The Regulation and Quality Improvement Authority

Review of Readiness for Revalidation in Primary Care in Northern Ireland

December 2011

informing and improving health and social care
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Contents

1 Context

1.1 Role of RQIA

The Regulation and Quality Improvement Authority (RQIA) is a non-departmental public body, established with powers granted under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. It is sponsored by the Department of Health, Social Services and Public Safety (DHSSPS), with overall responsibility for assessing and reporting on the availability and quality of health and social care services in Northern Ireland and encouraging improvements in the quality of those services.

1.2 Introduction

1.2.1 On 16 November 2009, the General Medical Council (GMC) introduced arrangements through which every doctor wishing to remain in active practice in the United Kingdom is required to hold a licence to practice. In future, all doctors will be required to undergo a process of revalidation if they wish to retain their licence to practice.

1.2.2 Revalidation will be based on local clinical governance systems and involve each doctor collecting a portfolio of evidence over a five year cycle to support, at annual appraisal, standards set out in the GMC's GMP Framework. Some of the medical Royal Colleges are developing guidance regarding the sort of supporting information doctors in different specialties may collect to support the appraisal process. Revalidation is planned to commence in late 2012 subject to approval by the Secretary of State for Health.

1.2.3 The Northern Ireland Assembly enacted legislation on 23rd June 2010 entitled **The Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010**. These regulations came into operation on 1 October 2010 and require each designated body including the Health and Social Care Board (HSCB) to nominate or appoint a Responsible Officer (RO). ROs will be responsible for ensuring effective clinical governance arrangements are in place and for making revalidation recommendations to the GMC concerning doctors linked to their organisation. A regional forum for ROs has been established to assist them in preparing for and carrying out this new role.

1.2.4 To underpin the revalidation recommendations of ROs, each organisation will need robust systems of clinical governance and delivery of medical appraisal. The NHS Revalidation Support Team (RST) in England has been developing guidance and tools to assist organisations there in assuring the quality of medical appraisal for revalidation. RST recommends external review of these systems every three years.

1.2.5 RQIA has been working with the GMC, RST and the healthcare systems regulators from the rest of the United Kingdom to consider how systems regulators can provide the GMC with assurance that healthcare providers have robust systems in place to underpin revalidation recommendations.

1.2.6 In 2010, RQIA carried out a review of readiness for revalidation in secondary care trusts in Northern Ireland. This is the report of a review of readiness for revalidation in primary care carried out in 2011.

1.3 Organisation of Primary Medical Care in Northern Ireland

1.3.1 On 1 April 2004, Primary Medical Services Performers Lists (PMPLs) were introduced into Northern Ireland by legislation.[1] A doctor is required to be listed as a primary medical services performer in order to treat health service patients in a primary care setting. HSCB is responsible for the admission of doctors to the Northern Ireland PMPL and for removal from the list, subject to strictly defined criteria set out in the regulations.

1.3.2 Most doctors working in primary care in Northern Ireland are based in general medical practices which are in contract with HSCB to provide a range of primary care services to patients on the list of the practice. A new General Medical Services (GMS) contract was implemented in April 2004 which introduced a Quality and Outcomes Framework (QOF) for general medical services.

1.3.3 Out of hours primary care services are coterminous with the five geographic HSC trust areas. Services are provided directly by trusts or by mutual organisations. Doctors working in these services frequently work in GMS practices during the day but some work exclusively for out-of-hours services. All GPs working in out-of-hours services are required to be on the PMPL.

1.3.4 Sessional general practitioners can work in a single practice or may provide locum cover for several practices. All are required to be on the PMPL to carry out this work.

1.3.5 Doctors from outside Northern Ireland who wish to work in a primary care setting here must apply to join the Northern Ireland PMPL even if they are already on a list in another part of the United Kingdom.

1.3.6 The HSC Board has contracted with the Northern Ireland Medical and Dental Training Agency (NIMDTA) for the delivery of medical appraisal for general practitioners on the PMPL. A GP Appraisal Central Board of Management has been established with representatives of relevant organisations to oversee arrangements.

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[1] The Health and Personal Social Services (Primary Medical Services Performers Lists) Regulations (Northern Ireland) 2004,

1.3.7 This review has focused on the governance arrangements and systems in HSCB and NIMDTA, as both organisations have key roles in relation to the future revalidation of primary care medical practitioners in Northern Ireland.

2. Methodology

The methodology for the review included:

1. Completion by each organisation of a self-assessment questionnaire.

   The HSC Board completed a self assessment questionnaire designed by the RST known as the Organisational Readiness Self-Assessment Tool (ORSA). This includes sections relating to the designated body, responsible officer, appraisal system and organisational governance arrangements.

   NIMDTA completed a self-assessment questionnaire issued by DHSSPS. This includes sections relating to clinical governance processes, managing risk and improving quality, performance issues, and complaint management.

2. Submission of completed questionnaires to RQIA together with supporting evidence.

3. Validation visits to each organisation by members of the review team.

4. Meetings with lead appraisers and appraisers and discussions with sessional doctors and representatives of the Royal College of General Practitioners.

5. Preparation of a report of the review findings across Northern Ireland. The report has been structured to reflect the sections of the ORSA tool.[2]

Members of the Review Team

The members of the review team who took part in the validation visits on Monday 16 May 2011 and Tuesday 17 May 2011 included:

Mrs Claire Hosie	NHS Tayside
Ms Vanda Clarke	NHS Revalidation Support Team
Mr Niall McSperrin	NI Court Services (Lay representative)
Dr Steven Wilson	Healthcare Improvement Scotland
Mr Chris Pratt	General Medical Council (Observer status)
Dr David Stewart	RQIA
Mr Hall Graham	RQIA

Project Support

Mrs Angela Belshaw	Project Manager RQIA

[2] Organisational Readiness Self- Assessment Tool (NHS Revalidation Support Team, 2011)

3. Findings

3.1 Details of the Designated Body – HSCB

3.1.1 The Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010 Schedule 1 Part 1 lists the Regional Health and Social Care Board as a Designated Body for the purposes of the legislation.

3.1.2 HSCB was established on 1 April 2009 and replaced four Health and Social Services Boards. The functions of HSCB include:

- Commissioning a comprehensive range of health and social services for the population of Northern Ireland
- Performance managing health and social care trusts
- Deploying and managing funding from the Northern Ireland Executive for health and social care

3.1.3 HSCB is responsible for the operation of the (General Medical Services Contracts) Regulations (Northern Ireland) 2004 and the HPSS (Primary Medical Performers Lists) Regulations (Northern Ireland) 2004.

3.1.4 At 31 March 2011, there were 1756 doctors on the Northern Ireland PMPL, and three other doctors employed by HSCB, for whom the RO will be responsible for making recommendations to the GMC, when the process of revalidation commences.

3.2 Responsible Officer

3.2.1 The HSC Board nominated the Assistant Director of Integrated Care (Head of General Medical Services) as its RO in September 2010, in keeping with the requirements of the regulations. The RO meets the designation requirement of having "been a medical practitioner throughout the previous five years".

3.2.2 Guidance on the role of ROs for doctors and their employers was issued by DHSSPS in February 2011. A regional forum for ROs has been established to support the development and implementation of the RO role, via shared learning and experience. A regional training needs analysis for ROs in Northern Ireland has been carried out by DHSSPS. Training will be co-ordinated at regional level.

3.2.3 The HSCB RO attends the regional RO forum and participated in the regional survey of training needs.

3.2.4 HSCB has received written assurance from the Royal College of General Practitioners (NI) that the RO has access to support in her role. HSCB can access support for the RO role through a regional agreement with the National Clinical Assessment Service (NCAS) and there are agreed arrangements with the GMC for the RO to discuss relevant cases.

3.2.5 The Responsible Officer Regulations (Part 2.12 (1)) state that "each designated body must provide the responsible officer appointed or nominated for that body with sufficient funds and other resources necessary to enable the officer to discharge their responsibilities for that body".

3.2.6 The HSCB Director of Integrated Care updated the board of HSCB on 20 September 2010 about the introduction of the RO regulations. He brought the stated requirement in the regulations for funding and resources to the attention of the board.

3.2.7 The review team was advised that HSCB had identified the need for an IT system to support the role of the RO and that plans were being developed to take this forward.

3.2.8 Regulation 4 of the Responsible Officer Regulations for Northern Ireland sets out a requirement that designated bodies have a duty to nominate or appoint a second RO in cases of conflict of interest, or appearance of bias, between an RO and a medical practitioner for whom the RO has responsibilities under the regulations.

3.2.9 At the time of the review visit, HSCB had not yet determined the arrangements which it would put in place to meet Regulation 4 but this was likely to be established as a mutual arrangement with the RO of another HSC organisation.

3.3 Appraisal System

3.3.1 Appraisal is recognised to be one of the cornerstones of revalidation. A system delivering high quality appraisal on an annual basis will be essential for a Responsible Officer to be assured that each medical practitioner is up to date and fit to practice.

3.3.2 In Northern Ireland the coordination and delivery of annual appraisal for all doctors on the primary care performers list has been provided by NIMDTA since 1 April 2006. A Service Level Agreement (SLA) is in place between HSCB and NIMDTA to "*deliver a quality assured appraisal scheme to individual general practitioners in Northern Irelan*d". The SLA is in place for one year at a time. At the time of the review visit, the SLA for 2011/12 had not yet been signed off by the respective organisations.

3.3.3 RQIA previously carried out a review of appraisal arrangements provided by NIMDTA in primary care in 2008. At that time it was concluded that the processes were well established with effective leadership. The 2008 review made 20 recommendations and an update on progress against these recommendations is set out in Appendix 1 of this report.

3.3.4 The ORSA tool sets out a number of criteria for assessment of the readiness of appraisal systems for revalidation. These criteria have been considered by the RQIA review team and presented as follows:

A medical appraisal policy with core content is in place

3.3.5 The governance arrangements for the delivery of GP appraisal by NIMDTA are set out in the SLA with HSCB which is supported by a detailed communication protocol. Operational guidance is set out in a document for appraisees which can be accessed through the NIMDTA website. These documents have been reviewed in relation to the recommended core content for a medical appraisal policy set out in ORSA.

3.3.6 The aims and objectives of the appraisal scheme are set out in the SLA between HSCB and NIMDTA. There are clear lines of accountability and reporting arrangements within the NIMDTA appraisal scheme.

3.3.7 The review team consider the communication protocol to be an example of best practice. The protocol sets out principles, processes and procedures in relation to:

- Regular communication between NIMDTA and HSCB
- Serious concerns about a doctor's fitness to practise identified by the HSCB or an appraiser
- GPs registered with undertakings at the GMC
- Areas for development for a doctor, identified by the HSCB
- Non-engagement and extenuating circumstances in the appraisal process
- Complaints and appeals procedures
- The PMPL including conditional inclusion or contingent removal
- Doctors working outside GMS such as solely for out of hours providers
- Appraisal for GPs working for other organisations
- Service needs identified through appraisal

3.3.8 The quality assurance arrangements for the appraisal scheme are specified in the SLA. NIMDTA have established an appraisal structure which facilitates quality assurance with a Regional Appraisal Co-ordinator supported by seven Lead Appraisers, each of whom is responsible for quality assurance of the work of around seven appraisers.

3.3.9 The current appraisal documentation for GPs was prepared by DHSSPS when appraisal commenced. A review of documentation is currently taking place at regional level.

3.3.10 The NIMDTA document "Guidance to Appraisees" sets out a description of the appraisal process, the arrangements for booking an

appraisal, and advice on the information which should be brought to the appraisal discussion. The document covers issues relating to confidentiality and quality assurance, and the steps which will be taken in exceptional circumstances, such as serious concerns arising during the appraisal discussion. The importance of feedback on the process is emphasised and the arrangements for this are set out. Following each appraisal, reminders are sent asking each appraisee to submit an evaluation form.

3.3.11 NIMDTA has established arrangements for the selection and recruitment of appraisers. Posts are advertised and there are job descriptions and personal specifications for both appraisers and lead appraisers. Training is provided for new and existing appraisers and there is an annual 2 day appraiser conference with updates and skills development. New appraisers have a probationary period when their appraisals are reviewed by their lead appraiser. Lead appraisers must have previous appraisal experience in the NIMDTA scheme before they can be appointed as a lead.

3.3.12 The appraisal guidance specifies that a new appraiser must be chosen every 3 years by an appraisee, with a gap of at least 2 years before that appraiser can again be involved.

3.3.13 Arrangements are set out in "Guidance to Appraiser" documentation as to the actions to be followed if there is a potential conflict of interest between an appraiser and appraisee.

3.3.14 The indemnity arrangements for doctors carrying out functions in relation to appraisal for NIMDTA are set out in a letter which states that as the doctor is acting as an agent for, or on behalf of NIMDTA, he or she is entitled to benefit from the indemnity and liability arrangements which are in place for the organisation.

3.3.15 The appraisal documentation reviewed was comprehensive. The documentation had not yet been updated to reflect the responsibilities of the RO in relation to revalidation. NIMDTA advised the review team that this will be done when there is clarity as to the requirements in relation to the new arrangements to support revalidation.

The number of doctors with whom the Designated Body has a prescribed connection who have a completed appraisal between 1 April 2010 and 31 March 2011

3.3.16 For the year ending 31 March 2011, NIMDTA completed appraisals for 1509 out of the 1756 doctors on the NI performers list. HSCB completed appraisal for three doctors who are directly employed but who are not on the performers list.

An exception audit has been performed to determine the reasons for all missed or incomplete appraisals

3.3.17 NIMDTA and HSCB have agreed procedures as to the actions to be taken when there is potential non-appraisal during each appraisal cycle.

3.3.18 NIMDTA and HSCB provided information to the review team on the 245 doctors who are on the PMPL but did not have an appraisal carried out in 2010/ 11 by NIMDTA. The reasons were:

- 203 performers did not require appraisal by NIMDTA during the 2010/ 11 cycle as they were new joiners or in Higher Professional Education and had not met the agreed criteria for appraisal through NIMDTA
- Nine performers had agreed extenuating circumstances
- 33 performers were appraised by other organisations for which there are agreed processes to check compliance
- Two performers were referred to HSCB by NIMDTA due to non-engagement in the process

3.3.19 One of the two cases referred to HSCB by NIMDTA related to an incomplete portfolio of supporting information. In the other case the appraisee asked for the meeting to be rearranged on several occasions and there was insufficient time to complete the process within the appraisal cycle.

3.3.20 HSCB has agreed arrangements to review the PMPL each year. In the event of a doctor not participating in appraisal, a letter is sent to the doctor, stating that participation in appropriate and relevant appraisal is an undertaking made by all doctors in their application for inclusion in the PMPL. The doctor is advised that relevant confirmation of completion of appraisal must be received within 28 days. If the doctor does not comply, the HSCB may decide to take further action which could include removal of the doctor from the PMPL.

The number of trained medical appraisers is sufficient for the needs of the organisation

3.3.21 HSCB advised that there were sufficient trained appraisers to carry out the agreed programme of appraisals in the contract with NIMDTA. The number of appraisals is considered during the annual review of the contract between HSCB and NIMDTA.

3.3.22 At 31 March 2011 there were seven lead appraisers and 45 other appraisers on the NIMDTA list. There was one trained appraiser in HSCB to carry out appraisal for the three directly employed HSCB doctors.

3.3.23 All active appraisers have received induction training and annually receive appraiser training through attending an appraisal conference

organised by NIMDTA. All active appraisers have received updates on revalidation.

3.3.24 The NIMDTA annual appraiser conference lasts two days. All appraisers attended for at least one day of the last conference in 2010. The programme covered updates on relevant issues and practical workshop to enhance appraisal skills.

3.3.25 NIMDTA also organises training and development opportunities for lead appraisers. In March 2011 this included a workshop on "Identified Underperformance in GPs through Appraisal" with inputs from HSCB, NCAS and the GMC.

Medical appraisers are supported in the role through access to leadership and peer support

3.3.26 The appraisal scheme organised by NIMDTA is designed to ensure that there is support provided to appraisers. The scheme is led by a regional appraisal coordinator and there are seven lead appraisers who each link to a team of appraisers. Lead appraisers can provide support, advice and guidance and there are quarterly meetings for each team of appraisers at which any issues can be discussed. The minutes of these meetings are considered by the regional coordinator to identify any issues for consideration across the whole scheme.

3.3.27 The review team met with the regional coordinator and with representatives of lead appraisers and appraisers and found that the scheme was well structured, with clear arrangements for support for appraisers in place.

3.3.28 Appraisers advised the review team that they felt they received adequate training to fulfil their role and they were able to recommend issues to be covered on training days. They felt the role of appraiser helps to share good practice across primary care. They advised that it was not uncommon for GPs to contact their appraiser out-with the appraisal process for advice and support.

Medical appraisers receive feedback on their performance in the role which includes feedback from appraisees or feedback on the quality of appraisal outputs [e.g. PDPs, appraisal summaries]

3.3.29 NIMDTA has established quality assurance arrangements for the appraisal scheme in relation to appraisal summaries and PDPs. New appraisers submit their first four Form 4s to their lead appraiser for immediate feedback and then a further two forms in their first year. Experienced appraisers and lead appraisers submit samples of their Form 4s for quality assurance. All forms are reviewed on an anonymous basis.

3.3.30 Quality assurance of Form 4s and PDPs is carried out using an agreed feedback template, with potential areas for appraiser development highlighted. Appraisers advised the review team that they received appropriate feedback on their performance in the role. They had confidence in the process of anonymous review of forms by lead appraisers.

3.3.31 Lead appraisers and appraisers both indicated that they would welcome the development of an online system to support the documentation handling processes in relation to appraisal. NIMDTA does not have an integrated IT system to support the appraisal process. The review team was advised that there is a process underway to reach agreement on which system to take forward. There is not yet an identified source of funding to implement a system.

3.3.32 Under the current arrangements, copies of Form 4s and PDPs are not routinely provided to the RO at HSCB. These can be held by individual doctors or at NIMDTA. Lead appraisers and some appraisers considered that it will be essential for ROs to have ready access to appraisal information to fulfil their responsibilities under the legislation. Some appraisers perceived that the sharing of Form 4s would cause anxiety about the process for their GP colleagues.

3.3.33 At the end of the appraisal process NIMDTA invites all appraisees to complete an anonymous online feedback questionnaire as to their experience of their appraisal. This information is continuously monitored and collated. The results of the annual survey are used to inform the organisation of the appraisal scheme.

3.3.34 The results of the survey for the year ending 31 March 2011 indicated that appraisees were generally satisfied with their individual appraisal and with the organisation of the scheme.

3.3.35 The online feedback questionnaire also collects information as to GP perceptions on their training needs. This information is used to inform the provision of training events for primary care.

3.3.36 Information collected at the appraisal discussion supports a reporting mechanism to identify local service needs. A quarterly return is made from NIMDTA to the HSCB enabling the HSCB to identify a GP's service delivery constraints within a Trust area.

3.3.37 Members of the review team discussed appraisal arrangements with sessional doctors who highlighted particular issues from their perspective including:

- Doctors working part time or on a locum basis across practices, can have limited opportunities to participate in clinical audit and, in particular, to complete the audit cycle by going back to review if lessons have been implemented.

- Sessional doctors may have difficulties in taking part in patient and colleague feedback systems when these are introduced, if they do not work regularly in one place.
- Information to support appraisal such as prescribing and referral rates is very limited for sessional doctors.
- There is a need to ensure that information is collected by sessional doctors throughout the process as it can be difficult to get retrospectively from a practice where a doctor has been a locum.
- Exit reports are not always provided in a timely way.
- Appraisal can be a costly process for a locum as it can take several days to compile a portfolio of evidence.

3.3.38 Sessional doctors commented favourably on the appraisers in the NIMDTA scheme whom they felt were aware of issues in general practice from a locum's perspective.

3.3.39 NIMDTA advised the review group that there are some doctors on the PMPL who work mainly outside Northern Ireland and this can create difficulties in providing sufficient relevant information to support appraisal. Similar difficulties can also be experienced doctors absent from clinical practice due to health related issues or conditions on their practice.

3.4 Organisational Governance

3.4.1 The RO in each designated body is responsible for ensuring that those medical practitioners with whom the organisation has a prescribed connection are up to date and fit to practise. In order to fulfil this responsibility the organisation must have robust governance systems and accountability arrangements in place.

3.4.2 HSCB completed the ORSA self-assessment tool and provided the review team with a comprehensive portfolio of evidence in relation to the governance arrangements in place. This was then subject to validation through meetings with HSCB officers and visits to relevant departments.

3.4.3 The findings are described below in relation to the criteria for organisational governance set out in the ORSA tool.

A governance structure or strategy is in place

3.4.4 HSCB has responsibility to manage contracts for all general medical practitioners providing General Medical Services (GMS) in Northern Ireland and also for the management of the PMPL. Although almost all doctors for whom the RO has responsibility are not directly employed by the organisation, HSCB recognises its duty to ensure that there are

satisfactory governance arrangements at individual practice level as well as at HSCB organisational level.

3.4.5 HSCB has developed a clinical governance framework for primary care. Each GMS practice is required to have a clinical governance lead and HSCB cascades information related to governance to the leads.

3.4.6 Each clinical governance lead (who must be GMC registered) is required to provide to HSCB an annual record of governance activity undertaken and to sign an annual practice governance declaration which includes statements that the practice:

- Has undertaken clinical governance activity within the past year in each of six specified governance areas
  - Audit
  - Evidence based practice
  - Risk management (including adverse incidents and professional regulation
  - CPD/ Education and training (including appraisal)
  - Patient involvement (including complaints)
  - Practice systems
- Has evidence of the activity undertaken which can be produced at the next practice visit or on request
- Can demonstrate the impact of this work on service delivery within the practice
- Has addressed areas of particular concern to HSCB which are identified on an annual basis. In 2010/11 these related to complaints and annual adverse incident reporting processes and professional regulation of all professional practice staff.
- Has ensured that all doctors working regularly within the practice are given the opportunity to participate in clinical governance activity.

3.4.7 HSCB, following consultation with RCGP, NIMDTA and the General Practice Committee (GPC) of the British Medical Association (BMA) has developed a self-assessment schedule for practices which describes the minimum standard that should be achieved in each of the six governance areas set out in the practice declaration.

3.4.8 HSCB has completed a governance mapping exercise to document the links between governance processes at practice and organisational level.

3.4.9 During the review visit, HSCB provided examples of completed clinical governance records from practices which demonstrated the range of activity being undertaken at practice level in this regard. Practice returns are considered during HSCB visits to practices.

3.4.10 In 2010, HSCB carried out a review of reporting arrangements for adverse incidents for all family practitioner services. Revised arrangements were established and these include clear lines or responsibility for reporting and for the handling of reports when they are received by HSCB. A manual setting out the procedures and revised documentation has been prepared.

3.4.11 Arrangements have been established to link the primary care incident reporting system with two regional systems. Firstly, incidents reaching specified criteria for a "Serious Adverse Incident" (SAI) are referred into the HSCB SAI Arrangements. Secondly, incidents which meet the criteria for the DHSSPS Early Alert System are referred by HSCB to DHSSPS.

3.4.12 As an example of how incidents are used to inform the review of procedures and to improve systems, HSCB advised the review team that, following some issues of data loss in GMS practices, guidance was developed and issued to all practices. This sets out back up procedures for clinical data. The clinical governance lead in each practice was asked to review the guidance, discuss it with the practice staff and ensure that any required actions were addressed.

3.4.13 Complaints in relation to primary care are managed by HSCB through agreed and documented arrangements. Practices are encouraged to seek to investigate and respond to complaints at local level with a copy of the complaint and response forwarded to HSCB. These complaints are then logged on an HSCB database. Following a complaint, any immediate concerns are considered by a professional adviser in HSCB. Trends in complaints by practice are made available to officers carrying out practice review visits.

3.4.14 Routine visits to GP practices are carried out on a three yearly basis at which QOF, contract performance and governance arrangements are considered. Additional visits are carried out if there are specific issues or concerns relating to the practice. Additional visits can include "QOF Outlier visits" if examination of QOF data sets indicates that the practice data relating to disease prevalence, disease coding or practice outcomes lies above statistical control limits.

3.4.15 The review team was advised of the arrangements for practice visits and reviewed examples of documentation. A typical HSCB practice visit team comprises a Medical Adviser and a Practice Support Manager. Prior to a visit, the team examine relevant documentation including QOF data and clinical governance records. Clinical and organisational issues are considered at the visit. A practice visit report is prepared and forwarded to the practice. Annual practice visits are also undertaken by medicines management advisers in relation to QOF indicators and quality and cost effectiveness of prescribing.

The governance systems are subject to external/independent review and are not the subject of improvement notices or formal action plans

3.4.16 HSCB is required to report to DHSSPS on its governance arrangements as part of the Controls Assurance process. Clinical and social care governance arrangements at HSCB are subject to review by RQIA. This review was carried out by RQIA in line with this responsibility.

3.4.17 As described above, HSCB carries out visits to individual practices which include consideration of the governance arrangements in practices.

There is a system for monitoring the conduct and performance of medical practitioners with whom the Designated Body has a prescribed connection

3.4.18 HSCB has systems in place to gather information for the monitoring of performance of GMS practices in the areas set out in the ORSA assessment tool. These systems include:

a) Review of QOF clinical and performance data using Statistical Process Control (SPC) methodology which is designed to identify practices who have indicators outside control limits.
b) Practice clinical governance records which describe governance activity (including audit) which took place in the practice in the previous year.
c) Contract performance data in areas such as the provision of enhanced services.
d) GP referral rates by practice to secondary care specialties.
e) COMPASS reports which provide detailed information about prescribing in the practice and with comparable data at Local Commissioning Group and HSCB level.
f) Post payment verification reports on individual practices in relation to GMS payments.
g) Information about complaints and incidents as set out above.

3.4.19 In general, the performance information collected by HSCB relates to the performance of GMS practices rather than individual practitioners unless the practice is single-handed. HSCB has sought to ensure that all practitioners contribute to governance activity. The clinical governance lead for the practice is required to sign an annual declaration which includes the statement “all doctors working regularly within the practice are given the opportunity to participate in clinical governance activity.”

3.4.20 There are limited systems in place which provide routine information to HSCB about the performance of doctors on the PMPL who work as locums across practices. All such doctors are required to participate in the appraisal arrangements managed by NIMDTA.

There is a system for obtaining and collating patient and colleague feedback for all doctors which accords with GMC guidance

3.4.21 There is not an agreed system in place for the systematic collection of patient and colleague feedback for doctors in primary care in Northern Ireland. At the time of the review visit, plans were in place to carry out a pilot exercise later in 2011 to inform the development of agreed arrangements.

The Designated Body's medical or clinical audit activity covers the areas recommended in national guidance

3.4.22 HSCB receives annual returns about clinical audit activity from each GMS practice as part of the Clinical Governance Record. Much of the audit activity relates to areas designated in QOF or where guidance to complete the audits has been provided by HSCB.

3.4.23 A Primary Care Intranet has been established by HSCB which is a valuable resource for sharing information relating to clinical governance. The review team were shown the "Audit Library" on the system which provides guidance and materials for a wide range of clinical audits which can be carried out by practices.

3.4.24 HSCB does carry out audits across practices as well as promoting individual audit at practice level. For example, in May 2009, an audit across all practices in the Eastern Areas was instigated relating to Anticoagulation in Primary Care.

The organisation monitors contributions to national clinical registries and patient safety supporting systems

3.4.25 The HSCB adverse incident arrangements for primary care include consideration as to whether an incident meets the criteria for reporting to the SAI reporting system for Northern Ireland, which is also managed by HSCB.

3.4.26 HSCB advised the review team that incident reports are checked to see which outside agencies have been informed and, if required, further action is taken with regard to reporting.

3.4.27 A project is currently underway to design a new Regional Adverse Incident and Learning (RAIL) system for Northern Ireland to ensure that there is learning from analysis of incidents to enhance patient safety. There is representation from primary care in HSCB on the project team.

3.4.28 Individual doctors in primary care can report incidents such as adverse drug reactions directly to national reporting systems. HSCB may not

be aware of such reports if the incident is not referred also under the HSCB arrangements.

There is a process in place for the Responsible Officer to ensure that key information [for example specified complaints, SUIs/ significant events, outlying performance/ clinical outcomes] is included in the appraisal portfolio and has been discussed in the appraisal so that development needs are identified

3.4.29 The communication protocol agreed between HSCB and NIMDTA (3.3.7 above) has agreed arrangements for the sharing of information to inform the appraisal discussion. Sample letters have been prepared to include the sharing of concerns, letter to the doctor of concerns shared and the requirement that Form 4 and PDP will be copied to HSCB.

Information relating to all new doctors is obtained from the doctor's previous Responsible Officer and/ or employing or contracting organisation

3.4.30 The RO for HSCB will be responsible for making recommendations to the GMC with regard to revalidation on doctors on the PMPL. Schedule 1 of the 2004 regulations for Northern Ireland sets out a detailed list of the information, declarations and undertakings to be included in an application for inclusion on the list. HSCB has procedures in place in this regard.

3.4.31 The 2004 regulations were amended in 2008. The amendments included a requirement for *"effect to be given to corresponding decisions in England, Wales and Scotland"* so that inclusion or retention on the PMPL in Northern Ireland had to take into account decisions made in the other jurisdictions.

3.4.32 The regulations and guidance relating to inclusion on the PMPL predate the RO regulations. There will be a need to review procedures to ensure that there are robust systems in place for information to be shared between ROs across the United Kingdom in relation to doctors on primary care performance lists. At present links are being made between the RO and other organisations who employ GPs who are on the NI PMPL such as the Ministry of Defence and Queen's University Belfast.

Exit reports for locums and temporary appointments are completed by the supervising consultant, doctor or another senior member of clinical staff for all doctors who have worked more than one week in the organisation

3.4.33 At the time of the review visit there were not agreed arrangements in place for exit reports to be completed on a routine basis for locum doctors working in primary care.

3.4.34 There are feedback cards available from NIMDTA, as part of the appraisal documentation, which can be used by any GP to express appreciation or offer constructive advice to a GP colleague.

3.4.35 HSCB advised the review team that a revised feedback card for sessional doctors was being developed. The process to use the cards and the format of the cards would be subject to consultation before implementation.

A process is established for the investigation of performance, conduct, health and fitness to practise concerns

3.4.36 In February 2009 DHSSPS published guidance on "Investigating Performance Concerns" in relation to primary medical services. This includes guidance on:

- Identifying the need and purpose of an investigation
- Roles and responsibilities and selecting investigators
- Collecting and documenting evidence
- Whistle-blowing and anonymity
- Support for the practitioner and complainant

3.4.37 HSCB has developed an operational framework to implement the regional guidance. Guidelines have been developed for case officers and senior managers when dealing with concerns about independent contractors. Documented procedures are in place for receiving, screening and managing concerns.

3.4.38 HSCB has established two groups to manage concerns regarding practitioners in primary care including GPs:

- The Regional Performance Panel
- The Reference Committee

3.4.39 The Regional Performance Panel is an advisory group which reviews concerns, provides advice on the management of cases, including remediation, and referral for investigation where appropriate.

3.4.40 The Reference Committee is an executive decision-making body which makes formal decisions on disciplinary matters on behalf of HSCB.

3.4.41 HSCB has also established a Regional Primary Medical Performers List Advisory Committee to provide advice in relation to its duties with regard to the management of the PMPL. This has a lay chair and has representation from organisations with an interest in the operation of the PMPL including NIMDTA.

A policy [with core content] for re-skilling, rehabilitation, remediation and targeted support is in place

3.4.42 HSCB advised the review team that, while there are some arrangements in place for re-skilling, rehabilitation, remediation and targeted support for doctors, these need to be reviewed.

3.4.43 NIMDTA advised the review team that there was previously a GP Returner Scheme for GPs who have not worked in general practice for two or more years. This provided them with a personal re-training programme under the supervision of a GP trainer for up to six months, followed by an assessment. The future of this scheme was being considered at the time of the review visit.

3.4.44 There is no identified source of recurrent funding to cover re-training or remediation of doctors. In recent years funding has provided by HSCB non-recurrently on a case by case basis but, with current funding pressures this funding may not be available in future.

3.4.45 HSCB advised that work was taking place to develop an options paper to consider how to take these issues forward in the light of the requirements set out in the Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010.

Where a medical practitioner is subject to conditions imposed by, or undertakings agreed with, the GMC, the Responsible Officer monitors compliance with those conditions or undertakings

3.4.46 HSCB has arrangements in place for the monitoring of doctors who seek inclusion in the NI PMPL about whom there are particular concerns under the auspices of the Regional PMPL Committee. Where there are performance concerns or a doctor is practising with GMC or local conditions this is monitored by the Regional Professional Panel.

3.3.47 New arrangements have recently been established to facilitate discussions between the GMC and HSCB about individual cases where the doctor is on the PMPL.

A description of the support available from the Designated Body for medical practitioners to keep their knowledge and skills up to date is in place

3.4.48 HSCB has a number of processes in place to provide primary care doctors with guidance and support and which contribute to maintaining their knowledge and skills.

3.4.49 Following the introduction of the GMS contract in 2004, Health and Social Services Boards (and subsequently HSCB) promoted programmes of direct training for GPs and practice staff which were designed to be timely and were free of charge. The review team was advised that priorities for training are influenced by:

- Statutory requirements relating to the GMS contract
- QOF requirements
- Updated clinical guidelines
- Learning needs identified through GP appraisal
- Discussions in local training committees
- Strategic and regional priorities

3.4.50 HSCB funds protected practice-based learning afternoons which may be used to facilitate delivery of HSCB training events or can be used for practices to organise their own training.

3.4.51 HSCB uses the Primary Care Intranet to disseminate relevant presentations, protocols and guidance to doctors and also to share details of training events.

3.4.52 Local Commissioning Groups within HSCB are establishing Primary Care Partnerships (PCPs) which will be groups of practitioners. PCPs will be asked to review and initiate improvements in services for patients. HSCB considers that PCPs will provide new opportunities for GPs to share best practice and to learn from colleagues.

3.4.53 NIMDTA coordinates an Educational Consortium which has been established to deliver continuing professional development for GPs through a range of providers. NIMDTA organises education and training events for primary care which can be booked online.

Relevant appraisal, revalidation and Human resources policies are fair and non-discriminatory

3.4.54 DHSSPS published advice in relation to PMPL list management in February 2009. This states that:

"There is no place for discrimination on grounds of gender, faith, race, disability, age or sexual orientation in the operation of any of the procedures dealt with in this guidance."

3.4.55 The ORSA assessment tool recommends that gender and ethnicity data should be collected for all doctors from whom a designated body has a prescribed connection. The current documentation for application to join the PMPL in Northern Ireland, and for registration for appraisal with NIMDTA, includes requests for information about gender, but not for ethnicity.

4. Conclusions

4.1 The aim of this review was to assess the state of readiness for the introduction of revalidation of primary care doctors in Northern Ireland. Revalidation is planned to commence in late 2012. The review focused on the systems and processes in two organisations which have essential roles to support revalidation:

- HSCB which manages contracts with General Practices and which is responsible for the PMPL in Northern Ireland.
- NIMDTA which is contracted by HSCB to provide appraisal for all doctors on the PMPL.

4.2 The review team considers that primary care in Northern Ireland is in a good position to begin revalidation. HSCB and NIMDTA have strong leadership in place with staff committed to ensuring that revalidation is successfully introduced. The team noted that there were effective working relationships between NIMDTA and HSCB which are underpinned by a well constructed communications protocol.

4.3 HSCB has been able to harmonise and build on clinical governance systems in place in legacy health and social services boards.

4.4 The appraisal system provided by NIMDTA continues to deliver the high standards found in the previous RQIA review in 2008 for all doctors on the PMPL.

4.5 HSCB has appointed an RO for the organisation who is working to ensure that systems are in place for revalidation. The review team has noted that the RO will be responsible for over 1700 recommendations to the GMC. To enable the RO to deal with this work load effectively a robust support system will be required. The review team recommends that HSCB review the support arrangements in place to enable the RO to fulfil the statutory responsibilities. Areas to consider include:

- The level of administrative resource required to support the RO function
- Succession planning, and the possibility of nominating deputy responsible officers

In the absence of guidance on the possible appointment of (a) deputy RO(s) and the acceptability of appointed deputies forwarding recommendations to the GMC, it was suggested that the GMC be invited to clarify the position.

4.6 The review team found that neither HSCB nor NIMDTA have IT systems in place to support their respective functions in relation to revalidation and appraisal. A process is underway to consider options to procure a system which will support these functions. The review team recommends that this process is completed as soon as possible to support the introduction of revalidation. HSCB advised that an

assessment of need will be completed when the requirements for Revalidation are finalised.

4.7 The review team was advised that, at present, there is no routine system through which the RO at HSCB is provided with access to the documentation on appraisal which will be essential to make recommendations to the GMC on revalidation. The review team recommends a system is established to ensure that the RO has access to the required information on appraisal.

4.8 The review team noted that policy on the rehabilitation and remediation of doctors is under development at HSCB in conjunction with NIMDTA and recommends that this is completed as soon as possible as effective arrangements in these areas will be important to support revalidation.

4.9 Doctors working on a sessional basis informed the review team of their difficulties in building a portfolio of evidence to support their appraisals. There are not agreed arrangements in place for the provision of exit reports when sessional doctors work as locums in GP practices. The review team recommends that HSCB and NIMDTA should jointly review the arrangements for the provision of information relating to sessional doctors to support their future revalidation.

4.10 A pilot is planned to test approaches to the provision of patient and colleague feedback for doctors in primary care in Northern Ireland. It is unlikely that arrangements, based on the findings of the pilot, will be in place in time for the introduction of revalidation next year. The review team recommends that the Revalidation Delivery Board for Northern Ireland agrees a way forward with the GMC to ensure that the absence of these arrangements does not impede the introduction of revalidation in 2012.

4.11 At the time of the review it was unclear as to the requirements which would need to be in place for revalidation in 2012. The review team recommends that relevant policies and guidance are updated to reflect the creation of the post of RO when relevant guidance has been issued in relation to revalidation.

4.12 At the time of the review visit, HSCB had not yet determined the arrangements to nominate or appoint a second RO in cases where there is a conflict of interest between a doctor and the HSCB RO. The review team recommends that these arrangements are agreed and established.

4.13 Responsible officers are now being appointed in all jurisdictions in the United Kingdom. There are doctors who work during the year across the different jurisdictions. There is a need to review procedures to ensure that there are robust systems in place for information to be

shared between ROs across the United Kingdom in relation to doctors on primary care performance list.

5. Recommendations

5.1 HSCB should review the support arrangements for its responsible officer to ensure that the organisation can fulfil its statutory functions in relation to the responsible officer regulations. Areas to consider include:

- The level of administrative resource required to support the RO function
- Nomination of deputy responsible officers

5.2 DHSSPS, HSCB and NIMDTA should ensure that the process to procure an IT solution to support the appraisal and revalidation functions of HSCB and NIMDTA is completed as soon as possible.

5.3 DHSSPS should ensure that arrangements are put in place so that the HSCB Responsible Officer has access to the information on individual doctor's appraisal which will be required to provide revalidation recommendations to the GMC.

5.4 HSCB, in partnership with relevant organisations should complete its review of policy on the rehabilitation and remediation of doctors in primary care to ensure that agreed arrangements are in place prior to the commencement of revalidation.

5.5 HSCB and NIMDTA should jointly review the arrangements for the provision of information relating to sessional doctors to support their future revalidation including the provision of exit reports for locum doctors.

5.6 The RDBNI should liaise with the GMC to determine an agreed position on patient and colleague feedback for the initial revalidation of doctors in 2012 to enable current pilot work to inform the development of appropriate systems, and to avoid the risk that the absence of such systems will lead to delays in making revalidation recommendations on individual doctors.

5.7 HSCB and NIMDTA should review and revise relevant policies and guidance to reflect the creation of the role of responsible officer.

5.8 HSCB should establish arrangements to nominate or appoint a second responsible officer in cases where there is a conflict of interest between a doctor and the responsible officer for the organisation.

5.9 The GMC should be asked to consider issuing guidance on the possible appointment of (a) deputy RO(s) and the acceptability of appointed deputies forwarding recommendations to the GMC.

5.10 The GMC and Health Departments should review procedures to ensure that there are robust systems in place for information to be shared between ROs across the United Kingdom in relation to doctors on primary care performance lists.

Appendix 1

Update on the recommendations of the 2008 RQIA Review of GP Appraisal

RQIA Review 2008 Recommendation	2011 Review
1. Review links with the Educational Consortium	Demonstrated that action has been taken and further improvements have been achieved • GP tutor and Appraiser representation on committee
2. Better links with other governance processes	Evidenced in: • SLA with HSSB • Communication protocol (NB The review team considered this document to be an example of good practice)
3. Inclusion of further clinical governance data in appraisal	Demonstrated that action has been taken • Communication with DHSSPS re need for system solution • Monitoring by Appraisers of quantity and quality of evidence received
4. Appraisal as a challenging process	Demonstrated that action has been taken • Appraisal training programme
5. Review of appraiser workload and remuneration.	Demonstrated that action has been taken • NIMDTA reviewed Appraisers sessional commitment
6. Research into impact of appraisal on General Practice	Research project completed
7. Recruitment from cohorts of younger and female practitioners	Demonstrated that action has been taken • Recruitment exercise invited interest from Female GPs

RQIA Review 2008 Recommendation	2011 Review
8. Dissemination of good practice	Demonstrated that action has been taken • Website • Taken forward by Appraisers
9. More contact for appraisers and lead appraisers with appraisal processes nationally	Demonstrated that action has been taken • Representation at NAPCE
10. Training made available to appraisers on assessment and use of further clinical governance material in the appraisal.	Demonstrated that action has been taken • Annual Appraisal Conference • Joint working with HSCB / Governance Strategy GMS
11. Support and training for appraisers appraising non UK graduates	Demonstrated that action has been taken • Research project re needs of non UK graduates • Liaison with HSCB
12. Work with HSSBs to provide induction training for non UK graduates	Demonstrated that action has been taken and work is on going • Communication with DHSSPS
13. Form 4 and PDP available at the start of the appraisal.	Demonstrated that action has been taken • Sourcing of software to facilitate this process
14. Support for sessional doctors	Demonstrated that action has been taken and work is on going Recommendation 5.5 (2011)
15. Appraisals for all doctors carried out in appropriate settings.	Evidenced through results of annual survey 2010
16. Feedback from appraisees.	Evidenced through on going quality assurance arrangements
17. Minimum data set	Demonstrated that action has been taken

RQIA Review 2008 Recommendation	2011 Review
18. Retention of all Form 4s and PDPs – to become mandatory	Demonstrated that action has been taken
19. Review process for matching appraisers and appraisees.	Demonstrated that action has been taken • Process has been reviewed
20. Development of an 'e-portfolio' on the NIMDTA website for appraisal information.	Demonstrated that action has been taken • Discussion with DHSSPS NB There has not been an identified source of funding to implement a system

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