DOCTORS' RESPONSIBILITIES

All practising doctors need to maintain a licence to practise, through

- Engaging in revalidation (five year cycle)
- Undergoing annual appraisals that cover their whole practice, for which they must declare and reflect on certain information

<u>This is each doctor's individual responsibility</u>

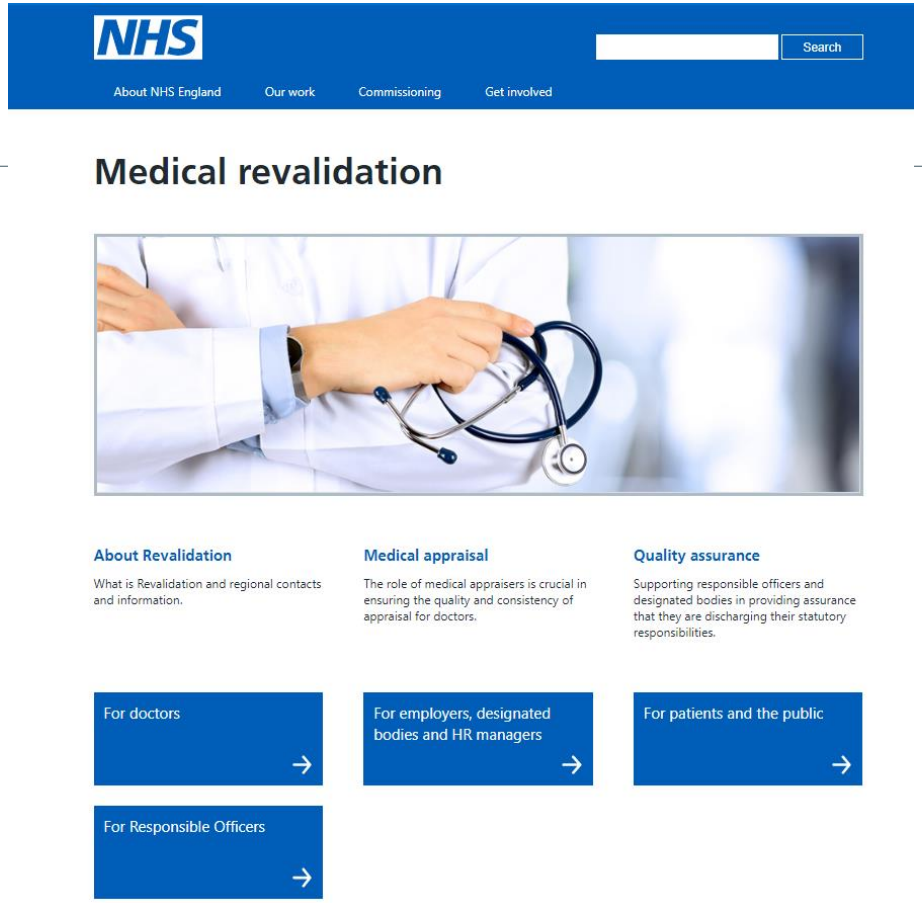
Every doctor* has a prescribed connection to one Designated Body (DB), who have certain responsibilities to support this process. A doctor who works in an NHS trust will be connected to that NHS Trust.

BACKGROUND- THE RO ROLE

Statutory role, required for each DB

ROs must ensure that the quality of the DB's systems supports the revalidation process. The RO's role includes:

- ensuring the DB has effective, quality assured appraisal processes
- making revalidation recommendations, based on appraisal and other information
- ensuring identification and investigation of concerns about doctors, including referring to the GMC when necessary
- ensuring that the DB's pre-employment/ contract checks are appropriate
- monitoring doctors' performance, supporting development
- supporting/ monitoring compliance with conditions/ undertakings
- reviewing the DBs 'general performance information including indicators relating to outcomes for patients', identifying information relating to doctors



https://www.england.nhs.uk/medical-revalidation/

NHS England and NHS Improvement

1. To enable doctors to discuss their practice and performance with their appraiser in order to demonstrate that they continue to meet the principles and values set out in Good Medical Practice and thus to inform the responsible officer's revalidation recommendation to the GMC.

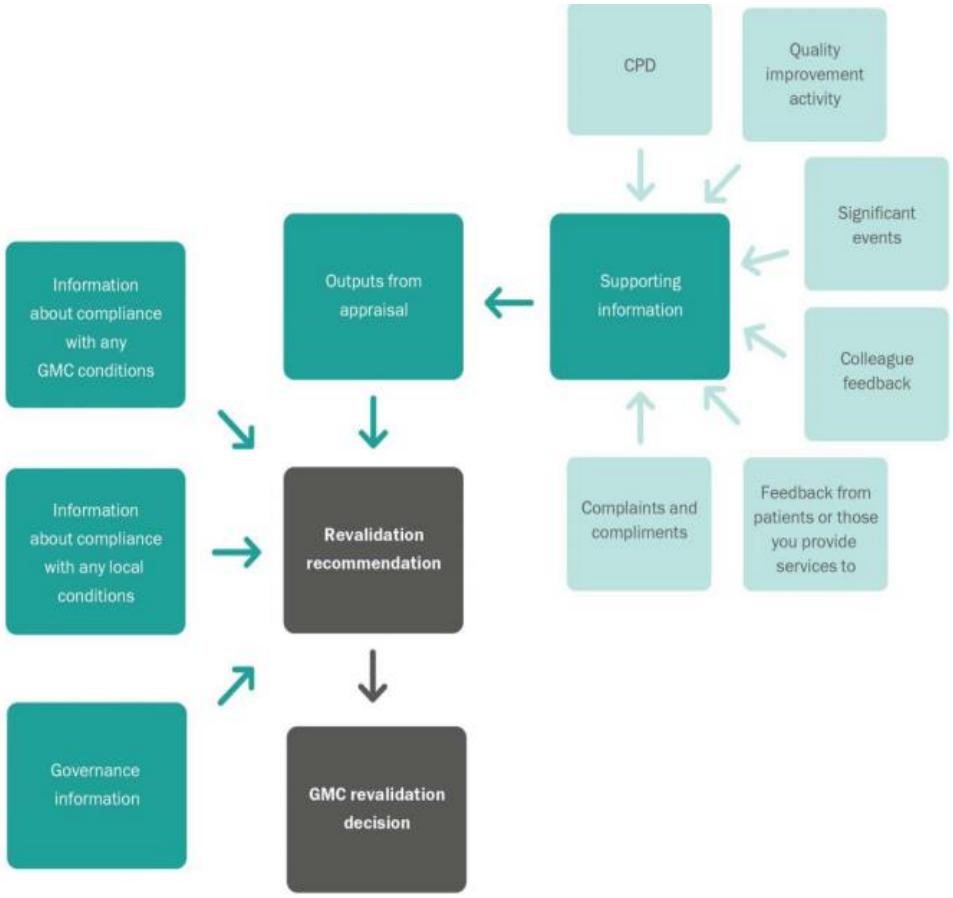
2. To enable doctors to enhance the quality of their professional work by planning their professional development.

3. To enable doctors to consider their own needs in planning their professional development.

(4. To enable doctors to ensure that they are working productively and in line with the priorities and requirements of the organisation they practise in)

MEDICAL APPRAISAL

INSERT


CPD
Quality improvement activity
Significant events
Colleague feedback
Feedback from patients or those you provide services to
Complaints and compliments
Supporting information
Outputs from appraisal
Information about compliance with any GMC conditions
Information about compliance with any local conditions
Governance information
Revalidation recommendation
GMC revalidation decision

INFORMATION SHARING

Information from appraisals should not be shared **routinely** by organisations where a doctor is working. The doctor should (be encouraged to) share anything that is required.

Information can be shared under some circumstances, but ROs should obtain advice before doing so, and the doctor should be informed (unless prohibited e.g. police investigation)

ROs will normally only have access to the appraisal outputs since a doctor's last revalidation, unless there is a particular need to access the full appraisals.

NHSE DECEMBER 2019

HTTPS://WWW.ENGLAND.NHS.UK/MEDICAL-REVALIDATION/RO/INFO-DOCS/ROAN-INFORMATION-SHEETS/SHARING-APPRAISAL-INFORMATION-WITH-EMPLOYERS/

Doctors are commonly asked to share information about their appraisal with employers [as pre-employment checks or part of routine governance]

Doctors report that the request can extend beyond simple proof of appraisal or provision of the appraisal outputs, to include the full portfolio. They can feel pressure to comply, with the implication that their position may be jeopardised if they do not…

Organisations are reminded that the appraisal documentation is confidential between the doctor and their appraiser…

…it should be sufficient for the doctor to share their appraisal outputs and not their full portfolio

Organisations should consider whether asking for more may be classed as forced consent under GDPR.

NHS England and NHS Improvement

The personal development plan is a record of the agreed personal and/or professional development needs to be pursued throughout the following year, as agreed in the appraisal discussion between the doctor and the appraiser.

Learning/development need	Agreed action or goal	Date this will be achieved by	How will you demonstrate that your need has been addressed?
Keep up to date with symptom control in palliative care	Attend symptom control study day	01/07/2018	Evidence of attendance and reflection
Undertake 360 patient/ colleague feedback for learning and revalidation	Undertake 360 assessment	01/05/2019	Report from assessment and reflection
Assess end of life care service in relation to national standards/ participate in QA activity	Undertake audit of end of life care based on national audit	01/05/2019	Evidence of report and actions
Address outcome of NHSE RO visit/ continuously improve TLC designated body and RO function	Work to meet the action plan arising from that visit	01/05/2019	Evidence of progress against action plan and reflection

Appraisal Summary

The appraiser must record here a concise summary of the appraisal discussion, which should be agreed with the doctor, prior to both parties signing off the document.

Summaries should be recorded in accordance with the four domains of Good Medical Practice. The appraiser should be aware of the attributes within each of the domains and ensure that this, and future appraisals, are in accordance with Good Medical Practice.

Domain 1: Knowledge, skills and performance

Very knowledgeable and well respected in his field

Domain 2: Safety and quality

practices within the governance structures and always looks to improve himself and those around him

Domain 3: Communication, partnership and teamwork

Calm, polite and accommodating and makes those around him Geel very comfortable and included

Domain 4: Maintaining trust

Very approachable and trustworthy

Date of appraisal meeting (dd/mm/yyyy)

22/01/2020

The **appraiser** makes the following statements to the responsible officer:

1. **An appraisal has taken place that reflects the whole of the doctor's scope of work and addresses the principles and values set out in Good Medical Practice.**

   - (●) Agree
   - ( ) Disagree

2. **Appropriate supporting information has been presented in accordance with the Good Medical Practice Framework for appraisal and revalidation and this reflects the nature and scope of the doctor's work.**

   - (●) Agree
   - ( ) Disagree

3. **A review that demonstrates progress against last year's personal development plan has taken place.**

   - (●) Agree
   - ( ) Disagree

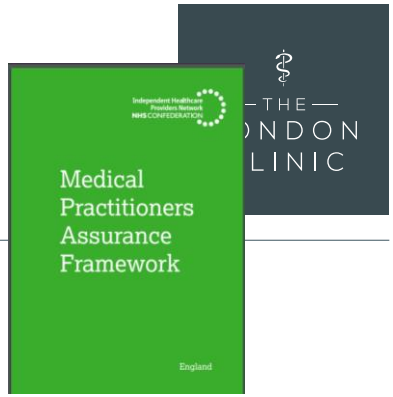
4. **An agreement has been reached with the doctor about a new personal development plan and any associated actions for the coming year.**

   - (●) Agree
   - ( ) Disagree

5. **No information has been presented or discussed in the appraisal that raises a concern about the doctor's fitness to practise.**

   - (●) Agree
   - ( ) Disagree

MPAF ON APPRAISALS AND REVALIDATION



-

MPAF:

Doctors should share appraisal outcomes (including PDP) as a minimum for practising privileges reviews. Further information should be requested if needed, and provided.

Doctors should also provide evidence of participation in quality improvement activity on application and review of practising privileges.

Responsible Officers in the NHS have a responsibility to routinely feedback and request information from Responsible Officers in the independent sector to inform whole practice appraisals and vice versa.

PATERSON INQUIRY ON APPRAISALS AND REVALIDATION

-

Paterson Inquiry:

Appraisal is unlikely to identify poor practice on its own and is not intended to do so. *Although we heard from health professionals that appraisal has not had a major impact on changing behaviour, it increases the chances of doing so when it is used alongside other measures.*

The view of the Inquiry's clinical panel was that revalidation does not add anything to appraisal. *Often, it is a "paper exercise" where the responsible officer offers limited challenge. In the Panel's view, poor quality of care would not easily be identified through revalidation.*

MY ROLE IN RELATION TO APPRAISALS

I see and approve the full annual appraisals for all of our doctors with a prescribed connection to us (50). (I also make their revalidation recommendation)

A sample of the full appraisals for doctors with practising privileges who submit a full appraisal to us is also reviewed. If we are not declared in the scope of practice, I ask that this is done.

All appraisal ‘outputs’ that we receive are checked as a minimum for confirmation that they have been signed off as satisfactory by the appraiser.

I provide governance information to doctors for their appraisals routinely (connected doctors) or on request (non-connected doctors)

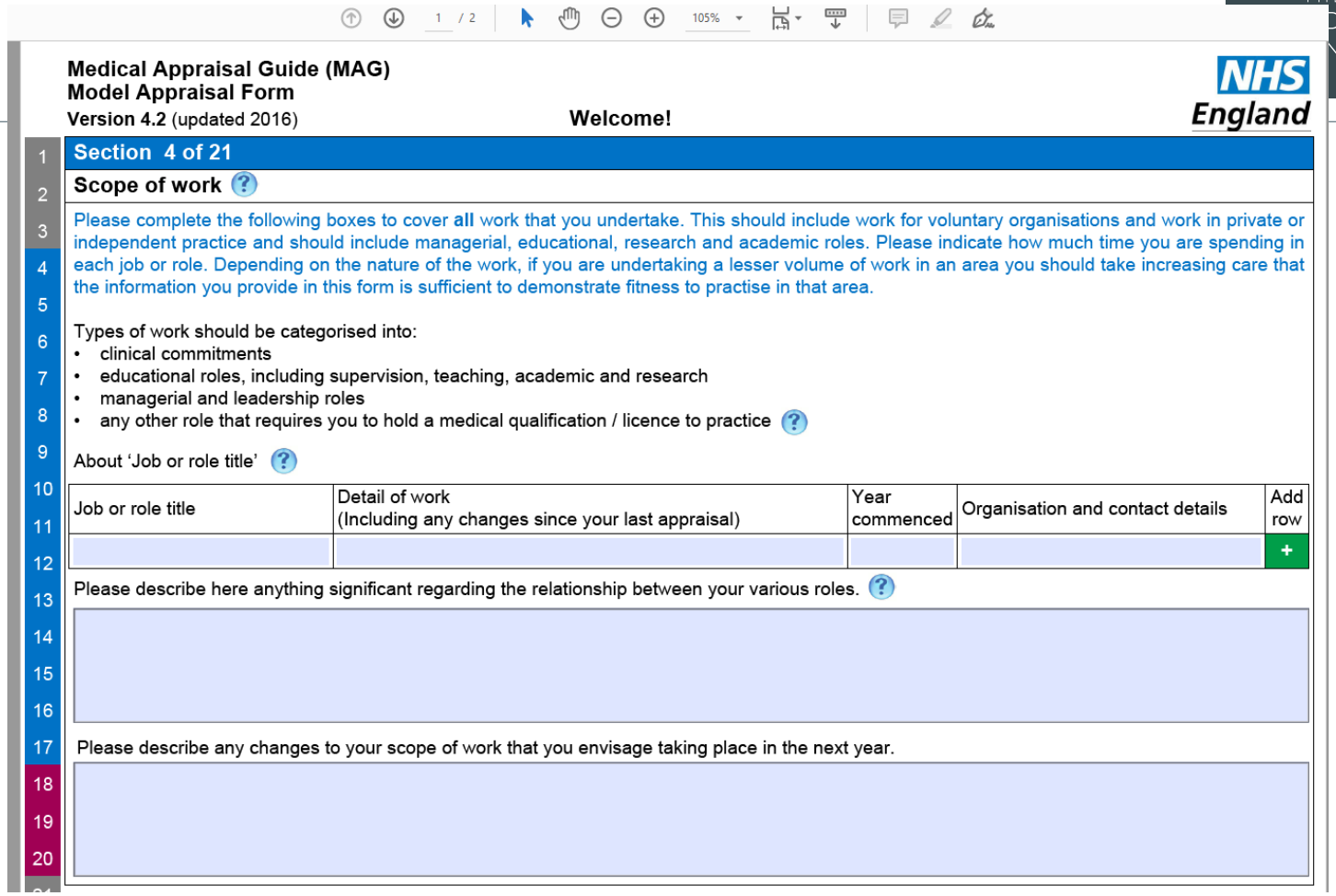
SCOPE OF PRACTICE

The term when used in appraisal usually refers to a broad description of the roles, places of work, and work that a doctor undertakes.

Outside of appraisals, the term is more often used to refer to a detailed list of procedures that a doctor is capable of undertaking/ permitted to undertake. This level of detail is not routinely requested or provided for appraisals.

Detailed scope of practice might indirectly reflect numbers/ outcomes/ markers, but does not inherently do so.

The NHS is usually taken to be the best source of scope of practice information- should it be?



Medical Appraisal Guide (MAG)
Model Appraisal Form
Version 4.2 (updated 2016)

Welcome!

NHS England

Section 4 of 21

Scope of work

Please complete the following boxes to cover **all** work that you undertake. This should include work for voluntary organisations and work in private or independent practice and should include managerial, educational, research and academic roles. Please indicate how much time you are spending in each job or role. Depending on the nature of the work, if you are undertaking a lesser volume of work in an area you should take increasing care that the information you provide in this form is sufficient to demonstrate fitness to practise in that area.

Types of work should be categorised into:

- clinical commitments
- educational roles, including supervision, teaching, academic and research
- managerial and leadership roles
- any other role that requires you to hold a medical qualification / licence to practice

About 'Job or role title'

Job or role title	Detail of work (Including any changes since your last appraisal)	Year commenced	Organisation and contact details	Add row
				+

Please describe here anything significant regarding the relationship between your various roles.

Please describe any changes to your scope of work that you envisage taking place in the next year.

MPAF ON SCOPE OF PRACTICE

MPAF:

Need a consistent approach to defining scope of practice, the level of detail needed, recording and accessing information.

Any central system would include a self-declared statement on the scope of practice of all roles to include: clinical codes (where applicable), procedures, volumes and registries where the doctor shares outcome data.

Providers should request scope of practice information, supported by relevant information from the doctor's annual whole practice appraisal, and application for and review of practising privileges

Monitoring and controls should be in place to identify and manage variances

PATERSON INQUIRY ON SCOPE OF PRACTICE

-

Paterson Inquiry:

…there should be a single repository of the whole practice of consultants across England, setting out their practising privileges and other critical consultant performance data, for example, how many times a consultant has performed a particular procedure and how recently. This should be accessible and understandable to the public. It should be mandated for use by managers and healthcare professionals in both the NHS and independent sector.

SCOPE OF PRACTICE CHALLENGES

Has the doctor been approved to undertake the work that they undertake with  , when, and how often is it reviewed?

How do you monitor what work a doctor undertakes with you (activity/ finance/ bookings/ PHIN etc)?

How are variances picked up and then addressed (Datix/ PROMs/ outliers/ soft intelligence)?

Is information shared by/ with you about doctors' work in your/ other locations?

MY ROLE IN RELATION TO SCOPE OF PRACTICE

Collect scope of practice list submitted by every doctor annually

Review and pass on flagged variances between booked procedures and listed scope of practice information

Support/ advise the governance team to manage issues that come to light through monitoring/ reporting

Liaise with other ROs to check scope of practice information in certain circumstances or to pass on concerns (not routine)

Support/ advise MD on addressing issues

QUESTIONS FOR INDEPENDENT PROVIDERS

Do you know where else all of your doctors with practising privileges work?

Do you know who their designated bodies are? Does their designated body know that they work with you?

Are all of your doctors requesting information from you to inform their appraisals **and** their revalidation recommendation?

What checks do you make of appraisals submitted to you?

Will your clinical governance systems pick up concerns about safety/ efficacy of procedures they undertake at your premises? Do you know when/ how to share that information with other places where they work?

Do you have an accurate scope of practice for all your doctors, is it reviewed and is it checked with their designated body?

CONCLUSIONS

All doctors must undergo appraisal and revalidation to maintain a licence to practise.

Appraisal is a formative process of facilitated reflection, and is not designed to pick up previously unknown issues.

A revalidation recommendation is in theory an additional layer of assurance, but is wholly dependent on the information supplied to the RO.

‘Scope of practice’ is often poorly defined and understood, and oversight across sectors can be patchy. Is there overreliance on the NHS?

Independent Healthcare Providers Network
NHS CONFEDERATION

MPAF Supporting Resources on the IHPN website:
https://www.ihpn.org.uk/mpaf-resources/

- Slide packs for Registered Managers and Executive Teams and Boards
- Frequently Asked Questions (FAQs)
- Template letters
- Patient information animation
- Slides from training sessions

Independent Healthcare Providers Network
NHS CONFEDERATION

IHPN Patient Animation