Medical Appraisal update to the Board

February 2013

1. Medical Appraisal Policy

The Medical Appraisal Policy was ratified by Executive Committee on 21st August 2012. It is likely to require minor updating due to the implementation of the Revalidation Management System; it is likely that a guide to doing appraisal using the RMS will simply be added as an appendix.

2. Revalidation Management System

Due to the GMC requirement that all appraisal now be undertaken electronically, the Trust now uses an online platform for revalidation, the Revalidation Management System (RMS). Initial implementation was smooth, and the Trust has offered extensive training, both formally (including one session via Medical Committee), and informal smaller sessions, including one to one support.

A significant problem with the RMS was encountered in November and December, when the spiralling number of users caused the speed of the system to slow to an unacceptable level. This was resolved in mid-December, with the providing company doubling their servers and introducing software solutions to result in an acceptable speed. Work is ongoing to improve the speed still further. This problem inevitably delayed a large number of appraisals, but despite this, the majority of our doctors have still been able to complete their appraisals.

All feedback regarding the RMS is welcomed and will be passed on to the provider; the Trust will also be maintaining a query log to keep track of common themes and potential problems that might arise with the system in order to anticipate solutions.

3. Appraisal Figures

Figures for completed and signed off appraisals by division are as follows:
ICAM: 90%
SCD: 76%
WCF: 85%

Total: 82%

It should be noted that figures for Surgery, Cancer and Diagnostics are lower partly because of an unexpected drop in experienced appraisers due to illness. The Trust will continue to train appraisers using the free sessions available from the Deanery.

These numbers do not include newly appointed consultants or Trust doctors who have arrived in the last two months, as these doctors will have their appraisal deferred for six months to give them time to collect adequate data for their portfolio.

4. ORSA

The January 2013 Organisational Readiness Self-Assessment tool, or ORSA, was submitted on 22nd January. In the September ORSA, the Trust had to answer ‘no’ to question 2.3 (‘Appropriate Responsible Officer training has been undertaken’) due to the recent appointment of Dr Martin Kuper to the post; the remediation policy had also not been ratified. In the January ORSA, the Trust was able to answer ‘yes’ to both these questions.

Figures from the January ORSA regarding our prescribed connection numbers are as follows:

Consultants (inc. honorary contract holders): 164
SASGs (inc. clinical assistants): 19
Temporary or short term contract holders: 33
Other (leadership, management or leadership roles): 1

These numbers are higher than the April ORSA figures due to doctors making themselves known to the Trust; it is likely that this will continue to change slightly due to fluctuation in Trust doctor numbers – in particular, those coming out of or entering Deanery posts. Medical Staffing will continue to monitor and update the GMC Connect list.

5. Trust Doctor Appraisal

It should be noted that there is now no difference in format between a consultant appraisal and appraisal for Trust doctors, though clearly the data collected for the portfolio will reflect the scope of practice of each individual doctor. All doctors without Deanery numbers who are not GPs must do appraisal in electronic format using the RMS.

6. Data for Appraisal

The Trust does have a responsibility to provide doctors with certain data that is collected centrally. This includes data on serious incidents, complaints, and registered audits, as well as some activity data which can be accessed on Dr Foster. There have been queries about the ways in which patients are logged under consultants' names on Datix, and it was noted at the October Medical Committee that there is work being done in ICAM on this issue. However, it has been emphasised that doctors should reference all serious incidents in which they have been named on Datix and should attach a reflective note if they were not the consultant on the case or were not directly involved. There is also further work to be done on ensuring that this data can be automatically linked from Datix into the RMS in real time.

7. Recommendations for Revalidation

The Responsible Officer has so far made one positive recommendation for revalidation. This will of course increase as the numbers of doctors who are due to revalidate increase.