Revalidation Support Team

Organisational Readiness Self-Assessment (ORSA) Report

A report on implementation indicators for revalidation in England as at 31 March 2012

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Contents

Executive summary

The Organisational Readiness Self-Assessment (ORSA) exercise was designed by the NHS Revalidation Support Team (RST) to help designated bodies in England develop their systems and processes in preparation for the implementation of revalidation.

The objectives of the ORSA exercise are to:

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

This report describes the progress made over the past 12 months and provides a comprehensive picture of organisational readiness across England for the year ending 31 March 2012.

It is important to note that the standards described within the ORSA questionnaire represent a raising of the quality bar. Organisations are being measured against best practice in each indicator and must meet exacting requirements to be able to provide positive assurances. The numbers and percentages contained within this report must be seen in this context.

Despite this, substantial progress has been made over the last year. Even with a significant increase in the number of responses, there has been a continued steady improvement in all measured key indicators. There are very high levels of engagement by designated bodies from all sectors and this will facilitate the identification of challenged designated bodies and those which are not currently engaged in preparing for revalidation.

The results also demonstrate significantly improved knowledge and understanding of the regulations and prescribed connections. There have been demonstrable improvements in leadership, governance, infrastructure, capacity, skills and knowledge. It is also clear that the ORSA exercises have stimulated improved record-keeping and enhanced data quality.

Since the last exercise was carried out a year ago, there has been a steady increase in the proportion of doctors covered by designated bodies which are rated green against the key indicators. Despite the larger number of responses overall, this proportion has doubled from 41% to 82% of doctors covered by this exercise.

Effective annual appraisal is one of the foundations of revalidation and is essential for the responsible officer to be assured that each doctor is up to date and fit to practise. For many organisations, the raised expectations of appraisal will mean a significant upgrading of their appraisal system and for others it will mean creating a completely new system. Despite this, appraisal rates have increased significantly for each type of doctor – the overall appraisal rate has risen to 73%. Consultant appraisal rates and rates for SAS doctors remain low in comparison their GP counterparts (73.1% and 53.1% respectively compared with 90.1%) and will require special attention in the coming year.

The primary reason for this is likely to be that in the past there has been a lack of resource, infrastructure and management of hospital appraisal systems. A higher standard of appraisal is now required and there is now strong evidence that these weaknesses are being addressed with the improved management and tracking of appraisals, the large rise in the numbers of trained appraisers and the significant improvement in the ratio of appraisers to doctors in hospital trusts.

The other key findings of this exercise are:

- There has been a further increase in the number of identified designated bodies and the total number of responses.
- The percentage response rate is 95% and the response rate from NHS organisations is 100%, showing that engagement from all sectors is very high.
- Data quality and record-keeping have improved showing a better understanding of the regulations and of prescribed connections.
- Locum agencies remain significant outliers in terms of engagement and whilst there are reasons to explain this, a significant improvement is required.
- Almost 100% of doctors covered by this exercise now have a responsible officer and almost 98% of doctors have a responsible officer who has received appropriate training.
- The proportion of doctors covered by designated bodies that have provided the responsible officer with sufficient resources is 74.6% overall (this proportion is 86% for non-deanery organisations and 42.7% for deaneries).

- 85% of doctors are now covered by designated bodies with an appraisal policy which is compliant with the requirements of revalidation.
- 86% of doctors are now covered by designated bodies with sufficient numbers of appraisers.
- The overall proportion of doctors covered by designated bodies with systems for monitoring fitness to practise is 91.7%. This has increased significantly from 60% in March 2011.
- The overall proportion of doctors covered by designated bodies with a process for investigation of capability, conduct, health and fitness to practise concerns is 97%.
- The overall proportion of doctors covered by designated bodies with a policy for re-skilling, rehabilitation, remediation and targeted support which is compliant with the responsible officer regulations is 58.4% – around half the doctors in NHS and independent sector designated bodies are not yet covered by these policies.

The next steps are to ensure robust action planning is undertaken within each designated body to address the needs identified through this exercise. These action plans should be received and reviewed by the strategic health authority (SHA) or strategic health authority cluster (SHA cluster). Challenged designated bodies should be supported to achieve readiness and appropriate action should be taken for those designated bodies yet to engage with this process.

The key actions outlined in Sir Bruce Keogh's letter to SHA medical directors in October 2011 included:

- the importance of strong clinical leadership and effective local action planning
- ensuring all designated bodies have been identified
- ensuring all responsible officers have the resources to carry out their role
- providing support for responsible officers through networks
- ensuring all doctors have an annual appraisal.

It is clear that substantial progress has been made in each of these areas but there is still much more to be done to ensure these principles are implemented and embedded. A strong momentum has developed in establishing robust policies and systems, but continued challenge from organisations' boards, together with the effective involvement of human resources departments, responsible officer networks, and clinical governance and appraisal staff, is essential to complete the final preparations for the implementation of revalidation at the end of 2012.

Introduction

Revalidation of doctors is a key component of a range of measures designed to improve the quality of care for patients; it is the process by which the General Medical Council (GMC) will confirm the continuation of doctors' licences to practise in the UK. The purpose of revalidation is to assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and fit to practise.

Through a formal link with their organisation, determined usually by employment or contracting arrangements, doctors will relate to a senior doctor in the organisation, the responsible officer. The responsible officer will make a recommendation about the doctor's fitness to practise to the GMC. The recommendation will be based on the outcome of the doctor's annual appraisals, normally over the course of five years, combined with information drawn from the organisational clinical governance systems. Following the responsible officer's recommendation, the GMC will decide whether to renew the doctor's licence.

The responsible officer is accountable for the quality assurance of the appraisal and clinical governance systems in their organisation. Improving these systems will support doctors in developing their practice more effectively, which will add to the safety and quality of health care in the UK. It will also enable the early identification of those doctors whose practice needs attention, allowing for more effective intervention.

All doctors wishing to retain their GMC licence to practise will need to participate in revalidation.

This publication has been prepared by the NHS Revalidation Support Team (RST). The RST works in partnership with the Department of Health (England), the GMC and other organisations to deliver an effective system of revalidation for doctors in England.

Background

Revalidation aims to support doctors in their professional development, to contribute to improving patient safety and quality of care and to sustain and improve public confidence in the medical profession. It also seeks to facilitate the identification of the small number of doctors who are unable to remedy significant shortfalls in their standards of practice. To achieve these aims, the GMC will require assurance that local systems of medical appraisal and clinical governance function effectively and fairly in distinguishing between satisfactory and unsatisfactory performance and that responsible officers are making correct and valid recommendations.

The Organisational Readiness Self-Assessment (ORSA) exercise was designed by the RST to help designated bodies in England develop their systems and processes in preparation for the implementation of revalidation. The self-assessment is an annual end-of-year exercise which was approved by the England Revalidation Delivery Board (ERDB) in February 2011.

The objectives of the ORSA exercise are to:

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

In the future, the ORSA questionnaire may also be used by the responsible officer in their own appraisal/revalidation portfolio as supporting information for demonstrating their fitness to practise in the role.

The first ORSA exercise was completed by designated bodies in April/May 2011 for the year ending 31 March 2011. The full report of this exercise was published in October 2011.[1] In order to assess the progress being made during 2011/12, two further interim exercises were carried out in September and December 2011 to show the position against a smaller number of key indicators. The findings from these exercises were reported to the ERDB in November 2011 and February 2012 respectively.

[1] *A Review of Integrated Clinical Governance in the Context of Medical Revalidation* (RST, 2011)

This report describes the progress made over the past 12 months and provides a comprehensive picture of organisational readiness across England for the year ending 31 March 2012.

The ORSA exercises have not only provided designated bodies with a snapshot of their position at each stage, but more importantly provided the basis for effective action plans to support them in moving to a position of readiness in time for the commencement of revalidation in late 2012. The exercises have provided organisations with an opportunity to assess the progress they have made in preparing for revalidation and understand how their action plans should be amended.

Methodology

As with previous self-assessments, this exercise was co-ordinated by the SHA clusters in England.

The data collection for this exercise took place during April/May 2012 using the *Organisational Readiness Self-Assessment End-of-Year Questionnaire 2011-12* (RST, 2011) which is shown in Appendix 1. The questionnaire is based on the statutory responsibilities contained in the responsible officer regulations[2] and guidance[3] and additional organisational criteria proposed by the GMC. It has been approved as a compulsory return for most NHS organisations by the Review of Central Returns (ROCR) process.

Each strategic health authority (SHA) or strategic health authority cluster (SHA cluster) invited known designated bodies to complete and submit the full ORSA questionnaire describing their position at 31 March 2012. During the reporting period, support was available to designated bodies from the RST organisational readiness team and from SHA cluster revalidation project teams to answer queries and to assist them in completing and submitting their forms. Additional notes were added to the questionnaire to help with the correct identification of prescribed connections and to encourage consistent responses.

[2] *The Medical Profession (Responsible Officers) Regulations 2010*

[3] *The role of responsible officer: Closing the gap in medical regulation - Responsible officer guidance* (Department of Health, 2010)

Responsible officers were invited to complete the self-assessment on behalf of their designated bodies, although this could be appropriately delegated. Input could also be provided by a range of staff including medical workforce or human resources teams, appraisal leads and clinical governance teams. As the ORSA submissions were made on behalf of the designated body, it was recommended that responsible officers present the report, together with an action plan, to the organisation's board or to an appropriate governance or executive group, to ensure there is a corporate understanding of the current state of readiness and the statutory responsibilities. Organisations were advised to include ORSA reports and action plans in their quality accounts and the reports should be made available on request.

As with the previous ORSA exercise, the RST commissioned an electronic reporting process to make their submissions automatically. An electronic version of the ORSA form was completed and submitted to a remote server where the results were automatically downloaded onto a central database. This database was then updated each day with any new submissions being added to the existing numbers. SHA revalidation project managers were informed each day of which organisations had completed the exercise so they could target their efforts to optimise the number of submissions. The data collection exercise closed on 21 May 2012 and preliminary results of the exercise were reported to ERDB on 29 May 2012.

The data shown in the tables is that reported by the designated bodies. Notes to the tables show where important errors have been made in the submissions or where direct comparison with the data in the earlier reports requires explanation.

Aligned to this, the RST has developed a method of defining readiness for revalidation in England which was agreed by the ERDB in March 2012. This describes a method of rating each designated body against a smaller number of key performance indicators. Each designated body has been awarded a 'red', 'amber or 'green' (RAG) rating based on this methodology (see Appendix 2).

It should be noted that, as with the previous exercise, this is a self-assessment and there has been no external validation of the findings. It is possible that the indicators have been interpreted differently by organisations and some trusts may have overstated or understated their position. Efforts have been made to ensure that participating trusts give an accurate picture of their current status. This includes additional explanatory notes and guidance on who should be involved in completing the self-assessment. Each SHA or SHA cluster will undertake some validation of the submissions as part of their local revalidation implementation plan.

Self-assessment responses

The results of the exercise are divided into the following sections:

Section 1: Details of designated body

Section 2: Responsible officer

Section 3: Appraisal system

Section 4: Organisational governance.

Section 1: Details of designated body

Section 1 of the self-assessment questionnaire contains details of the designated body, including the organisation type, the relevant SHA and the number and type of doctors who have a prescribed connection with the designated body.

Response rates

The numbers and types of organisations completing the self-assessment exercise within each SHA cluster are presented in figure 1 and figure 2. Comparison with the results of previous exercises is also shown.

Figure 1: ORSA responses and return rate by SHA cluster

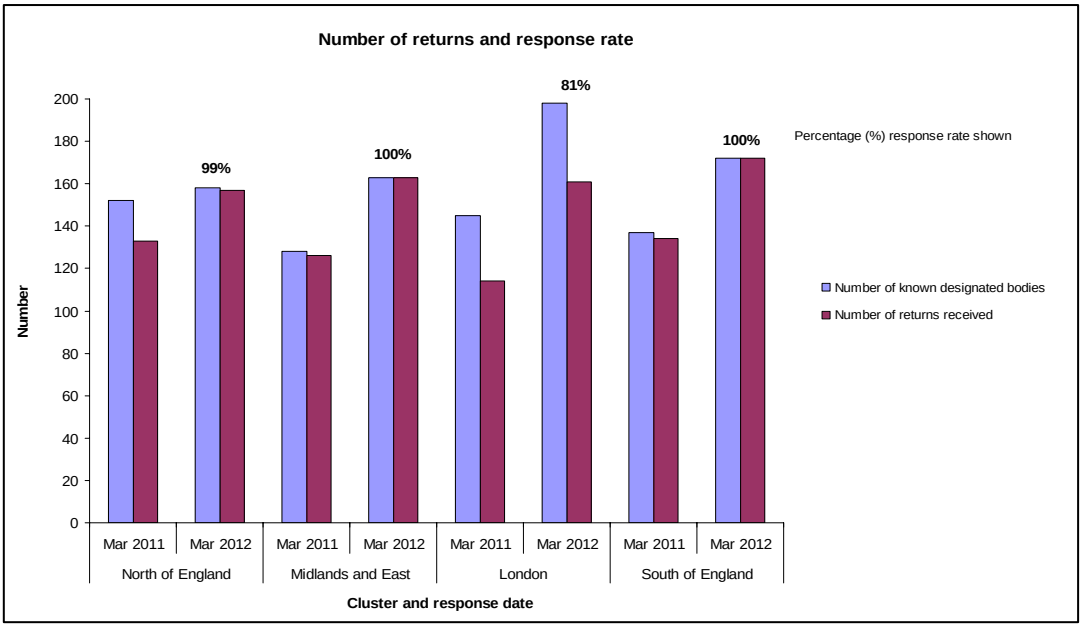


Figure 2: ORSA responses by SHA cluster and organisational type

SHA Area	Position at	Hospital trusts	Primary care trusts	Mental health trusts	Other NHS trusts / organisations	Faculties	Hospices, charity, voluntary sector	Independent healthcare providers	Locum agencies	Other independent / non NHS	Deaneries	Total
North	31.03.11	50	50	13	6	0	4	6	1	0	3	133
	31.03.12	**54**	**51**	**11**	**14**	**0**	**9**	**11**	**1**	**3**	**3**	**157**
Midlands and East	31.03.11	43	41	17	11	0	4	8	1	0	1	126
	31.03.12	**48**	**39**	**14**	**16**	**0**	**13**	**18**	**6**	**6**	**3**	**163**
London	31.03.11	29	31	9	4	3	5	29	2	1	1	114
	31.03.12	**30**	**31**	**8**	**8**	**4**	**9**	**53**	**6**	**12**	**1**	**162**
South	31.03.11	35	31	11	12	0	16	20	1	4	4	134
	31.03.12	**38**	**30**	**9**	**13**	**0**	**35**	**31**	**4**	**7**	**5**	**172**
Total	31.03.11	157	153	50	33	3	29	63	5	5	9	507
	30.09.11	166	145	38	28	3	36	77	4	8	12	517
	31.12.11	169	153	42	37	3	49	91	9	18	12	583
	31.03.12	**170**	**151**	**42**	**51**	**4**	**66**	**113**	**17**	**28**	**12**	**654**

These figures show improving numbers of responses. Of the 691 designated bodies known to SHAs, 654 have submitted a return, equating to a 95% response rate. The response rate for the NHS designated bodies was 100% and there are also notable increases in response rates from the non-NHS sector. The number of responses has risen from 507 to 654 over the 12-month period. The overall percentage response rate has risen despite the larger number of designated bodies, which demonstrates strong engagement and networking through the SHA cluster teams. The larger number of known designated bodies is also an indication that there is better knowledge and understanding of the requirements at a local level and improved engagement in the process.

However, despite increased numbers, there are persistently low response rates for locum agencies. There are 53 suppliers on the existing framework which are designated bodies under the regulations and only 17 of these have submitted a response (this has increased from 5 responses in March 2011). One likely contributory factor is that the Government Procurement Service is establishing a replacement framework agreement for the supply of locum doctors to the NHS and some agencies may be delaying engagement until the new framework is announced. The new framework agreement will come into force in the autumn of 2012. The statutory obligations of the responsible officer regulations are considered within the procurement process. Completion of ORSA is a compulsory requirement of the new framework and the RST will ensure all agencies selected for the new framework undertake an ORSA exercise on appointment so that their development needs can be properly evaluated. The RST will facilitate a national information event for short-listed locum agencies, currently planned for 18 September 2012. Additional customised support, including further meetings and events will be put in place once the locum agency ORSA returns have been evaluated.

There are a large number of small designated bodies with very low numbers of doctors. In view of this, it is now more appropriate to display some of the key indicators as the proportion of doctors covered by designated bodies with a positive response rather than a simple percentage of designated bodies, to ensure the small designated bodies do not have a disproportionate effect on the results. Where necessary, past data has been recalculated to ensure a like for like comparison.

These figures represent the best current estimate of the total number of designated bodies, but there may be other designated bodies that have not yet identified themselves to their SHA and some that have not yet recognised they are designated bodies. Excepting the locum agencies for the reasons outlined above, it is likely that the designated bodies in both of these groups are small organisations. The GMC has launched a campaign to ensure prescribed connections are identified for all doctors. This will help to ensure these additional designated bodies are identified and supported.

Number of doctors

Section 1 of the self-assessment questionnaire also requests details of the number and type of doctors who have a prescribed connection with the designated body. The following table (figure 3 overleaf) shows detailed data on the number of doctors as at 31 March 2011 covering different organisational types. The figures from the previous exercises are shown for comparison.

Figure 3: Number of doctors by organisational type

Organisational Type	Position as at	Total designated bodies	Consultant	Staff grade, associate specialist, specialty doctor	GP	Trainee	Practising privileges	* Temporary or short-term contract holders	Other	Total doctors
Hospital trusts	31.03.11	157	33974	12524	78	5194	0		1571	53341
	31.03.12	**170**	**37118**	**9000**	**50**	**1378**	**28**	**6620**	**335**	**54529**
Primary care trusts	31.03.11	153	293	191	43689	996	0		583	45752
	31.03.12	**151**	**88**	**5**	**44554**	**435**	**0**	**27**	**61**	**45170**
Mental health trusts	31.03.11	50	3808	1508	10	805	0		233	6364
	31.03.12	**42**	**3416**	**1178**	**66**	**198**	**0**	**215**	**56**	**5129**
Other NHS trusts / organisations	31.03.11	33	962	502	20	5	29		187	1705
	31.03.12	**51**	**1050**	**504**	**14**	**3**	**0**	**187**	**583**	**2341**
Deaneries	31.03.11	9	0	0	0	38520	0		7	38527
	31.03.12	**12**	**1**	**0**	**2**	**41191**	**0**	**217**	**7**	**41418**
Independent / non-NHS (total) (Different types are shown below)	31.03.11		1149	1144	109	168	2515		1561	6646
	31.03.12		**1324**	**1480**	**349**	**13**	**1910**	**2395**	**1941**	**9412**
- Faculties	31.03.11	3	36	11	0	0	0		850	900
	31.03.12	**4**	**36**	**11**	**0**	**0**	**0**	**0**	**876**	**923**
- Hospices, charity, voluntary sector	31.03.11	29	58	79	13	11	11		47	248
	31.03.12	**66**	**110**	**188**	**1**	**4**	**24**	**10**	**50**	**387**
- Independent healthcare providers	31.03.11	63	574	503	96	7	2004		255	3502
	31.03.12	**113**	**526**	**324**	**23**	**9**	**1881**	**48**	**195**	**3006**
- Locum agency	31.03.11	5	463	544	0	150	500		8	1670
	31.03.12	**17**	**83**	**384**	**17**	**0**	**1**	**2098**	**70**	**2653**
- Other independent / non-NHS	31.03.11	5	18	7	0	0	0		401	431
	31.03.12	**28**	**569**	**573**	**308**	**0**	**4**	**239**	**750**	**2443**
Total doctors	31.03.11		40186	15869	43906	45688	2544		4142	152335
	30.09.11		40296	11678	44127	53490	2006	6153	2263	160013
	31.12.11		42348	11480	45291	51502	2218	7093	4067	163999
	31.03.12		**42997**	**12167**	**45035**	**43218**	**1938**	**9661**	**2983**	**157999**

* No figures for doctors in this group for March 2011 as it is a new category

The total number of doctors covered by the exercise has decreased to 157,999 despite a larger number of designated bodies. There are fewer apparent errors in prescribed connections (for example, fewer trainees and general practitioners have been wrongly included by hospital trusts) and, whilst these inaccuracies are relatively minor, they would result in some double counting of doctors. This suggests that training and local network activities have resulted in improved knowledge and understanding of the regulations and specifically of prescribed connections. It is also likely that organisational systems have improved, resulting in improved record-keeping and enhanced data quality.

The data in figure 3 shows the numbers of doctors with whom designated bodies have a prescribed connection, but a number of potential inaccuracies may still be present in these figures. Designated bodies may not know all the doctors with whom they have a prescribed connection or may have included doctors who have a prescribed connection elsewhere (for example, trainees and GPs included in hospital trust figures). Some designated bodies have not previously needed to record information about prescribed connections and their systems may not yet be fully functional (for example, in the case of some locum agencies and membership organisations). There are significant numbers of doctors reported to be on temporary or short-term contracts in hospital trusts (6,620 in total).

The total number of licensed doctors practising in England is not accurately known and there are a variety of estimates:

- 151,070 doctors practising in England[4]
- 173,054 doctors with a licence to practise who have a registered address in England[5]

The GMC has highly accurate information on the number of doctors currently registered and licensed to practise and can also confirm how many of these doctors have a registered address in England. There is also relatively accurate data on the number of doctors working in the NHS, but the numbers working in the independent sector and those working as locums is not accurately known. The data reported by designated bodies does not include doctors who do not have a prescribed connection under the regulations. The GMC will determine how these doctors are able to revalidate and the GMC ‘Make Your Connection’ campaign will identify prescribed connections where they exist.

[4] OECD Health Data 2009, figures for 2007

[5] GMC data

Section 2: Responsible officer

Section 2 of the ORSA questionnaire covers the responsible officer role. The indicators for this section are shown in figure 4.

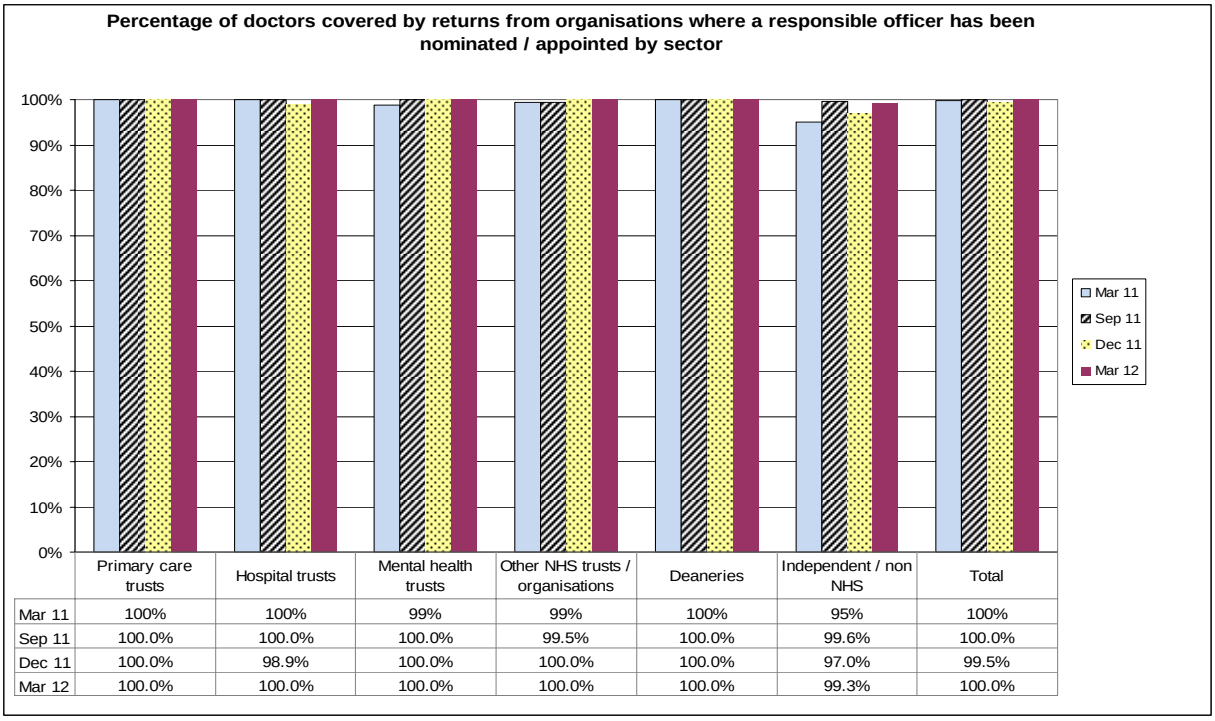
Figure 4: ORSA section 2 indicators

Section number	Indicator
2.1	A responsible officer has been nominated/appointed in compliance with the regulations
2.2	A second responsible officer has been nominated/appointed where a conflict of interest or appearance of bias has been agreed with the level two responsible officer[6]
2.3	Appropriate responsible officer training is undertaken
2.4	Local/regional support is available to the responsible officer
2.5	Provision of funding and resource from the designated body is sufficient to undertake the responsibilities of the role

[6] For the purpose of this document the 'level two responsible officer' is the responsible officer at the strategic health authority or strategic health authority cluster

Figure 5 shows the number of doctors covered by designated bodies where a responsible officer has been nominated or appointed in compliance with the regulations.

Figure 5: Responsible officer nominated or appointed

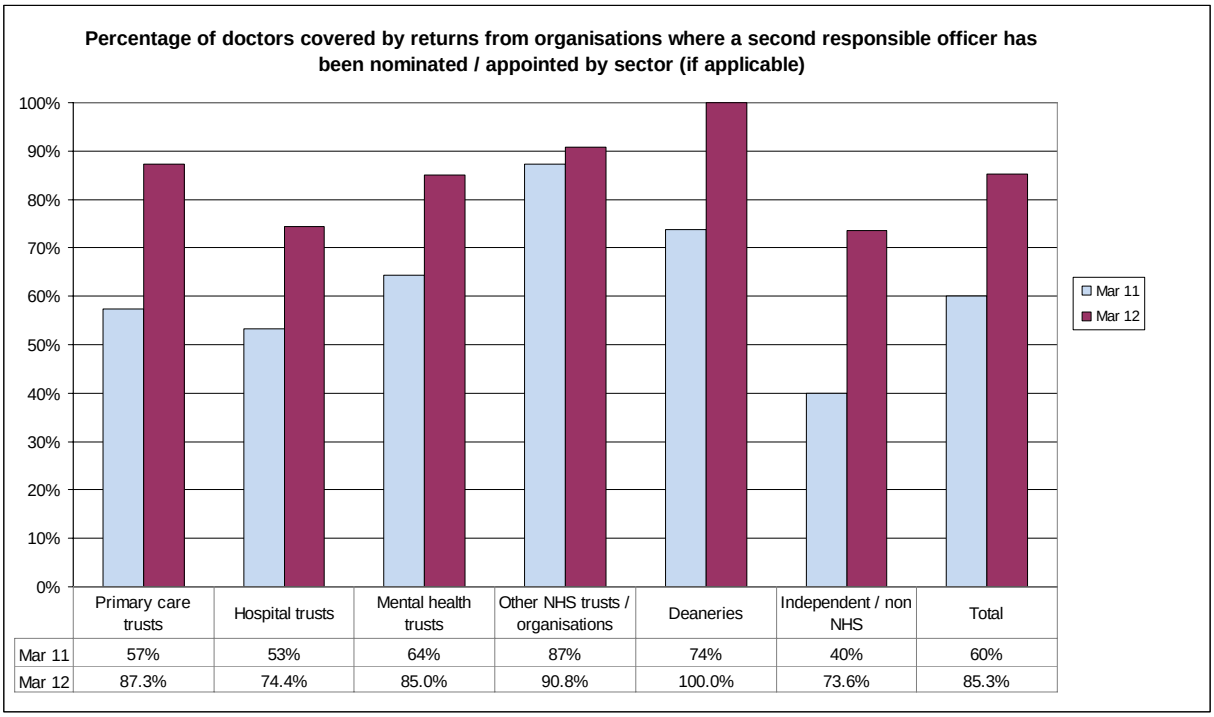


	Primary care trusts	Hospital trusts	Mental health trusts	Other NHS trusts / organisations	Deaneries	Independent / non NHS	Total
Mar 11	100%	100%	99%	99%	100%	95%	100%
Sep 11	100.0%	100.0%	100.0%	99.5%	100.0%	99.6%	100.0%
Dec 11	100.0%	98.9%	100.0%	100.0%	100.0%	97.0%	99.5%
Mar 12	100.0%	100.0%	100.0%	100.0%	100.0%	99.3%	100.0%

The data shows almost 100% (99.96%) of doctors covered by this exercise are have prescribed connections to designated bodies with a responsible officer. All NHS designated bodies have now appointed a responsible officer and only 9 of the 654 designated bodies submitting responses have yet to do so.

Figure 6 shows the proportion of doctors covered by designated bodies where a second responsible officer has been nominated or appointed when a conflict of interest or appearance of bias is present.

Figure 6: Second responsible officer nominated or appointed where this is applicable

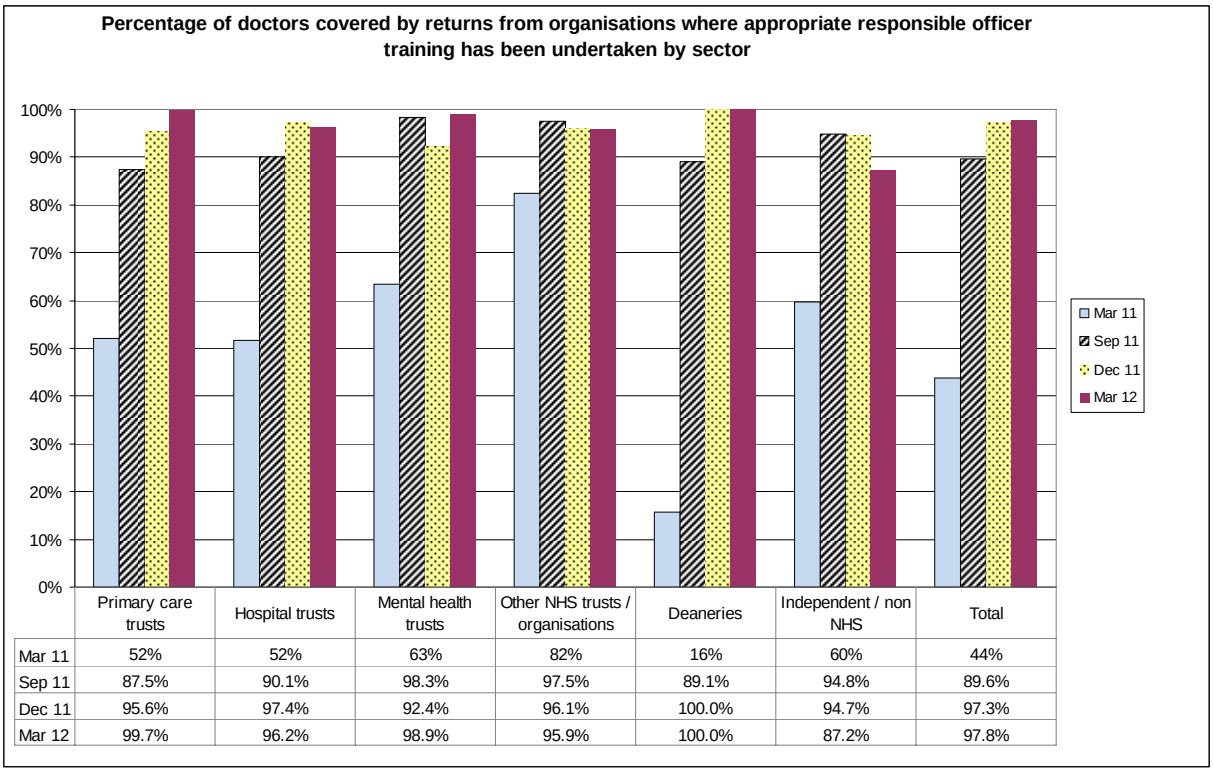


	Primary care trusts	Hospital trusts	Mental health trusts	Other NHS trusts / organisations	Deaneries	Independent / non NHS	Total
Mar 11	57%	53%	64%	87%	74%	40%	60%
Mar 12	87.3%	74.4%	85.0%	90.8%	100.0%	73.6%	85.3%

This shows that there is a steady improvement in the understanding of the responsible officer role and the importance of ensuring a second responsible officer is appointed where there is a conflict of interest or appearance of bias.

Figure 7 shows the proportion of doctors covered by designated bodies where the responsible officer has received appropriate training.

Figure 7: Appropriate responsible officer training undertaken

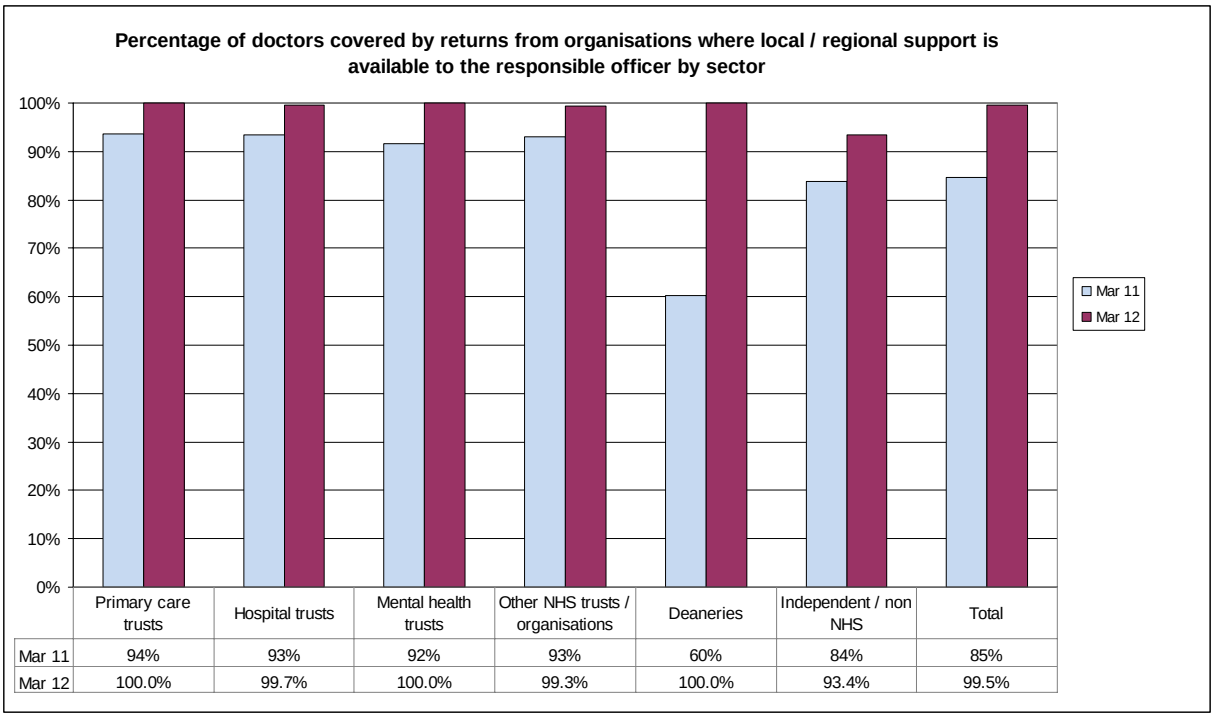


	Primary care trusts	Hospital trusts	Mental health trusts	Other NHS trusts / organisations	Deaneries	Independent / non NHS	Total
Mar 11	52%	52%	63%	82%	16%	60%	44%
Sep 11	87.5%	90.1%	98.3%	97.5%	89.1%	94.8%	89.6%
Dec 11	95.6%	97.4%	92.4%	96.1%	100.0%	94.7%	97.3%
Mar 12	99.7%	96.2%	98.9%	95.9%	100.0%	87.2%	97.8%

Figure 7 shows 97.8% of doctors are covered by designated bodies where the responsible officer has received appropriate training. This reflects the large numbers of responsible officers and other relevant staff who have attended the RST introductory responsible officer training programme. The training programme will continue to run throughout 2012/13 and further training modules will be offered.

Figure 8 shows the proportion of doctors by designated bodies where local or regional support is available to the responsible officer.

Figure 8: Local or regional support is available to the responsible officer

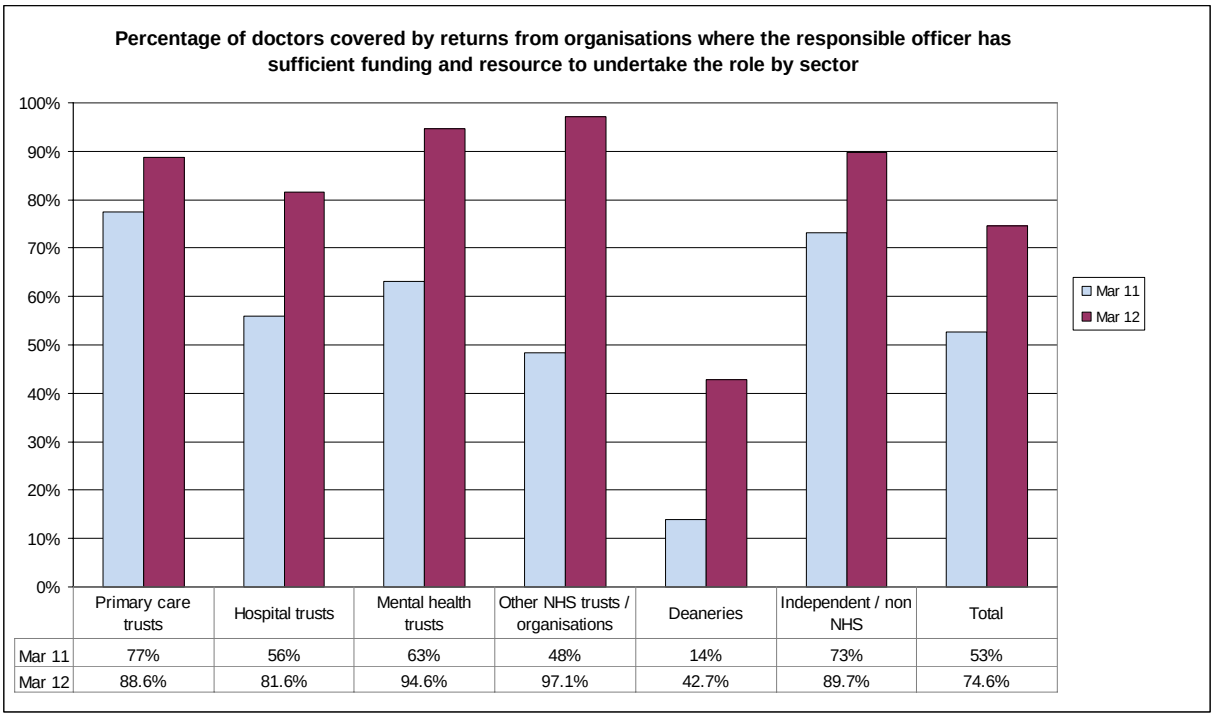


	Primary care trusts	Hospital trusts	Mental health trusts	Other NHS trusts / organisations	Deaneries	Independent / non NHS	Total
Mar 11	94%	93%	92%	93%	60%	84%	85%
Mar 12	100.0%	99.7%	100.0%	99.3%	100.0%	93.4%	99.5%

This shows that overall 99.5% of doctors are covered by designated bodies where the responsible officer has local support available. This has increased from 85% in March 2011. Responsible officer networks have been set up in all SHA clusters and these include external support from the GMC and the RST.

Figure 9 shows the proportion of doctors covered by designated bodies where the provision of funding and resource from the designated body is sufficient for the responsible officer to undertake the role.

Figure 9: Sufficient funding and resource is provided to the responsible officer



	Primary care trusts	Hospital trusts	Mental health trusts	Other NHS trusts / organisations	Deaneries	Independent / non NHS	Total
Mar 11	77%	56%	63%	48%	14%	73%	53%
Mar 12	88.6%	81.6%	94.6%	97.1%	42.7%	89.7%	74.6%

Figure 9 shows that 74.6% of doctors are covered by designated bodies where the responsible officer feels they have sufficient funding and resource to discharge the responsibilities of the role. This has increased from 53% in March 2011. The proportion is significantly lower in deaneries (42.7%) than in other organisations (the average excluding deaneries is 86%). This may be due to uncertainty about the resources required, due to a delay in the GMC and the deaneries reaching agreement about the model of revalidation for doctors in training. This would be an important issue for all designated bodies to address in their action plans and deanery responsible officers will need to ensure they have been allocated sufficient resources to perform the duties outlined in the regulations.

The overall findings in this section show that, since the responsible officer regulations came into force on 1 January 2011, the role of responsible officer has become well established, supported and resourced. The introductory training programme for responsible officers will continue to be run by SHA clusters through the current year and additional training modules will be offered.

Section 3: Appraisal system

In section three of the self-assessment questionnaire, designated bodies are asked to provide details of their medical appraisal systems. Effective appraisal is one of the foundations of revalidation and is essential for the responsible officer to be assured that each doctor is up to date and fit to practise. Appraisal must also provide a safe environment for personal development needs to be discussed and agreed. For many organisations the raised expectations of appraisal will mean a significant upgrading of their appraisal system and for others it will mean creating a completely new system.

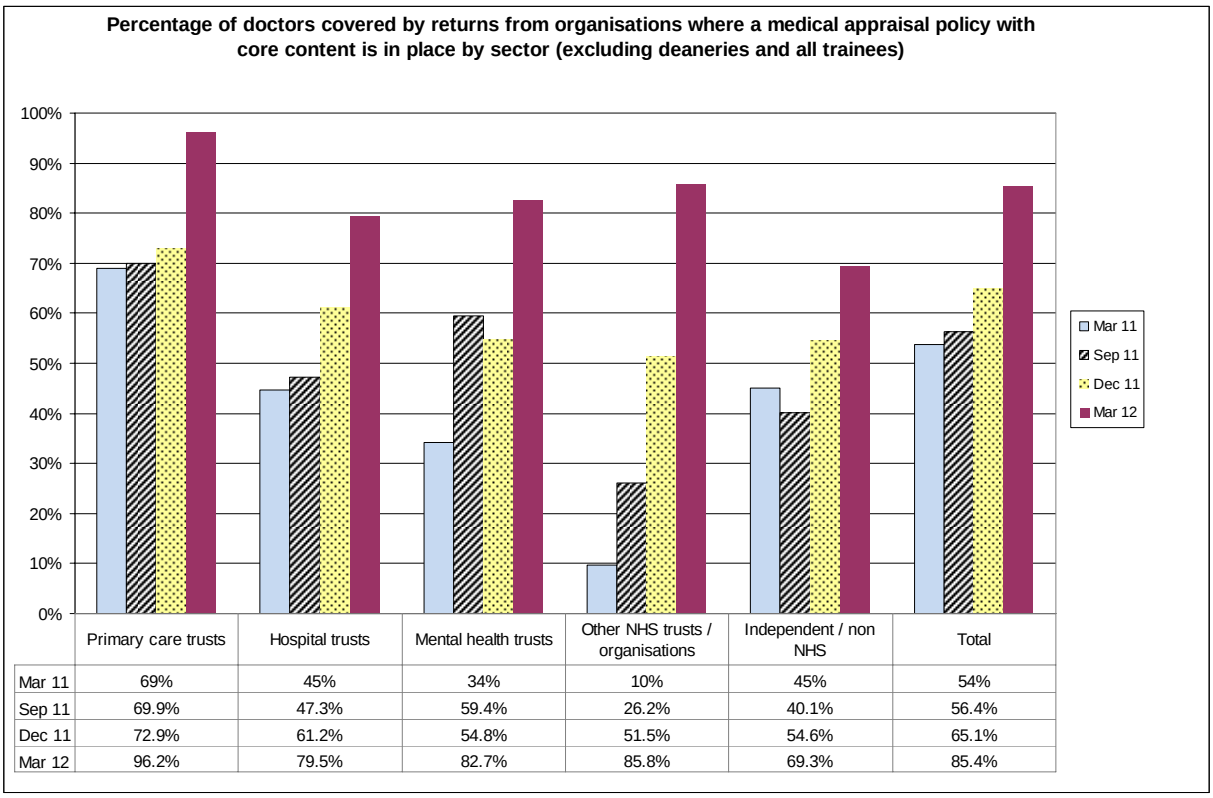
Deaneries are excluded from the results in this section, as doctors in training are subject to the Annual Review of Competence Progression (ARCP) process and do not undertake annual appraisal. Trainees have been removed where they have been included in error by other types of designated bodies. The indicators for this section are shown in figure 10.

Figure 10: ORSA section three indicators

Section number	Indicator
3.1	A medical appraisal policy with core content is in place
3.2	Numbers of doctors (and doctor type) with whom the designated body has a prescribed connection who have a completed appraisal between 1 April 2011 and 31 March 2012
3.3	An audit has been performed to determine reasons for all missed or incomplete appraisals
3.4	The number of trained medical appraisers is sufficient for the needs of the designated body
3.4.1	Number of active medical appraisers at 31 March 2012
3.4.2	Number of active medical appraisers at 31 March 2012 who have attended an appraiser training course at any time
3.5	Medical appraisers are supported in the role through access to leadership and peer support
3.6	Medical appraisers receive feedback on their performance in the role which includes feedback from appraisees or feedback on the quality of outputs of appraisal (such as personal development plans and appraisal summaries)

The proportion of doctors covered by organisations with an appraisal policy in place is shown in figure 11. The results are shown by organisational type and data from the previous exercise is shown for comparison.

Figure 11: Medical appraisal policy in place

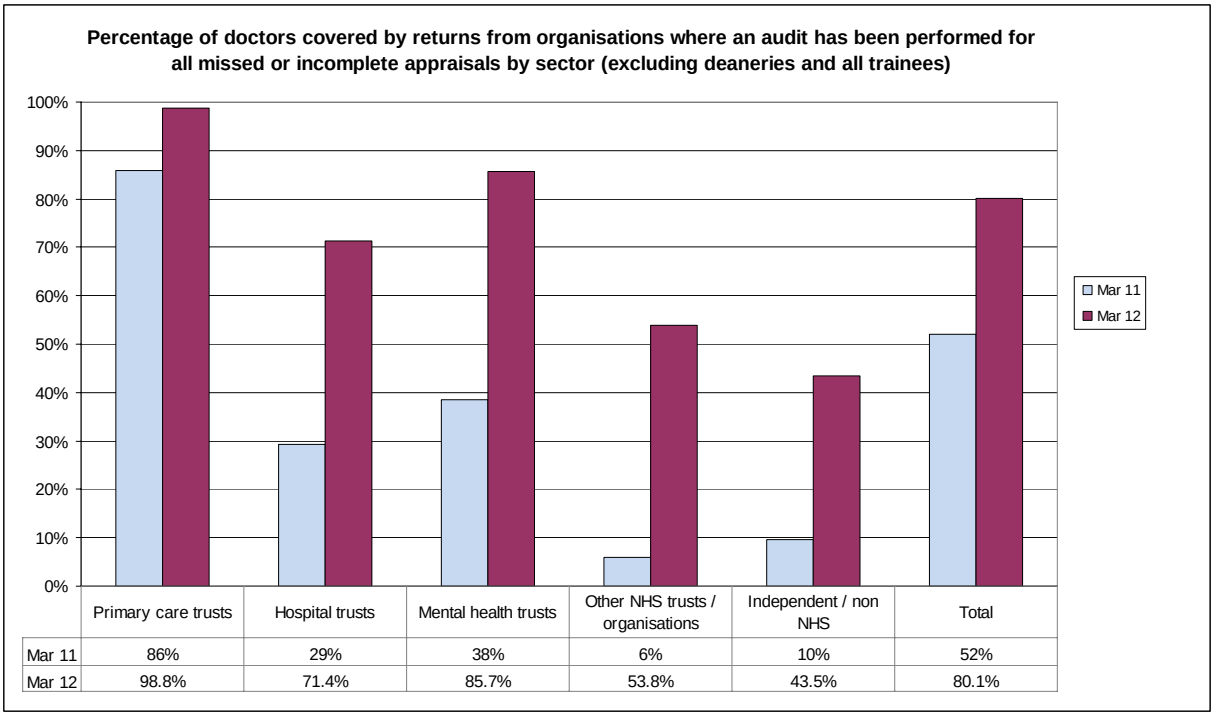


	Primary care trusts	Hospital trusts	Mental health trusts	Other NHS trusts / organisations	Independent / non NHS	Total
Mar 11	69%	45%	34%	10%	45%	54%
Sep 11	69.9%	47.3%	59.4%	26.2%	40.1%	56.4%
Dec 11	72.9%	61.2%	54.8%	51.5%	54.6%	65.1%
Mar 12	96.2%	79.5%	82.7%	85.8%	69.3%	85.4%

This shows an overall increase in the number of doctors covered by designated bodies that have an appraisal policy in place. The overall proportion now stands at 85.4% and has increased from 54% since March 2011. The data shows that the proportion of doctors in hospitals covered by appraisal policies is lower than for other types of NHS organisations at 79.5%; the percentage for doctors in primary care trusts is 96.2%.

The proportion of doctors covered by organisations that are undertaking an audit to determine reasons for all missed or incomplete appraisals is shown in figure 12. The results are shown by organisational type and data from the previous exercise is shown for comparison.

Figure 12: Audit performed to determine the reasons for all missed or incomplete appraisals



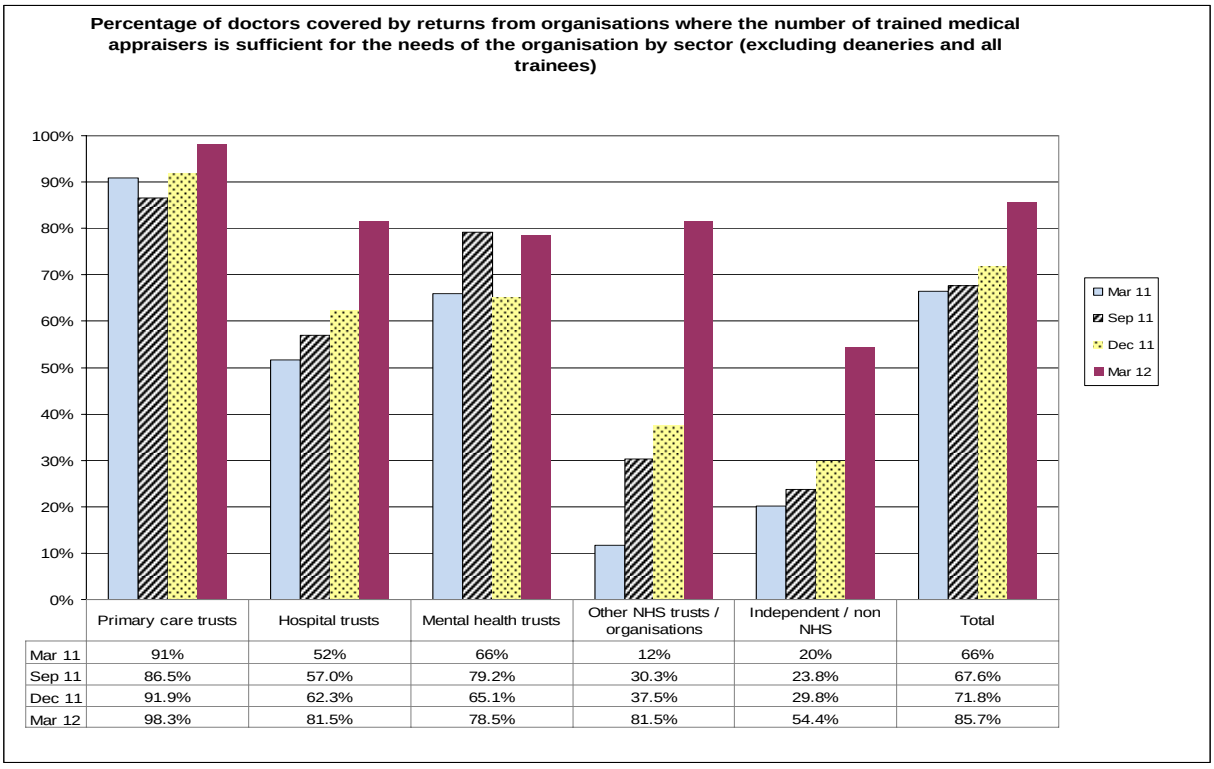
	Primary care trusts	Hospital trusts	Mental health trusts	Other NHS trusts / organisations	Independent / non NHS	Total
Mar 11	86%	29%	38%	6%	10%	52%
Mar 12	98.8%	71.4%	85.7%	53.8%	43.5%	80.1%

This shows that 80.1% of doctors are covered by designated bodies that perform an audit to understand the reasons for missed or incomplete appraisals. This has improved in all organisational types and demonstrates that the management of appraisal systems has been significantly strengthened. The overall percentage has increased from 52% in March 2011.

Numbers of appraisers

The proportion of doctors covered by organisations with sufficient appraisers is shown in figure 13. The results are shown by organisational type and data from the previous exercise is shown for comparison.

Figure 13: Sufficient medical appraisers



	Primary care trusts	Hospital trusts	Mental health trusts	Other NHS trusts / organisations	Independent / non NHS	Total
Mar 11	91%	52%	66%	12%	20%	66%
Sep 11	86.5%	57.0%	79.2%	30.3%	23.8%	67.6%
Dec 11	91.9%	62.3%	65.1%	37.5%	29.8%	71.8%
Mar 12	98.3%	81.5%	78.5%	81.5%	54.4%	85.7%

The results show a steady increase in the proportion of doctors covered by designated bodies with sufficient appraisers. This proportion has increased from 66% to 85.7% over the year, with the highest rates in primary care where 98.3% of doctors are covered by primary care trusts with sufficient numbers of appraisers. A large national programme of revalidation training for current appraisers commenced in January 2012. This is co-ordinated by the SHA clusters with funding provided by the RST and will run until the end of March 2013. The aim of this training programme is to build local training capacity and expertise and to provide a module of revalidation training to 10,000 appraisers during this period.

The detailed numbers of medical appraisers in each sector are shown by organisational type in figure 14. The results from the previous exercises are shown for comparison.

Figure 14: Total numbers of active appraisers by organisational type

Organisation type	**Total number of active medical appraisers***		**Total number of active medical appraisers trained (% of total appraisers)**			
	2011	**2012**	**2011**		**2012**	
	Number	Number	Number	% of total	Number	% of total
Primary care trusts	3487	3462	3406	97.7%	3436	99.2%
Hospital trusts	5445	7986	4487	82.4%	7456	93.4%
Mental health trusts	993	1188	942	94.9%	1105	93%
Other NHS trusts/Organisations	161	393	119	73.9%	349	88.8%
Independent/Non NHS	461	1160	398	86.3%	961	82.8%
Total	10547	14189	9352	88.7%	13307	93.8%

*Active appraisers are those who have performed at least one appraisal in the appraisal year.

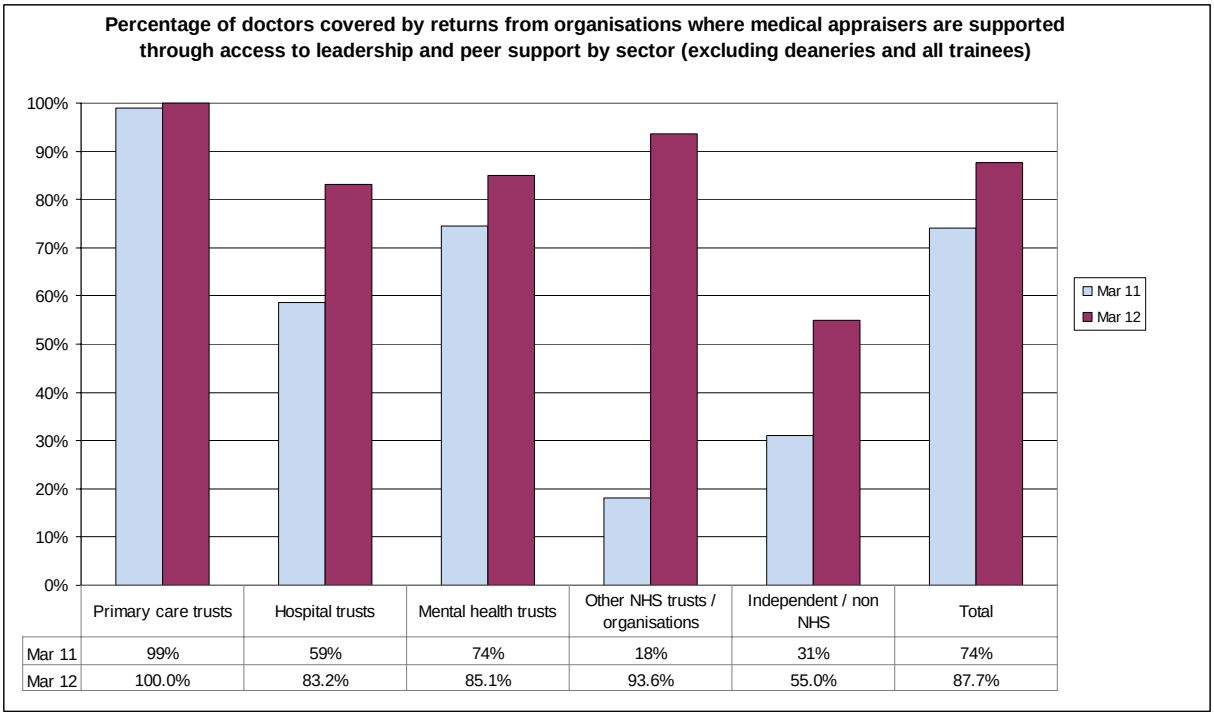
This shows that there are over 14,000 active medical appraisers. Taking into account the total number of doctors covered by this exercise, there is a ratio of 1 appraiser to 11.1 doctors and 1 trained appraiser to 11.8 doctors. There have been significant increases in numbers of appraisers, especially in hospital trusts, where the number of trained appraisers has increased by 66% over 12 months. This has resulted in a reduction in the ratio of appraisers to doctors from 1 appraiser to 11.9 doctors to 1 appraiser to 7.3 doctors in hospital trusts.

The results show that 93.8% of the total number of appraisers had received appraiser training at some stage. The highest rates of appraisers who had received training were in primary care (99.2%). The building of appraisal infrastructure, including appraiser capacity and capability, is an essential precondition of improving the quality of appraisal systems.

Support for appraisers

The role of appraiser is central to the quality of appraisal and the RST has produced guidance to ensure all appraisers are appropriately trained and supported[7]. The proportion of doctors covered by organisations where appraisers are supported in the role through access to leadership and peer support is shown in figure 15. The results are shown by organisational type and data from the previous exercise is shown for comparison.

Figure 15: Appraisers are supported in the role through access to leadership and peer support



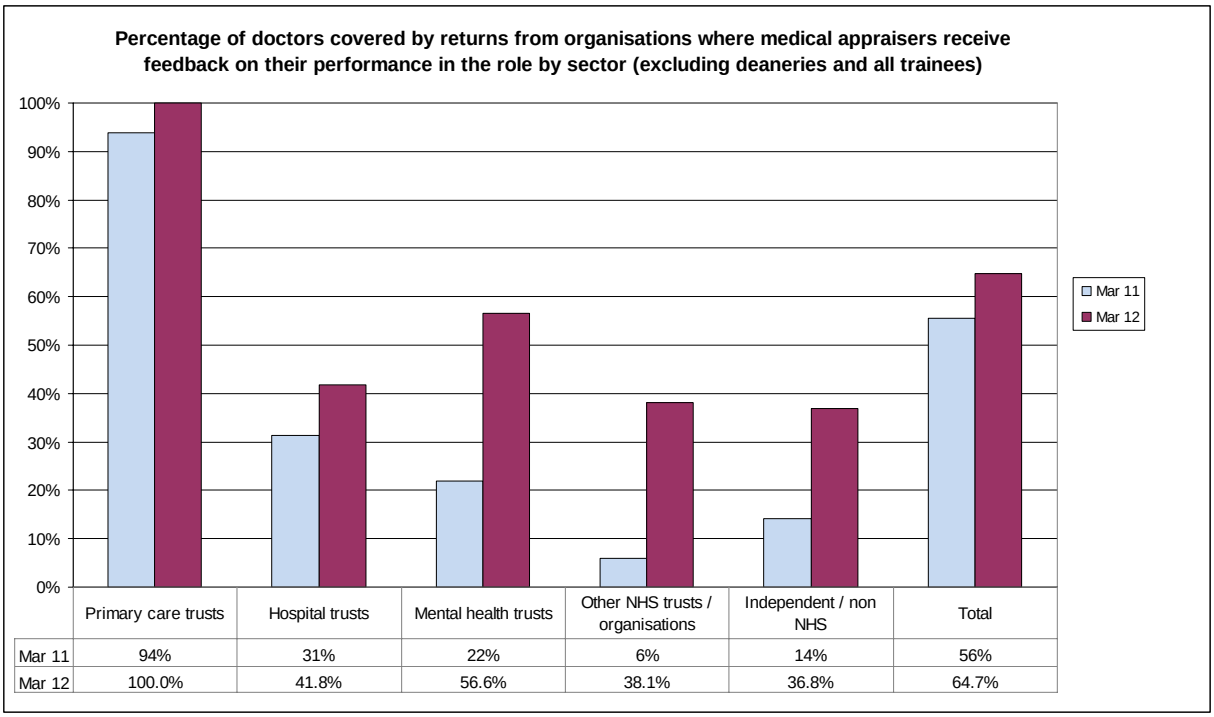
	Primary care trusts	Hospital trusts	Mental health trusts	Other NHS trusts / organisations	Independent / non NHS	Total
Mar 11	99%	59%	74%	18%	31%	74%
Mar 12	100.0%	83.2%	85.1%	93.6%	55.0%	87.7%

87.7% of designated bodies reported that their medical appraisers were supported in the role through access to leadership and peer support. This was answered positively in 100% of PCTs and 83.2% of hospital trusts.

[7] *Quality Assurance of Medical Appraisers*: *recruitment, training, support and review of medical appraisers in England* (RST, 2012)

The proportion of doctors covered by designated bodies where appraisers receive feedback from appraisees or feedback on the quality of outputs of appraisal is shown in figure 16. The results are shown by organisational type and the results from the previous exercises are shown for comparison.

Figure 16: Medical appraisers receive feedback on their performance in the role



	Primary care trusts	Hospital trusts	Mental health trusts	Other NHS trusts / organisations	Independent / non NHS	Total
Mar 11	94%	31%	22%	6%	14%	56%
Mar 12	100.0%	41.8%	56.6%	38.1%	36.8%	64.7%

The results show that 64.7% of doctors are covered by designated bodies where medical appraisers receive feedback on their performance in the role, including feedback from appraisees or feedback on the quality of appraisal outputs. This is an important component of a quality assurance framework for appraisers and also allows the appraiser to reflect on their performance in the role. The overall rate has increased from 56% since March 2012. The rate for primary care trusts is 100% and the rate for hospital trusts is 41.8%.

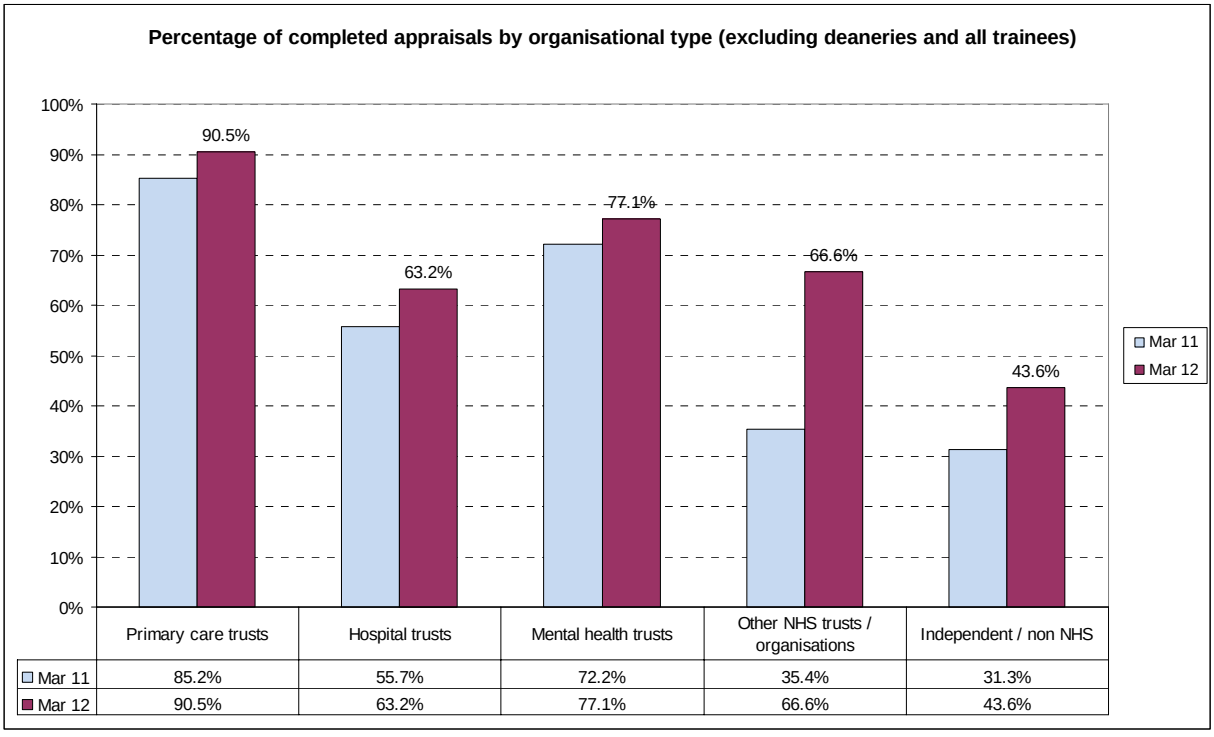
Appraisal rates

The percentage of completed appraisals is shown by organisational type in figure 17. A completed appraisal was defined for the purpose of ORSA as:

> "*one where the appraisal meeting has taken place within the appraisal year and the summary of appraisal discussion/PDP have been signed off by appraiser and appraisee within 28 days of the appraisal meeting*".

For the purposes of ORSA the organisational appraisal year runs from 1 April until 31 March. Trainees are subject to the Annual Review of Competence Progression (ARCP) process and do not undertake annual appraisal in the same way as other doctors. Trainees have a prescribed connection with the deanery and those who have been wrongly included in submissions from other designated bodies have been removed. The results from the previous exercise in March 2011 are shown for comparison.

Figure 17: Percentage of completed appraisals by organisational type



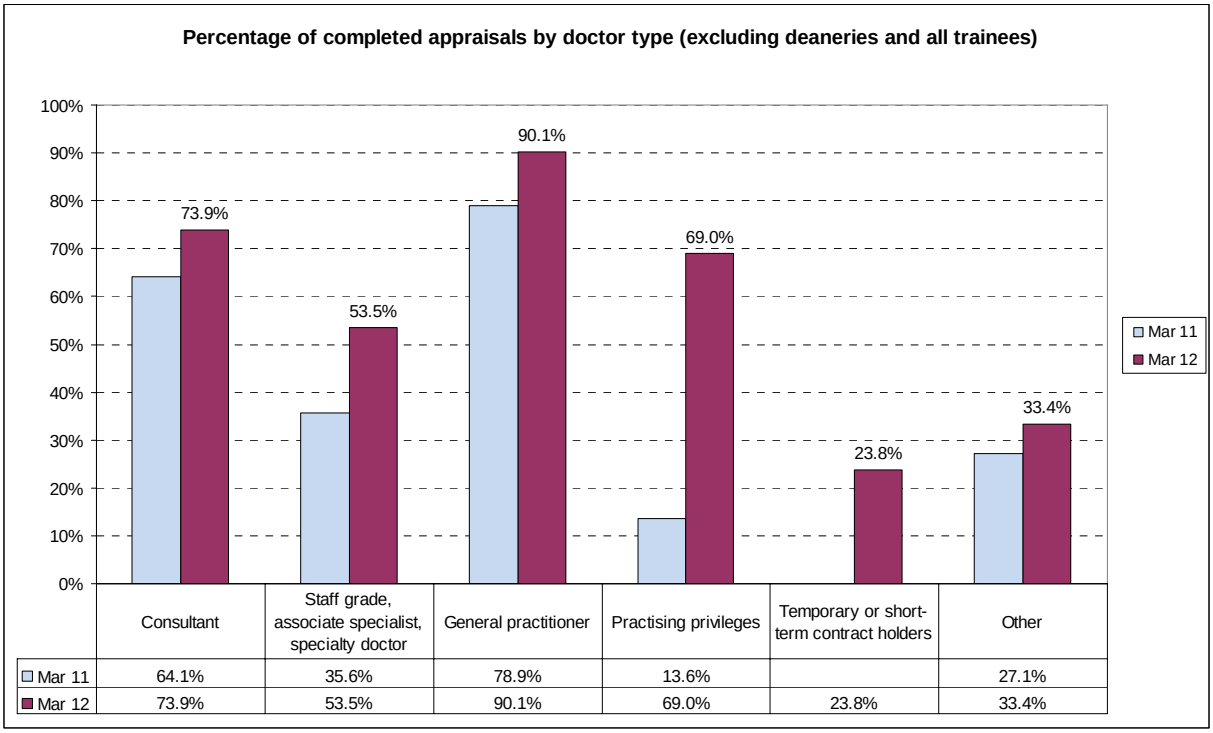
	Primary care trusts	Hospital trusts	Mental health trusts	Other NHS trusts / organisations	Independent / non NHS
Mar 11	85.2%	55.7%	72.2%	35.4%	31.3%
Mar 12	90.5%	63.2%	77.1%	66.6%	43.6%

This shows that each organisational type has improved its appraisal rates over the past 12 months. This indicates that, as well as ensuring that local appraisal systems are providing improved coverage, designated bodies are establishing effective systems to track and record the number of completed appraisals performed.

Many non-NHS organisations are starting from a low baseline as they may not have provided appraisal for their doctors in the past. Despite this and the large number of newly identified designated bodies in this sector, the proportion of doctors appraised has increased significantly.

The percentage of completed appraisals is shown by doctor type in figure 18 and figure 19. Results from previous exercise are shown for comparison.

Figure 18: Percentage of completed appraisals by doctor type



	Consultant	Staff grade, associate specialist, specialty doctor	General practitioner	Practising privileges	Temporary or short-term contract holders	Other
Mar 11	64.1%	35.6%	78.9%	13.6%		27.1%
Mar 12	73.9%	53.5%	90.1%	69.0%	23.8%	33.4%

Figure 19: Percentage of completed appraisals by doctor type (table)

Doctor type	Percentage	
	March 2011	March 2012
Consultant	64.1%	73.9%
Staff grade, associate specialist, specialty doctor	35.6%	53.5%
General practitioner	78.9%	90.1%
Practising privileges	13.6%	69.0%
*Temporary or short-term contract holders	Not applicable	23.8%
Other	27.1%	33.4%
Reported total (excluding trainees) as submitted by organisations	73.7%	72.7%
Calculated total (excluding trainees) obtained by summing reported rates for individual doctor types	63.3%	72.7%

*No figures for doctors in this group for March 2011 as it is a new category

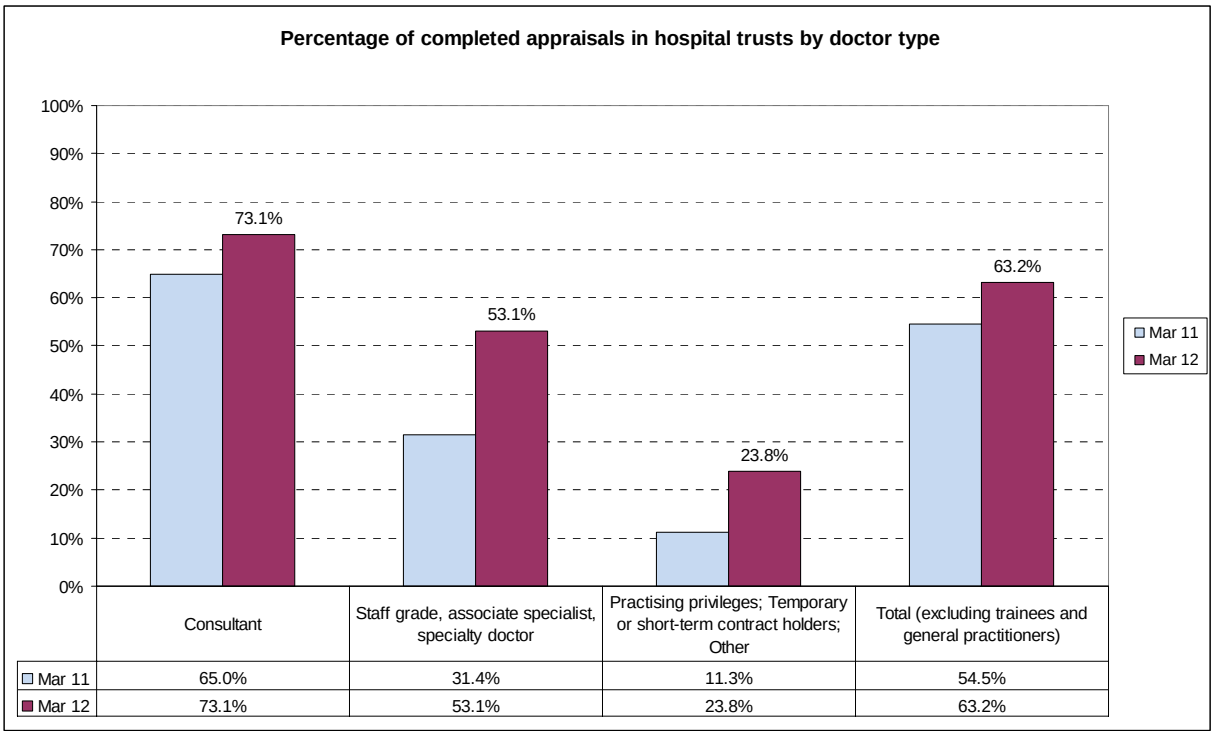
The data shows there has been an increase in completed appraisal rates for all doctor types and some of these improvements are substantial. The rates for staff and associate specialist doctors and for doctors on temporary or short-term contracts remain low despite steady improvements and this will need special attention in the coming year.

The total appraisal rate reported by individual designated bodies for the year ending March 2011 was 73.7%. However, if the total appraisal rate is calculated from the sum of data reported for each individual doctor type in the same exercise, the rate is 63.3%. The likely explanation for this anomaly is the poor data quality reported by a number of designated bodies in March 2011 resulting from immaturity of the systems for managing and recording appraisals within their organisations. Some simple data input errors from the designated bodies have also been identified and corrected in this revised rate.

The completed appraisal rate for hospital trusts has increased from 55.7% to 63.2%, but this remains lower than the other mainstream NHS organisations.

The percentage of completed appraisals in hospital trust doctors is shown by doctor type in figure 20. Where trainees and GPs have been wrongly included in the returns they have been removed from these results. The results from the previous exercises are shown for comparison.

Figure 20: Percentage of completed appraisals in hospital trusts by doctor type



	Consultant	Staff grade, associate specialist, specialty doctor	Practising privileges; Temporary or short-term contract holders; Other	Total (excluding trainees and general practitioners)
Mar 11	65.0%	31.4%	11.3%	54.5%
Mar 12	73.1%	53.1%	23.8%	63.2%

This shows that the previously lower than expected rate of completed appraisal for consultants has improved but remains lower than expected, with 73.1% of consultants having completed an appraisal during the year. This rate may be affected by staff turnover, newly appointed consultants, maternity leave, suspension, sickness absence and other long-term absence, but it remains significantly lower than that for general practitioners (90.1%).

There is evidence that, in the past, there has been inadequate resource, management and infrastructure to support hospital appraisal systems. This is illustrated, for example, by the previously low capacity and capability of trained appraisers in hospital trusts. A quality assured standard of appraisal is now required and there is evidence that these deficits are being addressed, for example, in the large rise in the numbers of trained appraisers shown in figure 14 and the significant improvement in the ratio of appraisers to doctors in hospital trusts.

The rates for staff and associate specialist doctors remain low despite steady improvements and this will need special attention in the coming year. The large numbers of doctors on short-term or temporary contracts provide special challenges due to their movement through the health system and hospital trusts will need to develop arrangements to ensure these doctors are included in appraisal systems and their appraisals are completed when they are due.

The overall findings in this section show that over the past year there have been substantial improvements in the capacity and capability of medical appraisal systems in all sectors. The improvements in infrastructure and management, including the training and quality assurance of appraisers, will provide a firm foundation for improving the overall quality of medical appraisal and for further improvements in appraisal rates for all doctors.

Section 4: Organisational governance

In section 4 of the self-assessment questionnaire, designated bodies are asked to provide details of their organisational governance systems. The indicators for this section are shown in figure 21.

Figure 21: ORSA section four indicators

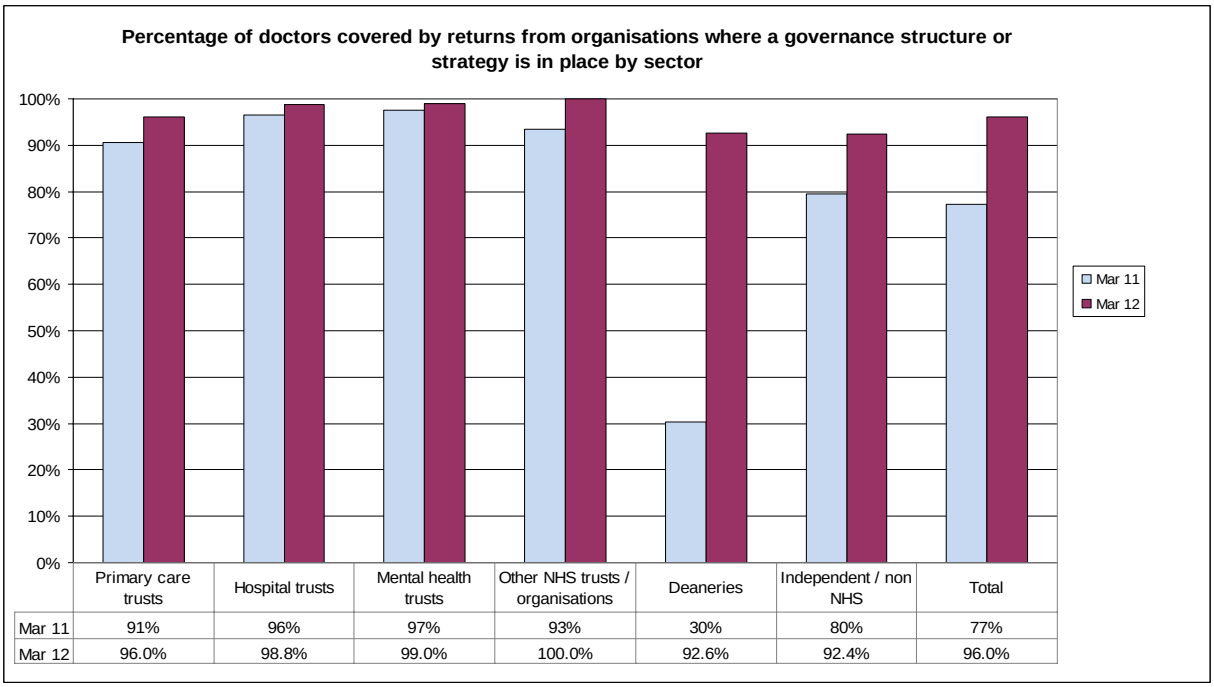
Section number	Indicator
4.1	A governance structure or strategy is in place (including clinical governance where appropriate)
4.2	The governance systems (including clinical governance where appropriate) are subject to external or independent review
4.3	There is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection
4.4	All doctors with whom the designated body has a prescribed connection are able to obtain structured feedback from patients and colleagues in compliance with GMC criteria
4.5	The designated body's clinical audit activity is in line with national guidance (including contributions to clinical registers and databases and confidential enquiries)
4.6	There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified
4.7	There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors
4.8	There is a process in place to ensure fitness to practise evaluations and appraisals take account of all available information relating to the doctor's fitness to practise, from the work carried out for the designated body and for any other organisation
4.9	A process is established for the investigation of capability, conduct, health and fitness to practise concerns

4.10	A policy (with core content) for re-skilling, rehabilitation, remediation and targeted support is in place.
4.11	Where a doctor is subject to conditions imposed by, or undertakings agreed with the GMC, the responsible officer monitors compliance with those conditions or undertakings
4.12	A description of the support available from the designated body for doctors to keep their knowledge and skills up to date is in place
4.13	Relevant appraisal, revalidation and human resources policies are fair and non-discriminatory

The proportion of doctors covered by designated bodies with a governance structure or strategy is in place is shown by organisational type in figure 22. The results from the previous exercises are shown for comparison.

Designated bodies are accountable for their doctors and there should be a description of the structures and arrangements in place for assuring the quality of services provided or the quality of contractors/members.

Figure 22: Governance structure or strategy is in place



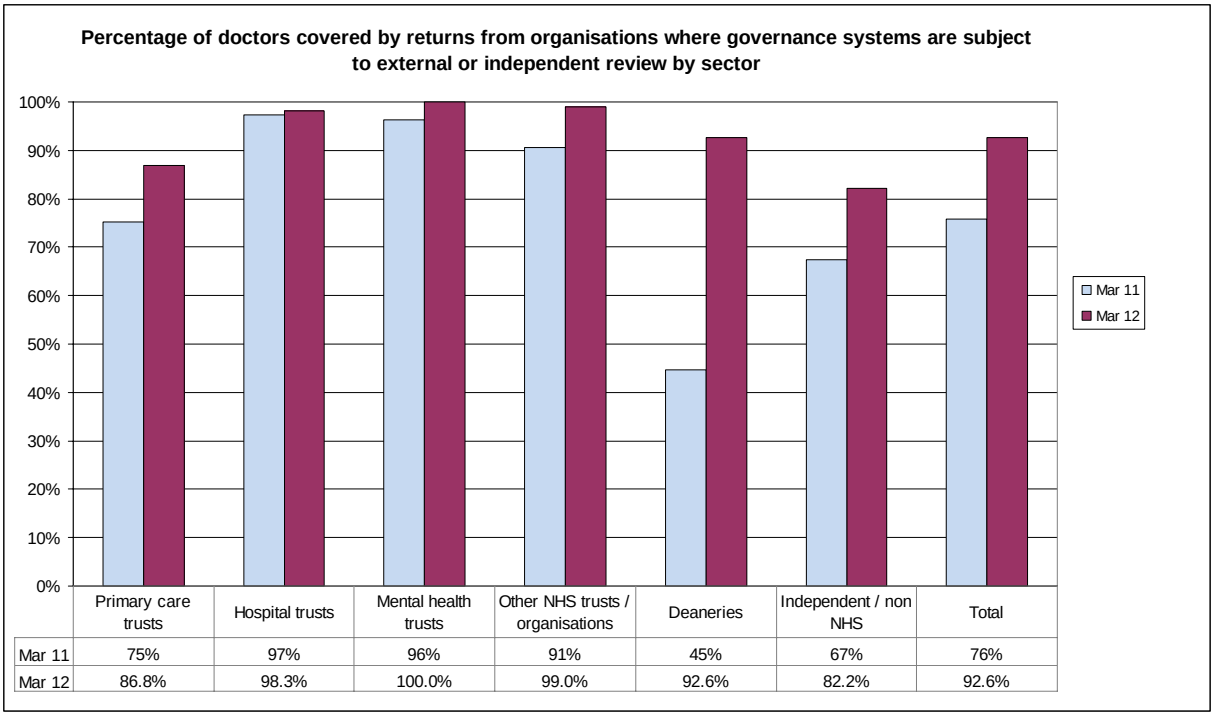
	Primary care trusts	Hospital trusts	Mental health trusts	Other NHS trusts / organisations	Deaneries	Independent / non NHS	Total
Mar 11	91%	96%	97%	93%	30%	80%	77%
Mar 12	96.0%	98.8%	99.0%	100.0%	92.6%	92.4%	96.0%

The results show that 96% of doctors are covered by designated bodies with governance strategies or structures in place (including clinical governance, where applicable).

The proportion of doctors covered by designated bodies where the governance systems are subject to external or independent review is shown by organisational type in figure 23. Results from previous exercises are shown for comparison.

Most designated bodies will be subject to external or independent review by a regulator or another external body. Designated bodies which are healthcare providers are subject to review by the national healthcare regulators (the Care Quality Commission or Monitor). Primary care trusts are overseen by the SHA or SHA cluster. Deaneries are monitored and reviewed by the GMC. Some designated bodies are not regulated or overseen by an external body (for example, locum agencies and organisations which are not healthcare providers) and an alternative external or independent review process should be agreed with the level two responsible officer.

Figure 23: Governance systems are subject to external or independent review



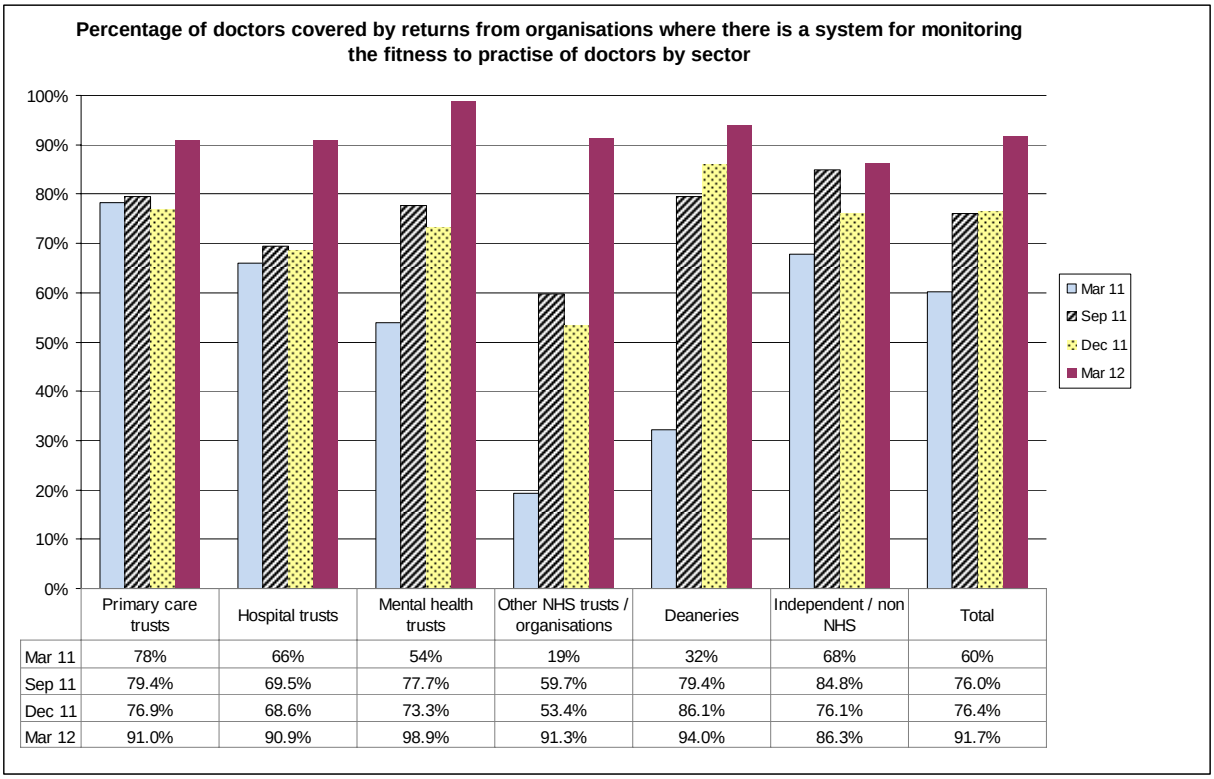
	Primary care trusts	Hospital trusts	Mental health trusts	Other NHS trusts / organisations	Deaneries	Independent / non NHS	Total
Mar 11	75%	97%	96%	91%	45%	67%	76%
Mar 12	86.8%	98.3%	100.0%	99.0%	92.6%	82.2%	92.6%

The results show that 92.6% of doctors are covered by designated bodies with governance systems which are subject to external or independent review. This has increased from 76% since March 2011.

The proportion of doctors covered by designated bodies where there is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection is shown by organisational type in figure 24. The results from the previous exercises are shown for comparison.

This is specified in the responsible officer regulations and is one of the fundamental elements of the governance systems on which revalidation is based.

Figure 24: System for monitoring the fitness to practise of doctors



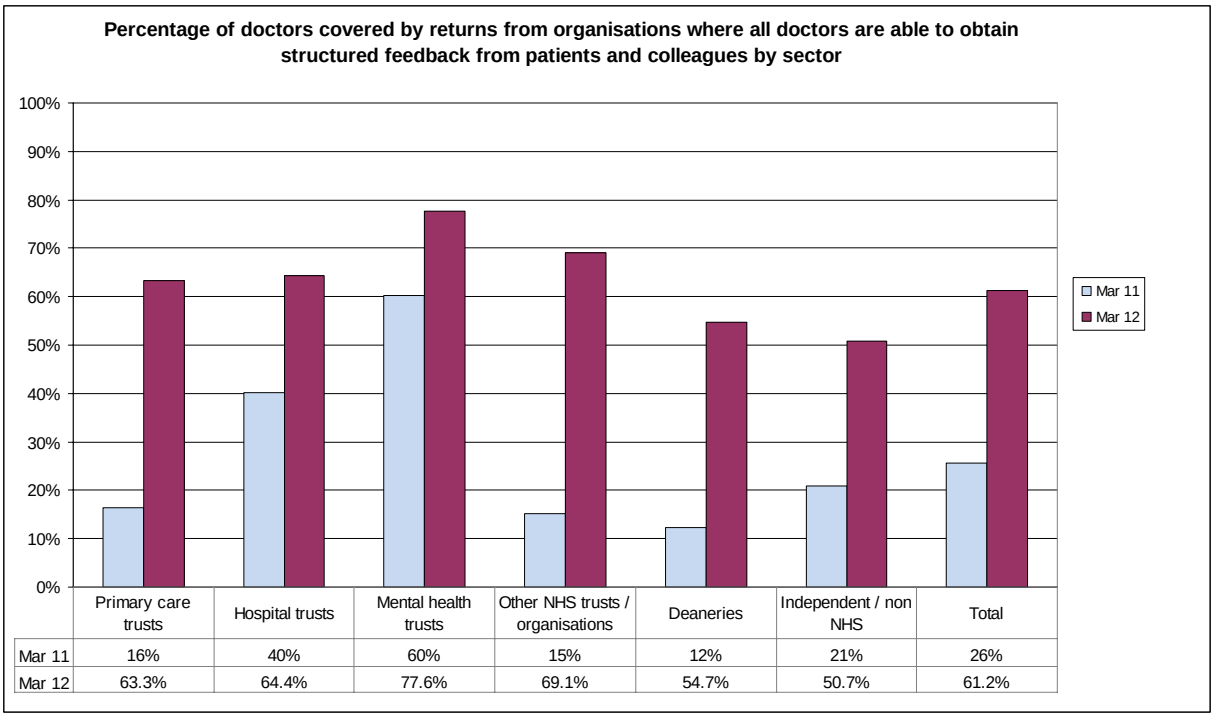
	Primary care trusts	Hospital trusts	Mental health trusts	Other NHS trusts / organisations	Deaneries	Independent / non NHS	Total
Mar 11	78%	66%	54%	19%	32%	68%	60%
Sep 11	79.4%	69.5%	77.7%	59.7%	79.4%	84.8%	76.0%
Dec 11	76.9%	68.6%	73.3%	53.4%	86.1%	76.1%	76.4%
Mar 12	91.0%	90.9%	98.9%	91.3%	94.0%	86.3%	91.7%

The results show that 91.7% of doctors are covered by designated bodies with a system for monitoring fitness to practise. This has increased from 60% since March 2011 and all types of organisation show significant improvements over the last 12 months. Improvements are especially notable in responses received from deaneries, mental health trusts and other NHS organisations.

The proportion of doctors covered by designated bodies where the doctors are able to obtain structured feedback from patients and colleagues in compliance with GMC criteria is shown by organisational type in figure 25. The results from the previous exercises are shown for comparison.

It is important that all doctors are aware of the requirement for completion of a patient and colleague feedback exercise which complies with GMC requirements. The responsible officer should have a system which enables them to identify those doctors who have not completed a patient and colleague feedback exercise within the revalidation cycle.

Figure 25: Doctors are able to obtain structured feedback from patients and colleagues

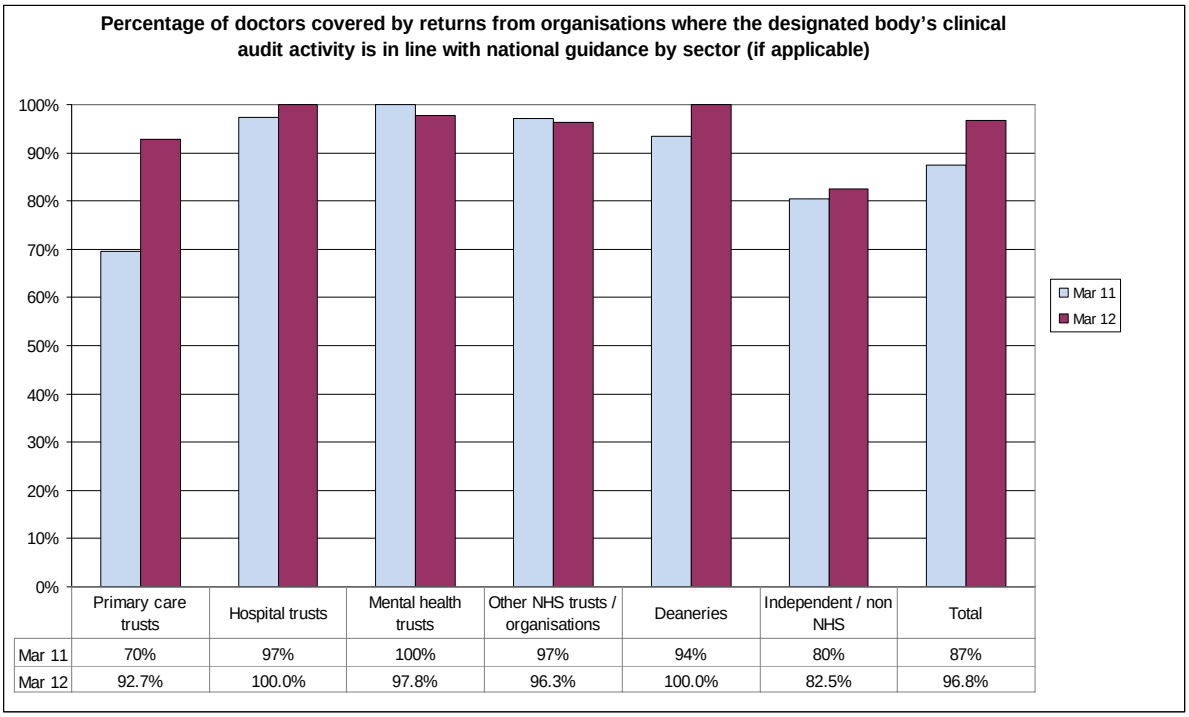


	Primary care trusts	Hospital trusts	Mental health trusts	Other NHS trusts / organisations	Deaneries	Independent / non NHS	Total
Mar 11	16%	40%	60%	15%	12%	21%	26%
Mar 12	63.3%	64.4%	77.6%	69.1%	54.7%	50.7%	61.2%

The results show that 61.2% of doctors are covered by designated bodies where the doctors are able to obtain structured feedback from patients and colleagues in compliance with GMC criteria. This proportion has increased significantly from 26% in March 2011. The original GMC guidance was published in April 2011 and further guidance was published in May 2012 (after the period of this ORSA exercise) which provides clarification on the requirements for patient and colleague feedback during the early years of implementation.

The proportion of doctors covered by designated bodies where clinical audit activity (where this is applicable) is in line with national guidance is shown by organisational type in figure 26. Results from the previous exercises are shown for comparison.

Figure 26: Clinical audit activity is in line with national guidance where this is applicable



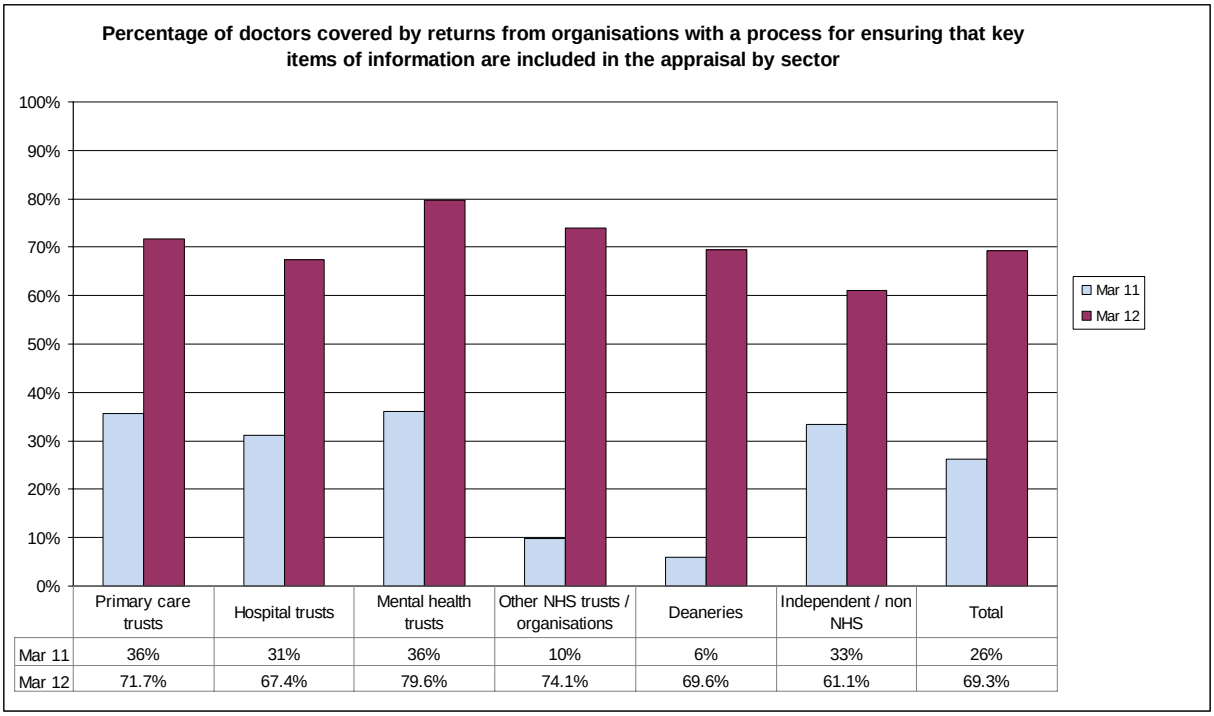
	Primary care trusts	Hospital trusts	Mental health trusts	Other NHS trusts / organisations	Deaneries	Independent / non NHS	Total
Mar 11	70%	97%	100%	97%	94%	80%	87%
Mar 12	92.7%	100.0%	97.8%	96.3%	100.0%	82.5%	96.8%

The results show that 96.8% of doctors are covered by designated bodies where clinical audit activity is in line with national guidance, where this is applicable.

The proportion of doctors covered by designated bodies where key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting is shown by organisational type in figure 27. Results from the previous exercises are shown for comparison.

It is important that issues and concerns about performance or conduct are addressed at the time they arise. The appraisal meeting is usually not the most appropriate setting for dealing with concerns and in most cases these should be dealt with outside the appraisal process in a clinical governance setting. Learning by individuals from such events is an important part of resolving concerns and the appraisal meeting is usually the most appropriate setting to ensure this is planned and prioritised. The responsible officer may therefore wish to ensure certain key items of supporting information are included in the doctor's portfolio and discussed at appraisal so that development needs are identified and addressed.

Figure 27: Key items of information are included in the appraisal portfolio and discussed at the appraisal meeting



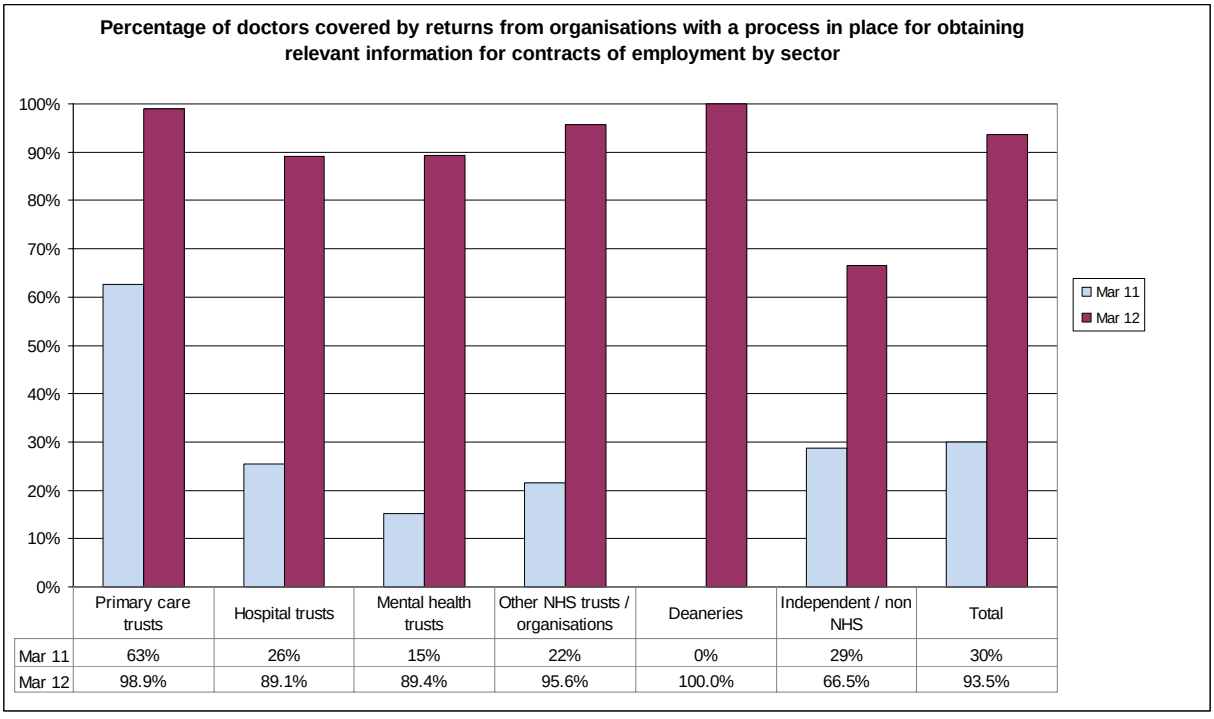
	Primary care trusts	Hospital trusts	Mental health trusts	Other NHS trusts / organisations	Deaneries	Independent / non NHS	Total
Mar 11	36%	31%	36%	10%	6%	33%	26%
Mar 12	71.7%	67.4%	79.6%	74.1%	69.6%	61.1%	69.3%

The results show that 69.3% of doctors are covered by designated bodies where key items of information are included in the appraisal portfolio and discussed at the appraisal meeting. This has increased from 26% since March 2011.

The proportion of doctors covered by designated bodies with a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors is shown by organisational type in figure 28. The results from the previous exercises are shown for comparison.

This is an important means of ensuring unresolved issues and concerns are passed on when the doctor moves to a different area or a new role.

Figure 28: Process for obtaining relevant information when entering into a contract of employment or for the provision of services with doctors



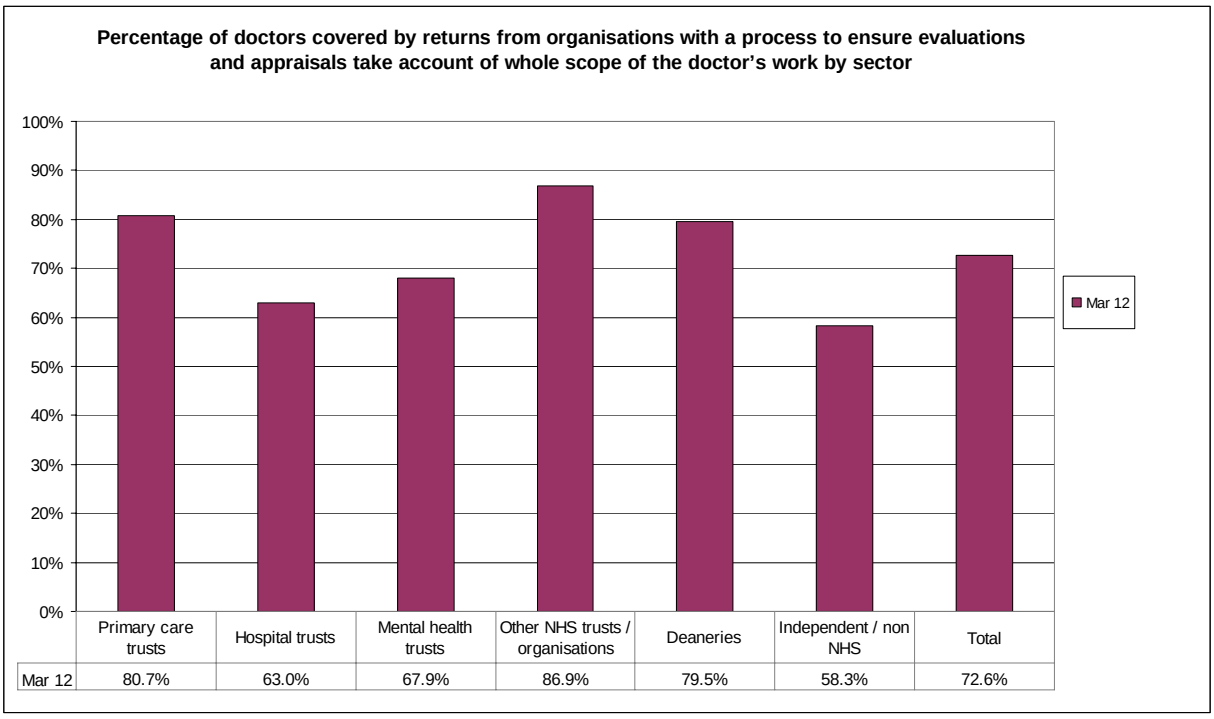
	Primary care trusts	Hospital trusts	Mental health trusts	Other NHS trusts / organisations	Deaneries	Independent / non NHS	Total
Mar 11	63%	26%	15%	22%	0%	29%	30%
Mar 12	98.9%	89.1%	89.4%	95.6%	100.0%	66.5%	93.5%

The results show that 93.5% of doctors are covered by designated bodies where there is a process for obtaining relevant information when entering into a contract of employment or for the provision of services with doctors. It is clear from the previous results in March 2011 that this has been a major weakness in systems of governance and information-sharing about doctors and there has been significant progress in addressing this weakness.

The proportion of doctors covered by designated bodies where fitness to practise evaluations and appraisals take account of all available information relating to the doctor's fitness to practise, from the work carried out for the designated body and for any other organisation is shown by organisational type in figure 29. This is a new indicator and no comparators are available.

This is a specific requirement of the responsible officer regulations. It is important that a process is in place to ensure that relevant information from all the doctor's roles and places of work is available when appraisal and fitness to practise evaluations are performed.

Figure 29: Fitness to practise evaluations and appraisals take account of information from the whole scope of the doctor's work



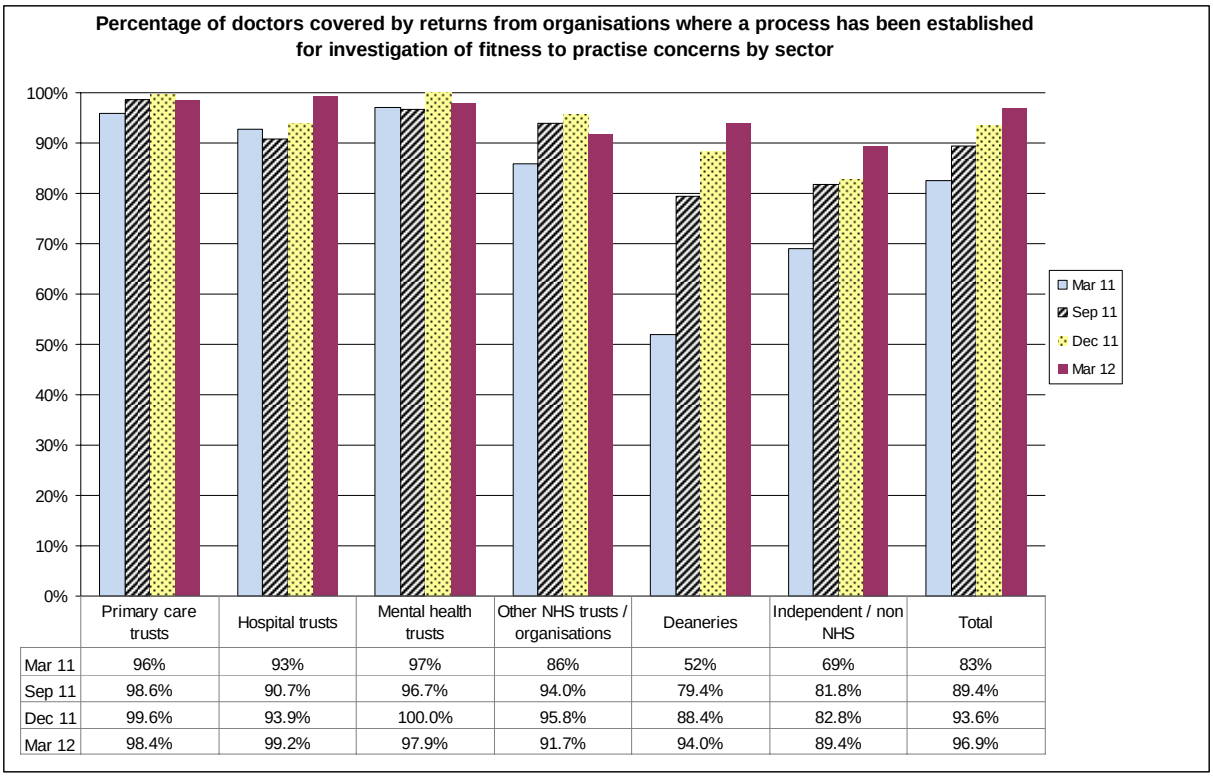
	Primary care trusts	Hospital trusts	Mental health trusts	Other NHS trusts / organisations	Deaneries	Independent / non NHS	Total
Mar 12	80.7%	63.0%	67.9%	86.9%	79.5%	58.3%	72.6%

The results show that 72.6% of doctors are covered by designated bodies where fitness to practise evaluations and appraisals take account of information from the whole scope of the doctor's work.

The proportion of doctors covered by designated bodies with a process for investigating capability, conduct, health and fitness to practise concerns is shown by organisational type in figure 30. Results from the previous exercises are shown for comparison.

This is a specific requirement of the responsible officer regulations and is one of the fundamental elements of the governance systems on which revalidation is based.

Figure 30: Process for investigating capability, conduct, health and fitness to practise concerns



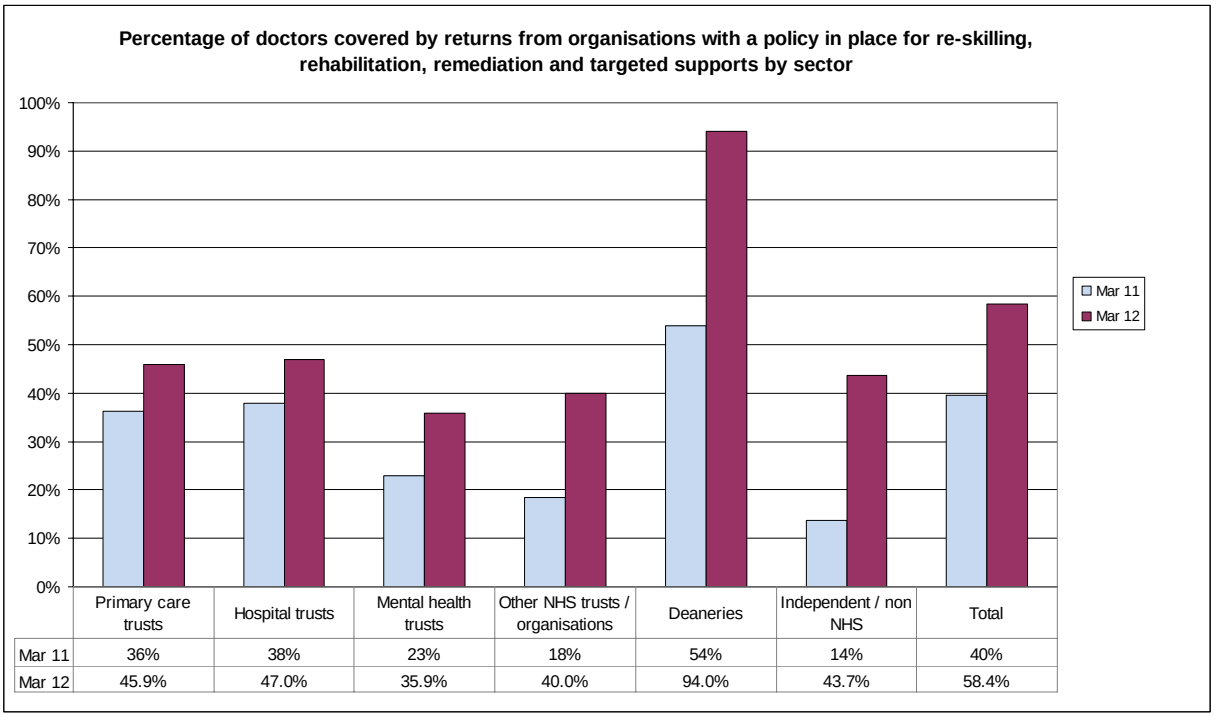
	Primary care trusts	Hospital trusts	Mental health trusts	Other NHS trusts / organisations	Deaneries	Independent / non NHS	Total
Mar 11	96%	93%	97%	86%	52%	69%	83%
Sep 11	98.6%	90.7%	96.7%	94.0%	79.4%	81.8%	89.4%
Dec 11	99.6%	93.9%	100.0%	95.8%	88.4%	82.8%	93.6%
Mar 12	98.4%	99.2%	97.9%	91.7%	94.0%	89.4%	96.9%

The results show that 96.9% of doctors are covered by designated bodies where there is a process for investigating capability, conduct, health and fitness to practise concerns. This has increased from 83% since March 2011.

The proportion of doctors covered by designated bodies with a policy for re-skilling, rehabilitation, remediation and targeted support is shown by organisational type in figure 31. The results from the previous exercises are shown for comparison.

The regulations require responsible officers to ensure that appropriate measures are taken to address concerns about a doctor's practice. These may include training, rehabilitation and other forms of support.

Figure 31: Policy for re-skilling, rehabilitation, remediation and targeted support



	Primary care trusts	Hospital trusts	Mental health trusts	Other NHS trusts / organisations	Deaneries	Independent / non NHS	Total
Mar 11	36%	38%	23%	18%	54%	14%	40%
Mar 12	45.9%	47.0%	35.9%	40.0%	94.0%	43.7%	58.4%

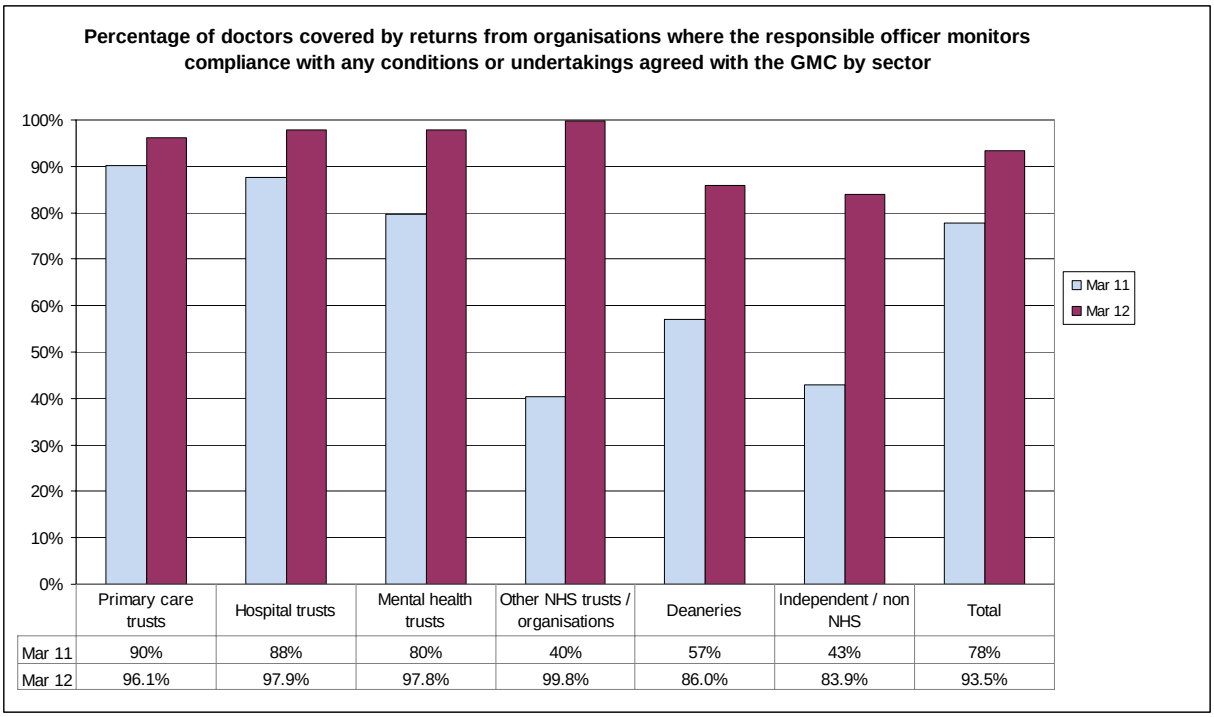
The results show that 58.4% of doctors are covered by designated bodies where there is a policy for re-skilling, rehabilitation, remediation and targeted support. This proportion is lower than for many of the other indicators. Contributory factors to this are the difficulties developing new policies or amending existing policies for this in NHS organisations without national agreement from relevant stakeholders (including NHS Employers and the British Medical Association). This issue will require further planning and agreement to ensure the development of local policies can move forward successfully. New guidance is available from the RST[8] and NHS Employers[9], which will support this process. For NHS organisations that are subject to reorganisation within the new NHS structure (including primary care trusts and SHAs), developing policies in the short time remaining may not be practicable or effective.

[8] *Supporting Doctors to Provide Safer Healthcare* (RST, 2012)

[9] *Staying on course - supporting doctors in difficulty through early and effective action* (NHS Employers, 2012)

The proportion of doctors covered by designated bodies where the responsible officer monitors compliance with GMC conditions or undertakings is shown by organisational type in figure 32. Results from the previous exercise are shown for comparison.

Figure 32: Responsible officer monitors compliance with GMC conditions or undertakings

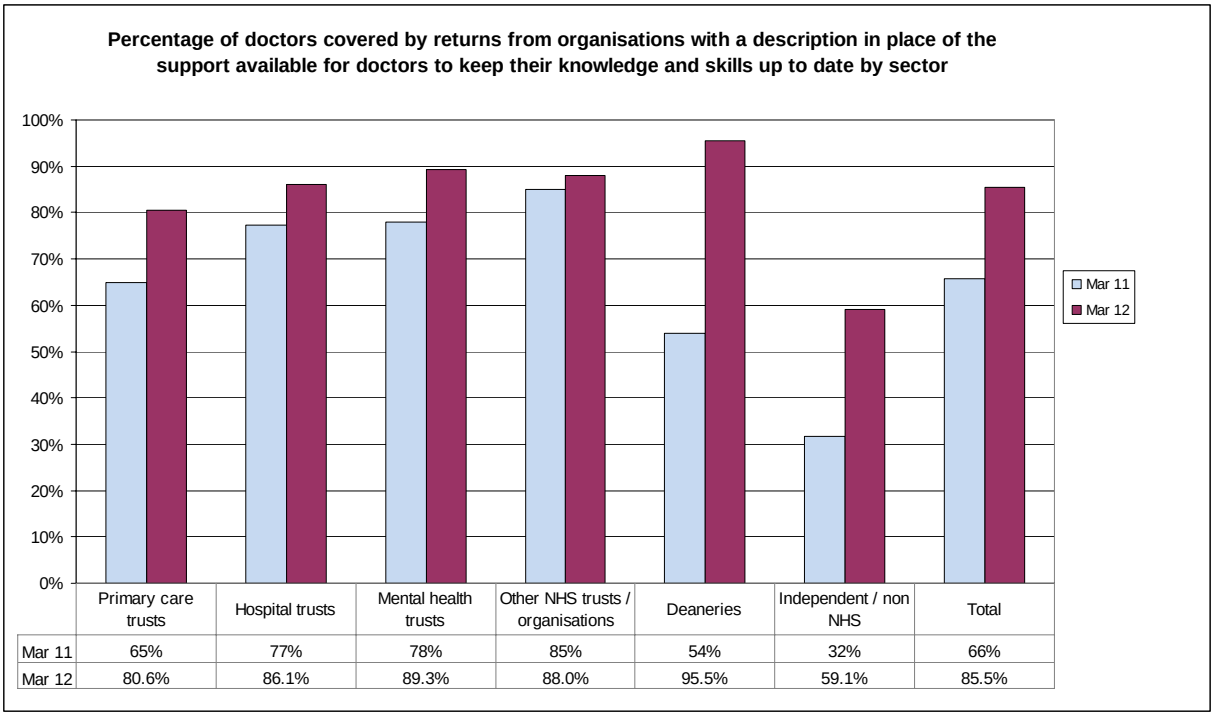


	Primary care trusts	Hospital trusts	Mental health trusts	Other NHS trusts / organisations	Deaneries	Independent / non NHS	Total
Mar 11	90%	88%	80%	40%	57%	43%	78%
Mar 12	96.1%	97.9%	97.8%	99.8%	86.0%	83.9%	93.5%

The results show that 93.5% of doctors are covered by designated bodies where the responsible officer monitors compliance with GMC conditions or undertakings. This has increased from 78% since March 2011. There have been especially notable improvements in this indicator in the independent sector organisations from 43% to 83.9%.

The proportion of doctors covered by designated bodies where there is a description of the support available from the designated body for doctors to keep their knowledge and skills up to date is in place is shown by organisational type in figure 33. The results from the previous exercise are shown for comparison.

Figure 33: Description of support available for doctors to keep their knowledge and skills up to date

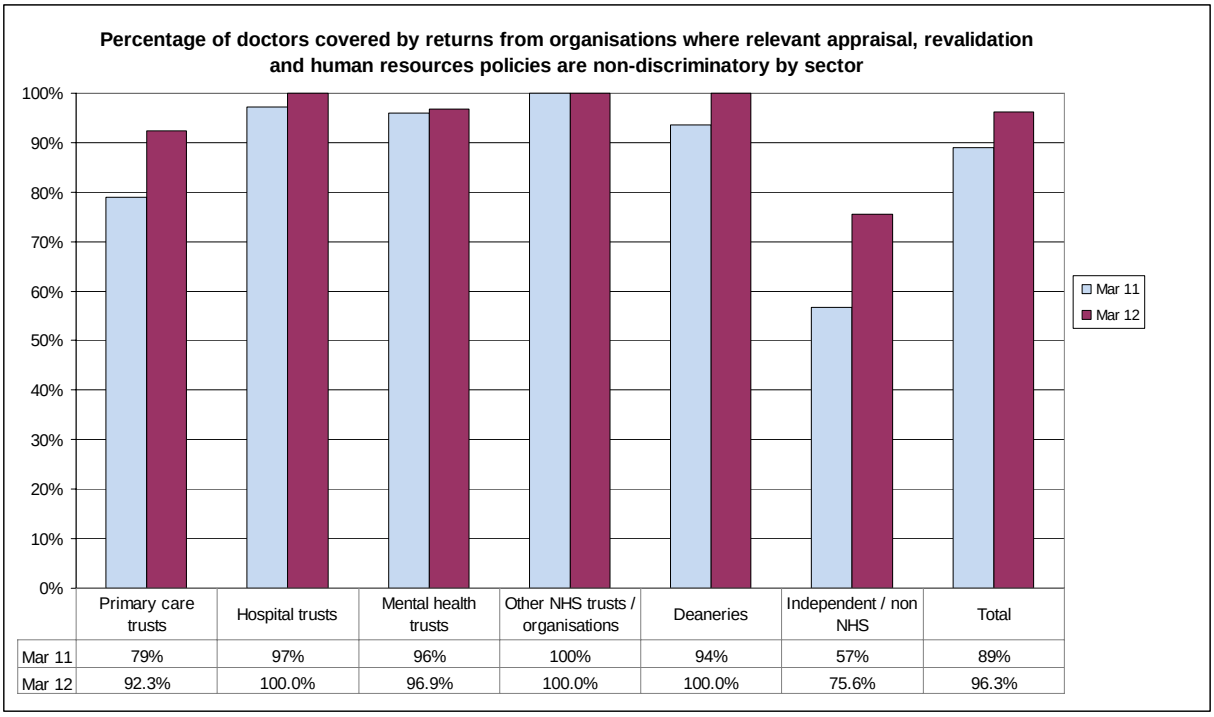


	Primary care trusts	Hospital trusts	Mental health trusts	Other NHS trusts / organisations	Deaneries	Independent / non NHS	Total
Mar 11	65%	77%	78%	85%	54%	32%	66%
Mar 12	80.6%	86.1%	89.3%	88.0%	95.5%	59.1%	85.5%

The results show that 85.5% of doctors are covered by designated bodies where there is a description of support available for doctors to keep their knowledge and skills up to date. The overall proportion has increased from 66% since March 2011. All sectors show significant improvements in this indicator.

The proportion of doctors covered by designated bodies where relevant appraisal, revalidation and human resources policies are fair and non-discriminatory is shown by organisational type in figure 34. Results from the previous exercise are shown for comparison.

Figure 34: Appraisal, revalidation and human resources policies are fair and non-discriminatory



	Primary care trusts	Hospital trusts	Mental health trusts	Other NHS trusts / organisations	Deaneries	Independent / non NHS	Total
Mar 11	79%	97%	96%	100%	94%	57%	89%
Mar 12	92.3%	100.0%	96.9%	100.0%	100.0%	75.6%	96.3%

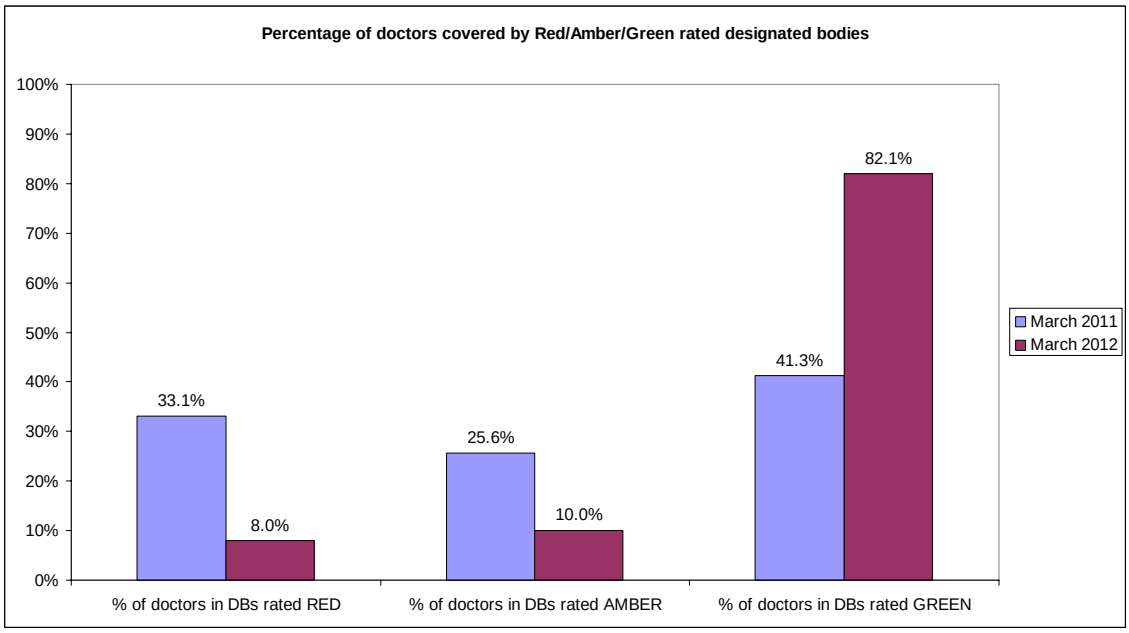
The results show that 96.3% of doctors are covered by designated bodies where appraisal, revalidation and human resources policies are fair and non-discriminatory.

Designated body ratings

The RST has developed a method of defining readiness for revalidation in England which was agreed by the ERDB in March 2012. This describes a method of rating each designated body against a smaller number of key performance indicators. Each designated body has been awarded a ‘red’, ’amber’ or ‘green’ (RAG) rating based on this methodology (see Appendix 2).

Figure 35 shows the overall proportion of doctors covered by designated bodies with red, amber or green ratings that submitted a return to each exercise. The results from the previous exercises are shown for comparison.

Figure 35: Percentage of doctors covered by red, amber or green rated designated bodies in each exercise



This shows the proportion of doctors covered by designated bodies rated green in this ORSA exercise has increased significantly despite the larger number of respondents from 41.3% to 82.1%.

The results of this ORSA exercise suggest that data quality and record-keeping have improved and it may be that the previously used estimate of 180,000 doctors practising in England is an overestimate. Therefore, for information, figure 36 shows the overall proportion of doctors covered by designated bodies with amber or green ratings using two different estimates (170,000 and 180,000) and also using the total number of doctors covered by the ORSA responses. The results from the previous exercises have been recalculated to show a like for like comparison.

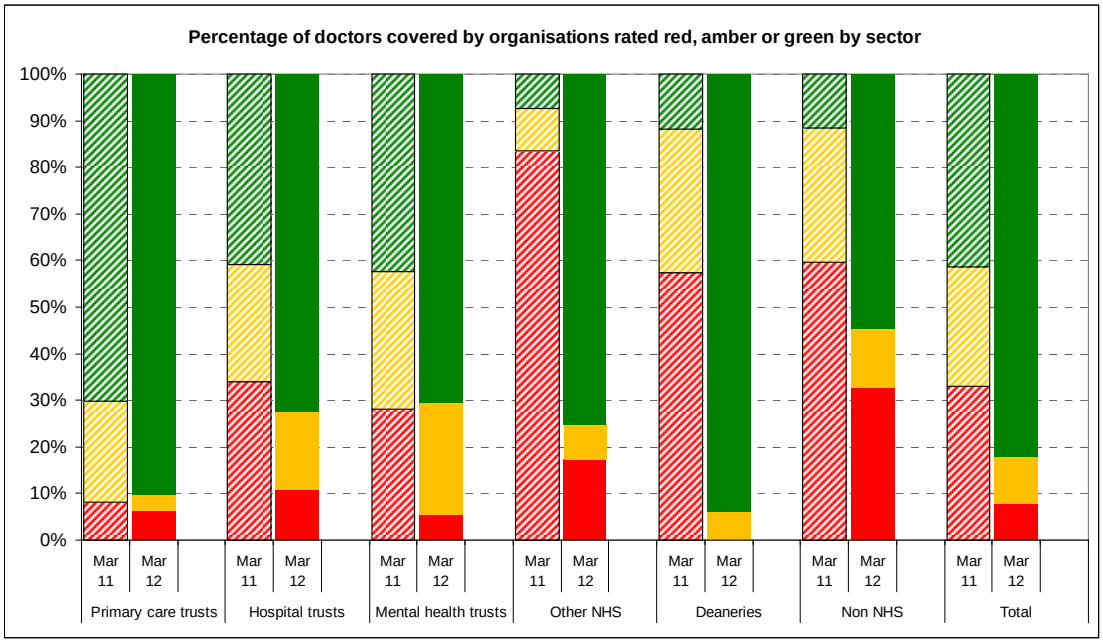
Figure 36: Doctors covered by amber or green rated designated bodies

	Using total number of doctors covered by ORSA responses (157,999)	**Using an estimate of 170,000 doctors**	**Using an estimate of 180,000 doctors**
% of doctors in green or amber DBs as at March 2011	67%	60%	57%
% of doctors in green or amber DBs as at September 2011	79%	74%	70%
% of doctors in green or amber DBs as at December 2011	84%	82%	77%
% of doctors in green or amber DBs as at March 2012	**92%**	**86%**	**81%**

The overall proportion of doctors covered by designated bodies with a green or amber rating has increased significantly despite the larger number of respondents from 57% to 81% using the estimate of 180,000 doctors and from 60% to 86% using the estimate of 170,000 doctors.

The proportion of doctors covered by designated bodies rated red, amber or green in each sector is shown in figure 37. The results from the previous exercises are shown for comparison.

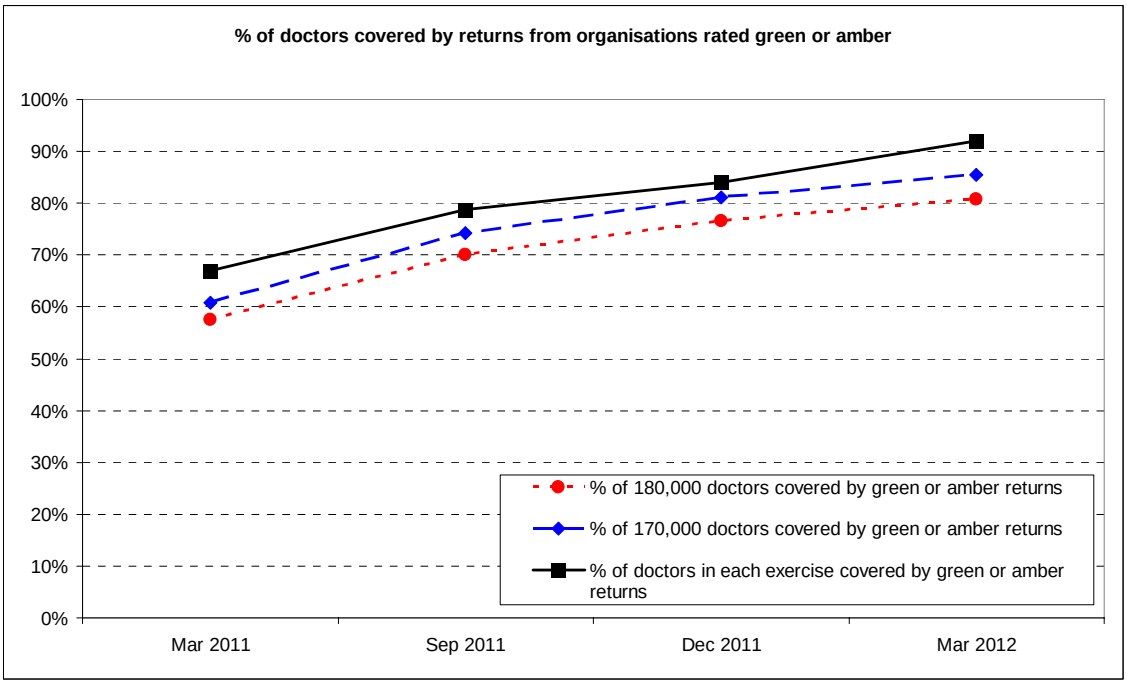
Figure 37: Proportion of doctors covered by red, amber or green rated designated bodies by sector



This shows that the proportion of doctors covered by designated bodies rated green in all sectors has increased significantly.

The rate of increase in the proportion of doctors covered by designated bodies that are advanced in their preparations for the implementation of revalidation comparing the total number of doctors covered by responses with the estimates of 170,000 and 180,000 is shown in figure 39.

Figure 39: Doctors covered by designated bodies rated green or amber



This shows the trajectory of the total proportion of doctors covered by designated bodies that are advanced in their preparations for the implementation of revalidation. The increase over the last year is a positive sign of readiness for implementation.

The overall findings in this section show that over the past year there have been substantial improvements in the organisational governance systems required to support revalidation. The improvements in the monitoring of doctors' fitness to practise, the investigation and management of concerns and the flow of key information provide a firm foundation for implementation.

Next steps

The reported data with national sector comparators has been forwarded to each SHA cluster to inform their planning and progress monitoring. Relevant data will be forwarded to the GMC and to the system regulators (the Care Quality Commission and Monitor) for information.

Action plans for each designated body which address development needs will be received and agreed by each SHA cluster. Where the level two responsible officer at the SHA cluster confirms that the action plan will achieve readiness by December 2012 then the designated body will be given an 'anticipated December RAG rating' of green. Progress against the action plans will be monitored.

Individual reports containing the responses to each indicator with national comparators and the designated body's RAG rating have been sent to every designated body. The designated bodies with the greatest challenges can be easily identified and support can be provided. Designated bodies which have not submitted a response can also be easily identified and appropriate steps taken to ensure their engagement.

The RST will continue to support the SHA clusters to deliver their local implementation plans. The ERDB has set up an Implementation Working Group led by the RST to co-ordinate support activities, ensure consistency and provide a forum for sharing knowledge and expertise. It will focus on the practical steps which will need to be put in place to support the designated bodies and responsible officers in each area. The RST is also planning to provide a range of customised national support activities for locum agencies, hospices, independent sector designated bodies, deaneries and primary care organisations.

A further interim survey is planned for the end of September 2012 to assess progress.

Conclusion

This ORSA exercise has once again shown a significantly increased number of responses and there has been a continued steady improvement in all the measured key indicators. There are very high levels of engagement by designated bodies from all sectors and this will facilitate the identification of challenged designated bodies and those which are not currently engaged in preparing for revalidation.

Substantial progress has been made over the last year. The findings demonstrate significantly improved knowledge and understanding of the regulations and prescribed connections. There have been demonstrable improvements in leadership, governance, infrastructure, capacity, skills and knowledge. It is also clear that the ORSA exercises have stimulated improved record-keeping and enhanced data quality.

There has been a steady increase in the proportion of doctors covered by designated bodies which are rated green against the key indicators. Despite the larger number of responses overall, this proportion has doubled from 41% to 82% of doctors covered by this exercise.

Effective appraisal is one of the foundations of revalidation and is essential for the responsible officer to be assured that each doctor is up to date and fit to practise. For many organisations the raised expectations of appraisal will mean a significant upgrading for their appraisal system and for others it will mean creating a completely new system. Despite this, appraisal rates have increased significantly for each type of doctor, the overall appraisal rate has risen to 73%. Consultant appraisal rates and rates for SAS doctors remain low in comparison the their GP counterparts (73.1% and 53.1% respectively compared with 90.1%) and will require special attention in the coming year.

The primary reason for this is likely to be that in the past there has been a lack of resource, infrastructure and management of hospital appraisal systems. A higher standard of appraisal is now required and there is strong evidence that these weaknesses are being addressed with the improved management and tracking of appraisals, the large rise in the numbers of trained appraisers and the significant improvement in the ratio of appraisers to doctors in hospital trusts.

The other key findings of this exercise are:

- There has been a further increase in the number of identified designated bodies and the total number of responses.
- The percentage response rate is 95% and the response rate from NHS organisations is 100%, showing that engagement from all sectors is very high.
- Data quality and record-keeping have improved showing a better understanding of the regulations and of prescribed connections.
- Locum agencies remain significant outliers in terms of engagement and whilst there are reasons to explain this, a significant improvement is required.
- Almost 100% of doctors covered by this exercise now have a responsible officer and almost 98% of doctors have a responsible officer who has received appropriate training.
- The proportion of doctors covered by designated bodies that have provided the responsible officer with sufficient resources is 74.6% overall. (This proportion is 86% for non-deanery organisations and 42.7% for deaneries.)
- 85% of doctors are now covered by designated bodies with an appraisal policy which is compliant with the requirements of revalidation.
- 86% of doctors are now covered by designated bodies with sufficient numbers of appraisers.
- The overall proportion of doctors covered by designated bodies with systems for monitoring fitness to practise is 91.7%. (This has increased significantly from 60% in March 2011.)
- The overall proportion of doctors covered by designated bodies with a process for investigation of capability, conduct, health and fitness to practise concerns is 97%.
- The overall proportion of doctors covered by designated bodies with a policy for re-skilling, rehabilitation, remediation and targeted support which is compliant with the responsible officer regulations is 58.4% – around half the doctors in NHS and independent sector designated bodies are not yet covered by these policies.

The next steps are to ensure robust action planning is undertaken within each designated body to address the needs identified through this exercise. These action plans should be received and reviewed at the SHA cluster. Challenged designated bodies should be supported to achieve readiness and appropriate action should be taken for those designated bodies yet to engage with this process.

The key actions outlined in Sir Bruce Keogh's letter to SHA medical directors in October 2011 included:

- the importance of strong clinical leadership and effective local action planning
- ensuring all designated bodies have been identified
- ensuring all responsible officers have the resources to carry out their role
- providing support for responsible officers through networks
- ensuring all doctors have an annual appraisal.

It is clear that substantial progress has been made in each of these areas but there is still much more to be done to ensure these principles are implemented and embedded. A strong momentum has developed in establishing robust policies and systems but the effective involvement of human resources departments, responsible officer networks, and clinical governance and appraisal staff is essential to complete the final preparations for the implementation of revalidation at the end of 2012.

Revalidation Support Team

Appendix 1

Organisational Readiness Self-Assessment (ORSA) tool

Revalidation Support Team

Organisational Readiness Self-Assessment

End of year questionnaire 2011-12

This questionnaire has been approved by the Review of Central Returns Steering Committee – ROCR

ROCR Reference number: ROCR/OR/2127/002MAND
ROCR Licence Expiry Date: 1 December 2012

For Admin Use Only		
A	B	C

electronic forms solution by Evenlogic Form EI006

March 2012
www.revalidationsupport.nhs.uk

The ROCR reference number for use when asking for this data is: **ROCR/OR/2127/002MAND**

This is for an annual mandatory collection from acute trusts, and voluntary from acute foundation trusts.

The Licence Expiry Date for this Collection continues to be: **1 December 2012**

For further information please contact rocr@ic.nhs.uk.

The ROCR team are keen to receive feedback on central data collections from the colleagues who complete/submit returns. In particular, around the length of time data collections take to complete and any issues, suggested improvements or duplication of data collections. Feedback can be submitted to ROCR using an online form:
http://www.ic.nhs.uk/webfiles/Services/ROCR/Data%20Collection%20Feedback%20Template.xls

Organisational Readiness Self-Assessment (ORSA): End of year questionnaire 2011-2012

Revalidation is the process by which doctors in the UK will have their licence to practise renewed. The purpose of revalidation is to assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and fit to practise.

Responsible officers are accountable for the quality assurance of the appraisal and clinical governance systems in their organisation. Improving these systems will support doctors in developing their practice more effectively, which will add to the safety and quality of health care in the UK. It will also enable the early identification of those doctors whose practice needs attention, allowing for more effective intervention.

The self-assessment exercise is designed to help designated bodies in England, as defined in *The Medical Profession (Responsible Officers) Regulations 2010* (Her Majesty's Stationery Office, 2010), develop their systems and processes in preparation for the implementation of revalidation. The results of this self-assessment will inform the Secretary of State's decision regarding commencement of revalidation. The aims of the self-assessment are therefore to:

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

A commitment has been made by the UK health departments and the GMC that, subject to an assessment of readiness, medical revalidation will start across the UK in late 2012 [*Revalidation: A statement of Intent* (GMC, 2010)]. For the NHS, the importance of preparing local systems in readiness for revalidation is highlighted in the NHS Operating Framework 2012/13:

"Medical revalidation is central to improving the quality and safety of care. NHS organisations should be ready in 2012 (as indicated by their organisational readiness self-assessment returns) with clinical governance arrangements including appraisals for doctors in place, to support responsible officers in fulfilling their duties."
[*The Operating Framework for the NHS in England 2012-13* (Department of Health, 2011)].

The self-assessment process will also enable designated bodies to provide assurance to the level two responsible officer[1], regulators, patients, the public, the profession and other interested bodies, that they are fulfilling their statutory obligations and their systems are sufficiently effective to support the responsible officer's recommendations.

[1] For the purpose of this document the 'level two responsible officer' is the responsible officer at the strategic health authority or the cluster of strategic health authorities.

Action planning

Following completion of the self-assessment it is important that designated bodies produce an action plan which addresses identified weaknesses and development needs in patient safety, quality assurance and appraisal systems. The action plan, including clear timescales for completion, should be agreed with the level two responsible officer and reported to the board or an equivalent governance or executive group.

The level two responsible officer has responsibility for making recommendations regarding the fitness to practise of each responsible officer in their area and the action plans will provide assurance that each responsible officer has established systems which will enable them to carry out their duties and that the designated body is moving towards readiness in an agreed timeframe. For the majority of designated bodies the action plans should achieve readiness by the end of 2012.

Using the data from the self-assessment

Board-level accountability for the quality and effectiveness of these systems is important and this report should be presented to the board, or an equivalent governance or executive group and should be included in an NHS organisation's quality account.

The collated data will be used for reporting overall progress on implementation to the England Revalidation Delivery Board and a report using collated information will be published on the NHS Revalidation Support Team (RST) website.

The RST will forward this report to the level two responsible officer with national and sector comparators. It will also be made available, on behalf of the level two responsible officer, to the GMC, the national healthcare regulators (the Care Quality Commission, Monitor), commissioners and other relevant bodies. The progress of individual designated bodies will be monitored and, where appropriate, highlighted to relevant bodies.

The content of the report may also be used by the responsible officer in their appraisal/revalidation portfolio as supporting information for the role of responsible officer.

This questionnaire has been approved by the Review of Central Returns Steering Committee – ROCR

How to use this document

The questionnaire is based on *The Medical Profession (Responsible Officers) Regulations 2010* (Her Majesty's Stationery Office, 2010) and associated guidance and additional criteria suggested by the GMC. Appendices give more detailed information with samples and details of core content.

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

The self-assessment tool is divided into four sections:

Section 1: Details of designated body

Section 2: Responsible officer

Section 3: Appraisal system

Section 4: Organisational governance

An electronic version of the form is available which should be completed by the responsible officer for each designated body in April/May 2012 for the year ending 31 March 2012. The deadline for completion is 21 May 2012. The information and guidance for submitting the electronic form will accompany the electronic form sent out at the end of March 2012.

This document should be read in conjunction with the responsible officer regulations and the responsible officer guidance. References to these documents are given in each section where appropriate.

Sources used in preparing this document

Appraisal Guidance for Consultants (Department of Health, 2001)

Appraisal Guidance for General Practitioners (Department of Health, 2004)

Assuring the Quality of Appraisers (NHS Revalidation Support Team, 2011)

Clinical Audit: A Simple Guide for NHS Boards & Partners (Health Quality Improvement Partnership, 2010)

Good Medical Practice (GMC, 2006)

Good Medical Practice Framework for Appraisal and Revalidation (GMC, 2011)

Good Medical Practice: Supplementary Guidance – Writing References (GMC, 2007)

Guidance on Colleague and Patient Feedback (GMC, 2010)

Guide to Independent Sector Appraisal for Doctors Employed by the NHS and Who Have Practising Privileges at Independent Hospitals – Whole Practice Appraisal (British Medical Association and Independent Healthcare Forum, 2004)

Information Management for Medical Appraisal and Revalidation in England: Guidance (NHS Revalidation Support Team, 2012)

Joint University and NHS Appraisal Scheme for Clinical Academic Staff (Universities and Colleges Employers Association, 2002)

The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2010)

The Medical Appraisal Guide (NHS Revalidation Support Team, 2012)

The Operating Framework for the NHS in England 2012-13 (Department of Health, 2011)

Preparing for the Introduction of Medical Revalidation: a Guide for Independent Sector Leaders in England (GMC and Independent Healthcare Advisory Services, 2011)

Revalidation: A Statement of Intent (GMC and others, 2010)

The Role of the Responsible Officer: Closing the Gap in Medical Regulation – Responsible Officer Guidance (Department of Health, 2010)

Supporting Information for Appraisal and Revalidation (GMC, 2011).

In this document when we refer to 'regulations', we mean *The Medical Profession (Responsible Officers) Regulations 2010* (2010) Her Majesty's Stationery Office. When we refer to 'guidance', we mean *The Role of the Responsible Officer: Closing the Gap in Medical Regulation - Responsible Officer Guidance* (2010) Department of Health.

Links to all referenced documents are available on the RST website: www.revalidationsupport.nhs.uk.

1.	**Section 1: Details of designated body** This section contains contact details along with information describing the designated body, to facilitate reporting and allow benchmarking between similar organisations. Names and contact details do not need to be included in public reports.		
	1.1	**Name of designated body:**	
		Address line 1	
		Address line 2	
		Address line 3	
		Address line 4	
		City	
		County	Postcode
		Responsible officer: GMC registered first name GMC reference number Email	 GMC registered last name Phone
		Chief executive (where appropriate) First name Email	 Last name

	1.2	**Type/sector of designated body:** (tick one)	Primary care trust		
			Hospital/secondary care foundation trust		
			Hospital/secondary care non-foundation trust		
			Mental health foundation trust		
			Mental health non-foundation trust		
			Other NHS foundation trust (care trust, ambulance trust, etc)		
			Other NHS non-foundation trust (care trust, ambulance trust, etc)		
			Other NHS organisation (strategic health authority, special health authorities, e.g. NHS Blood and Transplant)		
			Deanery		
			Independent/non NHS sector (tick one)	Independent healthcare provider	
				Locum agency	
				Faculty/professional body (for example, FPH, FOM, FPM, IDF)	
				Academic or research organisation	
				Government department or executive agency, armed forces, public bodies	
				Hospice, charity/voluntary sector organisation	
				Other non NHS (please enter type)	

	1.3	**Location of designated body:** [tick one]	North East SHA	
			North West SHA	
			Yorkshire and Humber SHA	
			East Midlands SHA	
			West Midlands SHA	
			East of England SHA	
			London SHA	
			South East Coast SHA	
			South Central SHA	
			South West SHA	
	1.4	**Number of doctors with whom the designated body has a prescribed connection as at 31 March 2012** The responsible officer should keep an accurate record of all doctors with whom the designated body has a prescribed connection [guidance, 4.5]. The prescribed connection is defined in detail in the regulations [regulations, 10] and the responsible officer must be satisfied that the doctor has correctly identified their designated body. To do this the responsible officer will need to understand this section of the regulations and will need to know the other roles the doctor performs. Detailed advice on establishing correct individual prescribed connections is contained in the regulations and guidance and further advice can be obtained from the level two responsible officer. A number of doctors, including locums, other employed or contracted doctors and doctors in wholly independent practice may not be included in these categories and should be entered under 'other'. All qualified general practitioners (GPs) including principals, salaried and locum GPs on the medical performers list should be entered under 'general practitioner'. Trainees on national training schemes, including GP trainees, have a prescribed connection to the deanery; trainees on independent schemes may have a prescribed connection to the employing trust. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work. Depending on their contractual status, secondary care locums may have a prescribed connection to a locum		

		agency or another designated body. Doctors with practising privileges may have a prescribed connection with the independent sector hospital depending on their other roles. The categories relate to current roles and job titles rather than qualifications or previous roles. The number of individual doctors in each broad category should be entered.		
		IMPORTANT: ONLY DOCTORS WITH WHOM THE DESIGNATED BODY HAS A PRESCRIBED CONNECTION SHOULD BE INCLUDED IN THIS SECTION. EACH DOCTOR SHOULD BE INCLUDED IN ONLY ONE CATEGORY **Please note that fields 1.4.1 – 1.4.7 are all mandatory and must not be left blank. Where the answer is nil, please enter "0".**		
		1.4.1	**Consultants (including honorary contract holders)**	
		1.4.2	**Staff grade, associate specialist, specialty doctor (including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere)**	
		1.4.3	**General practitioner (for primary care trusts only; doctors on a medical performers list)**	
		1.4.4	**Trainee: doctor on national postgraduate training scheme (for deaneries only; doctors on national training programmes)**	
		1.4.5	**Doctors with practising privileges (for independent healthcare providers only all doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)**	
		1.4.6	**Temporary or short-term contract holders (including trust doctors, locums for service, locums for training, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts)**	
		1.4.7	**Other (including some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc)**	
		1.4.8	**TOTAL (this cell will automatically sum 1.4.1 - 1.4.7)**	

2.	**Section 2: Responsible officer** *The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2010)* came into force on 1 January 2011. These regulations define the role and the statutory responsibilities of the responsible officer and should be read in conjunction with *The Role of the Responsible Officer: Closing the Gap in Medical Regulation - Responsible Officer Guidance* (2010, Department of Health). The contractual arrangements and job description for the responsible officer will depend on the type of designated body and the other responsibilities the post holder has. Appendix 1 contains suggested core content for a responsible officer role description.		
	2.1	**A responsible officer has been nominated/appointed in compliance with the regulations [regulations, 5 and 7]**	☐ Yes ☐ No
		To answer 'Yes': • The responsible officer has been a medical practitioner fully registered under the Act throughout the previous five years and continues to be fully registered whilst undertaking the role of responsible officer.	
	2.2	**A second responsible officer has been nominated/appointed where a conflict of interest or appearance of bias has been agreed with the level two responsible officer [regulations, 6]** Each designated body will have one responsible officer but the regulations allow for a second responsible officer to be nominated or appointed where a conflict of interest or appearance of bias exists. This will cover the uncommon situations where close family or business relationships exist, or where there has been longstanding interpersonal animosity. In order to ensure consistent thresholds and a common approach to this, potential conflict of interest or appearance of bias should be agreed with the level two responsible officer. An additional responsible officer should then be nominated or appointed by the designated body and will require training and support in the same way as the first responsible officer. To ensure there is no conflict of interest or appearance of bias, the second responsible officer should be an external appointment and will usually be a current experienced responsible officer from the same region.	☐ Yes ☐ No ☐ N/A
		To answer 'Yes': • In agreement with the level two responsible officer, the designated body has nominated/appointed a second responsible officer where there is a conflict of interest or appearance of bias between a doctor and the first responsible officer. • If no cases of conflict of interest or appearance of bias have been agreed with the level two responsible officer, 'not applicable' should be entered	

	2.3	**Appropriate responsible officer training is undertaken [Guidance, 4.48 - 4.49]** A minimum standard cannot be set for this important area as every responsible officer will have different training and development needs depending on their experience and the type of designated body they work in. A short general programme of initial training for responsible officers in England has been delivered regionally by strategic health authority clusters during 2011/12. The responsible officer's appraisal should help to prioritise their ongoing development needs in the role and these should be agreed with their appraiser and included in their personal development plan.	☐ Yes ☐ No
		To answer 'Yes': • Appropriate initial training has been undertaken. • Appropriate ongoing training and development is undertaken in agreement with the responsible officer's appraiser.	
	2.4	**Local/regional support is available to the responsible officer** Regional 'responsible officer networks' have been set up to facilitate the ongoing development and support of responsible officers. These will encourage the development of local/regional protocols for responding to concerns, managing conflicts of interest, information sharing, thresholds for intervention, etc. Within these networks, the responsible officer should have access to support from: • the level two responsible officer [guidance, 4.50] • their GMC employer liaison adviser [guidance, 4.27] • National Clinical Assessment Service [regulations, 18b] • medical royal colleges and faculties for advice regarding doctors' specialist practice [guidance, 4.7] • the RST	☐ Yes ☐ No
		To answer 'Yes': • The responsible officer has made themselves known to the level two responsible officer where they have a prescribed connection [guidance, 2.6]. • The responsible officer is engaged in the regional responsible officer network and has access to appropriate regional and national support.	

	2.5	**Provision of funding and resource from the designated body is sufficient to undertake the responsibilities of the role [regulations, 14, 19]** Each designated body must provide the responsible officer with sufficient funding and other resources necessary to fulfil their statutory responsibilities. This may include sufficient time to perform the role, administrative and management support, information management and training. The responsible officer may wish to delegate some of the duties of the role to an associate or deputy responsible officer. It is important that those people acting on behalf of the responsible officer only act within the scope of their authority.	☐ Yes ☐ No
		To answer 'Yes': • In the opinion of the responsible officer, sufficient funds and other resources have been provided to enable them to discharge their responsibilities under the regulations.	

3.	**Section 3: Appraisal system** The appraisal system is one of the cornerstones of revalidation and good quality appraisal is essential for the responsible officer to be assured that each medical practitioner is up to date and fit to practise. Appraisal must also provide a safe environment for personal development needs to be discussed and agreed. A good appraisal system is dependent on effective leadership and management, the quality of the supporting information and the quality and professionalism of the appraisers. Guidance on the model of medical appraisal including the supporting information for revalidation, the specialty aspects of appraisal and the outputs of appraisal (i.e. personal development plan, appraisal summary and appraiser statements) is now available in *The Medical Appraisal Guide* (NHS Revalidation Support Team, 2012). For revalidation to fulfil its primary objectives it is essential that information from all the doctor's roles is available at appraisal. Current agreements between NHS trusts and universities for joint appraisal arrangements for clinical academics governed by the Follett principles, are unaffected by this guidance and should remain in place. The appraisal system must be set up to deliver annual appraisal for all the doctors who have a prescribed connection with the designated body. In order to ensure all doctors have an annual appraisal, it is necessary for the responsible officers to establish the reasons for missed or incomplete appraisals, to satisfy themselves that the appraisal system is functioning effectively and also that doctors are fulfilling their professional and contractual obligations. The responsible officer is responsible for the quality and effectiveness of the appraisal system even if this has been commissioned from an external provider organisation. In these circumstances, it is advisable for a service agreement to be drawn up defining the required quality standards and key indicators. For the purposes of this guidance the organisational appraisal year runs from 1 April to 31 March. The appraisal year is defined in this way to assist the management and monitoring of the appraisal system and to allow comparison and benchmarking between organisations and sectors. A completed appraisal is one where the appraisal meeting has taken place within the appraisal year and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting. It is not suggested that these definitions, required for managing an effective organisational appraisal system, should be applied in the future to revalidation recommendations for individual doctors. The audit will give a detailed understanding of what has happened in all missed or incomplete appraisals and the responsible officer will exercise judgement on a case by case basis if an appraisal falls outside the appraisal year for acceptable reasons. In exceptional circumstances the designated body may wish to agree a different 'appraisal year' with the level two responsible officer but the principle remains that every doctor should have an appraisal within any agreed 12 month period. For deaneries the process of annual review of competence progression is considered to be equivalent to the appraisal process and the role of the educational supervisor is considered to be equivalent to the role of the appraiser.

	The role of medical appraiser is an important professional role and effective selection processes and structured initial training programmes are needed. Ongoing performance review, development and support of appraisers will also be necessary to maintain the skills of the appraiser and to assure the quality and consistency of appraisal. Further guidance on appraiser selection, training, support and performance review is contained in *Assuring the Quality of Appraisers* (NHS Revalidation Support Team, 2011), which is available on the RST website.		
	3.1	**A medical appraisal policy with core content is in place**	☐ Yes ☐ No
		To answer 'Yes': • A medical appraisal policy is in place covering the core content which is relevant to the designated body (see Appendix 3)	
	3.2	**Numbers of doctors with whom the designated body has a prescribed connection who have a completed appraisal between 1 April 2011 and 31 March 2012 [guidance, 3.10]** For the purposes of this guidance, a completed appraisal is one where the appraisal meeting has taken place within the appraisal year (between 1 April 2011 and 31 March 2012) and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting. In most circumstances the final sign-off of the appraisal should occur within a few days of the appraisal meeting. Some organisations may require additional sign-off from a medical manager, clinical director or medical director. These additional processes should be described in the organisation's appraisal policy with any necessary deadlines but the principle that should apply in all situations is that the appraiser and doctor should sign the agreed outputs within 28 days. The 28-day period is to allow for holidays and other absences and should be sufficient for agreement and sign-off in almost all circumstances. For example, an appraisal meeting taking place on 31 March would need to be signed off on 27 April for it to be included in the year. An appraisal that has not been signed-off within this period should be regarded as incomplete and included in the audit of missed/incomplete appraisals so the reason for the delay can be explored. In completing this self-assessment it is important to distinguish between the responsible officer's responsibility to manage the quality and effectiveness of the appraisal system and their responsibility to make recommendations on individual doctors. To manage the system the responsible officer needs to know that every doctor has an annual appraisal and the sign-off has been completed. In making recommendations on individual doctors the responsible officer can use their judgement to allow flexibility for appraisals delayed by holidays, sickness absence, study leave, etc. There is no suggestion that an individual appraisal will be invalidated by delays, but in managing the appraisal system the	

		organisation needs to set a reasonable expectation, track what's happening and understand the reasons for delays. It would be unusual for a designated body to appraise all the doctors for whom it has responsibility within the appraisal year. There are many potential reasons for this and the main purpose of this section is to help the designated body establish the reasons for missed or incomplete appraisals so that the management of the appraisal system can be optimised. The same categories of doctors in section 1.4 are used in this section to identify those doctors who have had a completed appraisal in the year 2011/12. Comparing the numbers in sections 1.4 and 3.2 will give an indication of the additional organisational capacity and training required. For deaneries the annual review of competence progression process should be considered to be equivalent to the appraisal process.		
		IMPORTANT: ONLY DOCTORS WITH WHOM THE DESIGNATED BODY HAS A PRESCRIBED CONNECTION SHOULD BE INCLUDED IN THIS SECTION. EACH DOCTOR SHOULD BE INCLUDED IN ONLY ONE CATEGORY **Please note that fields 3.2.1 – 3.2.7 are all mandatory and must not be left blank. Where the answer is nil, please enter "0".**		
		3.2.1	**Consultants (including honorary contract holders)**	
		3.2.2	**Staff grade, associate specialist, specialty doctor (including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere)**	
		3.2.3	**General practitioner (for primary care trusts only; doctors on a medical performers list)**	
		3.2.4	**Trainee: doctor on national postgraduate training scheme (for deaneries only; doctors on national training programmes)**	
		3.2.5	**Doctors with practising privileges (for independent healthcare providers only all doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)**	

		3.2.6	**Temporary or short-term contract holders (including trust doctors, locums for service, locums for training, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts)**	
		3.2.7	**Other (including some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc)**	
		3.2.8	**TOTAL (this cell will automatically sum 3.2.1 - 3.2.7)**	
	3.3	**An audit has been performed to determine reasons for all missed or incomplete appraisals [guidance, 3.10]** A missed or incomplete appraisal is an important occurrence which could indicate a problem with the appraisal system or a potential issue with an individual doctor which needs to be addressed. Missed appraisals are those which were due within the appraisal year but not performed. Incomplete appraisals are those where, for example, the appraisal discussion has not been completed or where the personal development plan or appraisal summary have not been signed off within 28 days of the appraisal meeting. For this exercise to be valuable every missed or incomplete appraisal should be included in the audit and, depending on numbers, it may not be possible to complete the audit within the ORSA reporting period. For deaneries the process of annual review of competence progression should be considered to be equivalent to the appraisal process.	☐ Yes ☐ No
		To answer 'Yes': • An audit of all missed or incomplete appraisals for the appraisal year 2011/12 has been completed or is underway. (See Appendix 2 for a suggested format of the audit report.) • Recommendations and improvements are enacted.	

	3.4	**The number of trained medical appraisers is sufficient for the needs of the designated body [guidance, 3.9, 3.10]** It is important that the designated body's appraiser workforce is sufficient to provide the number of appraisals needed each year. This assessment may depend on total number of doctors who have a prescribed connection, geographical spread, speciality spread, conflicts of interest and other factors. Depending on the needs of the designated body, doctors from a variety of backgrounds should be considered for the role of appraiser. This includes locums and salaried general practitioners in primary care settings and staff and associate specialist doctors in secondary care settings. An appropriate specialty mix is important though it is not possible for every doctor to have an appraiser from the same specialty. Further guidance on the recruitment of medical appraisers is available on the RST website. To ensure appraisal is of a sufficient standard to inform revalidation, appraisers should participate in an initial training programme before starting to perform appraisals. Further guidance on the training of medical appraisers for the needs of revalidation is available on the RST website. The training for medical appraisers should include: • core appraisal skills and skills required to promote quality improvement and the professional development of the doctor • skills relating to medical appraisal for revalidation and a clear understanding of how to apply professional judgement in appraisal • skills that enable the doctor to be an effective appraiser in the setting within which they work, including both local context and any specialty specific elements. It is suggested that during 2012/13 a minimum of 50% of current appraisers should receive a module of revalidation training to ensure they are aware of how appraisal will fulfil the new professional requirements of revalidation. The remaining current appraisers should receive a module of revalidation training the following year. All new appraisers should receive training which includes the requirements of revalidation from the start of 2012/13. For deaneries the role of the educational supervisor should be considered to be equivalent to the role of the appraiser.	☐ Yes ☐ No
		To answer 'Yes': • In the opinion of the responsible officer, the number of medical appraisers who have received appropriate training is sufficient for the designated body's needs.	

		3.4.1	**Number of active medical appraisers at 31 March 2012 [guidance, 3.9]** **[if answer is nil please enter "0"]** Active appraisers are those who have performed at least one appraisal in the appraisal year.	
		3.4.2	**Number of active medical appraisers at 31 March 2012 who have attended an appraiser training course at any time [guidance, 3.10]** **[if answer is nil please enter "0"]** The training history and current training status of all appraisers needs to be understood by the responsible officer so that plans can be made to update their training.	

	3.5	**Medical appraisers are supported in the role through access to leadership and peer support** Support for medical appraisers may include access to: • leadership and advice on all aspects of the appraisal process from a named individual, such as the appraisal lead • training and professional development resources to improve appraiser skills • peer support with opportunity to discuss the difficult areas of appraisal in an anonymised and confidential environment • specialty-specific support, where necessary • annual review of performance in the role of appraiser, including suggestions for inclusion in their personal development plan to address their development needs. Organisations may choose to satisfy these requirements in different ways, but there is evidence that a well structured appraiser support group led by an experienced appraisal lead or facilitator can meet these needs. For deaneries the annual review of competence progression process should be considered to be equivalent to the appraisal process and the role of the educational supervisor should be considered to be equivalent to the role of the appraiser. Further guidance on the support for medical appraisers is available on the RST website.	☐ Yes ☐ No
		To answer 'Yes': • As a minimum, support arrangements for appraisers should include access to: o leadership and advice on all aspects of the appraisal process from a named individual (for example, the appraisal lead) o peer support with opportunity to discuss handing the difficult areas of appraisal in an anonymised and confidential environment. o specialty-specific support, where necessary.	

	3.6	**Medical appraisers receive feedback on their performance in the role which includes feedback from doctors or feedback on the quality of outputs of appraisals (such as personal development plans and appraisal summaries)** Completion of training is not a guarantee that knowledge and skills have been assimilated or of competence in the role and feedback on performance in the role is included as a means of assuring the quality of the work of appraisers. Performance review may include: • feedback from doctors on the appraiser's performance in the role; • a review of outputs of appraisals (such as personal development plans and appraisal summaries); • a review of any complaints or significant events relating to the appraiser; or • a review or evaluation after initial training or after a probationary period. An example feedback questionnaire is shown in *Assuring the Quality of Appraisers* (NHS Revalidation Support Team, 2011), available on the RST website. For deaneries the role of the educational supervisor should be considered to be equivalent to the role of the appraiser. Further guidance on the methods of review and evaluation of medical appraisers is available on the RST website. It must be recognised that some appraisers may fail to maintain the necessary knowledge, skills and attributes to be an effective appraiser and, if appropriate remedial processes are unsuccessful, those individuals should not continue in this important professional role.	☐ Yes ☐ No
		To answer 'Yes': • The process of performance review should include at least one of the following methods: o feedback from doctors on the appraiser's performance in the role o a review of the outputs of completed appraisals (for example, personal development plans and appraisal summaries) NB. Before the end of 2012/13 the process of performance review should include both of the above methods.	

4.	**Section 4: Organisational governance** The responsible officer has responsibility for ensuring the doctors with whom the designated body has a prescribed connection are up to date and fit to practise. Those designated bodies involved in commissioning or providing healthcare have an additional statutory responsibility for the quality of the care provided on their behalf. This section deals with the governance and accountability arrangements required to fulfil these responsibilities.		
	4.1	**A governance structure or strategy is in place (including clinical governance where appropriate)** All designated bodies involved in commissioning or providing healthcare have a statutory responsibility for the quality of the care provided on their behalf. For most designated bodies the process by which this is achieved will be described in a board-approved governance strategy which includes clinical governance or clinical quality assurance. For designated bodies that do not have a board or do not directly deliver clinical care, the equivalent in these settings may be a description of the structures and arrangements for assuring the quality of contractors or the quality of services provided. This should include reporting and accountability arrangements and the methods of internal and external quality assurance. If the designated body is an agency, the description should include the means of assuring the quality of those who are delivering services through the agency. The document will need to be approved by the executive team, management team, council or an equivalent internal governance or management structure. For deaneries the description should include the process for information sharing between the clinical training placements and the deanery responsible officer. Processes for the management and governance of relevant information relating to individual doctors with whom the designated body has a prescribed connection should be described.	☐ Yes ☐ No
		To answer 'Yes': • A governance structure or strategy is in place with written description or policies for: o reporting and accountability arrangements for quality of services and internal and external quality assurance o management and governance of relevant information relating to individual doctors with whom the designated body has a prescribed connection [guidance, 4.32]	

	4.2	**The governance systems (including clinical governance where appropriate) are subject to external or independent review.** Most designated bodies will have external or independent review by a regulator. Designated bodies which are healthcare providers are subject to review by the national healthcare regulators (the Care Quality Commission or Monitor). NHS primary care trusts are overseen by the strategic health authority or cluster. Deaneries are externally approved for training by the GMC. Some designated bodies will not be regulated or overseen by an external regulator (for example locum agencies and organisations which are not healthcare providers) and an alternative external or independent review process should be agreed with the level two responsible officer. A potential solution in these circumstances is a periodic external review of the ORSA end of year report through a peer group agreed with the level two responsible officer. Further guidance on this will be available during 2012.	☐ Yes ☐ No
		To answer 'Yes': • Governance systems are subject to external or independent review by a national regulator or through a process agreed with the level two responsible officer • Improvement notices or formal action plans arising from external governance reviews are shared with the level two responsible officer	
	4.3	**There is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection [regulations 16(3)(a)]** In most situations the collection of detailed information which relates directly to the practice of an individual doctor is neither possible nor desirable, due to the nature of the doctor's work. In these situations, team-based or service-level information should be monitored. The types of information available will be dependent on the setting and the role of the doctor and will include clinical outcome data, audit, complaints, significant events and patient safety issues. An explanation should be sought where an indication of outlying quality or practice is discovered. The information/data used for this purpose should be kept under review so that the most appropriate information is collected and the quality of the data (for example, coding accuracy) is improved. In primary care this type of information is not always routinely collected from general practitioners or practices and new arrangements may need to be put in place to ensure the responsible officer receives relevant fitness to practise information. In order to monitor the conduct and fitness to practise of trainees, arrangements will need to be agreed	☐ Yes ☐ No

		between the deanery responsible officer and the trainee's clinical attachments to ensure relevant information is available in both settings. Appropriate records should be maintained by the responsible officer.	
		To answer 'Yes': • Relevant information (including clinical outcomes where appropriate) is collected to monitor the doctor's fitness to practise and is shared with the doctor for their portfolio • The quality of the data used to monitor individuals and teams is reviewed [guidance, 5.16]	
	4.4	**All doctors with whom the designated body has a prescribed connection are able to obtain structured feedback from patients and colleagues in compliance with GMC criteria [guidance, 3.5, 5.18]** Doctors are required to obtain feedback from patients and colleagues using structured feedback questionnaires at least once in each five-year revalidation cycle. The GMC's *Guidance on Colleague and Patient Feedback* (GMC, 2010) describes the criteria for implementation and administration. This exercise is an essential component of the revalidation portfolio of supporting information and if it is not present the responsible officer will not be able to submit a revalidation recommendation. It will be important for the responsible officer to identify those doctors who have not undertaken this exercise within the revalidation cycle so they can ensure it is completed. Some designated bodies may wish to arrange this exercise for their doctors whilst others may decide to ensure the doctor is aware of their responsibility to complete the exercise and highlight appropriate providers which the doctor can use. Patient feedback will not apply to doctors who have no direct patient contact but in these circumstances others may provide feedback, such as, carers, parents, students, clients and customers.	☐ Yes ☐ No
		To answer 'Yes': • All doctors with whom the designated body has a prescribed connection are aware of the requirement for completion of a patient and colleague feedback exercise which complies with GMC requirements. • The responsible officer can identify those doctors who have not completed a patient and colleague feedback exercise within the revalidation cycle.	

	4.5	**The designated body's clinical audit activity is in line with national guidance (including contributions to clinical registers and databases and confidential enquiries)** This may not apply to every designated body but those involved in commissioning or providing healthcare will need to ensure audit activity is appropriate and complies with national guidance relevant to their areas of medical work. Commissioners should ensure audit activity is aligned with strategic priorities, is effectively led and covers the whole pathway of care. The results of audits should contribute to service development and the monitoring of service quality, and relevant information should be shared with the doctor for inclusion in their portfolio. This section also includes contributions to clinical registers and databases, including the National Joint Registry and clinical outcome review programmes, which encompass confidential enquiries. Contributing to these registries and systems is a professional responsibility described in paragraph 14 of *Good Medical Practice* (GMC, 2006) and is a major means of improving patient safety and of improving the knowledge and understanding of specific medical conditions. Further information on ensuring clinical audit activity is in line with national guidance is available from Health Quality Improvement Partnership (HQIP) and a guide for all NHS Boards is available in *Clinical audit: A Simple Guide for NHS Boards & Partners* (January 2010) HQIP. Further information regarding clinical registers and databases is available from HQIP.	☐ Yes ☐ No ☐ N/A
		To answer 'Yes': • The audit activity within the designated body is in line with national guidance (for example guidance from HQIP, National Institute of Health and Clinical Excellence, National Clinical Audit Advisory Group, etc) [guidance, 4.25] • Audit reports and relevant information are shared with the doctor for inclusion in their portfolio	
	4.6	**There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified [regulations 11(3)]** It is important that issues and concerns about performance or conduct are addressed at the time they arise. The appraisal meeting is usually not the most appropriate setting for dealing with concerns and in most cases these are dealt with outside the appraisal process in a clinical governance setting. Learning by individuals from such events is an important part of resolving concerns and the appraisal meeting is usually the most appropriate setting to ensure this is	☐ Yes ☐ No

		planned and prioritised. In a small proportion of cases, the responsible officer may therefore wish to ensure certain key items of supporting information are included in the doctor's portfolio and discussed at appraisal so that development needs are identified and addressed. In these circumstances the responsible officer may require the doctor to include certain key items of supporting information in the portfolio for discussion at appraisal and may wish to check in the appraisal summary that the discussion has taken place. In some settings (for example, where the doctor and the appraiser work in the same organisation and the information can be sent through secure internal transfer) it may be appropriate for this information to be sent to both the doctor and the appraiser to discuss in the appraisal. The method of sharing key items of supporting information should be described in the appraisal policy. It is important that information is shared in compliance with principles of information governance and security. For further detail, see *Information Governance for Medical Appraisal and Revalidation in England* (NHS Revalidation Support Team, 2012).	
		To answer 'Yes': • There is a written description within the appraisal policy of the process for ensuring that key items of supporting information are included in the doctor's portfolio and discussed at appraisal.	
	4.7	**There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors [regulations, 16(2)]** The responsible officer has specific responsibilities when the designated body enters into contracts of employment or for the provision of services with doctors. This applies to locum agency contracts and also to the granting of practising privileges by independent health providers. The prospective responsible officer must: • ensure doctors have qualifications and experience appropriate to the work to be performed [regulations 16(2)(a)] • ensure that appropriate references are obtained and checked [regulations 16(2)(b)] • take any steps necessary to verify the identity of doctors [regulations 16(2)(c)] • where the designated body is a primary care trust, manage admission to the medical performers list in accordance with the regulations. [regulations 16(2)(d)] It is also important that the following information is available: • GMC information: fitness to practise investigations, conditions or restrictions, revalidation due date; [regulations,	☐ Yes ☐ No

		11(2)(d)] • Criminal Records Bureau check (although delays may prevent these being available to the responsible officer before the starting date in every case), and • gender and ethnicity data (providing this information is voluntary - to monitor fairness and equality). [guidance 4.47, 6.9] It may be helpful to obtain a structured reference from the current responsible officer which complies with GMC guidance on writing references and includes relevant factual information relating to: • the doctor's competence, performance or conduct • appraisal dates in the current revalidation cycle, and • local fitness to practise investigations, local conditions or restrictions on the doctor's practice, unresolved fitness to practise concerns See *Supplementary Guidance – Writing References* (GMC, 2007) and paragraph 19 of *Good Medical Practice* (GMC, 2006) for further details. In situations where the doctor has moved to a new designated body without a contract of employment, or for the provision of services (for example, through membership of a faculty) the information needs to be available to the new responsible officer as soon as possible after the prescribed connection commences. This will usually involve a formal request for information from the previous responsible officer.	
		To answer 'Yes': • When the designated body is entering into a contract of employment or for the provision of services with doctors, the responsible officer has a process for obtaining relevant information, as outlined in the responsible officer regulations, and maintains accurate records of all steps taken. • For primary care trusts, admission to the medical performers list is managed in accordance with the regulations. [regulations 16(2)(d)]	

	4.8	**There is a process in place to ensure fitness to practise evaluations and appraisals take account of all available information relating to the doctor's fitness to practise, from the work carried out for the designated body and for any other organisation. [regulations 11(1)(3)]** The responsible officer will need to ensure relevant information is available from all the organisations and settings in which the doctor works when appraisal and fitness to practise evaluations or investigations are performed. For doctors who move frequently between organisations, ensuring relevant information is available from a sample of the doctor's places of work may be adequate. To answer 'Yes': • There is a process in place to ensure that relevant information from all the doctor's roles and places of work is available when appraisal and fitness to practise evaluations are performed.	☐ Yes ☐ No
	4.9	**A process is established for the investigation of capability, conduct, health and fitness to practise concerns [regulations, 11(2)(b)]** It is the responsibility of the responsible officer to respond appropriately when unacceptable variation in individual practice is identified or when concerns exist about the fitness to practise of doctors with whom the designated body has a prescribed connection. The designated body should establish a procedure for initiating and managing investigations and appropriate records should be maintained of all steps taken. The responsible officer regulations outline the following responsibilities: • ensuring investigators are appropriately qualified [regulations, 16(4)(a)] • ensuring all relevant information is taken into account and that factors relating to capability, conduct, health and fitness to practise are considered [regulations, 16(4)(c)] • where appropriate, ensuring advice is taken from GMC employer liaison advisers, the National Clinical Assessment Service, local expert resources, specialty and royal college advisers [guidance, 3.10] • where appropriate, making a recommendation to the designated body that the doctor should be suspended or have conditions or restrictions placed on their practice; [regulations, 16(4)(g)] • where appropriate, taking any steps necessary to protect patients; [regulations, 16(4)(g)] • ensuring that a doctor who is subject to these procedures is kept informed about progress and that the doctor's	☐ Yes ☐ No

		comments are taken into account where appropriate; [regulations, 16(4)(e)(f)] • appropriate records are maintained by the responsible officer of all fitness to practise information. [regulations 11(2)(f)]	
		To answer 'Yes': • A description of the process for investigating concerns is in place which complies with the responsible officer regulations.	
	4.10	**A policy (with core content) for re-skilling, rehabilitation, remediation and targeted support is in place. [regulations, 16(4)(h)]** The responsible officer regulations outline the following responsibilities: • ensuring that appropriate measures are taken to address concerns, including but not limited to: o requiring the doctor to undergo training or retraining [regulations, 16(4)(h)(i)] o offering rehabilitation services [regulations, 16(4)(h)(ii)] o providing opportunities to increase the doctor's work experience [regulations, 16(4)(h) (iii)] o addressing any systemic issues within the designated body which may contribute to the concerns identified [regulations, 16(4)(h)(iv)], and • ensuring that any necessary further monitoring of the doctor's conduct, performance or fitness to practise is carried out [regulations, 16(4) (d)]. Further guidance for responsible officers on policies for re-skilling, rehabilitation, remediation and targeted support will be published on the RST website at the end of March 2012.	☐ Yes ☐ No
		To answer 'Yes': • A policy for re-skilling, rehabilitation, remediation and targeted support is in place which complies with the responsible officer regulations.	

	4.11	**Where a doctor is subject to conditions imposed by, or undertakings agreed with the GMC, the responsible officer monitors compliance with those conditions or undertakings [regulations, 11(2)(d)]**	☐ Yes ☐ No
		To answer 'Yes': • A process is in place to monitor compliance with GMC conditions or undertakings.	
	4.12	**A description of the support available from the designated body for doctors to keep their knowledge and skills up to date is in place** The doctor has the primary responsibility for keeping their knowledge and skills up to date. The medical royal colleges and faculties have responsibility for setting specialty standards for continuing professional development. Designated bodies will have different levels of responsibility in this area. For example, designated bodies that directly employ their medical staff will have higher levels of responsibility than those where the relationship is one of contractor or agency. The important principle is that the responsible officer should ensure that doctors are supported by the organisation in their efforts to keep their knowledge and skills up to date and to improve their performance and the quality of care they provide to patients [guidance 4.15]. This may be part of a wider education and training strategy and include provision of study leave, mandatory training and access to learning and development. As a minimum, it should involve provision of information about relevant learning and development opportunities, which may be provided either internally at minimum cost where common development needs are identified (for example training in resuscitation, safeguarding children), or externally, for example at local postgraduate centres.	☐ Yes ☐ No
		To answer 'Yes': • A written description of the support available from the designated body for medical practitioners to keep their knowledge and skills up to date is in place.	
	4.13	**Relevant appraisal, revalidation and human resources policies are fair and non-discriminatory [guidance 4.47, 6.9]**	☐ Yes ☐ No
		To answer 'Yes': • Doctors with whom the designated body has a prescribed connection are asked to provide gender and ethnicity information.	

Appendix 1: Core elements of a role description for a responsible officer

The role of responsible officer may be a stand-alone role or an integral part of a broader medical management role. The following are the core elements of the role of the responsible officer and should be incorporated in the job description of the individual performing the role. Where the term 'doctor' is used in this description it refers to doctors with whom the designated body has a prescribed connection under the regulations.

The job description of the postholder includes the following core elements in relation to the responsible officer role:		
1	In relation to monitoring doctors' conduct and performance, the responsible officer:	
	a	Regularly reviews and seeks to explain variations in the general performance and quality information held by the designated body including: • routine performance data and quality indicators • complaints • significant events and significant untoward incidents • audit
	b	Ensures relevant information relating to all the doctor's roles is available for monitoring fitness to practise and appraisal
	c	Maintains records of all fitness to practise evaluations, including appraisals, investigations and assessments
	d	Establishes a system for tracking completion of structured patient and colleague feedback exercise by doctors in compliance with GMC requirements

2	In relation to medical appraisal, the responsible officer:	
	a	Ensures that the designated body maintains a medical appraisal system which complies with national guidance and requirements
	b	Ensures there are sufficient numbers of trained medical appraisers
	c	Ensures that doctors undertake annual appraisals
	d	Ensures that medical appraisals take account of relevant information relating to all the doctor's roles
3	In relation to responding to concerns, the responsible officer:	
	a	Responds appropriately when variation in individual practice is identified
	b	Takes any steps necessary to protect patients
	c	Establishes procedures to investigate concerns about the capability, conduct, health and fitness to practise of a doctor
	d	Initiates investigations with appropriately qualified investigators and ensures that all relevant information is considered
	e	Recommends to the designated body, where appropriate, that the doctor should be suspended or have conditions or restrictions placed on their practice
	f	Ensures that appropriate measures are taken to address concerns, including but not limited to: • requiring the doctor to undergo training or retraining • offering rehabilitation services • providing opportunities to increase the doctor's work experience • addressing any systemic issues within the designated body which may contribute to the concerns identified
	g	Ensures that any necessary further monitoring of the doctor's conduct, performance or fitness to practise is carried out

	h	Ensures that a doctor who is subject to these procedures is kept informed about progress and that the doctor's comments are taken into account where appropriate
4	In relation to contracts of employment or contracts for the provision of services with doctors, the responsible officer:	
	a	Ensures that doctors have qualifications and experience appropriate for the work to be performed
	b	Ensures that appropriate references are obtained and checked
	c	Takes any steps necessary to verify the identity of doctors
	d	Where the designated body is a primary care trust, manages admission to the medical performers list in accordance with the regulations
	e	Maintains accurate records of all steps taken
	f	Provides structured references to a prospective new responsible officer in a timely manner
5	In relation to communicating with the GMC, the responsible officer:	
	a	Co-operates with the GMC in carrying out its responsibilities
	b	Makes recommendations to the GMC about doctors' fitness to practise, taking all relevant information into account
	c	Where appropriate, refers concerns about the doctor to the GMC
	d	Monitors a doctor's compliance with conditions imposed by or undertakings agreed with the GMC

6	In relation to governance and reporting, the role description includes a description of:	
	a	The responsible officer's governance and reporting responsibilities
	b	The responsible officer's responsibility to advise the board (or equivalent governance or executive group) on resources required to fulfil the statutory obligations
	c	The indemnity arrangements for responsible officer

Appendix 2: Suggested format of audit report to identify reasons for missed or incomplete appraisals

A missed or incomplete appraisal is an important occurrence which could indicate a problem with the appraisal system or a potential issue with an individual doctor which needs to be addressed. Missed appraisals are those which were due within the appraisal year but not performed. Incomplete appraisals are those where, for example, the appraisal discussion has not been completed or where the personal development plan or appraisal summary have not been signed off within 28 days of the appraisal meeting. For this exercise to be valuable, every missed or incomplete appraisal should be included in the audit.

Results of audit to identify reasons for all missed or incomplete appraisals			**Numbers**
1	**Doctor factors:**		
	a	Absence of doctor (for example due to maternity or sick leave)	
	b	Incomplete portfolio or insufficient supporting information	
	c	Appraisal outputs not agreed/signed off by the doctor within 28 days of the appraisal meeting	
	d	Factors relating to lack of time of doctor	
	e	Lack of engagement of doctor	
	f	Other doctor factors (describe)	

2	**Appraiser factors:**		
	a	Absence of appraiser	
	b	Appraisal outputs not agreed/signed off by the appraiser within 28 days of the appraisal meeting	
	c	Factors relating to lack of time of appraiser	
	d	Other appraiser factors (describe)	
3	**Organisational factors:**		
	a	Factors relating to administration or management of appraisal system	
	b	Factors relating to function or failure of electronic portfolio or other information system	
	c	Insufficient numbers of trained appraisers	
	d	Other organisational factors (describe)	
4	**Recommendations:**		

Appendix 3: Core content of medical appraisal policy

The following content may need to be covered in the designated body's appraisal policy. Some of these areas may not be required depending on the needs of the designated body. An example appraisal policy is available on the RST website.

The medical appraisal policy may cover the following areas:

1. Objectives of medical appraisal

   This must include professional development, revalidation and where relevant, organisational development needs. The appraisal system must cover all doctors with a prescribed connection [regulations, 11(2) (a)].
2. Accountability, management, quality assurance and reporting arrangements for the appraisal system
3. An explanation of how the appraisal system incorporates the standards in the GMC's *Good Medical Practice Framework for Appraisal and Revalidation* and, where appropriate, complies with current Department of Health appraisal guidance
4. Responsibilities of:
   - the designated body
   - the responsible officer
   - the appraiser (and appraisal lead, where this role exists), and
   - the doctor
5. Description of medical appraisal process

   This should include timescales, deadlines and to whom the outputs of appraisal are sent on completion. See *The Medical Appraisal Guide* (NHS Revalidation Support Team, 2012) for further detail.
6. Description of integration with quality improvement, clinical governance and performance monitoring systems

   This should include the transfer and sharing of information between these systems and the use of collated development needs to inform organisational development activity.
7. Description of the relationship of medical appraisal to the job planning process, if appropriate

8. Arrangements, if appropriate, for whole practice appraisal and joint appraisal for clinical academics with honorary contracts to comply with the Follett principles.
9. Description of essential supporting information requirements
10. Confidentiality, security and access arrangements; electronic portfolio support, if appropriate
11. Feedback from participants about the medical appraisal system
12. Principles of equality and fairness
13. Arrangements for allocation of doctors to appraisers, including:
    - whether doctors have a choice of appraiser and the situations where choice is limited or removed
    - appeals relating to allocation
    - conflicts of interest - this should cover common situations where a conflict may exist between doctor and appraiser, such as:
        - personal or family relationships
        - an appraiser and doctor sharing close business or financial interests
        - reciprocal appraisal - where two doctors appraise each other
        - an appraiser appraising a doctor who acts as their line manager in the same or in a different organisation;
        - a responsible officer or a doctor's direct employer acting as appraiser
        - financial arrangements - (an appraiser should not receive direct payment from a doctor for performing the appraisal; appraisers are contracted to, and paid by the designated body).
14. How specific situations will be dealt with, including:
    - illness, secondment, absence, suspension
    - missed or incomplete appraisals, including engaging disciplinary procedures where this is appropriate
    - description of the process which allows the responsible officer to ensure that key information (for example specified complaints, significant events, outlying clinical outcomes) is included in the appraisal portfolio and has been discussed in the appraisal, so that development needs are identified
    - risk of collusion/complacency between appraiser and doctor, and how this will be mitigated, for example through appraiser support/training activities, ensuring two different appraisers within the revalidation cycle, periodic joint appraisal or qualitative evaluation of appraisal outputs

- significant concerns or patient safety issues arising within appraisal
- complaints about the appraiser or the appraisal system

15. Selection, training and support of medical appraisers.

    For further information on this section including competencies, role description, person specification, training and support see *Assuring the Quality of Appraisers* (NHS RST, 2011) available on RST website], including:

    - description of the selection process for medical appraisers:
        - required competencies
        - probationary period or early review of skills [if applicable]
    - role description and person specification for medical appraisers
    - description of the training and development of medical appraisers
        - description of initial training
        - arrangements for access to leadership, support and ongoing development
        - arrangements for performance review, including feedback on performance in the role

16. Description of indemnity arrangements for medical appraisers

Appendix 2

Methodology for calculating RAG ratings for the ORSA 2011/12 exercise

This table summarises the methodology for calculating the RAG ratings of designated bodies for the ORSA exercise. The methodology has been approved by the ERDB.

Section 1: Details of the designated body		
Number of doctors (and different doctor types) with whom the designated body has a prescribed connection		Number
Section 2: Responsible officer		
2.1 A responsible officer has been nominated / appointed in compliance with the regulations		Yes/No
2.3 Appropriate responsible officer training is undertaken		Yes/No
Sectional RAG rating	2 Yes = Green 1 Yes = Amber 0 Yes = Red	Green Amber Red
Section 3: Appraisal system		
3.1 A medical appraisal policy with core content is in place		Yes/No
3.4 The number of trained medical appraisers is sufficient for the needs of the designated body		Yes/No
Sectional RAG rating	2 Yes = Green 1 Yes = Amber 0 Yes = Red	Green Amber Red
Note regarding deaneries: for the appraisal section, all deaneries have been allocated a rating of amber		
Section 4: Organisational governance		
4.3 There is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection		Yes/No
4.9 A process is established for the investigation of capability, conduct, health and fitness to practise concerns		Yes/No
4.10 A policy (with core content) for re-skilling, rehabilitation, remediation and targeted support is in place		Yes/No
Sectional RAG rating	3 Yes = Green 2 Yes = Amber 0 or 1 Yes = Red	Green Amber Red
Overall RAG rating		
Overall RAG rating	6 or 7 Yes = Green 4 or 5 Yes = Amber 0, 1, 2 or 3 Yes = Red Any individual section Red = Red No RO nominated/appointed = Red	Green Amber Red
Note regarding deaneries: for the overall rating, all deaneries have been allocated a minimum rating of amber		