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Medical Practitioners Assurance Framework
Registered Managers Training - London

Hashtag: #MPAFLONDON

slido

https://www.sli.do/
Event code: MPAFLondon

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www.ihpn.org.uk

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Context of the MPAF - 2018

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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"

Providers should be able to demonstrate how their individual systems and processes meet the expectations of the MPAF.

MPAF is designed to fit with existing legal and regulatory frameworks.

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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

#MPAFLONDON

Medical Practitioners Assurance Framework

Janene Madden, CEO

2020

London Bridge Hospital

HCAHealthcare UK

Registered Managers

As registered managers we are responsible and accountable for everything that occurs within our Hospital

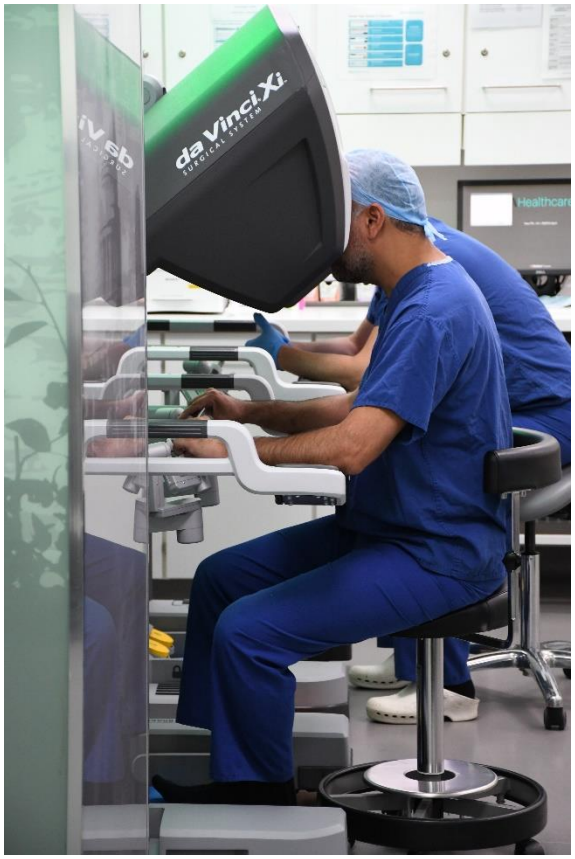
- Ensuring we have the right leadership team
- Ensure all clinical staff including Doctors are delivering to the standard we would want for our own family
- When faced with a challenging situation you need to be able to look yourself in the mirror and know you have done the right thing to protect patients, staff and doctors – let this be your guide when making difficult decisions (or alternatively the Daily Mail test!)
- Expand your knowledge – attend the coroner's court
- Critically read healthcare inquiries (Myles Bradbury, Ian Paterson etc). Could these failings happen in your hospital – identify and close the gaps?

Practising Privileges – the front entry!

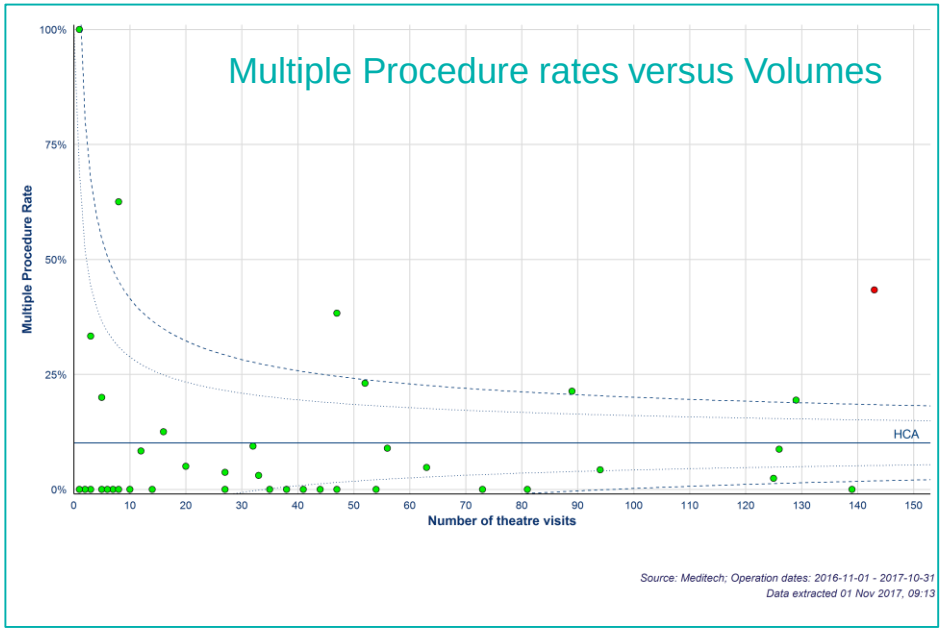
- ✓ **Initial application** - full informal vetting of an application before it reaches the CEO by consultant liaison.
- ✓ **Scope of Practice** – annual numbers
- ✓ **Consultant interview** – cover arrangements, expectations regarding patient care deliverables, MDT attendance, changes to scope, new procedure sign off, going full time private
- ✓ **MAC specialist review** – paying greatest attention to scope of practice and annual numbers
- ✓ **Minimum time at consultant level**
- ✓ **Consultants from outside your normal catchment**
- ✓ **Red Flags** – doctors in full time private practice at a young age, lone practitioners, practising at multiple Hospitals, poorly defined scope (claim to be master of all trades), behavioural concerns
- ✓ **Have the courage to decline!**

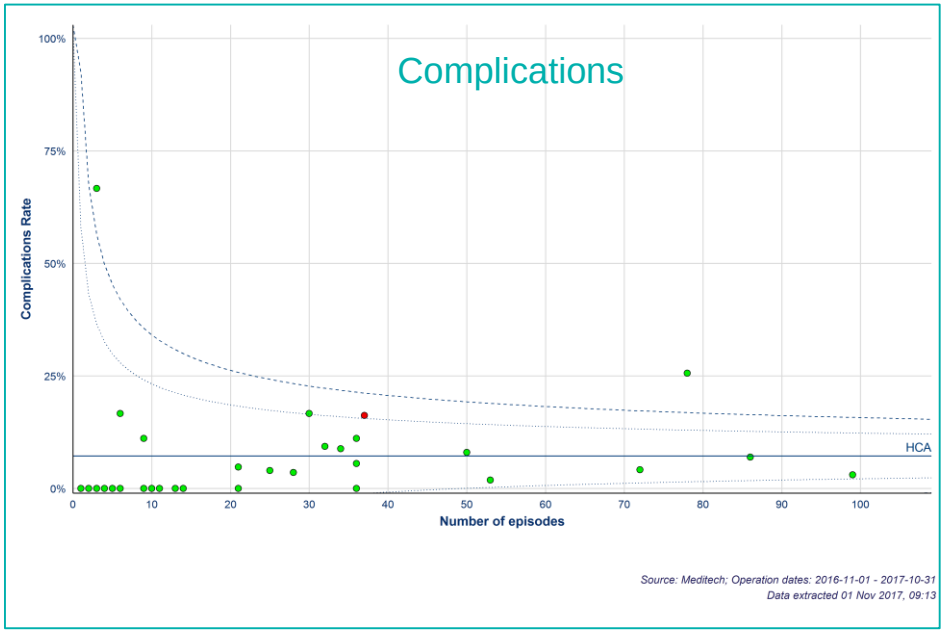
Consultant Oversight

- ✓ **Multi-disciplinary meetings**
- ✓ **Good governance – complaints and incident reporting/investigations.** As Hospital Manager ensure you see every complaint and datix
- ✓ **RO network**
- ✓ **Local DMG raising to corporate DMG for input**
- ✓ **Soft intelligence** – theatres, consultant comments, walking the hospital
- ✓ **Clinical Informatics – practice scorecards**
- ✓ **MAC and Medical Director support**
- ✓ **MAC approval for new procedures, changes of scope**
- ✓ **Good housekeeping** – credentials including appraisals
- ✓ **Consultant Renewals**
- ✓ **Encourage consultant team working**



Measuring performance and outcomes – practice scorecards





HCAHealthcare UK

Quality and standards accreditations – the ability to benchmark

CQC Outstanding

CHKS and ISO Accreditation, Investors in People

JACIE Accreditation – Bone Marrow Transplant Program

JAG and Endometriosis Accreditation

British Society of Echocardiography (BSE) accreditation

Contribution to all National Audits NICOR, NJR, BAUS, etc

PROMS

2020

HCAHealthcare UK

A whole systems failure – The Paterson Report

"This capacity for wilful blindness is illustrated by the way in which Paterson's behaviour and aberrant clinical practice was excused or even favoured. Many simply avoided or worked round him. Some could have known, while others should have known, and a few must have known. At the very least a great deal more curiosity was needed, and a broader sense of responsibility for safety in the wider healthcare system by both clinicians and managers alike" Right Reverend Graham James, Paterson Inquiry

- Encouraging staff to raise concerns – governance is everyone's responsibility
- Ensuring our healthcare professionals and leaders feel responsible for the healthcare they see being delivered in our hospitals
- Inquisitiveness and a healthy curiosity about everything that happens in your hospital

- ***Governance and Quality trumps finance every time!***


Thank you
London Bridge Hospital
part of HCAHealthcare UK

Support from the MAC

Tim Justin

Consultant General / Colorectal Surgeon & Chairman of MAC

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

- MAC structure more formalised
- Likely policy document, has Chair appointed by Manager
- Should represent the individual specialties working in the hospital along with the executive managerial team
- Formal minutes covering specific governance issues
- Distribution of information via these minutes or via a newsletter
- Voluntary commitment – although now some paying MAC Chairs a “time” honorarium and others employ doctors for governance role
- Ultimate responsibility lies with Registered Manager

MAC Chair's view

- Task of Committee varies by size of hospital
- 25 beds, 2 theatres, 60 consultants, mostly from local Trust
  - Fairly confident would detect issues based on word of mouth
- 173 beds, 8 theatres, 650 consultants, all over Midlands
  - Much bigger task

MAC Chair's view

- Definitely investigate more events in private sector
  - May well be ignored in NHS
  - Smaller size leads to higher scrutiny?
- Issue is demonstrating safety to external regulators and "sleeping peacefully at night"
- Don't require more regulation "hiding in plain sight"
- Likely clinical governance structures are sufficient but does the MAC function to help answer specific issues?
- MAC provides insight into local medical politics
- Profession "kick-back"

How can MAC help?

- At present no single reliable and definitive view of any given doctor's scope of practice, activity, outcomes or performance exists
- IHPN and its members overseeing development of secure system for use….
- No easy task!

Scope of Practice

- To include but not limited to:

- For surgeon's procedure codes
- For physician's codes (if feasible)
- Procedures undertaken?
- Volume of work in each area of practice?
- Registries where outcome data is shared

Scope of Practice

- Registries
  - Only surgeons / endoscopists
  - NJR
  - NBOCAP – colorectal cancer
  - NBSR – obesity surgery
  - JAG – endoscopy
  - Plastics – nothing
  - Ophthalmology – nothing
  - General / ENT / Gynae - nothing

How can the MAC help?

- Help with individual applications to give guidance on this issue
- Review of practice privileges with appraisal record
- Ensure have communication with local Trust with respect to clinical incidents / “soft” data exchange
- Post Paterson help

- Get MAC specialty rep to check scope of practice of all their current consultants – incorporate into MAC meeting
- 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"

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

Colleague credibility

MAC Pitfalls

- Personal agenda of member
  - 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

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What NHS Resolution can do for you

Independent Healthcare Providers Network

MPAF Registered Manager Training

Dr Sally Pearson, Responsible Officer and HPAN Lead

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

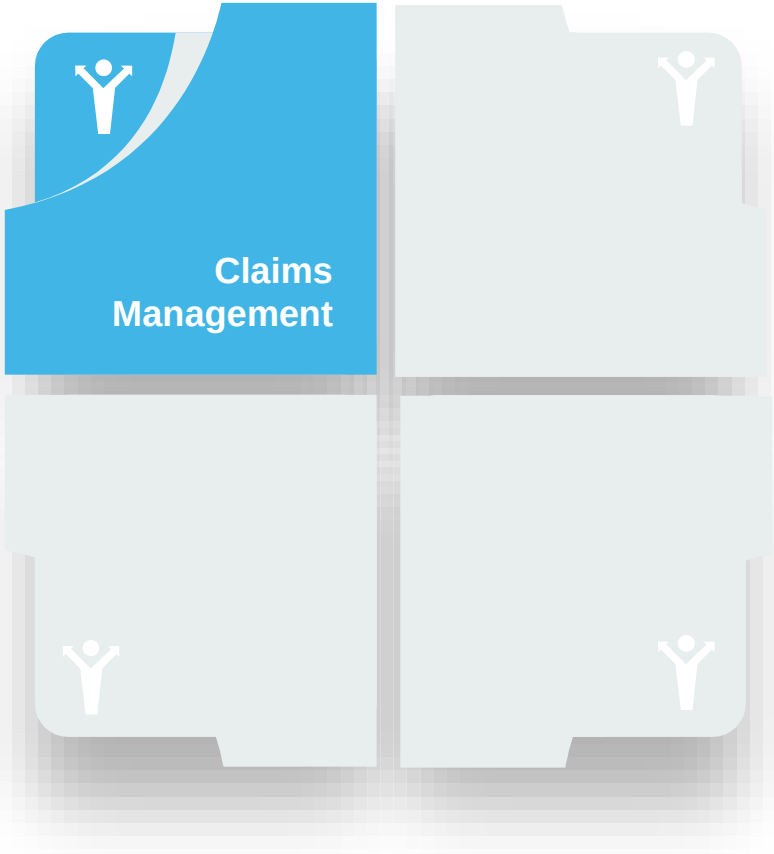
Primary Care Appeals

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)

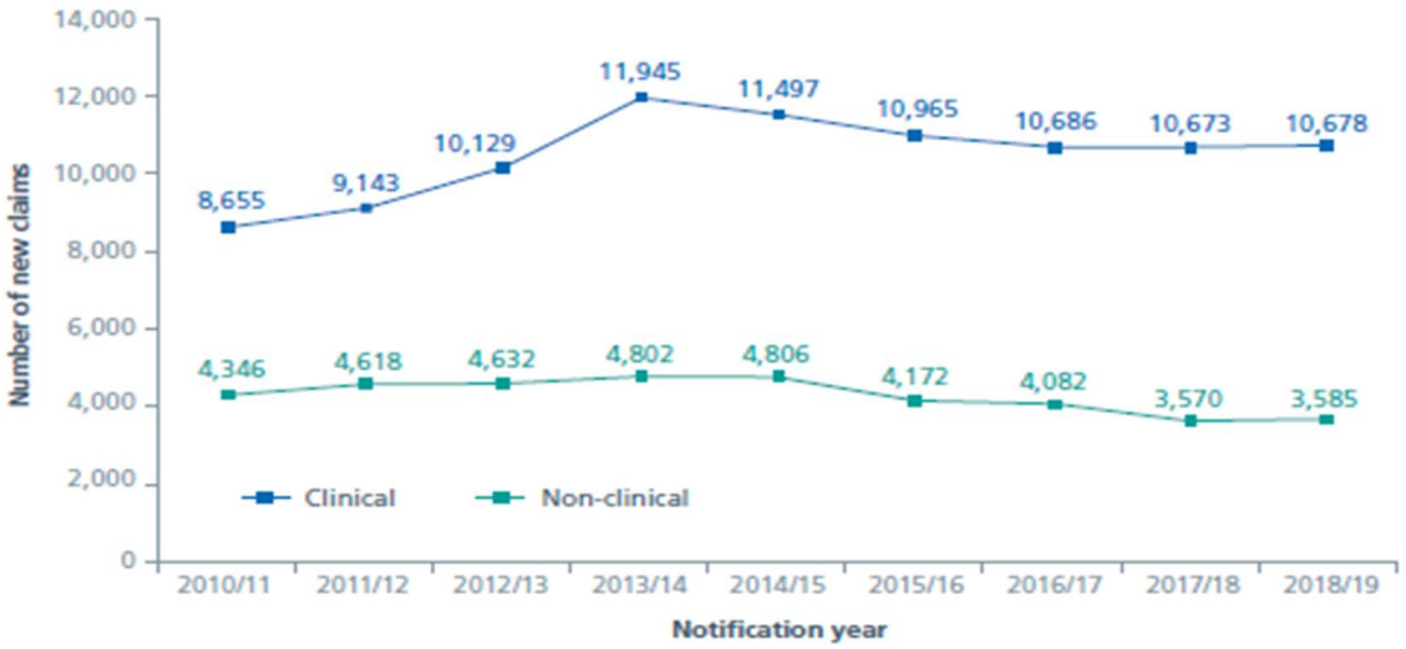
Non Clinical
Property expenses schemes (PES)
Liabilities to third parties scheme (LTPS) .

Claims Management

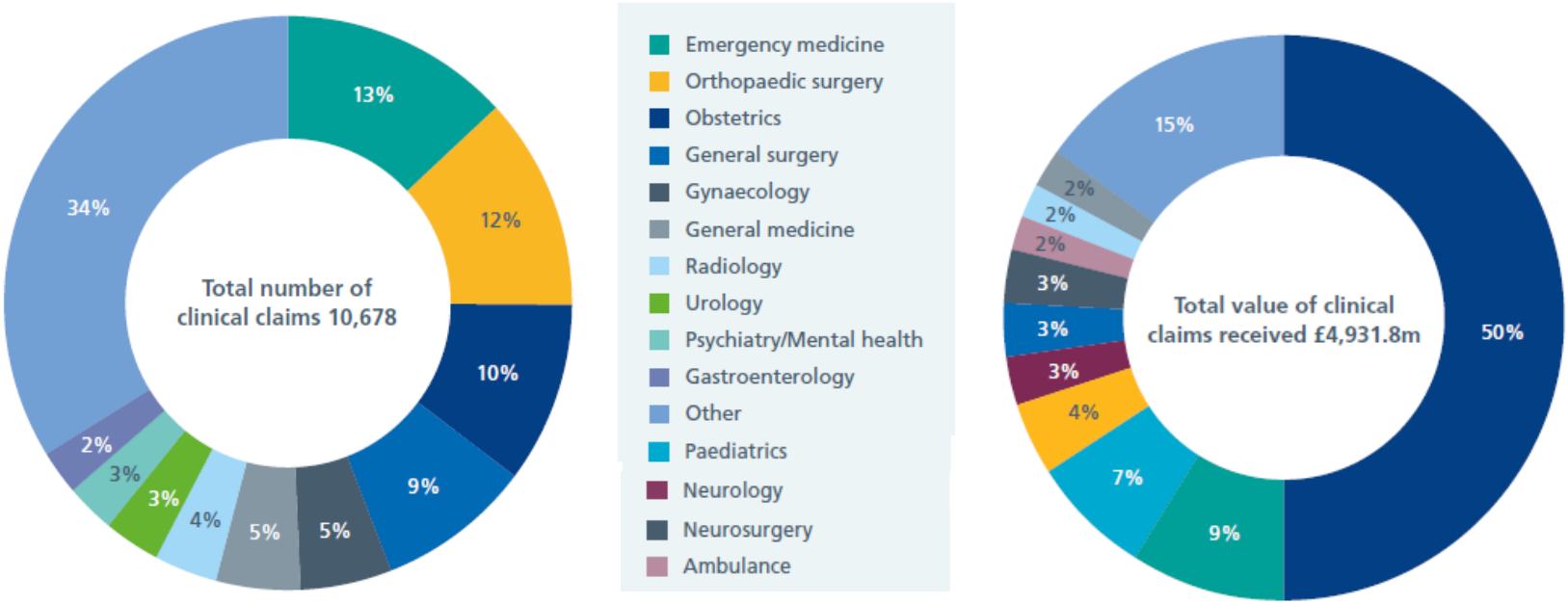
- NHS Resolution claims database
  - 100% claimant derived data on harm
- Significant human cost, to patients, staff and public
- Additional costs to the NHS system and to society
- £2.4 billion NHS funding 2018/19
  - spent as a result of harm
- Liabilities of £83 billion in 2019

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

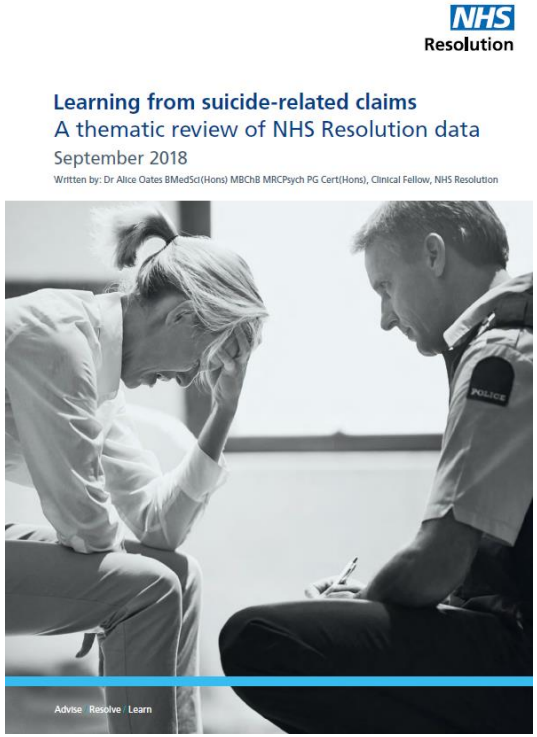


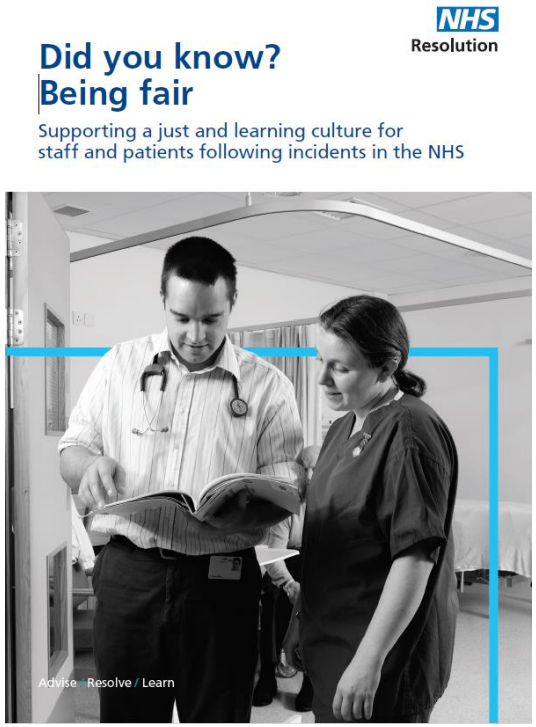
Safety and Learning

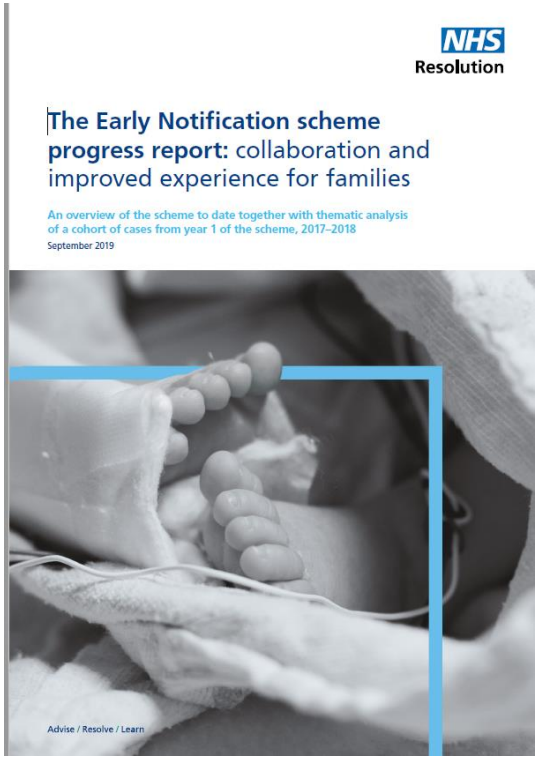
Learning lessons in maternity
Early notification scheme
Insights from assault cases
Being fair
Learning from suicide related claims

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

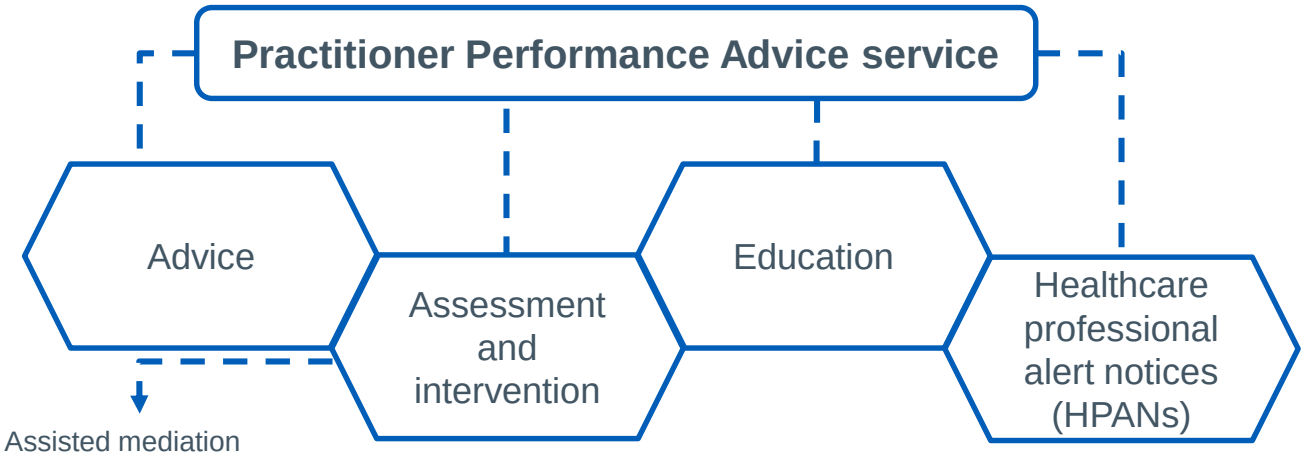
Assessment and intervention

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

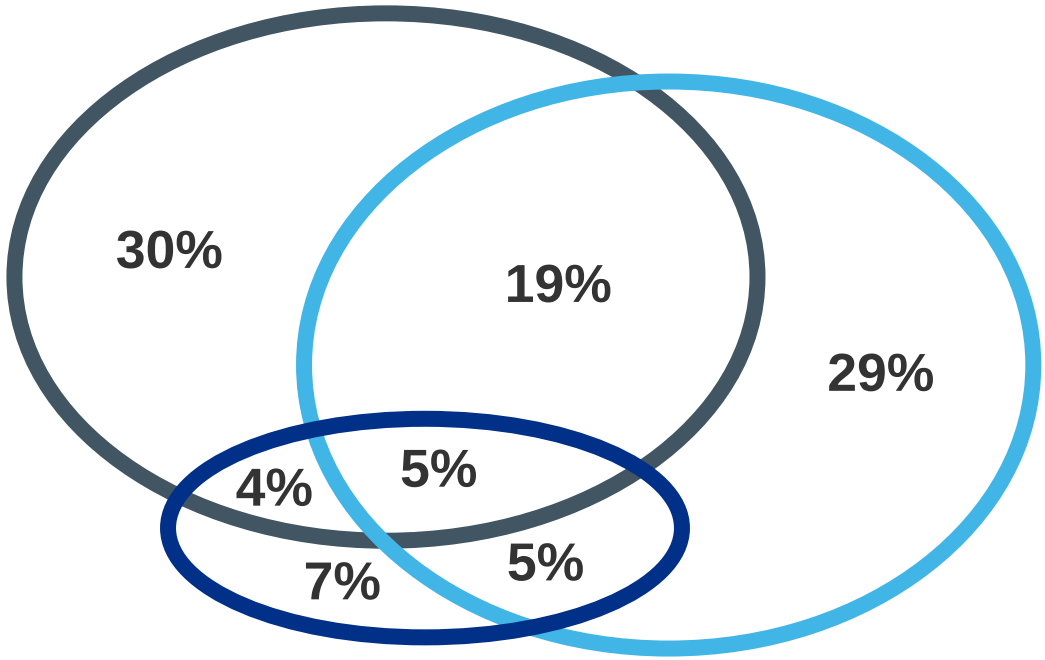
- Case investigator training: two-day workshop
- Case manager training: one-day workshop
- Half-day MHPS overview
- Bespoke workshops
- Safety and Learning events
- Contributors to events
- Action learning circles for case managers and case investigators
- Public dates, prices and booking form available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

What have we learnt?

Where do concerns come from?

Categorisation of concerns

58% categorised as behaviour /misconduct

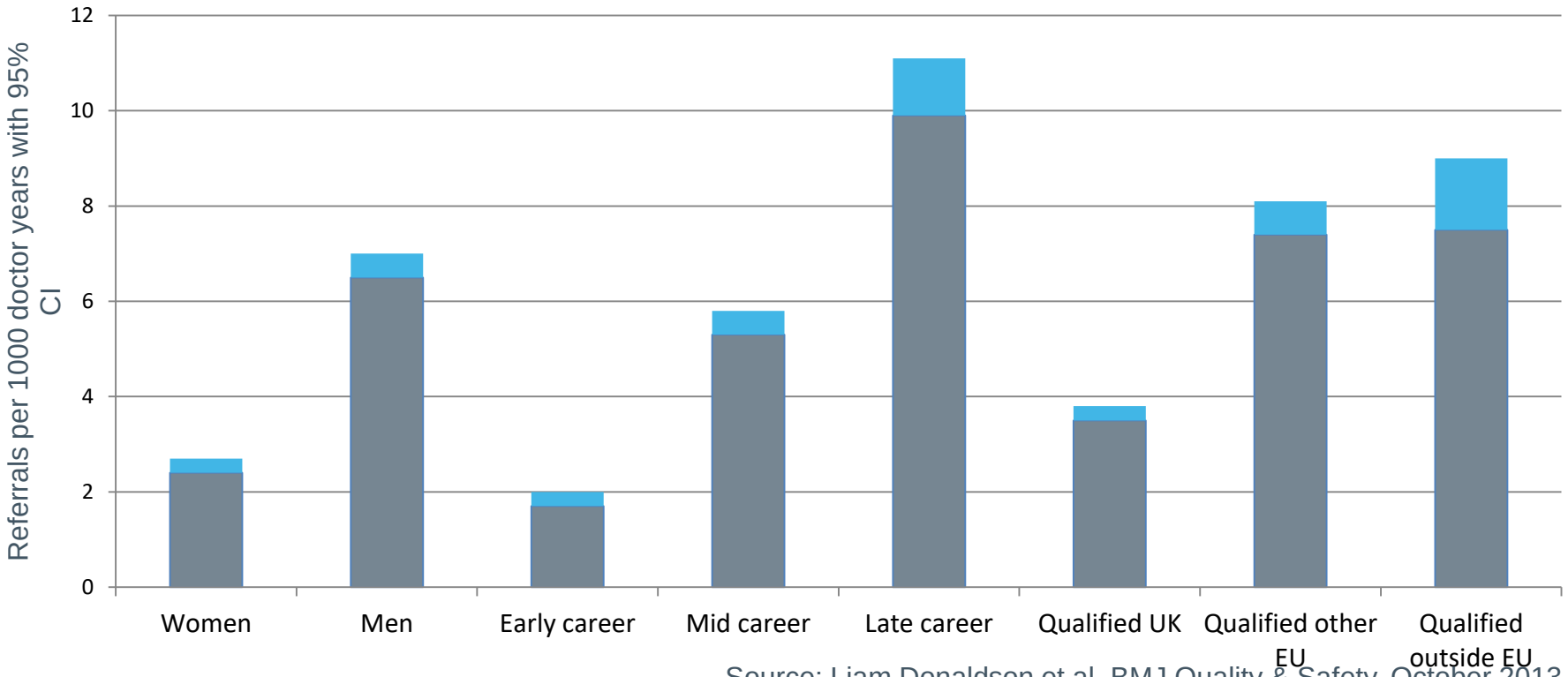


58% categorised as clinical including governance/ safety

21% categorised as health concerns

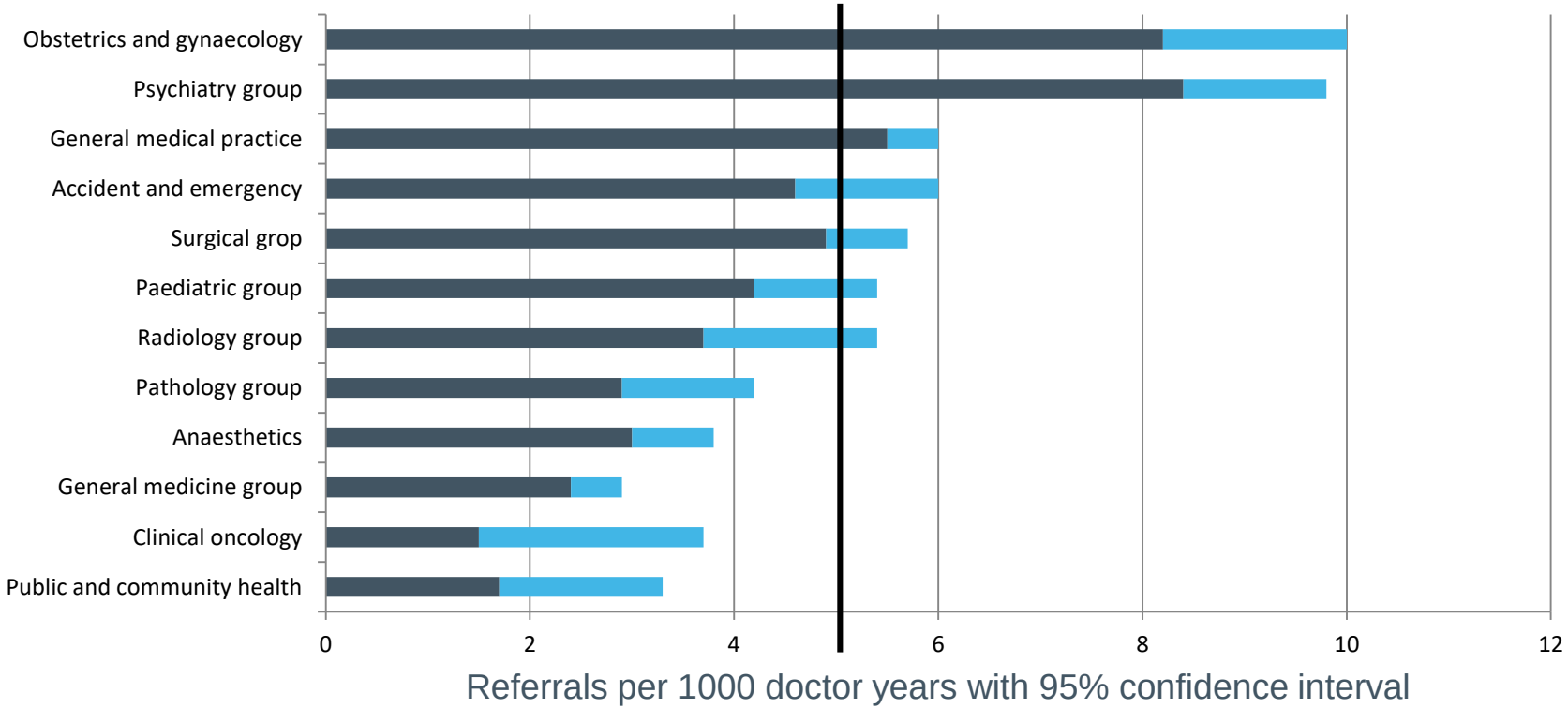
5634 cases requested for advice and support to us Dec 2007 – Sept 2013

Requests for advice and/or support



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

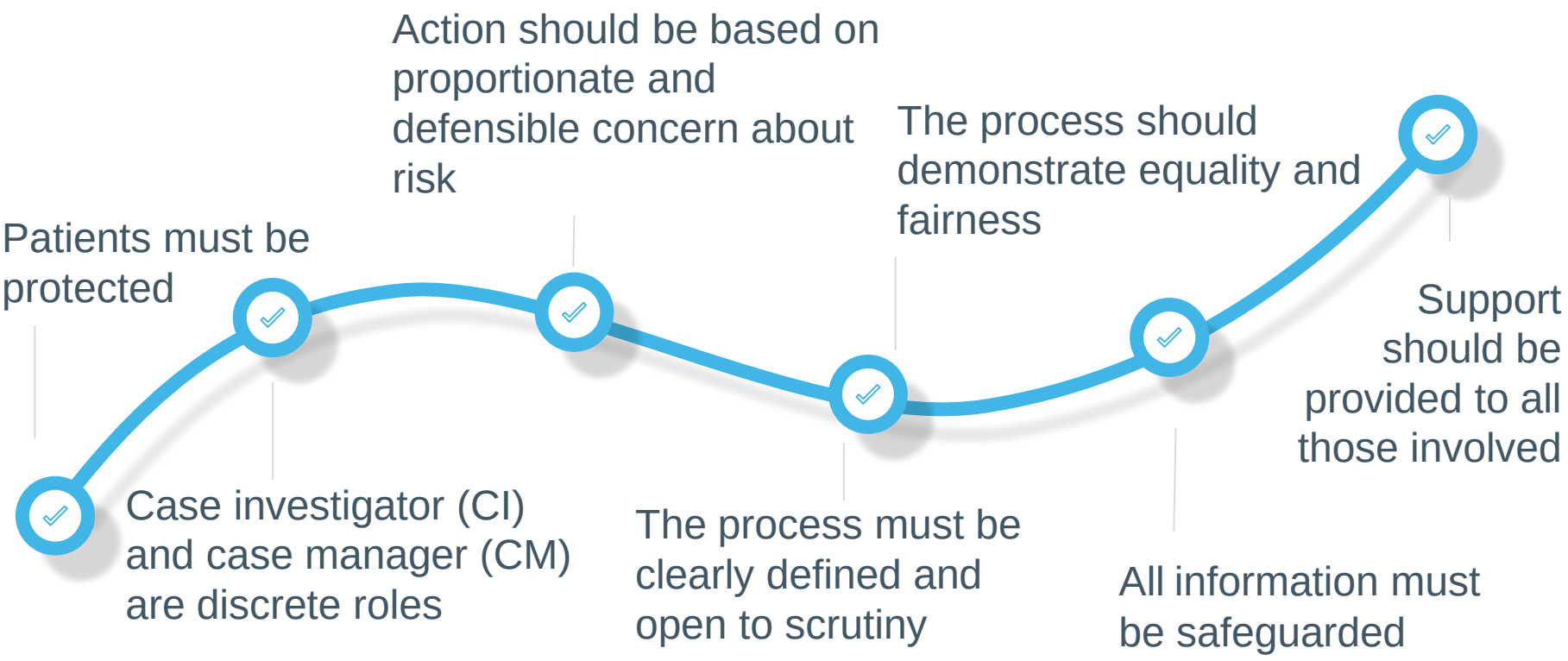
Requests for advice and/or support



Referrals per 1000 doctor years with 95% confidence interval

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

Framework common principles



Key question

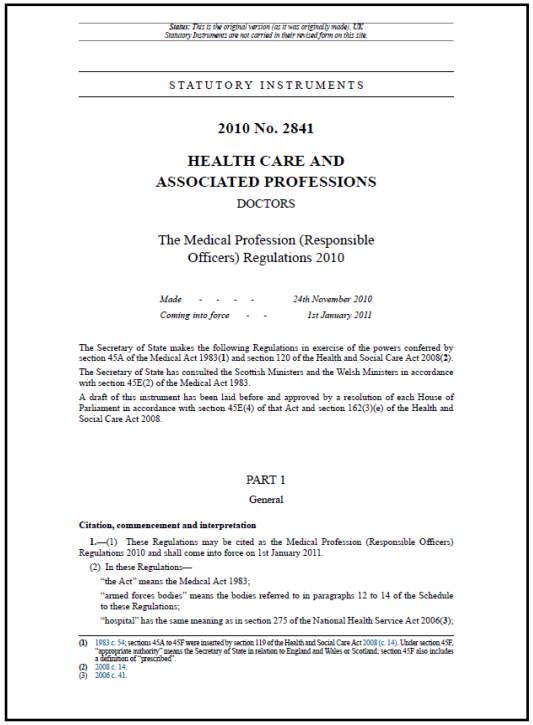
If there are concerns raised about a doctor, how can you distinguish between:

- 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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Hashtag: #MPAFLONDON

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slido **Event code: MPAFLondon**

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

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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)

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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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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

National Joint Registry
www.njrcentre.org.uk
Working for patients, driving forward quality

ODEP
Orthopaedic Data Evaluation Panel

Unit and Surgeon performance assessment using output from the NJR

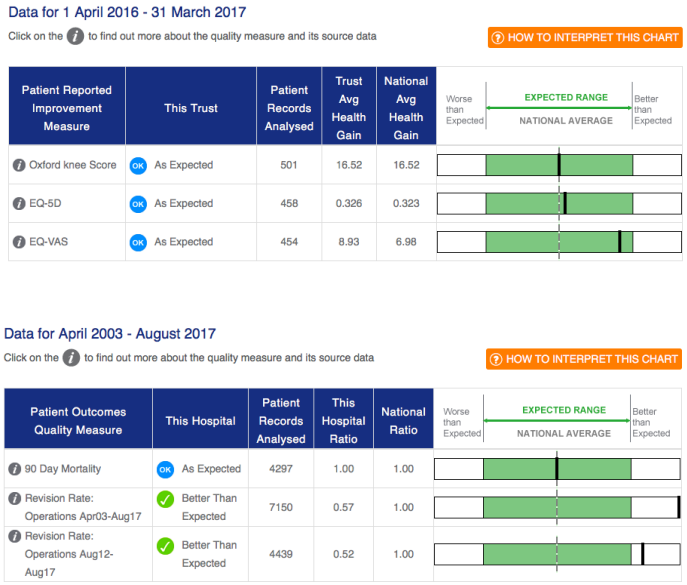
Mr Tim Wilton MA FRCS
Medical Director, NJR

Disclosures

- Past President BOA
- Past President BASK
- Previous Design Consultant to Smith and Nephew
- Speaker panel for Smith and Nephew
- Speaker panel for Stryker
- Speaker panel for Biomet
- Past Member MHRA Device Safety Committee
- Member ODEP and Beyond Compliance Committees
- No Financial or research support to myself or my unit from any commercial source

In the UK Registry Outcomes Data increasingly made publicly available

- Range and details are variable
- Many outcomes data are published by Unit
- Some outcomes data are published by Surgeon
- Some data include both NHS and private practice outcomes
- Data may be published to the public or sometimes restricted to certain audiences



Data for 1 April 2016 - 31 March 2017

Click on the i to find out more about the quality measure and its source data

HOW TO INTERPRET THIS CHART

Patient Reported Improvement Measure	This Trust	Patient Records Analysed	Trust Avg Health Gain	National Avg Health Gain	Worse than Expected / EXPECTED RANGE / NATIONAL AVERAGE / Better than Expected
Oxford knee Score	OK As Expected	501	16.52	16.52	
EQ-5D	OK As Expected	458	0.326	0.323	
EQ-VAS	OK As Expected	454	8.93	6.98	

Data for April 2003 - August 2017

Click on the i to find out more about the quality measure and its source data

HOW TO INTERPRET THIS CHART

Patient Outcomes Quality Measure	This Hospital	Patient Records Analysed	This Hospital Ratio	National Ratio	Worse than Expected / EXPECTED RANGE / NATIONAL AVERAGE / Better than Expected
90 Day Mortality	OK As Expected	4297	1.00	1.00	
Revision Rate: Operations Apr03-Aug17	✓ Better Than Expected	7150	0.57	1.00	
Revision Rate: Operations Aug12-Aug17	✓ Better Than Expected	4439	0.52	1.00	

Types of Outcome data

- Mortality data – Published by Surgeon and Unit
- Operation Numbers – Published by Surgeon and Unit
- Revision Data – Published by Unit
- PROMs Data – Published by Unit

Independent Sector Units

- Don’t have NHS PROMs data published if they treat no NHS patients
- Sometimes don’t have the PROMs data published even when they DO treat NHS patients
- May be at a disadvantage for NOT collecting and releasing these data if patients become more discerning

National Joint Registry
www.njrcentre.org.uk
Working for patients, driving forward quality

Transparency Agenda

- The purpose is a general increase in accountability, especially about goods and services paid for with public money
- This is a Government initiative and one supported by many professional organisations including RCS and BOA
- Bishop of Norwich Report already has emphasized the vital nature of such accountability and Cumberlege Report is likely to focus on this!

Outcomes Feedback

- This is a sensitive area
- Surgeons are dedicated professionals who expect to produce good outcomes
- They tend to be confident Type A personalities
- They may not take criticism well….even as well as others might!

Surgical Outcomes

- Are multi-factorial
- Multiple different measures give different results
- Even different PROMs give different results for the same surgeon and patient groups
- *Few surgeons believe they might be "Below Average"*

Reality

- 50% of surgeons are below average…….by definition!

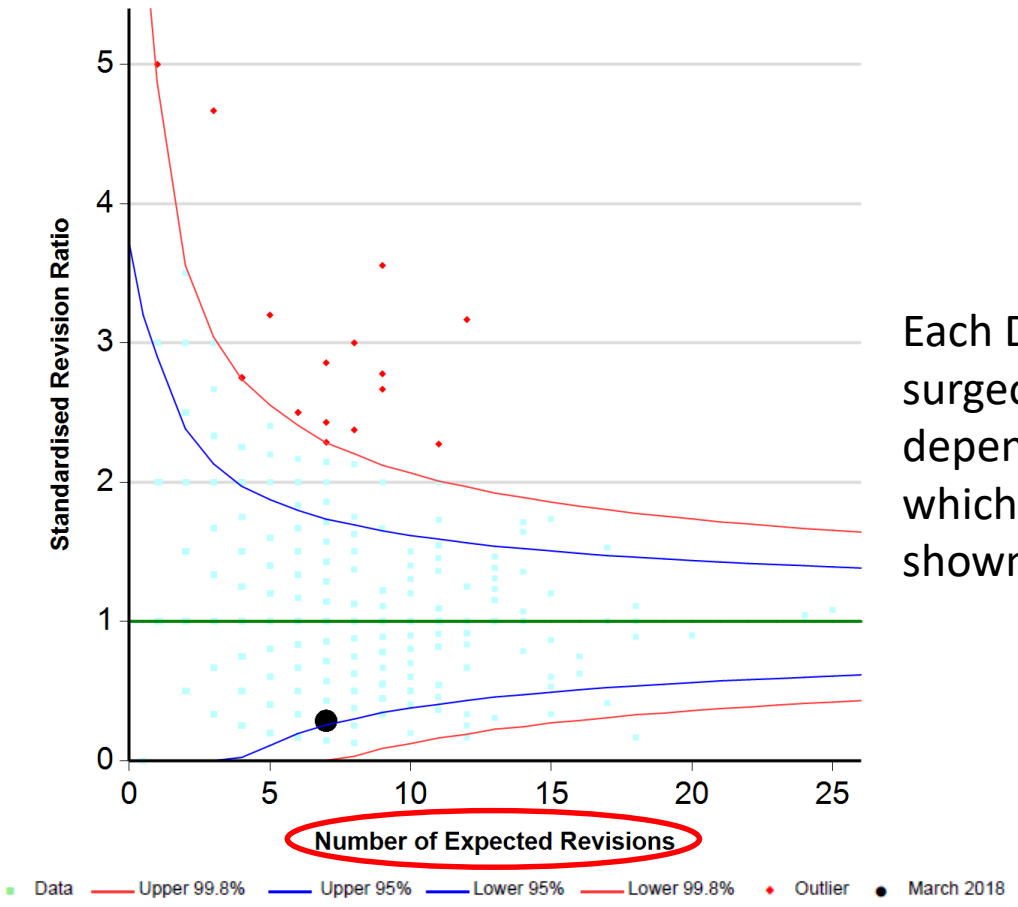
- The level of performance could *theoretically* be outstanding across all surgeons in a Unit/Region/Country/Continent in which case the “outliers” may still be performing well!

- Nevertheless…
- 50% of them would STILL be “below average”….for that population

How do we look at Outcomes?

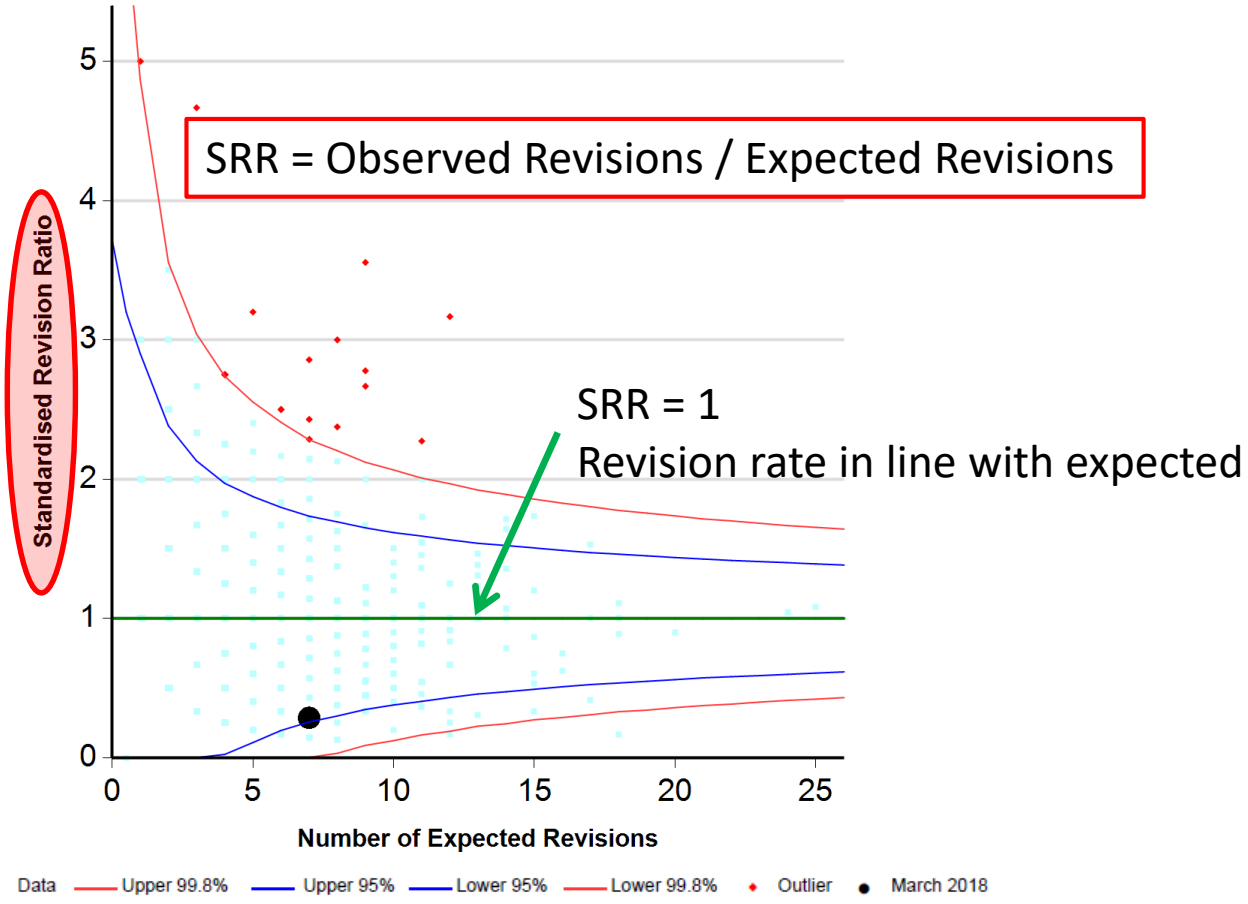
- Funnel plots showing surgeons/units their own positions against every other surgeon/unit for revision rates
- Similar plots for mortality
- Bar chart plots for PROMs, Satisfaction and Demographics
- Volume and scope of practice data

Anatomy of a funnel plot



Each Dot is a surgeon or hospital depending upon which is being shown in that chart

Anatomy of a funnel plot

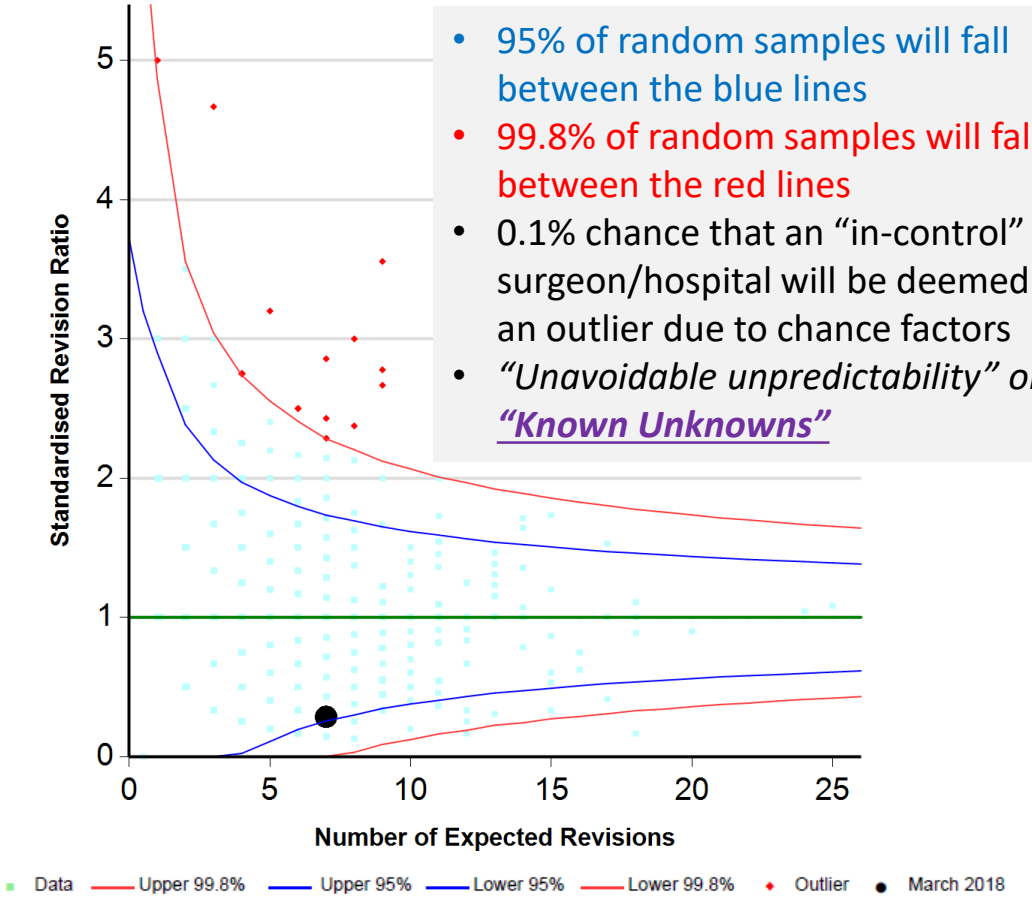


Anatomy of a funnel plot

Control limits
(not confidence intervals)

SRR = 1
Revision rate in line with expected

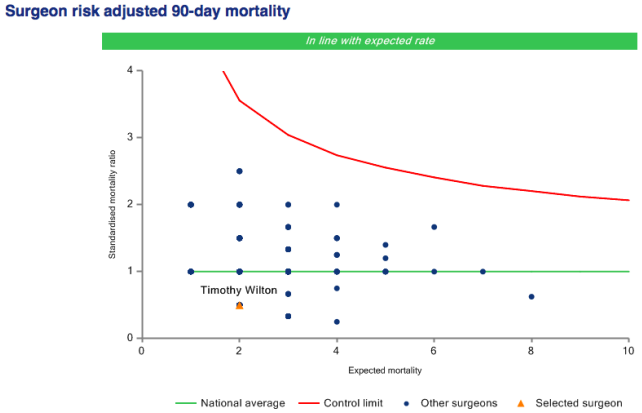
Anatomy of a funnel plot

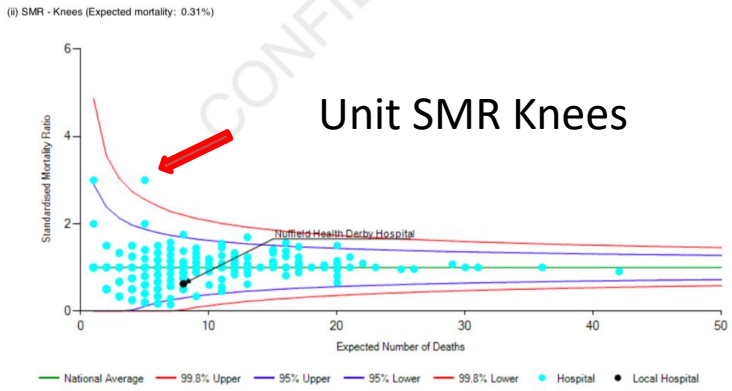


- 95% of random samples will fall between the blue lines
- 99.8% of random samples will fall between the red lines
- 0.1% chance that an "in-control" surgeon/hospital will be deemed an outlier due to chance factors
- *"Unavoidable unpredictability" or* ***"Known Unknowns"***

Mortality Data

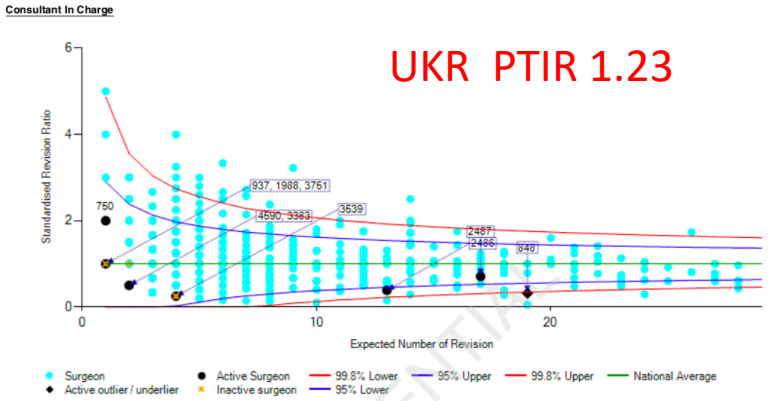
- Already available to the public by Surgeon and by Hospital
- Should not be a great concern in general for elective orthopaedics
- May be a concern if THR for Trauma was included!!
- Few if any individual “outliers”

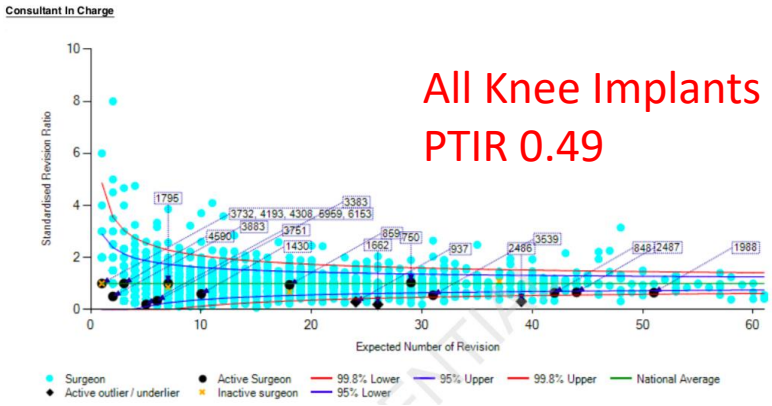




Revision Data

- Can be presented for a specific procedure
- Can be several procedures amalgamated
- BOTH ways are available routinely for surgeons to see their OWN DATA on NJR website
- Other surgeons' plots can be seen by all surgeons but Anonymised



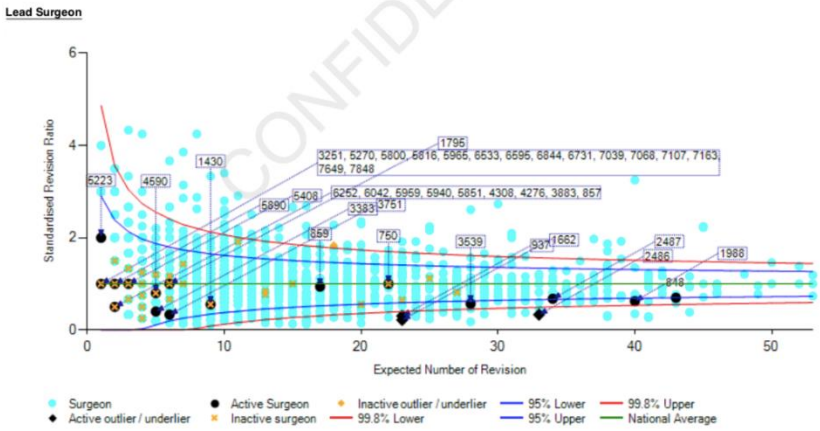


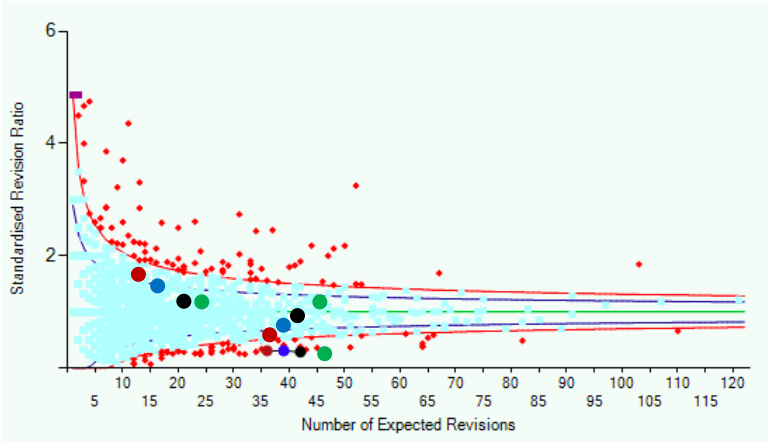
Patient Time Incidence Rate (PTIR)

- Measures failure against duration of survival
- DIFFERS between procedures
- Differences don't show up routinely on SRR funnel plots
- Considerable differences between TKR/UNI/PFJR and also different HIP procedures

Revision Data

- Failure rates AND proportion of cases vary considerably from surgeon to surgeon
- Consultant's Own Plots now include Time-sensitive "snail-trails"
- Revision plots anonymous as complexity and case mix make interpretation complicated and legitimate variation occurs





Looking at Hospital Annual Clinical Report

- Important Considerations:
  - Hospital Funnel Plots show Revisions ONLY for Primary cases done in that hospital
  - Consultant Funnel Plots show Revisions of ALL Primary cases done by that Consultant wherever they have been done
  - Revisions are registered against the Hospital which did the Primary case wherever the revision may have been performed
  - Revisions are registered against the Primary surgeon wherever the revision is performed (and by whoever)
  - *Uncorrected (raw) revision rates are relatively unhelpful*

Nuffield Health Derby Hospital

Annual Clinical Report

For the Financial Year 2018/19

National Joint Registry
www.njrcentre.org.uk

Explanatory Notes:

Data Linkability - The proportion of records which include a patient's NHS number compared with the number of procedures recorded on the NJR. The NHS number is required to link all primary and revision procedures relating to a single patient. The most common reason for low linkability is a poor process for gaining patients' consent to store their personal details on the NJR.

SRR - The Standardised Revision Ratio (SRR) is the statistical methodology used to calculate outlier status. Two control limits are used: Surgeons or hospitals above the upper limit are flagged as potential outliers, for further investigation.

SMR - The Standardised Mortality Ratio (SMR) is the statistical methodology used to calculate outlier status. Two control limits are used: Surgeons or hospitals above the upper limit are flagged as potential outliers, for further investigation.

An 'active' surgeon is defined as one who has undertaken at least one joint replacement procedure at the trust or hospital within the last financial year covered by the report. An 'inactive' surgeon is one who will previously have undertaken joint replacement procedures at the trust or hospital but for whom no procedures have been recorded in the last financial year covered by the report.

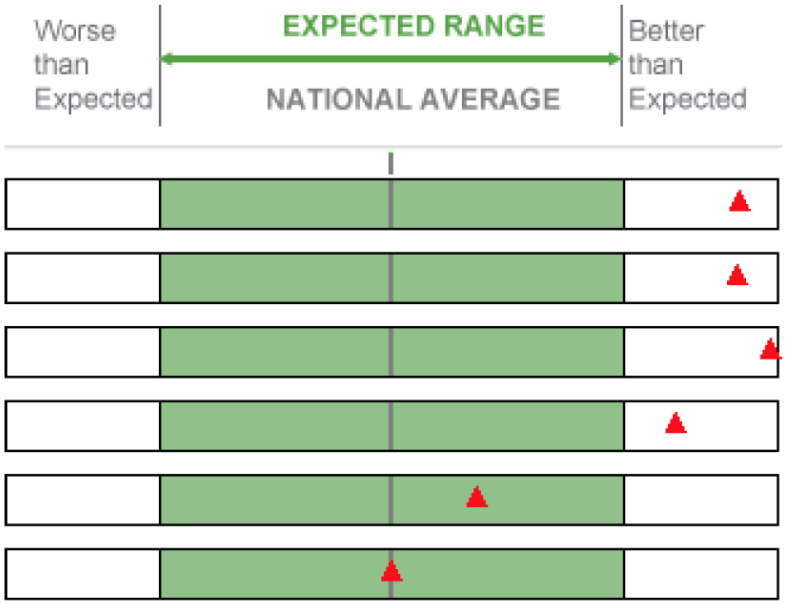
Indicator Summary

Performance against each indicator is shown as a thermometer plot. Each plot consists of a central, shaded band which represents the 'Expected Range' for the indicator. The limits of the band are based on all data submitted to the NJR with the central, vertical line representing the national expected value. The triangle marker represents the current position for the performance of the Trust/Hospital/Surgeon in relation to the 'Expected Range' and the 'National Expected Value'. For each indicator, to the left of the 'Expected Band' is a band indicating 'Worse than Expected' performance and to the right of the 'Expected' band is a band indicating 'Better than Expected' performance.

Disclaimer: The NJR data is limited to those procedures submitted by your organisation, and may therefore be incomplete. The information in this report does not take account of your surgeons' NJR compliance level. Raw submission figures are included on subsequent pages of the report.

National Joint Registry
www.njrcentre.org.uk

Indicator Summary



Indicator 1 – Hospital Consent Rate

Indicator 2 – Hospital Data Linkability

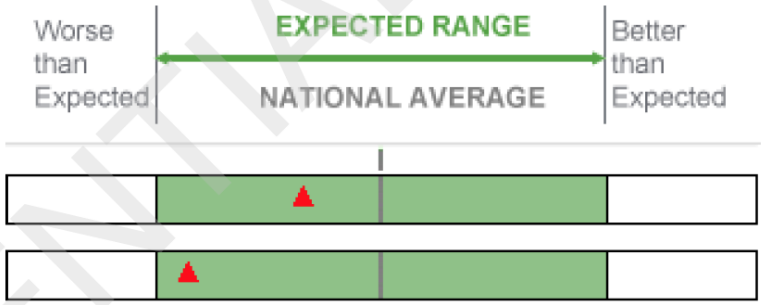
Indicator 3 – Hospital SRR Hips (latest 10 years)

Indicator 4 – Hospital SRR Knees (latest 10 years)

Indicator 5 – Hospital SMR Hips (latest 5 years)

Indicator 6 – Hospital SMR Knees (latest 5 years)

Hospital Surgeons



Indicator 7 – Highest surgeon SRR (latest 10 years)

Indicator 8 – Highest surgeon SRR (latest 10 years)

SRR – Standardised Revision Ratio

SMR - Standardised Mortality Ratio

Nuffield Health Derby Hospital
September 11th, 2019

Annual Clinical Report

1. Number of entries for the Hospital for primary and revision joint replacement.

The following tables give the number of records entered into the NJR for Nuffield Health Derby Hospital.

	2016/2017	2017/2018	2018/2019	Total NJR
Primary Hip	380	416	470	4,784
Revision Hip	6		2	33
Primary Knee	600	621	670	5,792
Revision Knee	3	8	5	72
Primary Ankle				
Revision Ankle				
Primary Shoulder	10	19	21	84
Revision Shoulder			1	1
Primary Elbow	4	3	2	14
Revision Elbow				
Totals	**1,003**	**1,067**	**1,171**	**10,780**

Total NJR figure is since data collection began in April 2003

National Joint Registry
www.njrcentre.org.uk

2. Data quality from the hospital

(i) Consent rate for hospital. Percentage of cases submitted to the NJR with patient consent confirmed. The benchmark figure is 95%.

	2016/2017	2017/2018	2018/2019	Total NJR
Nuffield Health Derby Hospital	96.91%	98.22%	98.89%	97.90%
Group Total	**95.34%**	**96.76%**	**97.76%**	**89.75%**
National	**92.41%**	**93.61%**	**94.19%**	**88.52%**

Total NJR figure is since data collection began in April 2003

(ii) Linkability for hospital. Percentage of cases submitted to the NJR with NHS number supplied, or identifiable through other supplied data. The benchmark figure is 95%.

	2016/2017	2017/2018	2018/2019	Total NJR
Nuffield Health Derby Hospital	95.71%	97.66%	98.80%	96.87%
Group Total	**97.56%**	**97.68%**	**97.29%**	**90.56%**
National	**97.85%**	**97.79%**	**97.63%**	**92.92%**

Total NJR figure is since data collection began in April 2003

Crude (Unadjusted) Revision Data

Hip Replacements Data collection started April 2003

	1 year			3 years			5 years			7 years			10 years		
	Linkable cases	Revisions	Revision Rate	Linkable cases	Revisions	Revision Rate	Linkable cases	Revisions	Revision Rate	Linkable cases	Revisions	Revision Rate	Linkable cases	Revisions	Revision Rate
Nuffield Health Derby Hospital	4,154	10	0.24%	3,388	23	0.68%	2,703	25	0.92%	2,110	29	1.37%	1,295	38	2.93%
Nuffield Health	**54,761**	**300**	**0.55%**	**42,687**	**518**	**1.21%**	**32,824**	**685**	**2.09%**	**25,250**	**883**	**3.5%**	**15,362**	**914**	**5.95%**
Whole NJR	**1,035,302**	**8,135**	**0.79%**	**841,241**	**12,705**	**1.51%**	**658,286**	**15,007**	**2.28%**	**495,876**	**16,338**	**3.29%**	**278,597**	**14,386**	**5.16%**

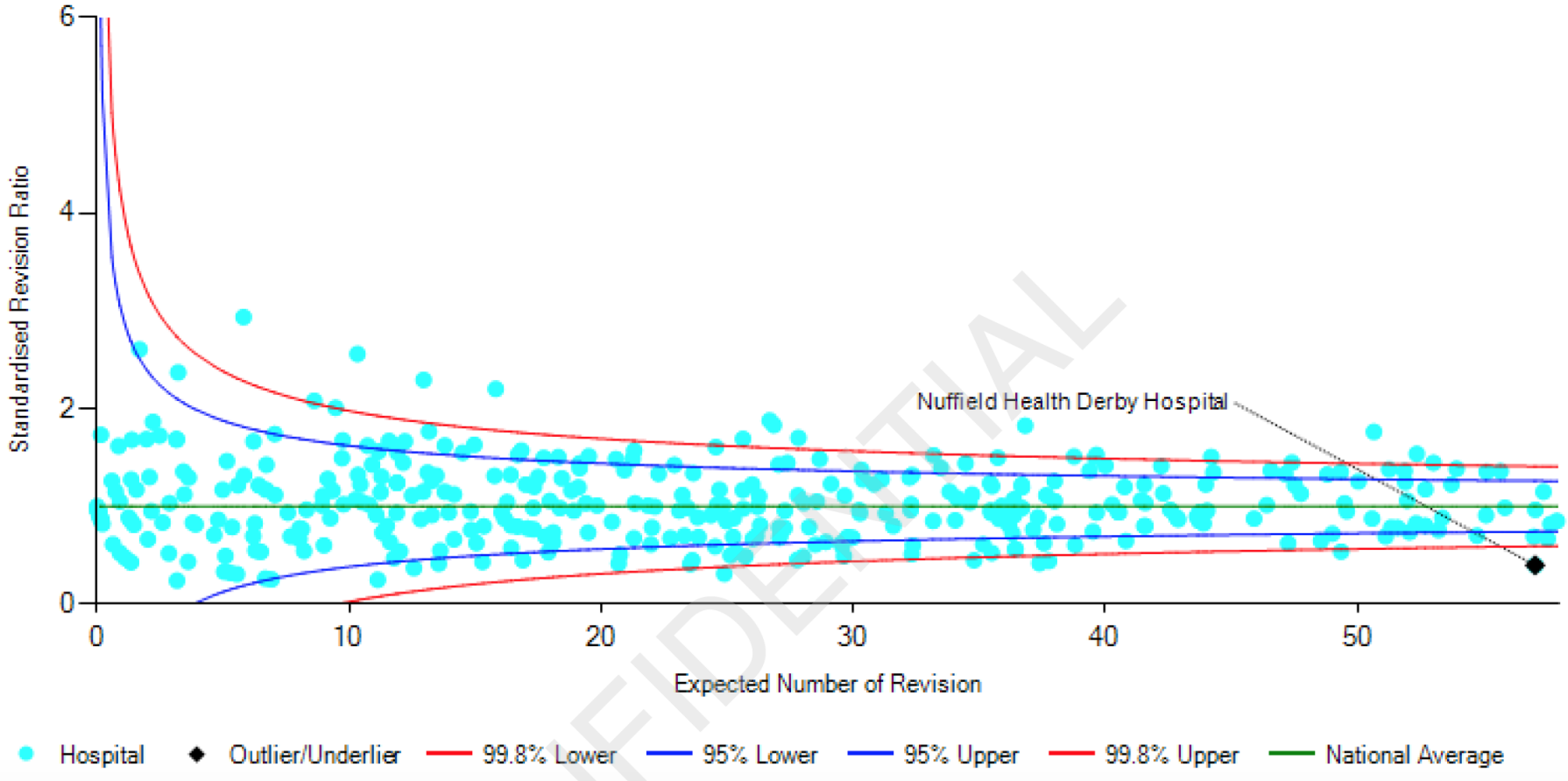
Knee Replacement Data collection started April 2003

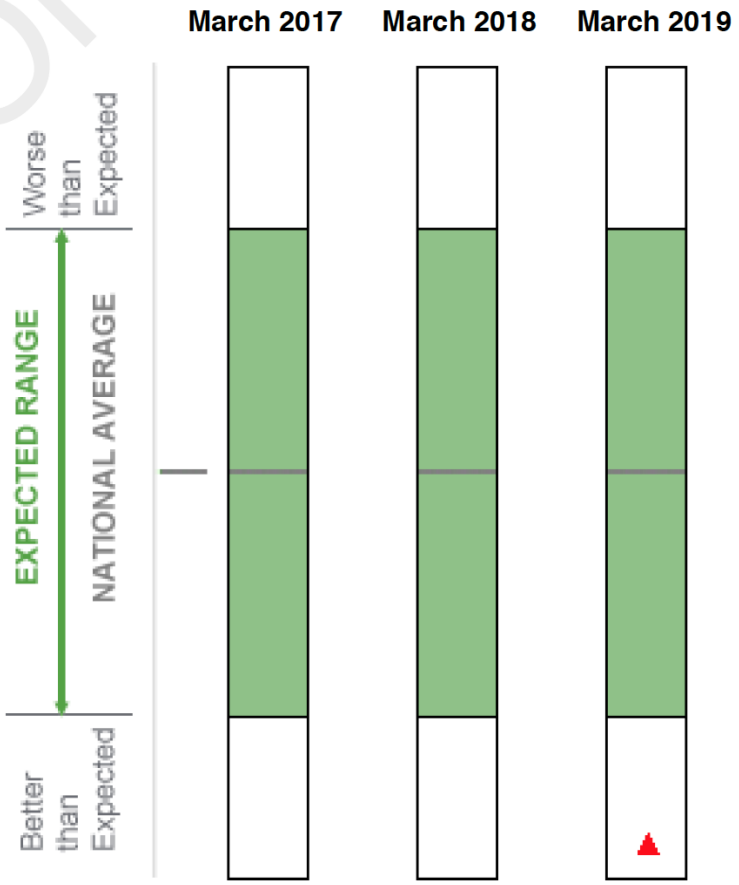
	1 year			3 years			5 years			7 years			10 years		
	Linkable cases	Revisions	Revision Rate	Linkable cases	Revisions	Revision Rate	Linkable cases	Revisions	Revision Rate	Linkable cases	Revisions	Revision Rate	Linkable cases	Revisions	Revision Rate
Nuffield Health Derby Hospital	4,954	15	0.3%	3,776	46	1.22%	2,752	53	1.93%	2,070	54	2.61%	1,278	36	2.82%
Nuffield Health	**59,922**	**260**	**0.43%**	**46,579**	**709**	**1.52%**	**35,056**	**796**	**2.27%**	**26,413**	**744**	**2.82%**	**15,486**	**583**	**3.76%**
Whole NJR	**1,130,244**	**5,435**	**0.48%**	**916,551**	**16,750**	**1.83%**	**715,365**	**19,103**	**2.67%**	**539,237**	**17,805**	**3.3%**	**296,899**	**12,463**	**4.2%**

Crude Revision Rate Data

- Not used for outlier analysis
- No case-mix adjustment
  - Average age primary hip
    - RNOH Stanmore – 59.3 years
    - Poole – 75.5 years

(i) Hospital SRR - Hips (latest 10 years)

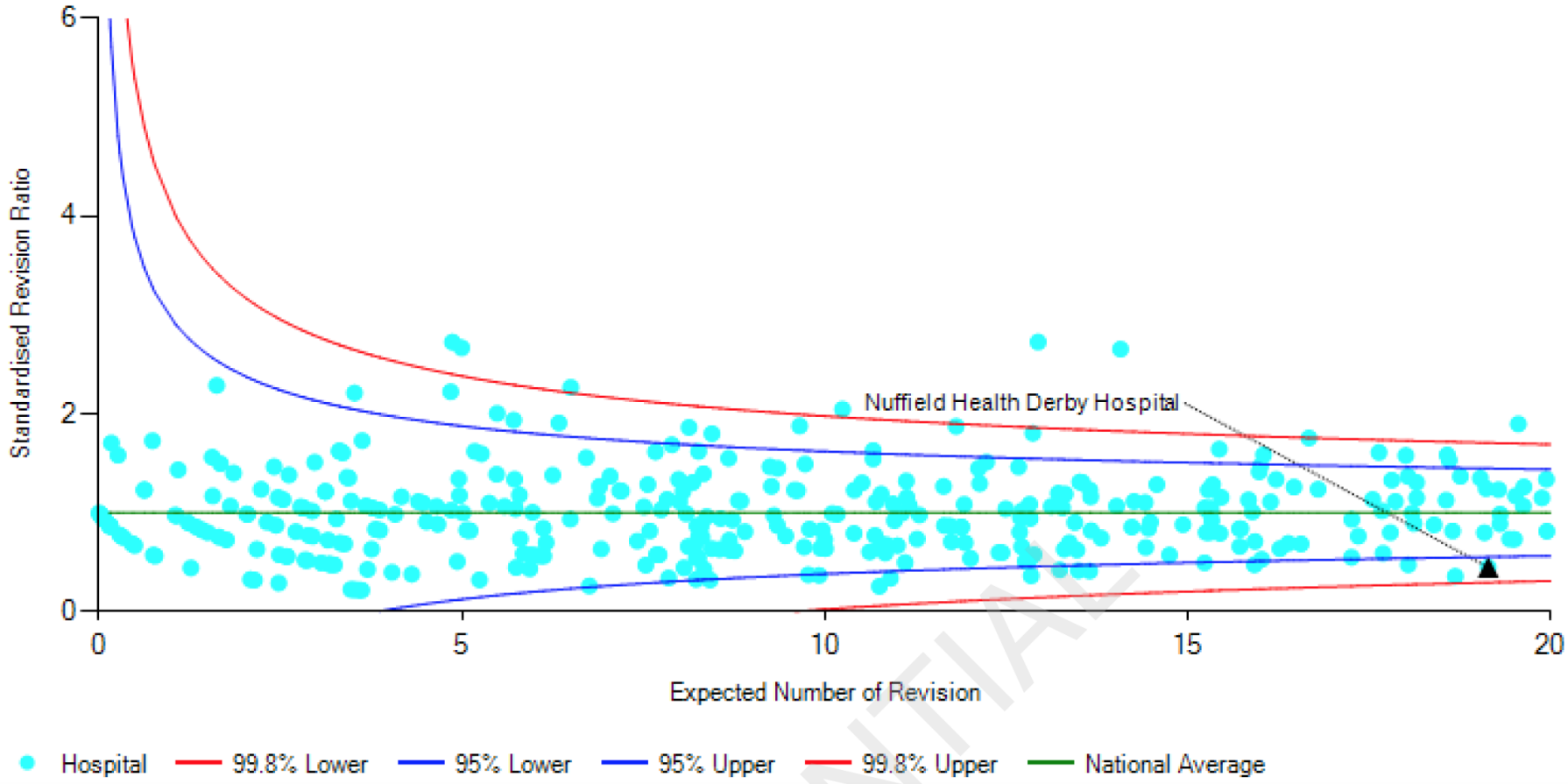




Represents the Unit Position on the funnel plot for 10yr SRR at each of the last 3 year's annual reports

10yr results only started being represented THIS year

(ii) Hospital SRR - Hips (latest 5 years)



Represents the Unit Position on the funnel plot for 5yr SRR at each of the last 3 year's annual reports

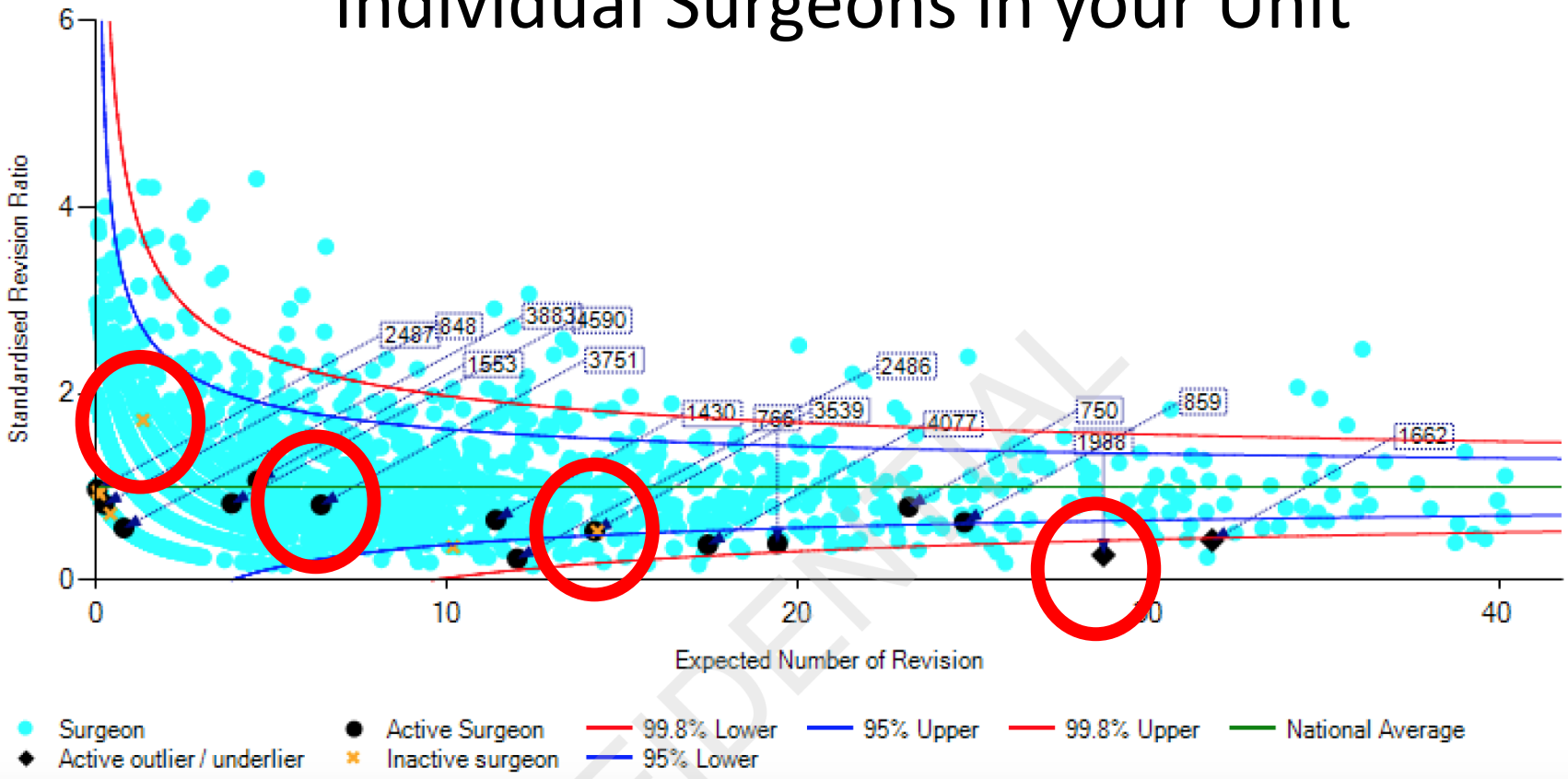
Revision Rate Data for a given period

- 5 year revision rate determined ONLY by procedures conducted > 5 years ago
  - Not affected by recent changes in practice
  - Cannot make use of more recent data

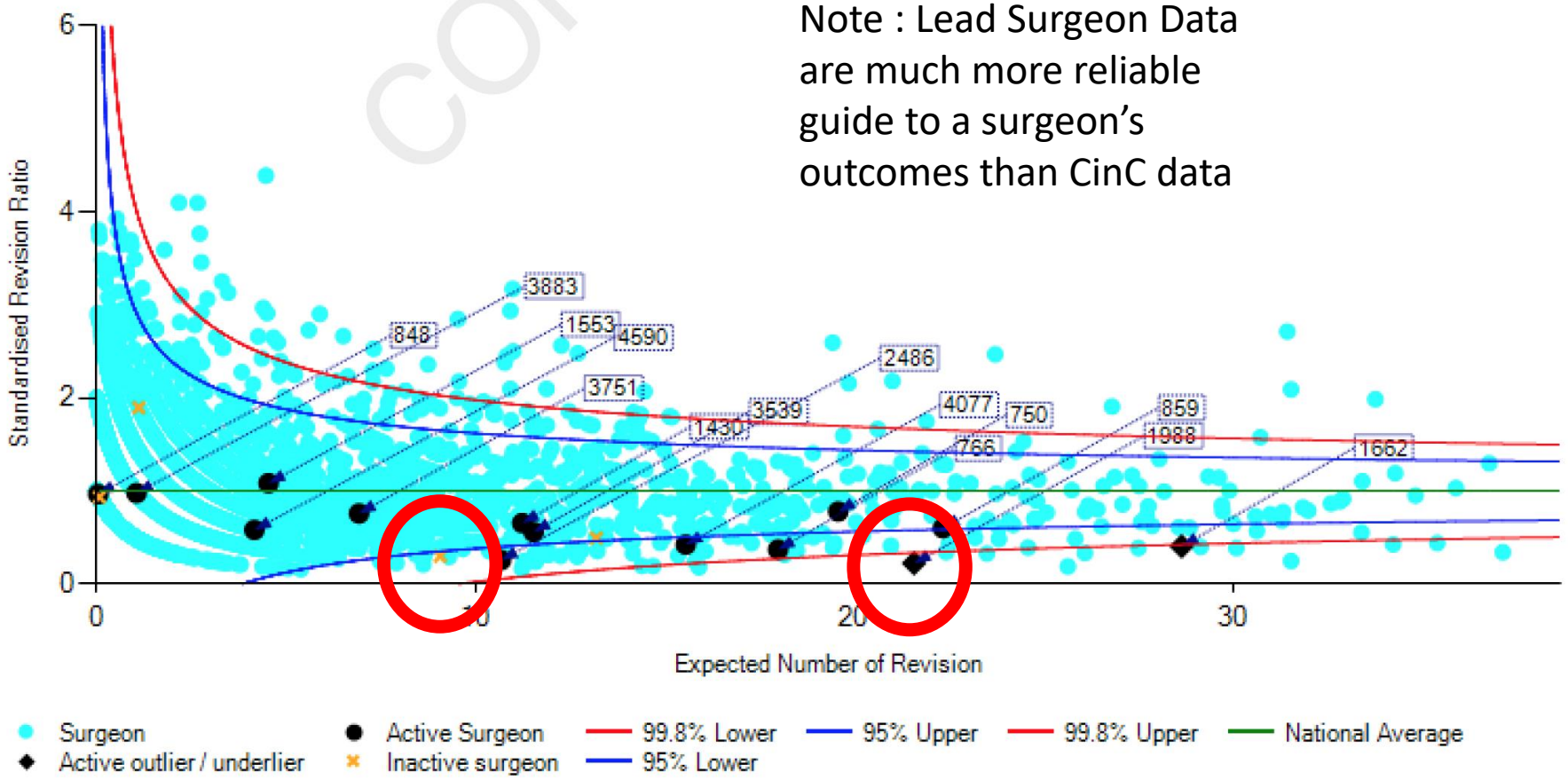
(v) Hip Surgeon - all procedures (latest 10 years) (Expected PTIR : 0.42)

Consultant In Charge

Individual Surgeons in your Unit



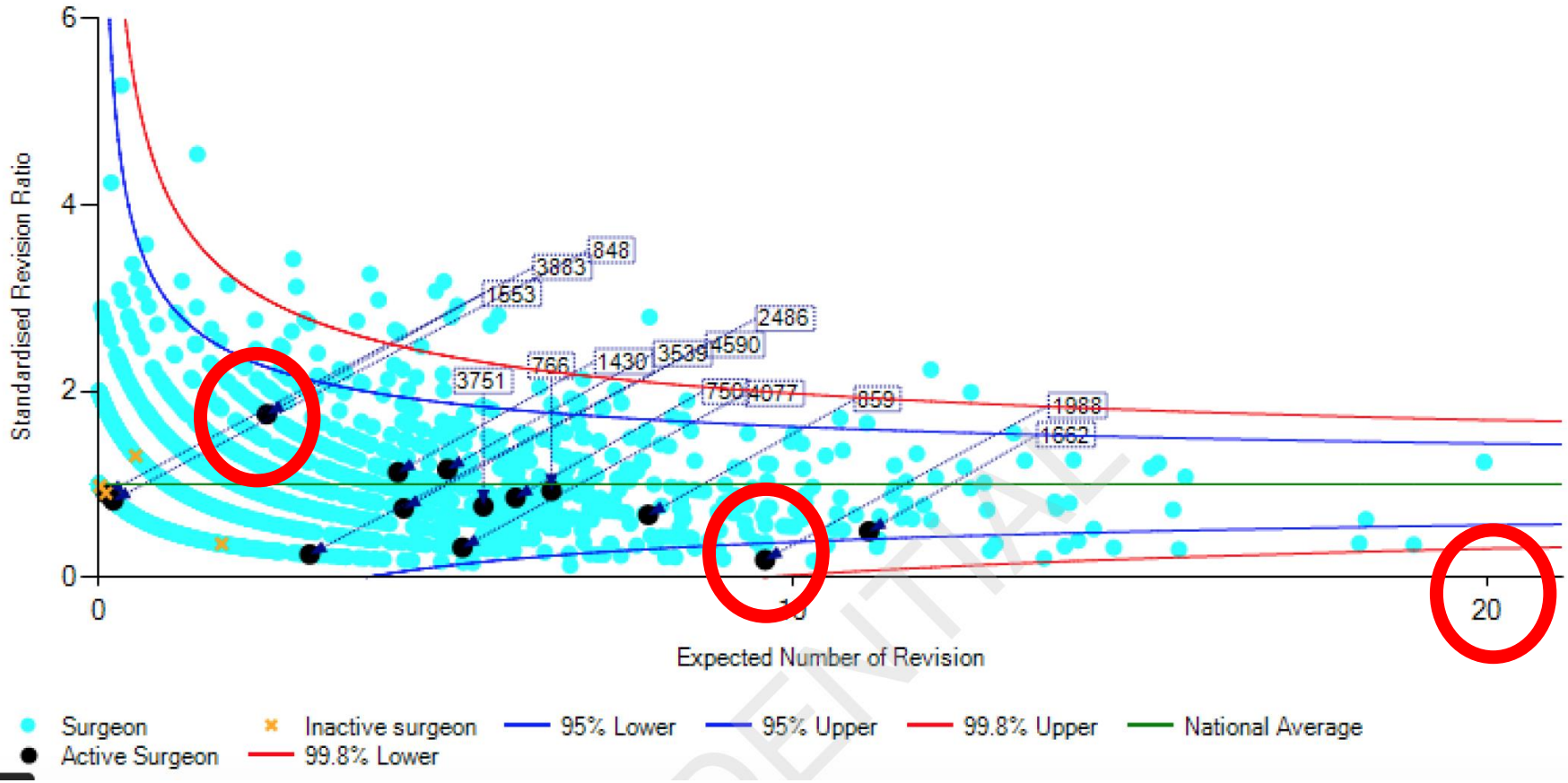
Lead Surgeon



Note : Lead Surgeon Data are much more reliable guide to a surgeon's outcomes than CinC data

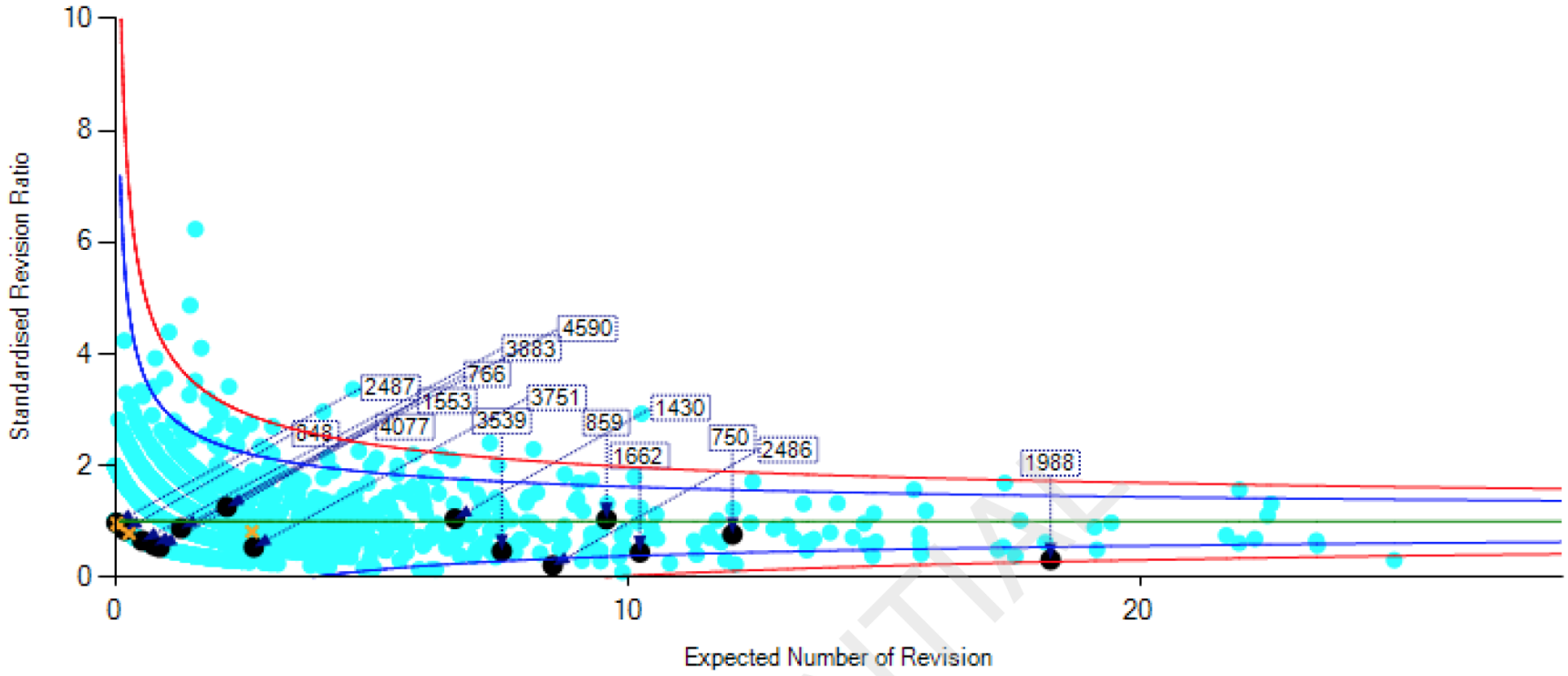
(vi) Hip Surgeon - all procedures (latest 5 years) (Expected PTIR : 0.47)

Consultant In Charge



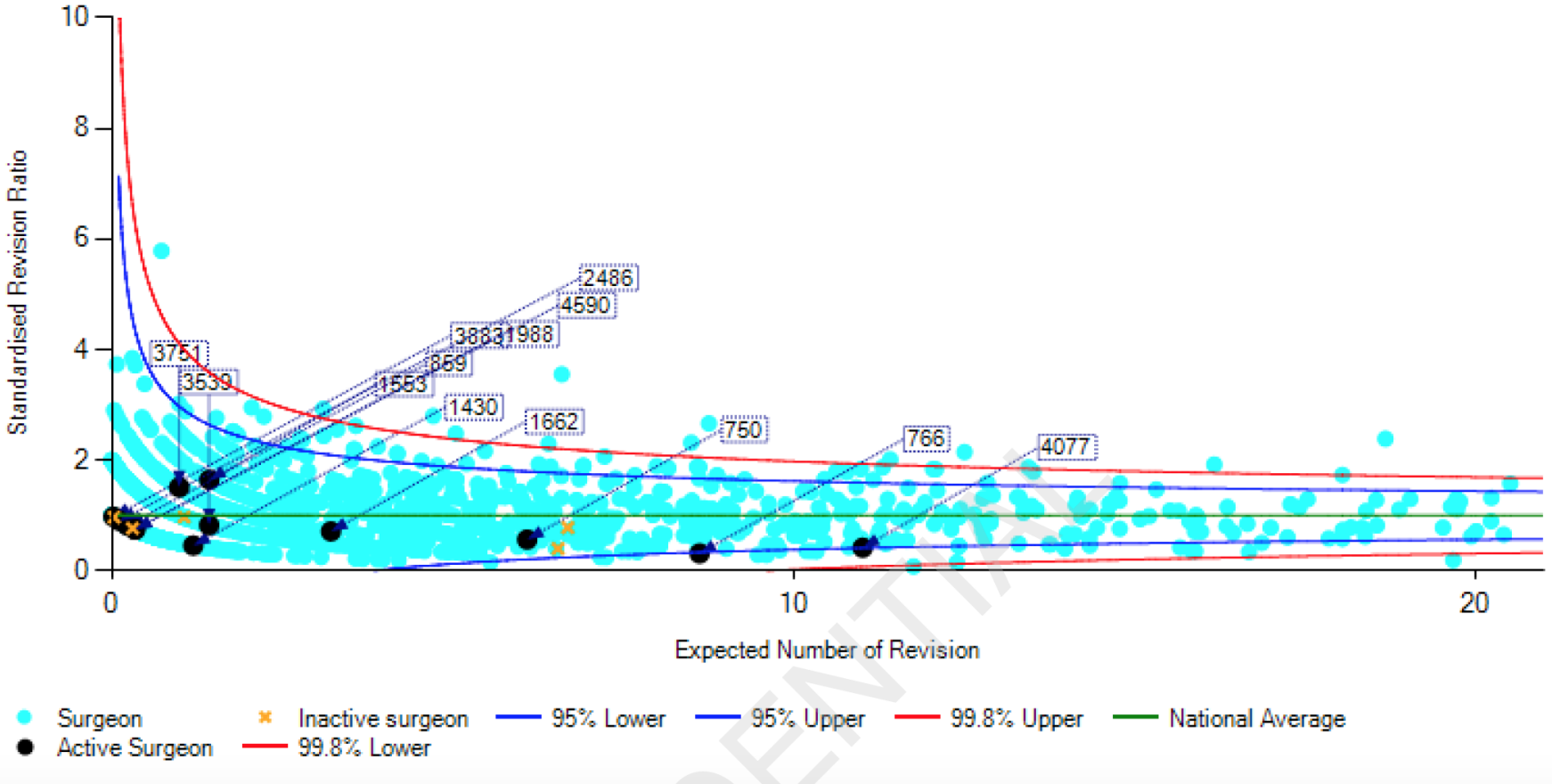
(vii) Hip Surgeon - cemented procedures (latest 10 years) (Expected PTIR : 0.33)

Consultant In Charge



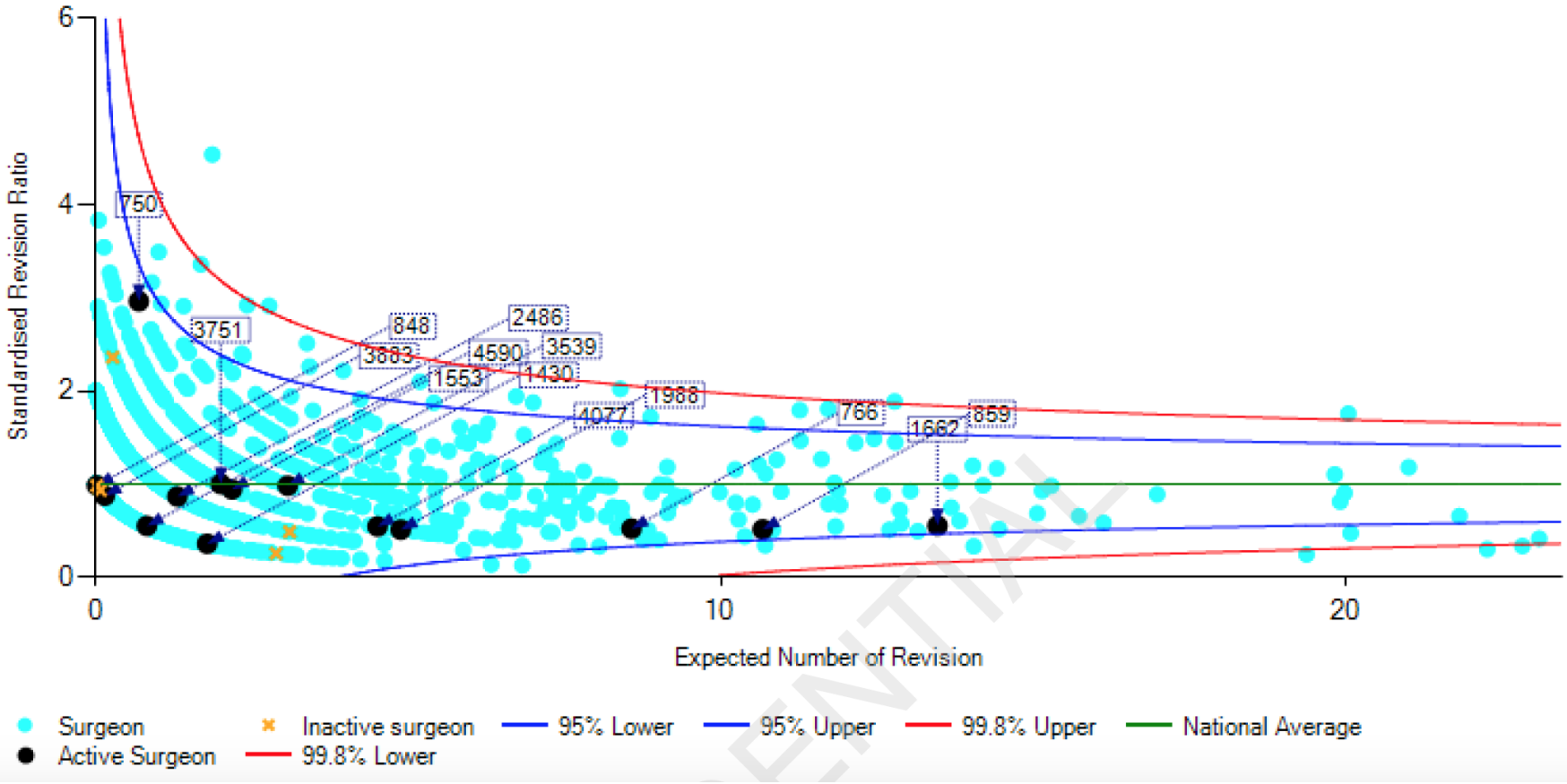
(viii) Hip Surgeon - cementless procedures (latest 10 years) (Expected PTIR : 0.43)

Consultant In Charge



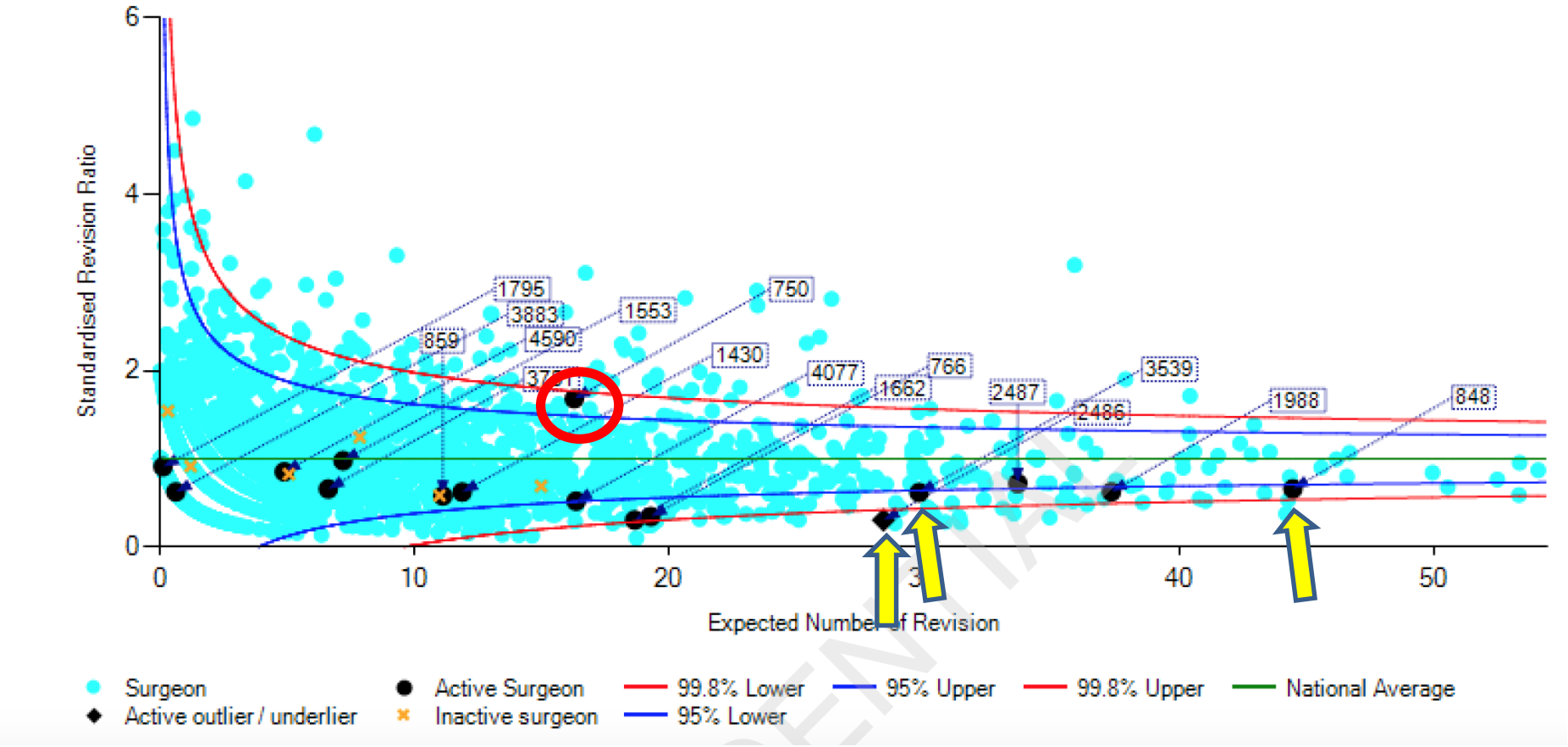
(ix) Hip Surgeon - hybrid procedures (latest 10 years) (Expected PTIR : 0.39)

Consultant In Charge

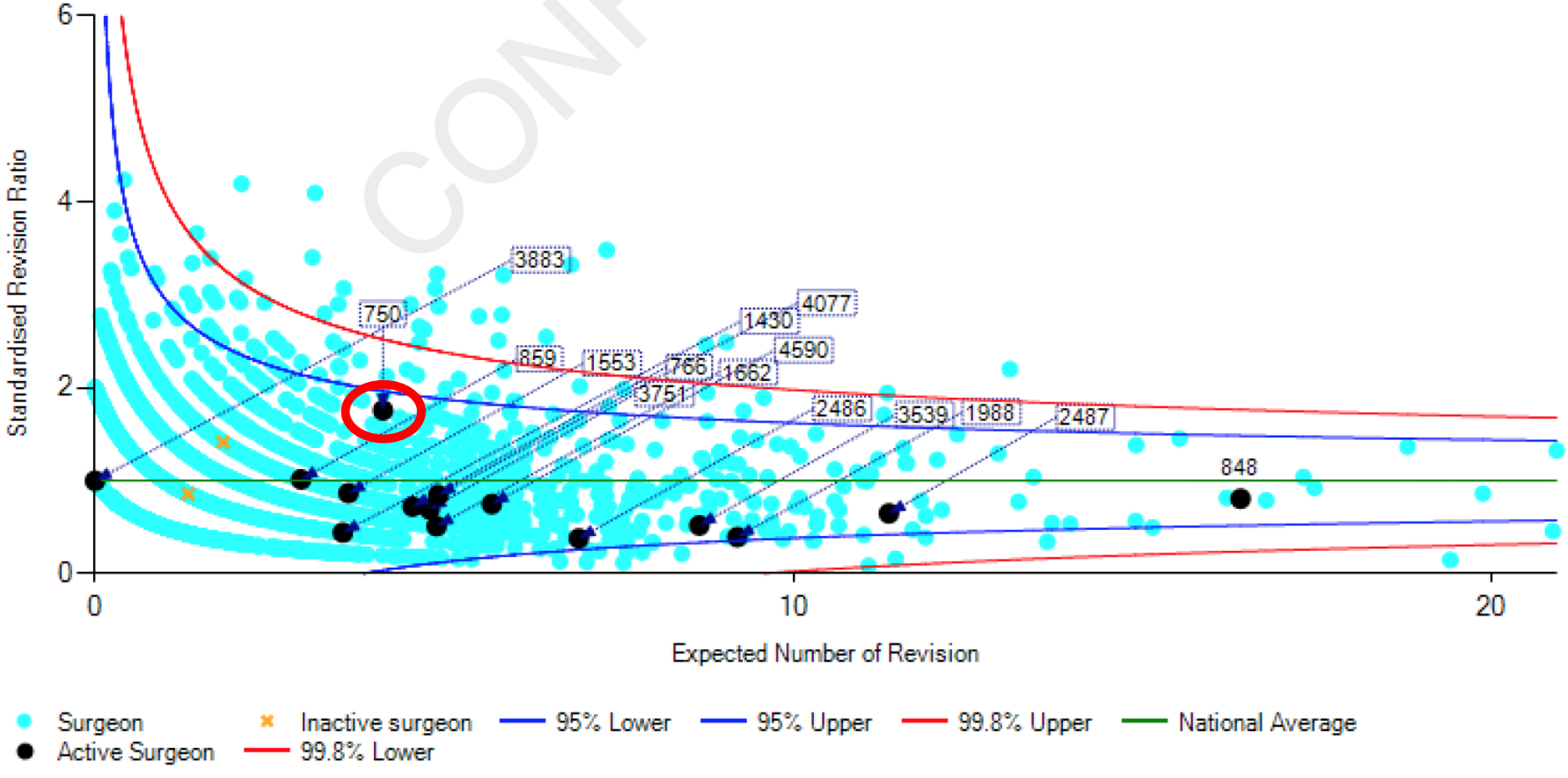


(x) Knee Surgeon - all procedures (latest 10 years) (Expected PTIR : 0.49)

Consultant In Charge

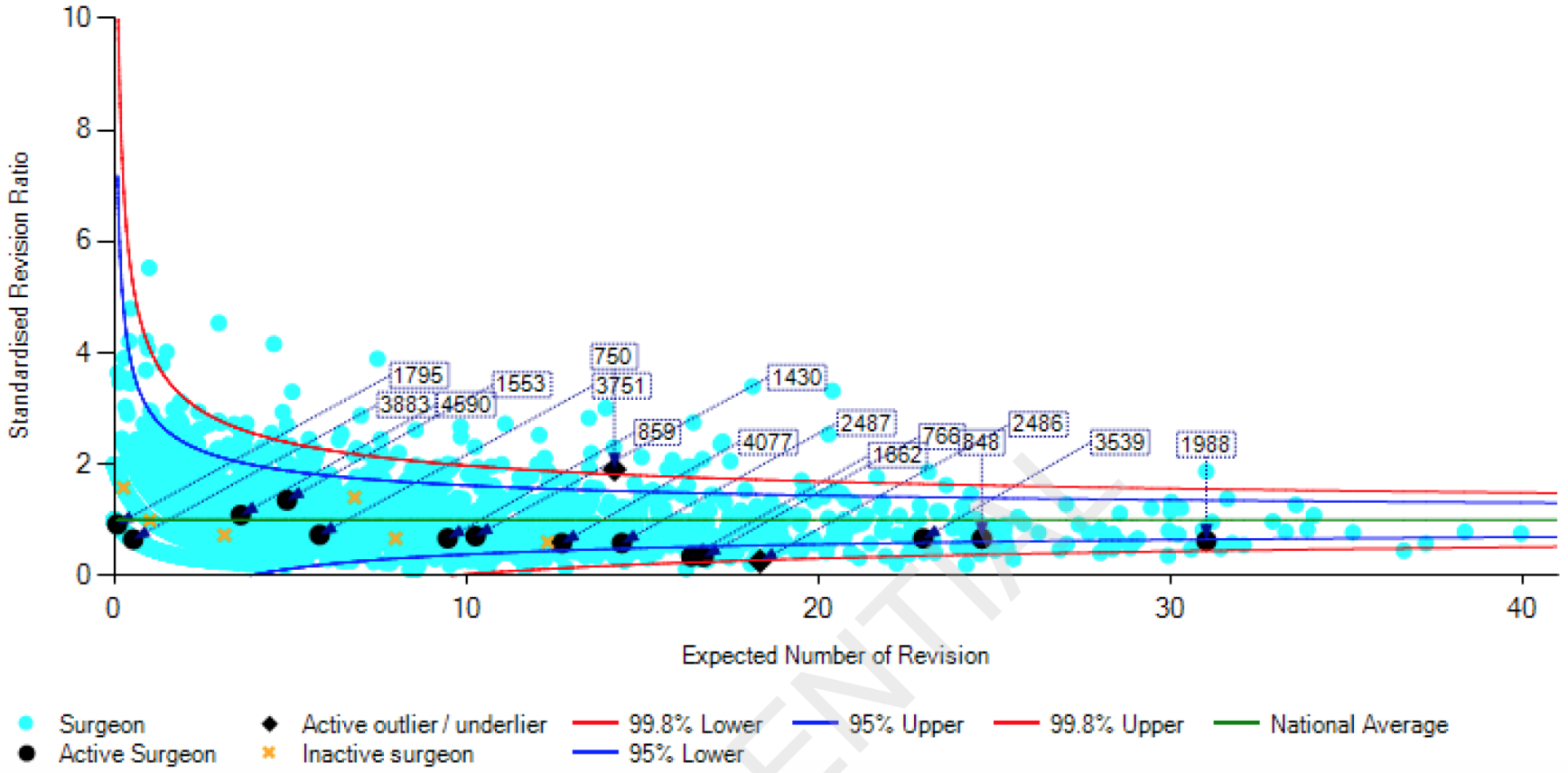


Lead Surgeon



(xii) Knee Surgeon - total knee replacement (latest 10 years) (Expected PTIR : 0.41)

Consultant In Charge

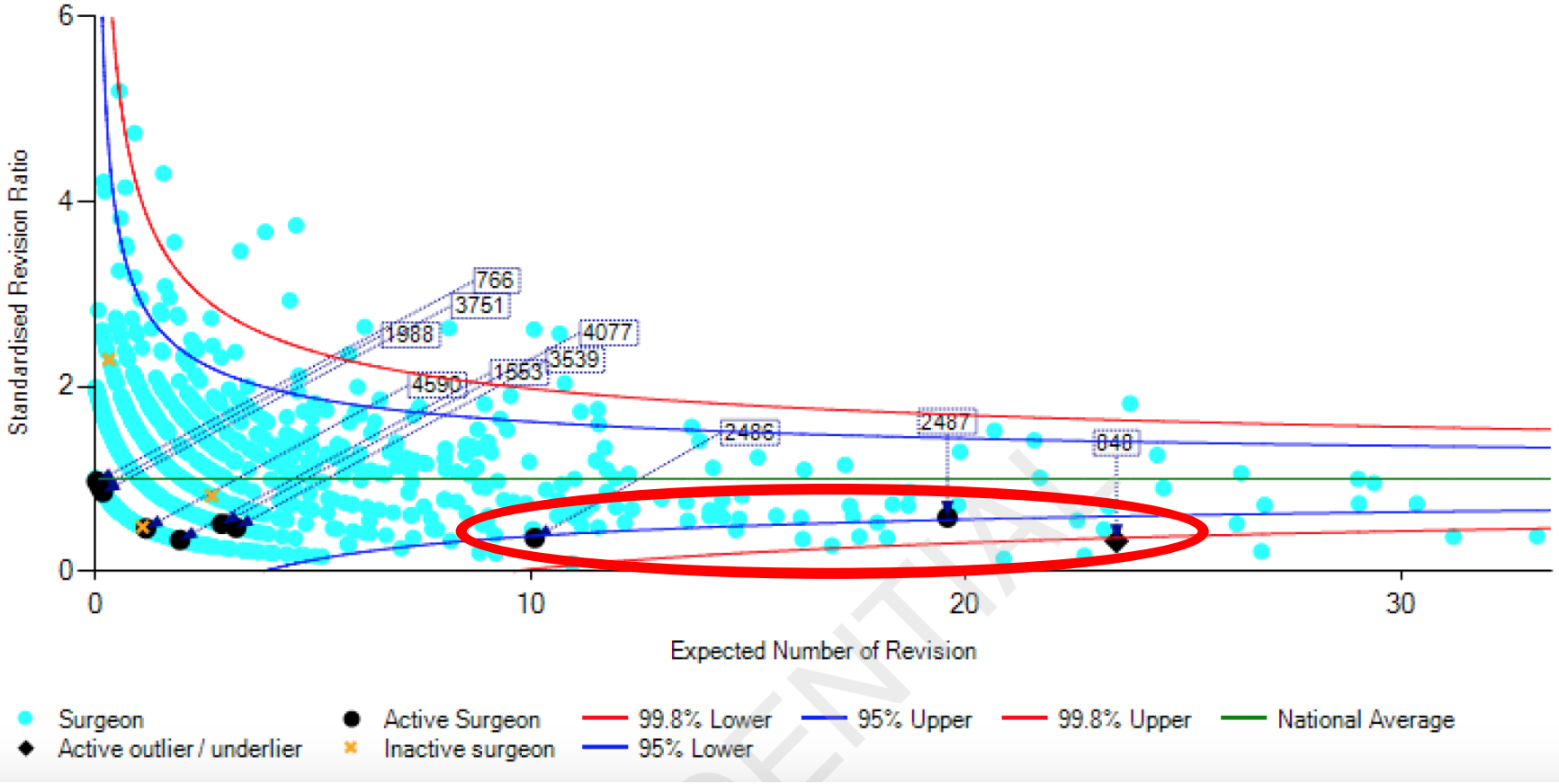


(xiii) Knee Surgeon - patello femoral procedures (latest 10 years) (Expected PTIR : 1.98)

Consultant In Charge

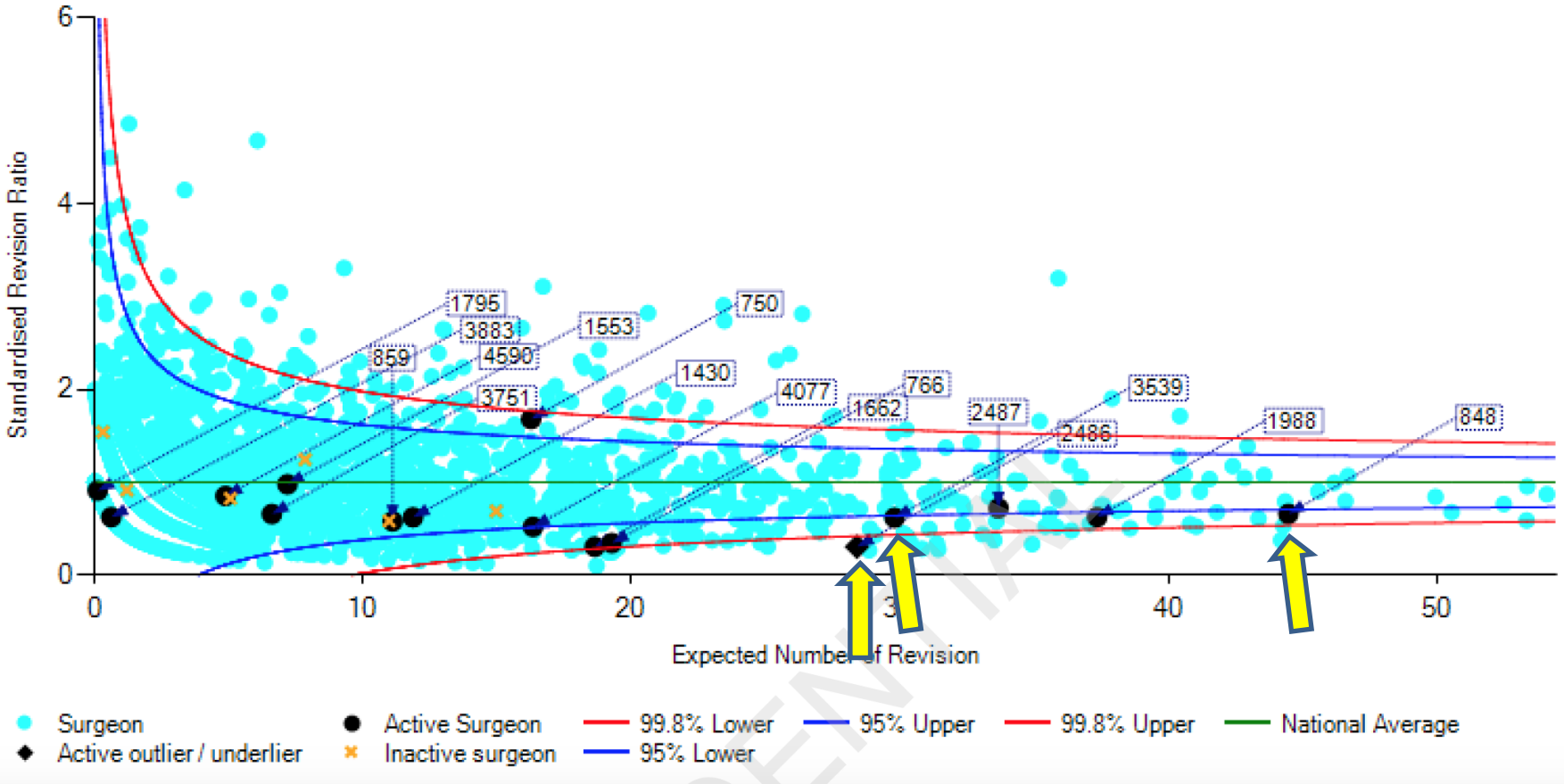
(xiv) Knee Surgeon - unicondylar procedures (latest 10 years) (Expected PTIR : 1.05)

Consultant In Charge



(x) Knee Surgeon - all procedures (latest 10 years) (Expected PTIR : 0.49)

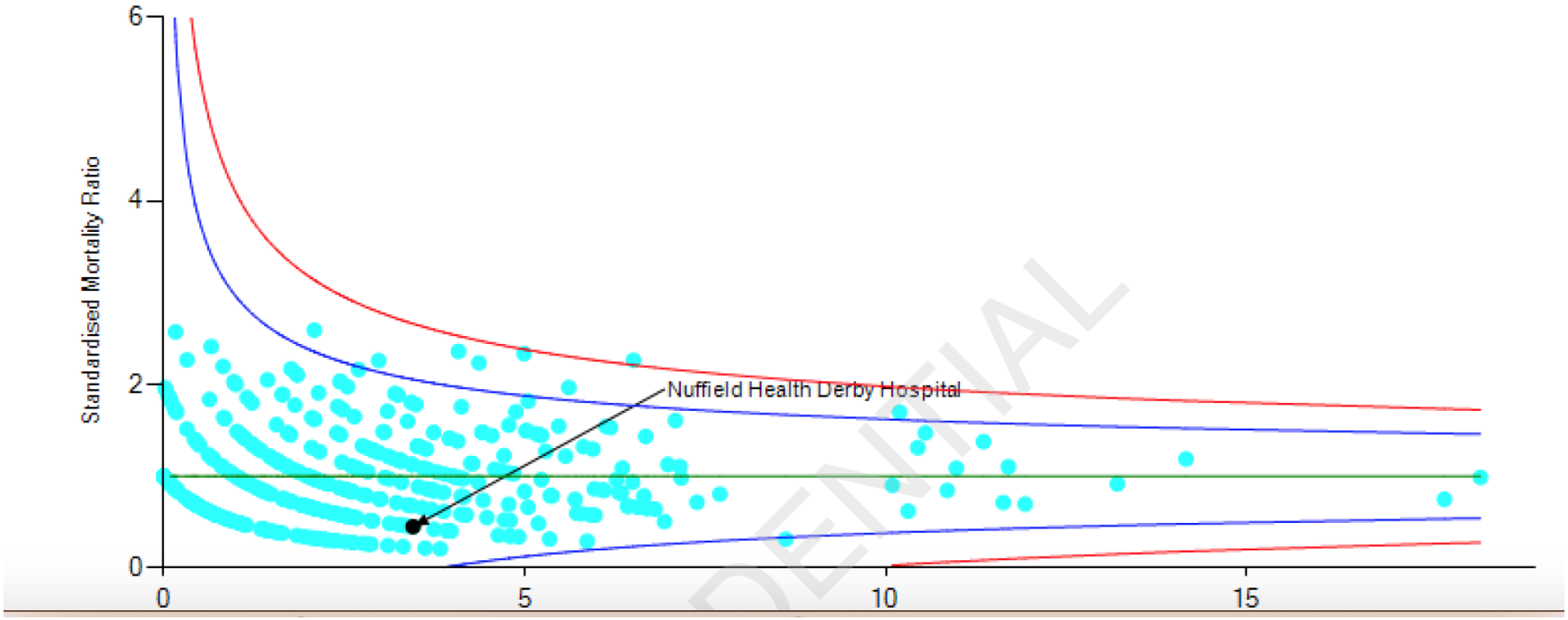
Consultant In Charge



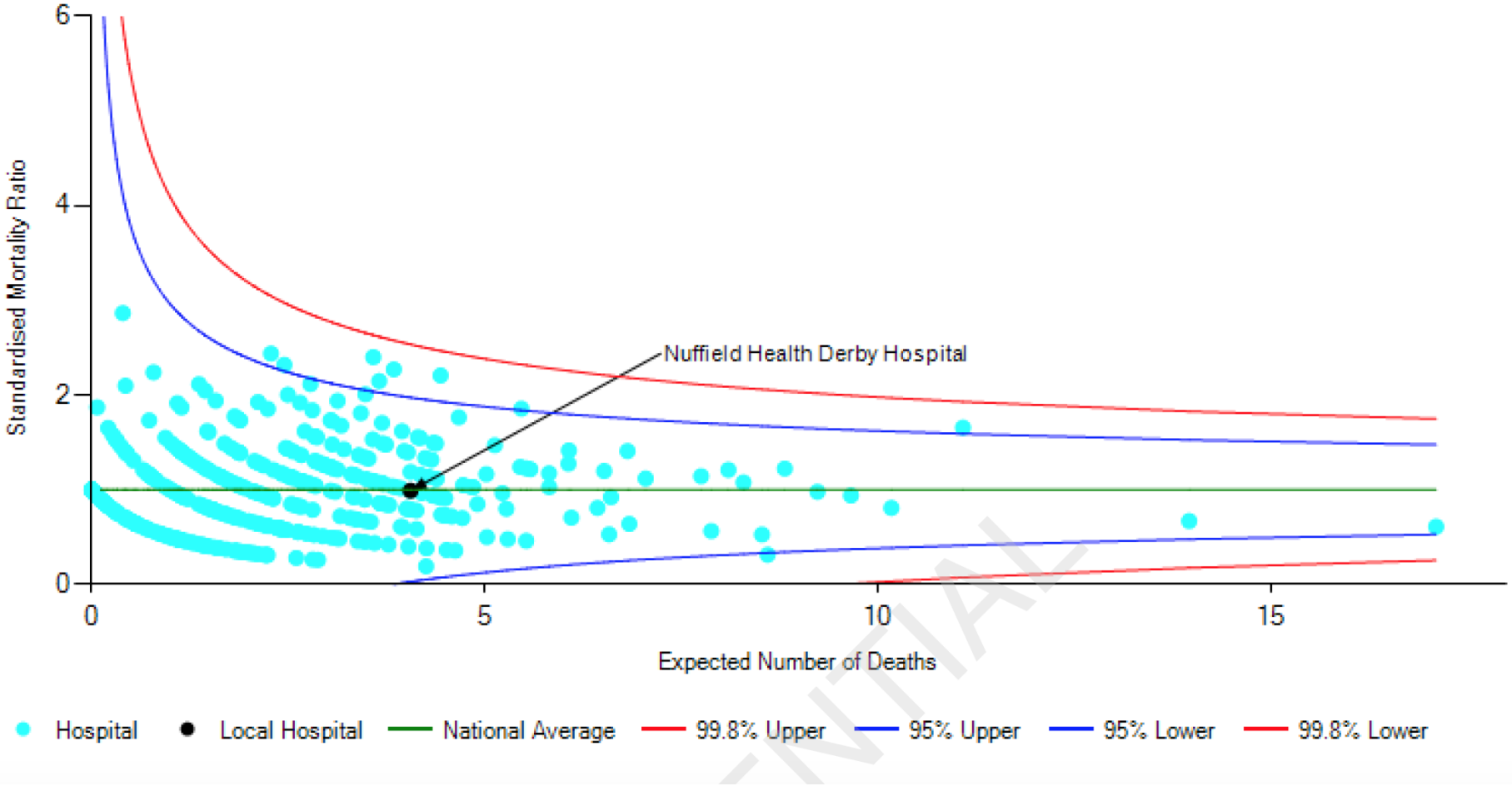
5. Standardised Mortality Ratio (SMR)

The standardised mortality ratio indicator shows the expected number of mortality events within 90 days following surgery against the observed number of mortality events. The indicator is based on the latest five years' of data submitted to the NJR.

(i) SMR - Hips – last 5 year 90 day all-cause mortality (excluding trauma and malignancy). (Expected mortality: 0.28%)



(ii) SMR - Knees – last 5 year 90 day all-cause mortality (excluding trauma and malignancy). (Expected mortality: 0.21%)



Hip Audit Results

Audit Year	Hospital	Total Primary For Audit Year	Total Primary Submitted Over 400 Days Late	Percent Of Primary Submitted Over 400 Days Late	Total Revision For Audit Year	Total Revision Submitted Over 400 Days Late	Percent Of Revision Submitted Over 400 Days Late
2015/2016	Nuffield Health Derby Hospital	332	8	2%	1	0	0%
2016/2017	Nuffield Health Derby Hospital	380	6	2%	6	0	0%
2017/2018	Nuffield Health Derby Hospital	416	1	0%	0	0	0%

Knee Audit Results

Audit Year	Hospital	Total Primary For Audit Year	Total Primary Submitted Over 400 Days Late	Percent Of Primary Submitted Over 400 Days Late	Total Revision For Audit Year	Total Revision Submitted Over 400 Days Late	Percent Of Revision Submitted Over 400 Days Late
2015/2016	Nuffield Health Derby Hospital	543	6	1%	6	2	33%
2016/2017	Nuffield Health Derby Hospital	600	18	3%	3	1	33%
2017/2018	Nuffield Health Derby Hospital	621	2	0%	8	0	0%

Total Audit Results

Audit Year	Hospital	Total Primary For Audit Year	Total Primary Submitted Over 400 Days Late	Percent Of Primary Submitted Over 400 Days Late	Total Revision For Audit Year	Total Revision Submitted Over 400 Days Late	Percent Of Revision Submitted Over 400 Days Late
2015/2016	Nuffield Health Derby Hospital	875	14	2%	7	2	29%
2016/2017	Nuffield Health Derby Hospital	980	24	2%	9	1	11%
2017/2018	Nuffield Health Derby Hospital	1,037	3	0%	8	0	0%

Previous Annual Reports

- Were presenting data from since the Registry began in 2003 instead of 10yr revision data
- 5 year data were presented as now
- This meant that early data were included which were less reliable and complete
- Change in practice would not have been rewarded
- Metal-on-Metal hip data would never have gone away by the old system even though they were no longer being done since 2010

How best to use the NJR data

- First and Foremost DO look at it!
- See how the unit is doing
- Are there individual surgeons with high “whole practice SRR”?
- If so are they doing “high revision rate procedures”

Is the reason for problems **the UNIT**

- High infection rate
- All surgeons not doing especially well
- Higher mortality
- Poor data quality in other respects

How best to use the NJR Data

- Are the surgeons meeting to discuss their NJR outcomes
- Is there any record of those meetings (eg at NHS TRUST)
- Are there Frank Outlier Surgeons for specific procedures?
- Do ALL Surgeons' Appraisals confirm they have used the CLR in appraisal discussions with an arthroplasty surgeon?

How best to use the NJR data?

- Are surgeons' results generally better/worse than average in the Unit
- If high risk operations are being done are THEY being done well?
- If ALL surgeons are doing higher risk procedures do other outcomes suggest the risk is worth it?
- Eg Better mortality, better PROMs gain, less infection etc

Other Outcome Measures (NOC)

Data for August 2009 - August 2019

Click on the i to find out more about the quality measure and its source data

HOW TO INTERPRET THIS CHART

Patient Outcomes Quality Measure	This Hospital	Patient Records Analysed	This Hospital Ratio	National Ratio	Worse than Expected / EXPECTED RANGE / NATIONAL AVERAGE / Better than Expected
90 Day Mortality: Operations Aug14-Aug19	OK As Expected	3810	0.43	1.00	
Revision Rate: Operations Aug09-Aug19	OK As Expected	7287	1.15	1.00	
Revision Rate: Operations Aug14-Aug19	OK As Expected	3898	1.33	1.00	

Other Outcome Measures

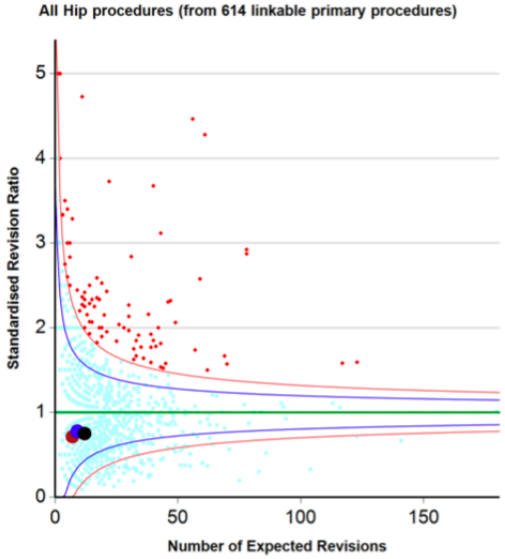
Data for 1 April 2018 - 31 March 2019

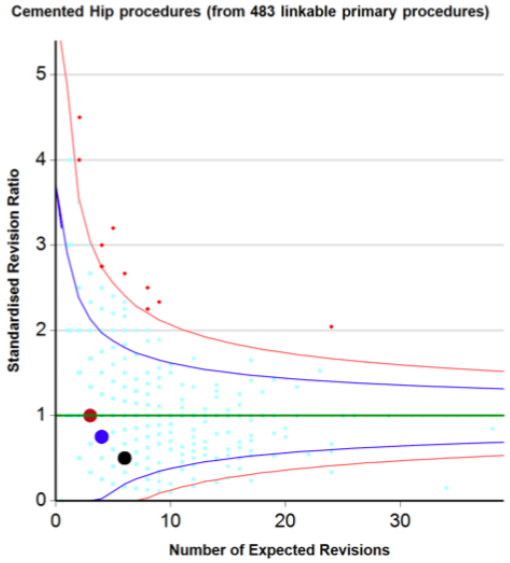
Click on the i to find out more about the quality measure and its source data

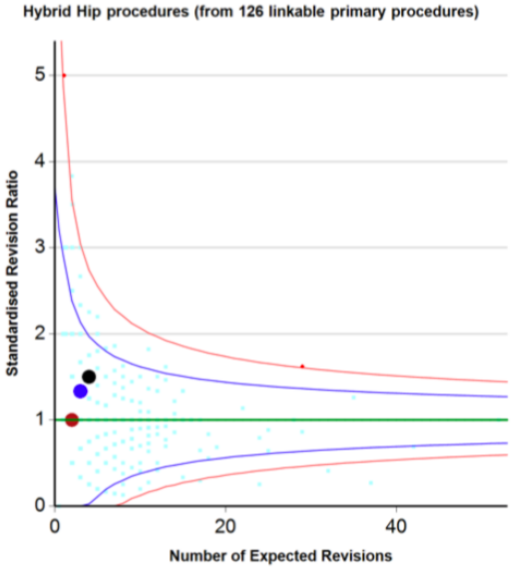
HOW TO INTERPRET THIS CHART

Patient Reported Improvement Measure	This Trust	Patient Records Analysed	Trust Avg Health Gain	National Avg Health Gain	Worse than Expected / EXPECTED RANGE / NATIONAL AVERAGE / Better than Expected
Oxford knee Score	OK As Expected	318	18.45	17.33	
EQ-5D	OK As Expected	305	0.353	0.341	
EQ-VAS	OK As Expected	315	8.67	7.51	

Are individual surgeons' results getting better or worse?







National Joint Registry
www.njrcentre.org.uk
Working for patients, driving forward quality

Thank you

Contact Details:

Mr Tim Wilton MA FRCS

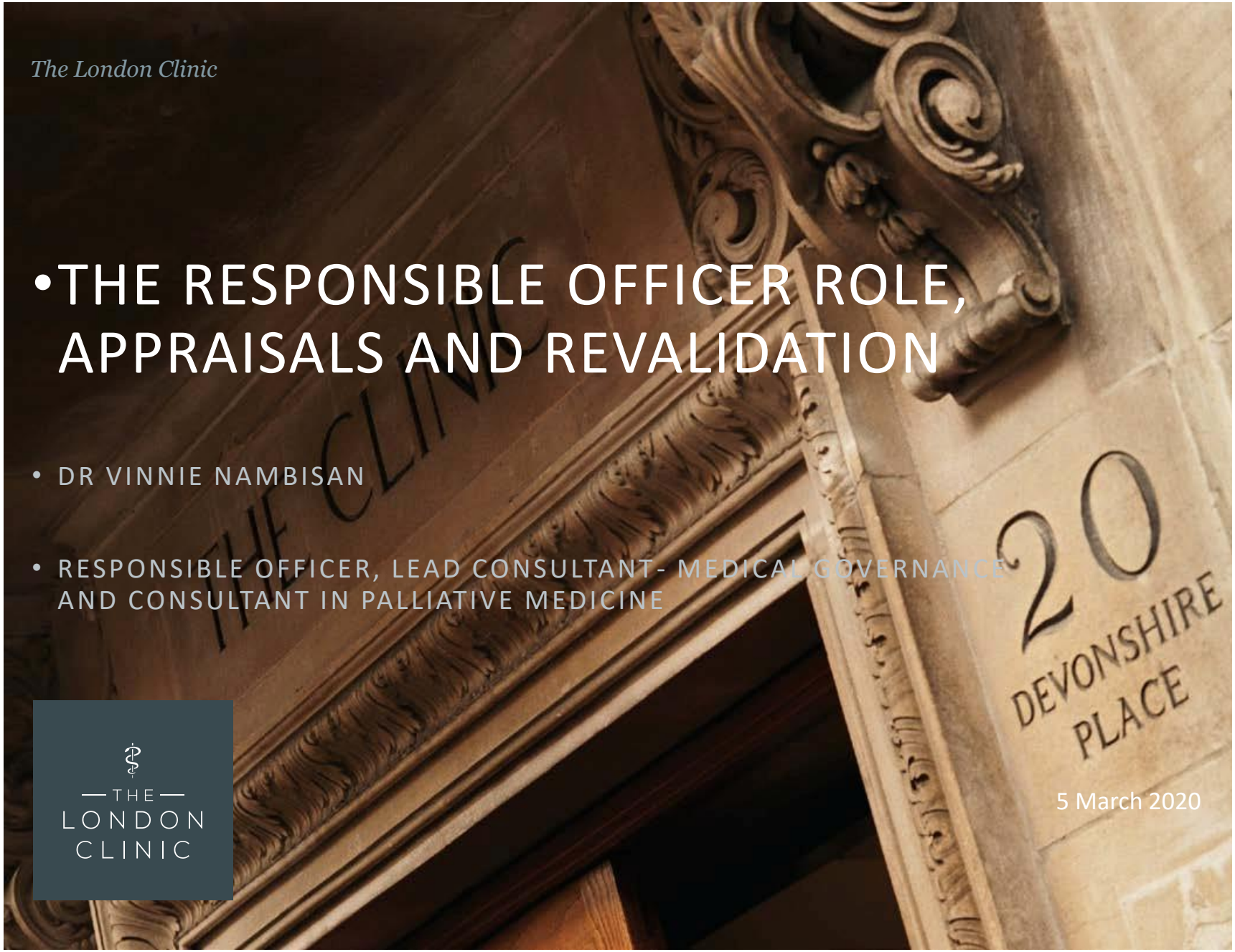
timothywilton@njr.org.uk

Beyond Compliance
Protecting Patients, Supporting Innovation

Independent Healthcare Providers Network
NHS CONFEDERATION

Supporting whole practice appraisal
Section 3

#MPAFLONDON



•THE RESPONSIBLE OFFICER ROLE, APPRAISALS AND REVALIDATION

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

THE LONDON CLINIC

5 March 2020

Contents

- The role of the Responsible Officer
- Information sharing
- Medical appraisal

Background- Doctors' responsibilities

General Medical Council

- All practising doctors need to maintain a licence to practise, through engaging in revalidation (five year cycle), which involves undergoing annual appraisal

- Organisations that contract with or engage the services of doctors will usually be classed in law as a 'designated body'

- Every* doctor has a 'prescribed connection' to one designated body, who have certain responsibilities to support revalidation/ fitness to practise. A doctor working in the independent sector who is employed by the NHS will be 'connected' to the NHS.

The Responsible Officer (RO)

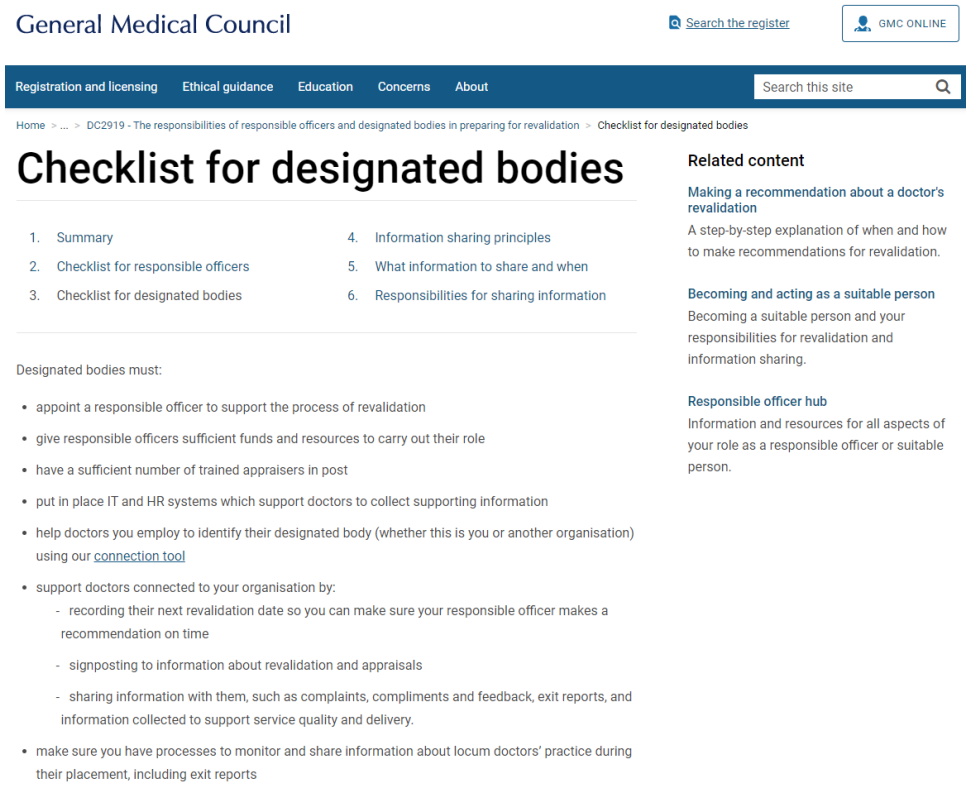
- Statutory senior medical role required for each designated body (organisations that employ or contract with doctors)

- ROs must assure themselves that the quality of their systems supports the evaluation of doctors' fitness to practise in a fair and consistent way.

- Focuses on fitness to practise, conduct and performance, and other governance-related matters (including pre-employment checks)

'The role of the responsible officer is to ensure organisations have in place processes that provide a framework within which doctors are encouraged to maintain and improve their practice.'

GMC resources for DBs, ROs and doctors



General Medical Council

Search the register | GMC ONLINE

Registration and licensing | Ethical guidance | Education | Concerns | About | Search this site

Home > ... > DC2919 - The responsibilities of responsible officers and designated bodies in preparing for revalidation > Checklist for designated bodies

Checklist for designated bodies

1. Summary
2. Checklist for responsible officers
3. Checklist for designated bodies
4. Information sharing principles
5. What information to share and when
6. Responsibilities for sharing information

Designated bodies must:

- appoint a responsible officer to support the process of revalidation
- give responsible officers sufficient funds and resources to carry out their role
- have a sufficient number of trained appraisers in post
- put in place IT and HR systems which support doctors to collect supporting information
- help doctors you employ to identify their designated body (whether this is you or another organisation) using our connection tool
- support doctors connected to your organisation by:
  - recording their next revalidation date so you can make sure your responsible officer makes a recommendation on time
  - signposting to information about revalidation and appraisals
  - sharing information with them, such as complaints, compliments and feedback, exit reports, and information collected to support service quality and delivery.
- make sure you have processes to monitor and share information about locum doctors' practice during their placement, including exit reports

Related content

Making a recommendation about a doctor's revalidation
A step-by-step explanation of when and how to make recommendations for revalidation.

Becoming and acting as a suitable person
Becoming a suitable person and your responsibilities for revalidation and information sharing.

Responsible officer hub
Information and resources for all aspects of your role as a responsible officer or suitable person.

https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/the-responsibilities-of-responsible-officers-and-designated-bodies-in-preparing-for-revalidation/checklist-for-designated-bodies

The Medical Profession (Responsible Officers) Regulations 2010 (regulations 11 and 16) and DoH guidance

- **In respect of those doctors who have a prescribed connection to the designated body:**

- Regular appraisals including quality assurance
- Establish and implement procedures for investigating concerns about doctors' fitness to practise and refer to the GMC where appropriate
- Monitor compliance with GMC conditions and undertakings
- Make recommendations to the GMC about doctors' fitness to practise (revalidation)
- Maintain records relating to the above
- Pre-employment/ contract checks (identity/ qualifications/ experience/ references)
- Review performance information held by the designated body, including clinical indicators, identify any issues from that information relating to medical practitioners, such as variations in individual performance; and ensure that the designated body takes steps to address any such issues
- Initiate and ensure that investigations are carried out properly, considering all relevant information, and take action at the end, including addressing any systemic issues within the designated body which may have contributed to the concerns identified.
- Quality assurance of clinical governance systems

RO or Medical Director?

	Medical Director	Responsible Officer
Legally-defined role		✓
Routinely a member of the executive board	✓	
Overall responsibility for investigations of doctors		✓
Responsible for overseeing appraisals		✓
Strategic business focus	✓	
Ultimate responsibility for revalidation decisions		(makes a recommendation)
Key role in individual doctors' job planning	(✓)	

The RO's role in investigations of doctors

- The RO is usually expected to the *case manager* for an investigation involving a connected doctor. This includes:
  - Deciding to open an investigation
  - Writing terms of reference and appointing the *case investigator*
  - Ensuring the correct process is followed
  - Deciding the next steps after receiving the report
- The *case investigator* is tasked with carrying out the investigation in line with the terms of reference
- The case manager and investigator should probably not be the same person

How might the RO and Registered Manager work together?

- Revalidation/ decision-making groups
- Sounding board for concerns about doctors
- Advising in relation to general governance issues (which might impact on doctors)
- Sharing certain information between organisations
- There is no guidance on when or how the RO and RM should work together- but in my experience, there is benefit to involving the RO early and often
- For organisations with a central RO and multiple RM's, a local consultant in a medical governance (deputy/ assistant RO?) role will be helpful

What takes up my time as an RO?

- Responding to requests for information about doctors- revalidation/ appraisals/ ftp
- Chasing up and reviewing doctors' appraisals to ensure they are satisfactory
- Seeking/ reviewing organisational information for revalidation recommendations/ conditions monitoring etc
- Dealing with concerns (including investigations) and influencing other senior staff in relation to medical governance
- Other governance related activities

Tensions and challenges of the RO role

- Is there an inherent conflict of interest in the RO role as it currently is?
- Should the RO and MD be the same person?
- Influencing/ negotiating with the designated body
- How good are revalidation decisions (and appraisals)?
- Knowing what information to share, with whom, and when

Case 1

- Dr A is the (NHS) RO for Dr C, a consultant in gastroenterology.

- Dr C applies for practising privileges at your hospital. You have heard ‘noise’ about him from consultants in your hospital, and ask your RO, Dr B, to talk to Dr A to see what they can find out.

- What should Dr B do?
- What should Dr A say?
- What should Dr C be told?

Sharing information- NHSE guidance on information flows

Responsible officer duty to share

- *On a routine basis, the responsible officer is only required to share information about a doctor's fitness to practise with the GMC.*

- *The responsible officer is not under any duty, routinely, to share information about a doctor's fitness to practise with any other person.*

- The Responsible officer has the prerogative to employ any suitable information flow necessary to discharge their statutory function and to protect patient safety.

ARCP (Annual Review of Competence Progression)
CG (clinical governance)
DB (designated body)
FTP (fitness to practice
GMC (General Medical Council)
HR (human resources)
MPIT (Medical Practice Information Transfer)
RO (responsible officer)

Appendix B: Summary tables of information flows:

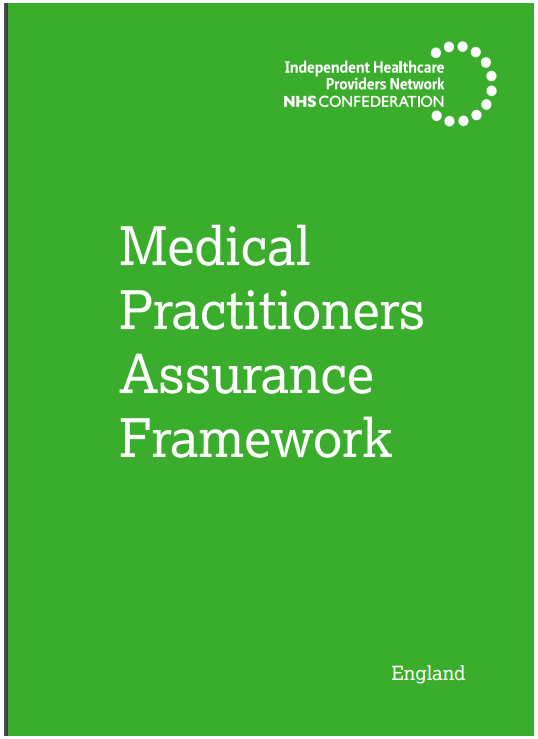
All flows

Information flows about a doctor's practice to support medical governance and responsible officer statutory functions.										
	Scenario	Flow	Circumstances	From:	To	Push/Pull?	What?	When?	How?	Shared with doctor?
Routine	Where a doctor takes up or leaves employment ('E')	E1	New employment	Doctor	HR	Pull by HR	Pre-employment information	Prior to employment	Following organisation's processes	N/A (from doctor)
		E2	New employment no change in DB	Doctor	RO	Push from doctor	Confirmation of new role	Next appraisal	In Scope of Work section of appraisal documentation	N/A (from doctor)
		E3	New employment no change in DB	CG Lead of employing organisation	RO	Push from new employer	Confirmation of new role	On commencement of employment	Electronically by secure mechanism using standard template	Yes - cc
		E4	New DB	Doctor	New RO	Pull by new RO	Details of previous RO/DB Last and next revalidation dates Appraisal documentation (unless trainee) Information of note	On forming new prescribed connection	As agreed with the new responsible officer	N/a - from doctor
		E5	New DB	Previous RO	New RO	Pull by new RO	Date of last appraisal/ARCP ARCP documentation (if trainee) Information of note	On forming new prescribed connection	MPIT form or equivalent	Yes - cc
		E6	End of employment/ placement with organisation other than designated body	CG Lead of employing organisation	RO	Push from CG lead	Information of note or confirmation there is no information of note	Within 2 weeks of end of placement	MPIT form or abbreviated version (e-MPIT)	Yes in almost all circumstances
	Appraisal ('A')	A1	Pre-appraisal	RO	Doctor and appraiser	Push from RO	Agreed expected information for inclusion at appraisal	Before appraisal	In suitable format for inclusion at appraisal	N/A (to doctor)
		A2	Pre-appraisal	CG lead of employing organisation	Doctor	Push from CG lead	Local CG outputs	When produced, preferably before appraisal	In suitable format for inclusion at appraisal	N/A (to doctor)
		A3	Pre-appraisal	Doctor	Appraiser	Push from doctor	Appraisal submission	Before appraisal	As defined by DB's appraisal policy	N/A (from doctor)
		A4	Post-appraisal	Appraiser	RO	Push from appraiser	Appraisal documentation	Within 28 days of appraisal meeting	As defined by DB's appraisal policy	N/A (doctor has copy)
		A5	Post-appraisal	Doctor	CG Lead of employing organisation	Pull by CG lead	If agreed, appraisal documentation	As agreed between doctor and employing organisation	As agreed between doctor and employing organisation	N/A (from doctor)
	Revalidation ('R')	R1	Recommendation is due	RO	GMC	Push from RO	Revalidation recommendation	Prior to notified recommendation due date	Via GMC Connect	Yes (good practice is to inform doctor before GMC)
Ad hoc	Information of Note ('IN')	IN1	Sharing new information of note with RO	Doctor	RO	Push from doctor	New information of note for the RO to note or take action	On identification of the information	As agreed with the responsible officer	N/A (from doctor)
		IN2	Sharing new information of note with RO	CG lead of employing organisation	RO	Push from CG lead	New information of note for the RO to note or take action	On identification of the information	MPIT form or other appropriate mechanism	Yes in almost all circumstances
		IN3	Sharing new information of note with RO	Appraiser	RO	Push from appraiser	New information of note arising from appraisal for the RO to note or take action	On identification of the information	Appraisal documentation, MPIT form or other appropriate mechanism	Yes in almost all circumstances
		IN4	Sharing new information of note with employing organisation	RO	CG leads in employing organisations	Push from RO	Confirmed information of note relevant to employing organisation	On confirmation of the information	MPIT form or other appropriate mechanism	Yes in almost all circumstances
		IN5	RO seeking information of note to cross-refer with other information	CG lead of employing organisation	RO	Pull by RO	Information of note or confirmation there is no information of note	Within 2 weeks of request from RO	MPIT form or abbreviated version (e-MPIT)	Yes in almost all circumstances
	Fitness to Practise ('FtP')	FtP1	When a doctor's behaviour crosses the threshold for GMC fitness to practise procedures to be engaged.	RO	GMC	Push from RO	Using the GMC referral form or in other format acceptable to the GMC	As soon as the threshold is reached	In the format set out in GMC FTP procedures	Yes in almost all circumstances

Information of note

- *The term 'information of note' is significant as it allows for the sharing of information at a lower threshold than a major concern, thereby permitting triangulation at an earlier stage.*

- *Sharing of information should not only occur when there is a crisis.*



Information of note

- The RO should share information of note with the clinical governance lead of other organisations if relevant

- *However, there is currently no provision for a responsible officer to provide routine assurance to any person or body, other than the GMC, relating to a doctor's fitness to practise, whether as part of pre-employment checks, or as part of routine governance processes in places where a doctor may be working.*

Information of note

- *The RO should sh… …linical governance lead of other orga…*
- *However, there is … …nsible officer to provide routine as… …ther than the GMC, relating to a doct… …s part of pre-employment chec… …ce processes in places where a do…*

Figure 2: Information of note about a doctor's practice:

1. Exemplar practice and significant achievements
2. Current restrictions on practice
3. Current GMC referral, or presence of GMC conditions or undertakings
4. Details of fitness to practise concerns, which require the responsible officer to note or take action
5. (On request from a doctor's responsible officer) confirmation that none of the above apply

Sharing information/ soft intelligence

Sharing information/ soft intelligence

- What do we really mean by soft intelligence? What do we expect to happen from sharing it?

- '*Soft Intelligence is all human emotional feedback, that is to say observations, thoughts, feelings, information of witnessed or heard events, or even hearsay.*' (https://softintelligence.co.uk/about-us/)

- Is it appropriate for ROs to share soft intelligence?

NHS England and NHS Improvement

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

'As ever, the key objective at appraisal is to provide an opportunity for the doctor to describe their achievements, their aspirations and the challenges they face as they pursue these. The component assuring practice for revalidation purposes, although essential, is straightforward for most.'

- *Keeping Appraisal Submissions Proportionate, May 2019*

Aims of appraisal

NHS England and NHS Improvement

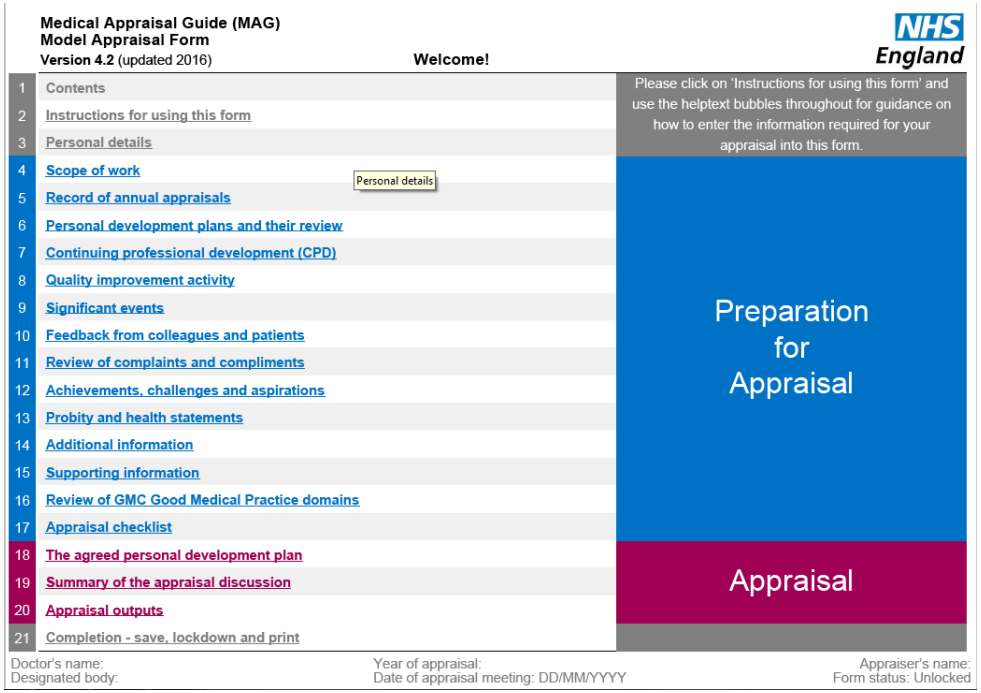
1. To enable doctors to discuss their practice and performance with the appraiser in order to demonstrate that they continue to meet the principles and values set out in Good Medical Practice and thus to inform the responsible officer's revalidation recommendation to the GMC.

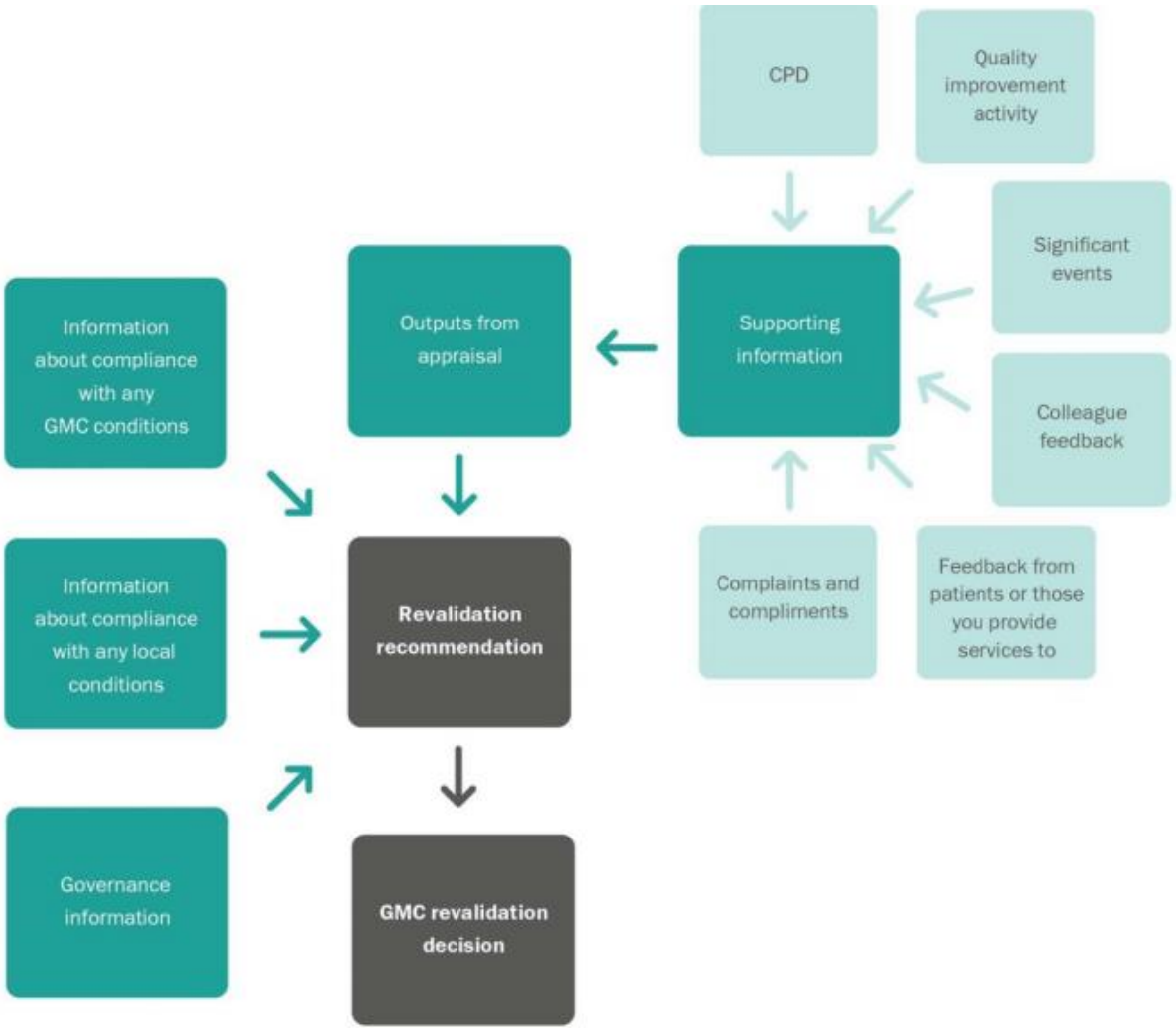
2. To enable doctors to enhance the quality of their professional work by planning their professional development.

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




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

NHSE December 2019

NHS England and NHS Improvement

https://www.england.nhs.uk/medical-revalidation/ro/info-docs/roan-information-sheets/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.*

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.**

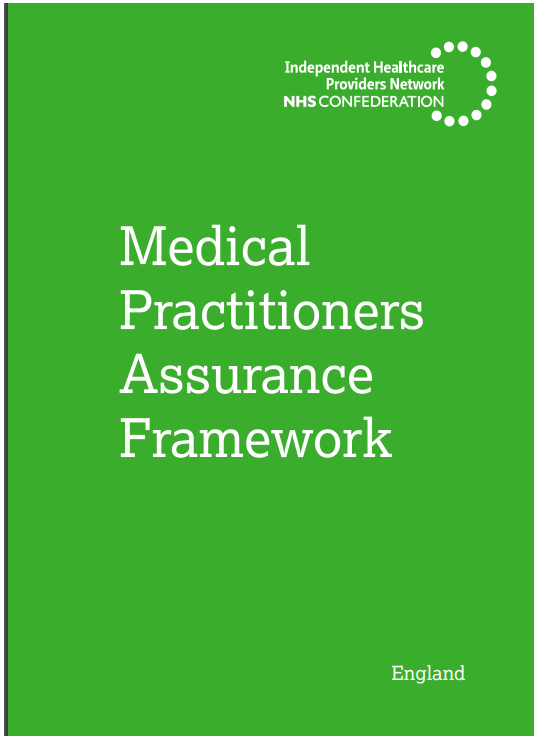
- (●) Agree
- ( ) Disagree

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

- (●) Agree
- ( ) Disagree

Appraisals

- *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

- ***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 as an RO: appraisals

- I review and approve the full annual appraisals for all of our doctors with a prescribed connection to us (50). I also make their revalidation recommendations
- A sample of the full appraisals for doctors with practising privileges who submit them, is also reviewed. If we are not declared in the 'scope of work' section, 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 hospital governance information to doctors for their appraisals routinely (connected doctors) or on request (non-connected doctors)
- I facilitate peer review of appraisal outputs for our prescribed connection doctors

Some suggestions for basic medical governance measures

- Do you know the other locations in which your doctors with practising privileges work?
- Do you know who their designated bodies are, and do their designated bodies know that they work with you?
- Are you sure that all your doctors requesting information from you to inform their appraisals **and** their revalidation recommendation?
- What checks do you make of appraisals submitted to you?
- Is your RO involved enough in clinical governance in your organisation?
- Are you clear about when information can/ should be shared about doctors, and when it cannot/ shouldn't be? Are you clear about how you record intelligence (whether 'soft' or 'hard')

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.
- ROs are a valuable resource for medical governance matters and should be involved early
- Be wary of overreliance on appraisals, revalidation and ROs to ensure good medical governance- they are only part of the answer

Independent Healthcare Providers Network
NHS CONFEDERATION

Panel Q&A Session using Slido

https://www.sli.do/
Event code: MPAFLondon

Independent Healthcare Providers Network
NHS CONFEDERATION

IHPN Patient Animation