

# External Quality Assurance of NHS Highland Pilot of Medical Revalidation in Scotland

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October 2011

Healthcare Improvement Scotland is committed to equality and diversity. This publication reports on an external quality assurance exercise of a pilot of the medical revalidation process in NHS Highland. The pilot was undertaken to identify whether the information required to support medical appraisal in secondary care is available across all specialties. An Equality Impact Assessment has not been carried out at this stage as this exercise was to support the overall revalidation process and therefore does not relate closely to the health service user.

On 1 April 2011, Healthcare Improvement Scotland took over the responsibilities of NHS Quality Improvement Scotland.

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# 1 Background and Introduction

In February 2007, the UK Government published a White Paper; *'Trust, Assurance and Safety – The Regulation of Health Professionals in the 21<sup>st</sup> Century'*. The intention of the policy was to *"provide for safer patient care in the UK and will enable the public and patients to be confident that the health professional who cares for them is practising to nationally agreed standards based on an ethos of high quality care"*<sup>1</sup>.

To implement this policy, since November 2009, any doctor wishing to practise medicine in the UK must be registered with the General Medical Council (GMC) and hold a licence to practise that needs to be revalidated (usually) every 5 years<sup>2</sup>.

The process of revalidation is a 5-year continuous process rather than a single event. The Scottish Government Health Directorates (SGHD) described the purpose of revalidation as:

*"The purpose of revalidation is to assure patients, employers and other healthcare professionals that licensed doctors are up to date and are practising to the appropriate professional standards. Revalidation will provide a focus for doctors' efforts to maintain and improve their practice, and for the organisations in which they work to support them in doing this. In these ways, it will contribute to improvement in the quality of patient care"*<sup>3</sup>.

As part of SGHD implementation policy for enhanced medical appraisal and revalidation, three pilots were undertaken throughout NHSScotland:

- one in NHS Tayside focusing on the evaluation of the RCGP Scotland new Personal Education Planning (nPEP) Learning Needs Assessment Tool for use in revalidation
- a second in NHS Lothian focusing on standardising documentation; and
- the third in NHS Highland. This was funded by SGHD to undertake a pilot of enhanced medical appraisal based on the GMC Working Framework for Appraisal and Assessment.

The objectives of the NHS Highland pilot were to:

- test the design and implementation of a model of Enhanced Medical Appraisal across a cohort of consultants from different specialties in one NHS board, and to identify implications for Form 4's

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<sup>1</sup> DH (2007) *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21<sup>st</sup> Century* p21. A UK Government White Paper. DH England.

<sup>2</sup> Revalidation is an umbrella term that covers both re-licensing (meeting the GMC's generic standards) and re-certification (meeting any relevant specialty specific standards as prescribed by the individual Royal Colleges).

<sup>3</sup> <http://www.scotland.gov.uk/topics/Health/NHS-Scotland/paper>

- identify gaps in the existing information available to support medical appraisal and, ultimately, revalidation; and
- share lessons learned with NHS Boards across Scotland.

The pilot focused on enhanced medical appraisal for 21 consultants from a range of specialties, working in Raigmore, Belford and Wick hospitals. Multi-source feedback was used by all participants on the recommendation of the GMC. The pilot documentation used was developed by NHS Fife in conjunction with the Scottish Government's National Appraisal Leads Group and The Academy of Medical Royal Colleges and Faculties in Scotland.

Following the NHS Highland pilot, the Scottish Government commissioned Healthcare Improvement Scotland to externally quality assure the pilot to review and optimise the learning from the NHS Highland experience. This was carried out in February and March 2011. The approach involved undertaking individual structured interviews with the participants of the pilot as well as a formal external quality assurance meeting with NHS Highland representatives who provided clinical leadership and had responsibility for undertaking the pilot.

## **2 Key Findings**

### **2.1 Delivering enhanced medical appraisal**

The NHS Highland experience of piloting the current draft enhanced medical appraisal system was mixed. They found it lengthy and time consuming although they did find the new process more robust than the previous system. The main concern was the risk of the process being resource heavy. The pilot highlighted the importance of support from administration, clinical governance, human resources and IT staff and systems. This is particularly important during the implementation phase when current IT and e-health system data cannot be easily reported on to support the enhanced medical appraisal process.

### **2.2 Protected Time for Appraisal**

The current scheme recommends that each appraiser carries out ten appraisals every year. This is based on the likely number of appraisers and appraisees and on the five year revalidation cycle. Without protected time, consultants reported concerns that they would not be able to sustain this and that it could be detrimental to patient care. Adequate support may address these concerns. NHS Highland reported that in their experience, undertaking five appraisals per annum may be more realistic to avoid rushing appraisals in an effort to fit all 10 into an existing busy schedule. NHS Highland stressed that for this process to be credible and to lead to improved care and practice, it was essential that appraisals were well prepared, robust and followed through.

### **2.3 Preparation**

The pilot and the EQA highlighted the time involved in preparing and undertaking appraisal. Participants reported that the time involved for training, sourcing and gathering evidence, preparing and completing the documentation and attending the appraisal interview was more than they anticipated. While, the timescale involved to collect the supportive information was reported as an obstacle, these may reduce as systems improve to provide the data requested. Over time appraisees and appraisers will gain more experience of and confidence in the process.

The GMC framework involves duplication of evidence and further work is required to streamline the process. Reporting on appraisals may also need to be simplified in terms of the forms involved.

### 3 Conclusions and Recommendations

#### Healthcare Improvement Scotland and NHS Highland concluded that:

- enhanced medical appraisal is an important part of providing public and professional assurance
- delivering a robust, credible and sustainable scheme will take time and we will learn from experience and develop and enhance the process
- support from administration, HR, clinical governance and IT is essential. This needs to be coordinated, risk assessed and managed and to report into NHS Board clinical governance committees
- Responsible Officers (RO) will need support, particularly where remediation is required as there is a risk in relation to the dual role of line management and RO; and
- the pragmatic approach taken in Scotland is a strength and is critical to successful implementation of enhanced medical appraisal. This approach does not in any way compromise the effectiveness of appraisal  
*“It’s a worthwhile process giving the opportunity for feedback and reflection. If the interview goes well it leads to an honest discussion about the appraisee’s relative strengths and weaknesses as well as their struggles.”*

#### Healthcare Improvement Scotland and NHS Highland recommends that:

- the GMC provides clarity and direction on what is required to demonstrate robust content, process and quality assurance of revalidation and enhanced medical appraisal
- the Royal Colleges need to be involved in defining and agreeing the information required as evidence
- there is a centrally coordinated robust selection and training process to make sure appraisers have the necessary skills and ability to appraise effectively and see beyond the paperwork and prevent the process becoming a ‘tick box’ exercise. The NHS Education Scotland scheme provides the model for this
- NHS Boards develop and provide routine reports on activity and outcome to underpin appraisal, using data already collected wherever possible
- NHS Boards report annually on the status of enhanced medical appraisal scheme taking a proportionate and risk based approach
- Healthcare Improvement Scotland carries out external quality assurance of enhanced medical appraisal

- Healthcare Improvement Scotland coordinate interaction with the GMC with the aim of providing them with consistent assurance, advice and information on readiness for revalidation; and
- the National Appraisal Leads Group should provide guidance for NHS Boards to advise appraisees on what is required from their participation in the process including guidance on adequate preparation which includes collection of evidence to the required quality and standard.

## 4 Recruitment and training for the Enhanced Medical Appraisal (EMA) pilot

### 4.1 Recruitment

The pilot recruited 21 volunteer consultants from across 13 specialties and a range of settings covering teaching, psychiatric and district general hospitals as well as a university. NHS Highland representatives are aware that this approach results in selection bias but it was expected that it would mean that attrition rates would be minimised. Interviewees had different drivers for being involved, for example:

*“When new proposals come along, it is important to engage with them and ensure that they are properly assessed. I wanted to give honest and robust feedback to ensure that the GMC and others like the SGHD and Healthcare Improvement Scotland understand the implications of the proposals.”*

The pilot ran alongside the original medical appraisal process and several appraisers continued with the “standard” medical appraisal as well as having their enhanced medical involvement. The recruits included both experienced “standard” medical appraisers and those who had never been an appraiser before. Volunteers were expected to participate both as an appraiser and as an appraisee in the pilot.

All those interviewed were clear from the written and oral communications that this was a pilot. However, there seems to be some confusion about what was expected from them and the degree of commitment that would be required to see it through.

### 4.2 Training

Each participant, whether they had been previously trained as an appraiser or not, was invited to attend one of two 1 day courses provided by NHS Education Scotland (NES). Those not able to attend the session were invited to take up a personal, informal session with the pilot lead.

Interviewees who attended the NES course were generally positive about the training session which involved a combination of theory and practice. The practical element comprised of videoed role-play whereby participants worked in groups of three taking on appraiser, appraisee and observer roles in turn. This included practice in dealing with people from other specialties. The main focus during the exercise was on developing appraiser probing and challenging skills.

There was some reference to guidance on what supporting information would be required as evidence. However, trainers didn't dwell on this but, rather, referred participants to GMC and Royal College materials.

The importance of training for appraisers was a recurring theme from interviewees and they stressed the need for EMA training to be mandatory in future.

## 5 Allocation of appraisees / appraisers

Under the standard Medical Appraisal (MA) system, appraisers selected their own appraisers. For the purpose of the pilot, the pilot lead undertook the process of matching appraisees and appraisers. Most interviewees indicated that they felt that allocation is better than a self-selection approach. However, most of those who prefer allocation would wish to retain a “refusal option” if they felt that they had been inappropriately matched, for whatever reason.

Views changed during the course of the training in terms of how matching should be done. At the outset, it would appear that most interviewees’ preference was to be appraised by someone from within their own specialty. Several now take a different view although it is not unanimous. The pilot tested both scenarios, with some appraisals being done within the specialty and others across specialties.

Another area where there were different views is the role of the doctor’s line manager and how the different elements that support revalidation are or should be linked.

*“I understand that the idea is that ‘support’ should be ‘off-line’ but I do struggle with how to separate enhanced appraisal from line management and the job planning process.”*

This debate reflects the need to be absolutely clear about the purpose of EMA within the whole process of holding doctors to account, as that ought to drive the decision about who should be the appraiser.

For the EMA pilot each appraiser was generally allocated only one appraisee. Interviewees are aware of the proposal that, under EMA, appraisers should be responsible for approximately ten appraisals. While some can see the advantages of that approach, others have concerns.

## 6 Resources to support the EMA process

The consultant contract's supporting professional activities (SPAs) reflect activities that are essential to the long-term maintenance of service quality but do not represent direct patient care. These activities include teaching, training, education, continued personal development (CPD), audit, appraisal, research, clinical management, clinical governance and service development. The 2003 consultant contract recommends two and a half SPAs in a ten programmed activity contract, with a higher proportion of SPAs for those working part-time.

### 6.1 Organisational support for the pilot

EMA is an SPA activity and NHS Highland made no time provision beyond the norm for appraisees / appraisers involved in the pilot.

NHS Highland provided the EMA with physical folders that contained the new appraisal documents developed by NHS Fife and the National Appraisers Lead Group. The appraisal documents were also made available on-line but not all participants were aware of this. Most interviewees accepted that, unless participants had easy access to a scanner, there would continue to be the need for some evidence to be held manually. Therefore their plea was for as much as possible to be done electronically.

NHS Highland also used SGHD pilot funding to provide administrative support to the project. The administrative support was part time (8-10 hours per week depending on the stage of the project) and involved managing queries about; the training, the multi-source feedback (MSF) process, the information required and the documentation. Most interviewees were unaware of any additional support for the pilot but did appreciate the input from the pilot lead and regarded him as their direct point of contact.

*"The pilot lead kept us informed through meetings and emails during the course of the pilot. If I'd had any issues and wanted to appeal about anything I would have gone to him."*

The organisation also arranged for appraisees to be automatically sent outputs relating to them from the existing complaints system and it commissioned the MSF work that was undertaken by a company recommended by the GMC.

### 6.2 The EMA process for appraisees

Appraisees are routinely responsible for the administration of their own appraisal documentation and ensuring that they are appraised annually to comply with future revalidation requirements. The key steps are:

- identifying, obtaining and collating their supporting information in their appraisal folder. A key difference for the EMA pilot was the requirement to provide feedback from approximately forty patients and twenty colleagues, (ie MSF)
- submitting their folder to their appraiser in a timely fashion
- undertaking the review meeting with their appraiser

- signing off the Form 4 with their appraiser after the meeting; and
- providing feedback on the process, including appraiser performance, to the pilot lead via the Form 5.

Most interviewees reported that they had completed their folder on their own but some had limited support. For example, with the distribution of MSF patient questionnaires from clinic receptionists or nursing staff.

### **6.3 The EMA process for appraisers**

Once trained, the key steps in the process for appraisers are:

- agreeing the appraisal date with the appraisee
- reviewing the appraisee's folder and preparing for the review meeting
- undertaking the review meeting with the appraisee
- obtaining agreement with the appraisee on the Form 4 and submitting it to medical staffing; and
- providing feedback on the process to the pilot lead via the Form 5.

While the expectation is that appraisees will submit "evidence" in advance, this does not always happen for a range of reasons.

Despite the responsibility being on the appraisee to ensure that they submit their folder and get appraised, appraisers can find themselves wasting time having to pursue their appraisee.

Interviewees expect that it will be mandatory for appraisees to provide "folders" to their appraiser at least 2 weeks in advance in future.

The need for appraisees to be able to share "folders" with their appraiser supports the case for a predominantly electronic approach.

### **6.4 Resources required from appraisees and appraisers**

It is impossible to identify accurately the level of commitment required for EMA from appraisees and appraisers because the consultants have not split their SPA sessions up to show it separately. However, the feedback is that it is more than the standard system because:

- it requires more supporting information to be submitted as evidence, e.g., as indicated above, MSF from colleagues and patients is a new requirement
- the interview itself is expected to take approximately two hours instead of one, as is expected under the standard system; and
- where matching is done across mixed specialties, it takes longer for appraisers to understand the different types of evidence.

*"Going through the MSF feedback took a long time this time around. But remember, it will usually only be required once in a 5 year cycle so we shouldn't take so long in other years. I really don't think that that's unreasonable."*

The feedback from those who completed their Form 5 is summarised in the NHS Highland Final Project Report<sup>4</sup> .

Timescales regarding preparation to be appraised, preparing to appraise a colleague and to attend appraisal interviews varied. The maximum time to prepare to appraise was 20 hours. Preparing to interview colleagues was reported to take up to a maximum of five hours with the maximum time for an appraisal interview being two and a half hours.

Some interviewees indicated that they expect to become quicker in their appraiser role as they become more experienced with the EMA process.

For the pilot, interviewees reported that they had no significant issues and were readily able to get agreement on signing off the Form 4s without the need to involve a third party. Even so, time is clearly an issue for all those concerned and this could be exacerbated if problems and issues arise during the process.

The feedback given indicates that the appraiser role, in particular, needs to be given a realistic time allocation to fully reflect the number of appraisees. It needs to be recorded as a separate entry as part of the consultant's job plan and monitored accordingly. This will be particularly important for those employed on the new consultant contract where the basic SPA is 1:10 instead of the previous 2.5:10.

## **6.5 Leadership / oversight of EMA**

NHS Highland's governance group was charged with formally overseeing the pilot project<sup>5</sup> and the RO confirmed that there would be an ongoing requirement for a steering group to oversee the process. NHS boards should, therefore, also take this into account when drawing up their resource plans for the process.

## **6.6 Impact on other professions / departments**

While most of the work relating to EMA falls on the consultants involved, there are also implications for other professions and departments. For example, there will be potential implications for:

- organisation leaders / senior managers involved in the steering / governance of the EMA process
- the procurement function in commissioning a suitable MSF system
- any receptionists / nurses involved at clinics in obtaining patient feedback through the administration of questionnaires
- the complaints function to provide information on each appraisee's involvement in any complaints
- the IT department in providing access to information systems such as activity information

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<sup>4</sup> Medical Revalidation in Scotland, Final Project Report, Enhanced Appraisal Pilot in NHS Highland, Sean Kelly, 2011

<sup>5</sup> Medical Revalidation in Scotland – appraisal pilot, NHS Highland, (PID) December 2009

- the clinical governance / risk management / patient safety functions in providing access to information systems covering clinical audits and clinical incident data; and
- the medical staffing function to ensure that the process runs smoothly in future in relation to training, matching appraisers and appraisees, access to appraisal documentation and guidance and maintaining outputs on a confidential basis.

As previously indicated, there was some but limited involvement from other professions / departments for the pilot. However, some interviewees reported that they had difficulty in delivering what was required from them.

Those responsible for the oversight of the process need to think about the future corporate resource requirement and not just in relation to the medical profession. In particular, support staff need to be involved in the planning and implementation of EMA to ensure that they can advise on what is available / possible and so that they can fully understand what is expected from them, by whom, and when.

## 7 Information

### 7.1 Supporting information

Interviewees confirmed that there is still confusion about the supporting information required to meet GMC and Royal College evidence requirements. The Royal Colleges are at different stages in terms of providing guidance to their members on this, so some interviewees indicated that they were in a better position than others in terms of knowing what will be expected of them.

Interviewees were also frustrated that the same evidence seems to be used to verify different elements of the process. This feedback would suggest that there is still scope for the GMC to streamline the process. However, some interviewees also made the point that, once information requirements are agreed, it should be easier in future. An overview of the feedback from interviewees is provided in Table 1.

**Table 1**

<b>Proposed information requirement</b>	<b>Response</b>
Your Job Plan	Interviewees reported no basic problems with providing this although not all interviewees had one signed off.
A full description of your clinical activities, <b>including</b> quantitative data e.g. <ul style="list-style-type: none"> <li>· OP/DC/EA/IP</li> <li>· procedures</li> <li>· prescribing</li> </ul>	<ul style="list-style-type: none"> <li>· NHS Highland does not have an IT infrastructure and e-systems in place that can routinely provide activity data for individual clinicians</li> <li>· The ability to provide quantitative data varies between specialties</li> <li>· Some clinicians collect their own activity data on simple spreadsheets on a voluntary basis</li> <li>· Systems that do exist are not always easily accessible / capable of analysis.</li> </ul>
A declaration about any events that might impact on your probity	Interviewees reported no basic problems with providing this information although not all interviewees were persuaded about the value of it.
A declaration about your health	Interviewees reported no basic problems with providing this information however, as above, not all interviewees were persuaded about the value of it.
A declaration about any complaints / significant clinical incidents that involved you	<ul style="list-style-type: none"> <li>· NHS Highland provided each appraisee with a list (or a nil return) of each entry that included their name in the complaints database; and</li> <li>· There does not appear to have been any equivalent information provided on clinical incidents.</li> </ul>
Evidence of your compliance with SPSP <sup>6</sup> requirements e.g.	This did not appear to feature high on anyone's list of information sources required for the pilot.
Evidence of your participation in audits	Interviewees reported that this could be provided from local and / or national audits.
Evidence of the scope of	Interviewees reported no basic problems with

<sup>6</sup> Scottish Patient Safety Programme

any private work you have undertaken	providing this although not all interviewees were persuaded about the value of it.
Evidence of your fitness to practice e.g. <ul style="list-style-type: none"> <li>· audit results</li> <li>· MSF results</li> </ul>	MSF was the major new information element required for the pilot and there are mixed views about the value of it. NHS Highland proposes to require it routinely once in year 2 or 3 of the revalidation cycle so that the appraisee has time to take on board any important messages. However, the timing would be flexible, with the board prepared to change the timing / frequency for an appraisee if issues suggest that this is required.
Your professional development plan	Interviewees reported no basic problems with providing this although not all interviewees were persuaded about the value of it.

As table 1 shows, the supporting information comes from a varied range of sources:

- patients and carers e.g. thank you cards and letters
- the appraisee eg CPD course information, local clinical audit data and self declarations; and
- the organisation via local or national information systems eg activity, complaints, incidents, national audits and MSF results.

## 7.2 Accessing supporting information

From an appraisee's point of view, some interviewees are not clear what local and national information systems exist, what data are held in them and what help they can expect from the organisation.

This is an issue that needs to be addressed if it is to continue to be up to individual clinicians to request relevant data from the organisation.

As previously indicated, some interviewees also have concerns about the timeliness of the information. More needs to be done to ensure that information systems and processes can produce outputs in accordance with the EMA timescale requirements.

The format of the data received from the organisation may also be an issue for the future. If this is a general problem, tackling this issue now could avoid problems further down the line.

From the appraiser's point of view, there is an access issue in that he/she only receives information directly from the appraisee. This leaves the appraisee in the driving seat for the EMA process and that is a concern for some.

## 7.3 Supporting decisions

The key issue about the supporting information is whether it is deemed sufficient to enable appraisers to feel confident about signing off the Form 4.

For the purposes of the pilot, appraisers indicated that they felt reasonably confident about making their judgement. However, they did report that they were doing so largely on the basis of knowing the individual rather than based on the EMA information supplied.

Most appraisers indicated that they did not let the lack of supporting evidence affect the outcome of the appraisal but this was not always the case.

## 8 Feedback / Quality Assurance (QA)

After the EMA appraisal meeting the appraiser and appraisee are required to agree and sign off the Form 4 before the appraiser sends it on to medical staffing. They also complete a feedback form, (Form 5), which was sent to the pilot lead.

Interviewees reported that they were unaware if any QA on the Form 4s had been undertaken as part of the EMA process. The RO and pilot lead indicated that confidentiality issues had impacted on the ability of the RO to delegate responsibility for QA for the pilot.

The key issue for the RO is whether the Form 4s provide sufficient assurance for him to feel able to make a positive recommendation to the GMC about the revalidation of an individual doctor. The RO and pilot lead have indicated that assurance depends on 2 key factors - the quality of the appraiser and the quality of the supporting information.

*“Well trained appraisers are vital. They need to be able to ask the right questions. This is supposed to be about reflective practise so, where there is an issue, the right question is about how the appraisee handled the situation and what they’ve learned for the future. This isn’t about performance management.”*

Last year the RO reviewed 10 Form 4s under the standard MA system and this took four to five hours per case. The outcome was that he sent three back because they were sub-optimal. The RO indicated that he has not formally reviewed the pilot documentation, from a brief look at those he has seen, they are an improvement on what has been submitted previously.

*“They seem to be more comprehensive, more thoughtful, there are more references to information and the information itself is better. They are also more strategic and talk more about future requirements. That may be down to a change in attitudes and the pilot selection bias rather than EMA requirements but it seems less like a tick box exercise and more robust than before.”*

The RO indicated that, given the heavy time commitment to review Form 4s and the supporting documentation, the QA process in future should rely more on quality assuring the appraisers and that there should be an explicit link to incidents.

The pilot lead and RO stated that they would favour having a secondary care lead appraiser to support the QA process otherwise the burden on the RO would be challenging. However, this requires clarity about what the RO can delegate and how to deal with confidentiality issues surrounding access to appraisees’ personal data.

The RO and pilot lead also indicated that more thought needs to be given to how to deal with an appraisee requiring remediation since the RO is not entirely independent of the EMA process. They reflected that when such cases arise, it may be better to manage them nationally rather than within the NHS board and that the Royal Colleges might have a role to play in such instances.

## **9 Barriers and Opportunities**

### **9.1 Overview**

The key barriers to success cited by interviewees were the lack of:

- clarity and agreement on the purpose of EMA
- clarity and agreement on the supporting information required as evidence
- access to sufficiently robust, good quality information and IT support; and
- time as well as the organisational culture.

The opportunities that need to be exploited are also inter-related and are frequently the “flip-side” of the barriers. For example:

- where the purpose of EMA is clear, this should help define the supporting information required to evidence revalidation
- clarity on the information required will help specify the Minimum Data Set (MDS) requirements
- understanding the MDS requirements will allow employers to identify and prioritise filling gaps in the data and show where to target IT investment; and
- having easy access to robust, relevant data produced as a by-product of delivering clinical services will support doctors and enhance the prospect of them being engaged in the process in a positive way.

### **9.2 Clarity of purpose**

It is clear that there are different expectations from the process from different groups and this poses a barrier to the successful delivery of revalidation. For example, some politicians, media and the public appear to be looking for a system that can identify and deal with “bad apples” such as Dr Shipman. Interviewees are unanimous that even an enhanced appraisal process will not and, indeed, could not be expected to deliver this.

The worry is that this confusion about purpose will result in a costly process that does not satisfy anyone’s expectations or requirements. It is imperative that all stakeholders work together to clarify the purpose of the process and to achieve a shared agenda. That means there needs to be an effective communications strategy that shows clearly how EMA links particularly with clinical governance and performance assessment /management and how all these different elements contribute to the revalidation process.

### **9.3 Clarity on the supporting information required as evidence**

Frustration about the lack of clarity on the supporting information required as evidence is palpable in feedback from interviewees. Stakeholder leaders need to collectively resolve this issue and then to communicate the outcome to all those involved in the process.

## 9.4 Information and IT

Lack of access to sufficiently robust, good quality information and IT was a recurring theme from interviewees.

Employing organisations need to take the opportunity to:

- implement the proposed secondary care e-solution<sup>7</sup> to administer and manage the EMA as soon as it becomes available
- liaise with NHS National Services Scotland's Information Services Division about the contribution that national data sets can make to the EMA agenda
- review their current local information systems and
  - make clear what information can be provided by the organisation and give clear guidelines about how to access it
  - identify and prioritise gaps, e.g. the development of hospital dashboards (covering activity, efficiency and outcomes) that provides audit results as a by-product; and
  - draw up resource / investment plans to implement solutions to support the process.

## 9.5 Timescales

Interviewees agreed unanimously that lack of time is a barrier to success and that the opportunity cost of the process is substantial. Potential opportunities for the organisation to ease time pressures include:

- using IT to full effect, eg
  - by providing the facility to maintain e-folders through the secondary care version of SOAR
  - by making scanners more readily accessible
  - by supporting remote appraisals where individuals are comfortable with this approach and where telecommunications are sufficiently robust
- providing more data automatically to EMA participants
- allocating appraisers for 3 years which is deemed long enough to develop a relationship and an understanding of the appraisee's work but not too long to encourage collusion
- use retired consultants as appraisers to reduce the pressure on clinical services that could impact adversely on waiting lists and waiting times; and
- phasing of appraisals to stop "bunching" at the end of the calendar year, subject to the supporting information being available to achieve this.

## 9.6 Culture

Several interviewees highlighted cultural barriers, in particular:

- lack of buy-in from professionals who do not see it as being fit for purpose

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<sup>7</sup> NES is responsible for commissioning an extension to the existing primary care (SOAR) system to cover secondary care.

- fear of the process
- lack of trust / common goals between clinicians and managers; and
- a current negative political environment.

Despite these cultural barriers, some interviewees also drew attention to changing attitudes that the GMC and other stakeholder leaders need to build on to positively engage clinicians.

*“There is a growing acceptance that relicensing is here to stay and that it needs some probing / searching system to underpin it.”*

### Desktop review sources

Consultants' Contract: Annual Appraisal

For Consultants, PCS (DD)2001/2

[http://www.sehd.scot.nhs.uk/pcs/PCS\(DD\)2001\(2\).pdf](http://www.sehd.scot.nhs.uk/pcs/PCS(DD)2001(2).pdf)

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### **Letter**

Update on new developments – GMC, 14 December 2010

Healthcare Improvement Scotland is grateful to all of the interviewees for their full and frank input this EQA review.

### Interviewees

Dr Ian Bashford, Medical Director, NHS Highland

Dr Karen Blagden, Consultant Psychiatrist, New Craigs Hospital

Mr Ron Coggins, General Surgeon, Raigmore Hospital

Dr Fergusson, Consultant Psychiatrist/Clinical Director Argyll & Bute Hospital, Lochgilphead

Mr David Finlayson, Consultant Orthopaedic Surgeon, Raigmore Hospital

Professor David Godden, Centre for Rural Health, Raigmore Hospital

Dr Rod Harvey, Consultant Physician, Raigmore Hospital

Dr Alistair Hay, Consultant Psychiatrist, New Craigs Hospital

Mr Sean Kelly, Consultant Orthopaedic Surgeon / Pilot Lead, Raigmore Hospital

Dr Steven Leslie, Consultant Cardiologist, Raigmore Hospital

Dr Robert Peel, Consultant Renal Physician, Dr Peel Office, Renal Unit

Ms Donna Tabua, Senior Medical Staffing Officer

Dr James Vestey, Consultant Dermatologist, Raigmore Hospital

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The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Intercollegiate Guidelines Network (SIGN) and the Scottish Medicines Consortium are key components of our organisation.

