READY
STEADY
REVALIDATE

Taking Stock of Readiness for Medical Revalidation in Scotland

October 2010
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We would also like to thank Martin Shelley and the NHS (England) Revalidation Support Team who developed the Assuring the Quality of Medical Appraisal for Revalidation (AQMAR) tool. This was a source of guidance throughout this study.

A number of quotes provided during the interviews have been used throughout the report appendices to provide examples of key points. There was considerable consensus among those participating.
Executive summary

This report aims to present a clear and up-to-date view of the current status, and associated challenges, of medical appraisal (MA) in Scotland.

Approach

A combined approach was adopted in undertaking this scoping exercise. This included:

- analysis of routine data and relevant materials to obtain background information
- development of a semi-structured interview schedule based on the 4 high level AQMAR indicators (to reflect NHS board annual reporting requirements)
- undertaking interviews with representatives from a sample of NHS boards and other key stakeholders.

Four NHS boards (NHS Fife, NHS Grampian, NHS Greater Glasgow and Clyde, and NHS Shetland) were selected to participate in the scoping exercise to achieve cross-sectional representation of NHSScotland in terms of geography, size and perceived readiness for revalidation. The core interviewees were medical directors, directors of human resources and heads of clinical governance, or their representatives, to get a full and rich perspective on medical appraisal and their organisation’s readiness for revalidation.

In addition to interviewing the four NHS boards, interviews were also carried out with key stakeholder groups involved in medical appraisal and revalidation to establish their current activities in relation to revalidation.

Key messages

Summary: We found that NHSScotland is:

- **Well poised for revalidation**
  
  NHSScotland has made steady progress in setting up the necessary infrastructure at national and local levels to support readiness for revalidation. The combined approach taken to this review was particularly welcomed. While there is still much work to be done to fully satisfy the requirements, we found that **NHSScotland is near the UK forefront in terms of preparedness for revalidation**.

- **Enthusiastic and committed**
  
  We found good evidence that there is a willingness and enthusiasm for implementing revalidation arrangements. This is contrast to the position 4 years ago when there were still significant concerns about the approach and its implementation.
- **Keen to move forward**

All those involved in revalidation are very aware that the timescales are critical and narrowing. This is particularly important if we are to maintain momentum in terms of public assurance and local adoption. While none of the NHS boards involved in this scoping exercise expressed the view that their NHS board is fully ready for revalidation, there was a clear desire to progress with the process. Central to this is the need for the General Medical Council (GMC) to press ahead with setting a firm timetable for implementation.

**Key discussion points**

Two key discussion points came up at every stage and these are explored in greater detail in the body of the report. We have highlighted the main associated points below.

- **Nature of medical appraisal**

There is an ongoing debate about whether medical appraisal is predominantly concerned with an individual’s personal development or about performance management. The general trend in opinion is towards the latter and even those who have previously viewed it as a formative process acknowledge and accept that in the new environment there needs to be a link between the two. The consensus is that the previous tendency for medical appraisal to be simply an informal discussion is not tenable.

- **Maintaining momentum**

Local activities in relation to training and support systems have largely been deferred pending the outcome of national activities. NHS boards are also looking to the GMC, the Royal Colleges and the SGHD to take a lead on addressing a number of grey areas such as:

- how to resolve the tension between the British Medical Association (BMA) and some appraisers’ concerns around the confidentiality of a doctor’s appraisal documentation
- ensuring that Responsible Officers (RO) are sufficiently equipped to be able to make a revalidation recommendation
- how to deal with locums and private practitioners, and
- clarification on what evidence the GMC and the Royal Colleges are going to deem as being adequate to allow relicensing and recertification.
Next steps

NHS QIS will:

- finalise the assessment tool (based on the AQMAR tool and prepared in collaboration with stakeholders)
- pilot the finalised assessment tool
- develop an external quality assurance (EQA) model to support ROs in their assessment of the readiness of NHS board arrangements for the development and implementation of medical appraisal, and
- support the introduction of clinical indicators for appraisal portfolios.

NES will:

- prepare and implement a national training programme for Secondary Care Appraisers, and
- take forward the development of an electronic system to support Secondary Care Appraisal based on a development of the Scottish Online Appraisal Resource (SOAR) database.

SGHD will:

- continue to refine the tools and guidance necessary to support appraisal
- continue to work in partnership with the BMA to address any ongoing concerns
- facilitate customised training of ROs, in response to the identification of training needs, in preparation for their statutory roles in Scotland
- facilitate understanding of statutory guidance for ROs from the Department of Health (DH)
- facilitate implementation in Scotland of medical revalidation once the GMC decides on a way forward following analysis of outputs from their public consultation, and
- consider the outputs from the NHS Highland pilot on appraisal to assess implications and learning points.
1 Introduction

Background

NHS QIS’ vision is of an NHS that achieves excellence in the care of every patient every time. It leads on the use of knowledge to promote improvement in the quality of healthcare for the people of Scotland and performs three key functions:

- providing advice and guidance on effective clinical practice, including setting standards
- driving and supporting implementation of improvements in quality, and
- assessing the performance of the NHS, reporting and publishing the findings.

Clinical governance and patient safety are core elements of each of these functions and NHS QIS has overall responsibility for co-ordinating both dimensions in NHSScotland. It is within this context that we are working closely with NHS boards and the SGHD to support the preparation for and implementation of medical revalidation.

Medical revalidation – What is it?

In February 2007, the UK Government published a White Paper; ‘Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st 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”.

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

The process of revalidation is a 5-year continuous process rather than a single event. The 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”.

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2 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).

3 http://www.scotland.gov.uk/topics/Health/NHS-Scotland/paper
Medical revalidation is evidence of fitness to practise medicine. It provides an assurance that all practising doctors are licensed, up to date and working to the necessary professional standards. Revalidation is core to continual improvement of patient care.

**The revalidation model – how will it work?**

The legislation underpinning revalidation is a matter for Westminster, as the regulation of doctors is a reserved matter. As required by the Health and Social Care Act 2008, the Secretary of State for Health consulted the Scottish Ministers before laying the Medical Profession (Responsible Officers) Regulations 2010 before Westminster in July. These regulations prescribe which organisations are required to have ROs, and RO duties and functions relevant to evaluating the fitness to practise of medical practitioners. This will feed in to the revalidation process. Subject to due Parliamentary process, these Regulations will come into operation on 1 January 2011, and from that date, all designated organisations will be statutorily required to appoint an RO. The Regulations and associated guidance have been published on the Department of Health website.

In Scotland, it is planned that the NHS board executive medical director will be appointed as the RO and maintain overall accountability for revalidation, although they may delegate individual tasks. Normally each doctor will only have one RO and will be expected to link with the RO in the area where they undertake the majority of their clinical work.

**General Medical Council**

The GMC is the independent regulator for doctors in the UK. Its purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. It does this by; controlling entry to and maintaining a list of registered and licensed medical practitioners; setting the educational standards for medical school; determining the principles and values that underpin good medical practice; and taking firm action against doctors’ registration where standards of good medical practice have not been met.
The GMC has illustrated the revalidation process as follows:

NHS Education for Scotland

NHS Education for Scotland (NES) has been funded by the SGHD to support a national approach to GP appraisal since 2003. This had been successful in ensuring that all GPs have a robust annual appraisal and that GP appraisals are carried out to a similar standard across Scotland. Factors which have contributed to this success are: assessed national training of appraisers; ongoing support and quality assurance of appraisers by Board appointed GP appraisal leads; regular local meetings of appraisers including an ongoing training element; and nationally organised training events for experienced appraisers, some of which include a quality assurance function. All of this means that GP appraisal is well placed to support medical revalidation and undertake further training with GP appraisers linked to the specialist standards being developed by the Royal College of General Practitioners (RCGP) and the GMC. The SOAR database has also provided NHS boards with an invaluable tool in managing the administration of appraisals and supported them in tracking which GPs require an appraisal in any given year. This will be an important tool to support ROs with their responsibilities for revalidation in the future.
With regard to support for revalidation for secondary care doctors, NES has only recently become involved in this area, undertaking pilot appraiser training for secondary care doctors from January to May this year. The results of the pilot have been disseminated in a final report which was shared with the National Appraisal Leads Group in July 2010. The main recommendations from the pilot were that NES be given a mandate by the Scottish Government and NHS boards to take forward a national training programme for secondary care appraisers and that NES be given authority and resources to take forward the development of an electronic system to support secondary care appraisal based on a development of the SOAR database. The SGHD have agreed to both these recommendations in principle and discussions are currently under way regarding funding for NES to implement them over the next 2 years.

Implementing revalidation in Scotland

The main vehicle for delivering the GMC’s revalidation requirements is medical appraisal.

Appraisal has been mandatory for NHS consultants since April 2001 and career grade doctors since April 2002. For medical appraisal to successfully support revalidation, we need to know:

- the status of existing medical appraisal systems across NHSScotland to determine whether they are sufficiently robust for ROs to use for revalidation
- their strengths and weaknesses, and
- the actions and resources required at local and national level so that NHS boards can meet their legal obligations.

The quality of medical appraisal varies across organisations throughout the UK. The GMC (as licensing body) needs an assurance that systems and processes are sufficiently robust to support revalidation. This is described as a ‘Statement of Readiness’.

At a local level, NHS boards need to assure themselves about their organisation’s readiness for revalidation. An important component of an NHS board’s internal assurance is its annual report on medical appraisal which all NHS boards are required to produce and submit to their governance committees.

The purpose of the annual report is three-fold:

- to give a clear signal to NHS boards about the forthcoming implementation of revalidation and the need to make sure that it is properly managed and governed
- to allow NHS boards to identify areas that require development, and define action plans with timescales and priorities, and
- to highlight issues that may need to be addressed at national level.

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4 Doctors in training are managed by PMETB and NES arrangements.
In future, it may be beneficial that annual reports are produced in line with the four high level indicators developed for AQMAR, covering:

- organisation ethos
- appraiser selection
- appraisal discussion, and
- system infrastructure.

Each of these domains is supported by a series of criteria against which compliance can be assessed.

EQA is also required and, in Scotland, NHS QIS is responsible for assessing whether the necessary components of medical appraisal are currently developed, implemented and embedded in local systems at national level to enable the roll-out of revalidation. NHS QIS will report to SGHD on the ‘readiness for revalidation’ in NHSScotland.
2 The current position

NHS board readiness

The pertinent issue for NHS boards is whether they believe their systems are currently equipped to support revalidation. There were varying responses, however, the general consensus was that further development is required before the NHS boards will be in a position to effectively support revalidation.

"As ready as anyone else – there’s safety in numbers! But there’s a lot of confusion and anxiety about the whole thing. The GMC need to be more explicit about what they want – but do they know themselves?"

"No, but I find the GMC’s position really strange that they’ll not come until we tell them we are ready….."

Challenges

Interviewees raised a number of challenges facing the NHS boards that need to be addressed, many of which have already been raised in this report. However, in summary, the key issues are:

- Grey areas
  Specifically, further clarity is required around the issues of:
  
  - *The purpose of the appraisal and revalidation process*
    
    Is revalidation concerned with finding bad apples or continuous improvement? The real danger is that it achieves neither and results in alienation. Several interviewees see this as Shipman driven and they worry that there is a lack of realism about what medical appraisal can achieve and a failure to manage the public’s expectations.

  - *What is now required from medical appraisal?*
    
    What will the change to enhanced/strengthened medical appraisal mean?
    
    How can NHS boards effectively quality assure a confidential process?
    
    - How will the appraisal and revalidation of non-NHS board employees, such as locums and high street practitioners, be managed?
      
      Several interviewees expressed the need for a national register or national bank for locum doctors.
    
    - What information and evidence will be required from the GMC and the Royal Colleges?
How can NHS boards ensure the availability of sufficiently robust data to support the appraisal process?

- **Willingness and ability of individuals involved**

  The issues raised around this area relate to:
  
  - **Appraisees**
    Appraisal needs to demonstrate its value to avoid being seen as a management tick box exercise.
  
  - **Appraisers**
    Consideration will need to be given as to how NHS boards can recruit and maintain the number of appraisers required for secondary care.

- **Resources**

  The main issues raised were in relation to the funding for training and the support system.

- **Skills of the appraisers and how to deliver education and training**

  The main challenge is to ensure that national standards are agreed and achieved and that, given the funding constraints, a proportionate approach is taken to training.

- **Standardised system to support the management of medical appraisal**

  This is seen as an urgent requirement to be able to support the process from data capture right through to analysis and outputs (e.g., the annual report) and it needs an agreed minimum data set and standard definitions.

- **Communications**

  Given the size of the agenda and the range of groups involved, the challenge is to ensure that sufficiently comprehensive and consistent messages get to those responsible for managing the system. NHS boards require substantive information to drive the system forward.

- **Timescales**

  Interviewees have real concerns around the timescales involved around the following issues.

  - Relicensing has set the revalidation clock ticking and the first round is due in 2011 but they don’t see the GMC giving a lead on taking it forward.
  - Pilots designed to answer some of their questions are not due to complete until December 2010.
  - The 2010 general election may impact on legislation
  - EU procurement rules will have an impact on getting a support system in place.
  - Some believe there is too much idealism and that areas such as the evidence requirements are going too far too soon. They would prefer a simpler approach and regard this as work in progress.
The Department of Health has now confirmed that the piloting period will now been extended for a further year.

Opportunities

Despite the identified challenges, interviewees viewed the process positively and highlighted a number of important opportunities that medical appraisal can deliver.

- Drive up standards and make a difference to patients by giving doctors the opportunity to genuinely reflect and get feedback on their work.
- Change the culture to reflect the new environment and to persuade appraisees and the BMA that this protects doctors and will allow them to get support if and when it is required.
- Ensure explicit links between Specific, Measurable, Realistic and Timed (SMART) objectives and Personal Development Plans (PDP), and service requirements and job plans.
- Identify doctors who are not able to provide adequate evidence to give assurance about their fitness to practise.
Appendix 1: Detailed findings

1.1 Organisation ethos

The requirement

The AQMAR process requires assurance that there is “unequivocal commitment from the highest levels of the responsible organisation to deliver a quality assured system of appraisal in support of revalidation that is fully integrated with local clinical governance systems.”

1.2 Leadership

All those interviewed were clear about the requirement for strong leadership in this process. They accept that the executive medical director will most likely become the NHS board RO, with accountability for both primary and secondary care once the legislation becomes effective.

One interviewee summed up the RO’s role:

“I see it almost like being a ring-master bringing all the elements together – objectives, job plans, medical appraisal and PDPs, all of which should feed each other”

In practice, the executive medical director often delegates some areas of responsibility for medical appraisal and this varies from NHS board to NHS board. All three of the larger NHS boards interviewed had a committee to oversee the process. In one NHS board, this committee has now been dissolved. Medical appraisal is currently being managed in line with clinical governance structures, although the committee is expected to be re-instigated under new arrangements. In the remaining two NHS boards which have maintained these committees, the groups now also have job planning in their remit.

What is recognised is that there needs to be a clear link from the chief executive and RO to the appraisee whether or not the medical appraisal is being undertaken by the appraisee’s line manager.

1.3 Support

Administrative support for the process is mainly provided from within the clinical and medical management structures. The current involvement of human resources (HR) is variable across the NHS boards. However, now it has been accepted that medical appraisal underpins revalidation, HR departments are becoming more involved in the process. Notably, they are providing support for training and in establishing and managing the links between medical appraisal and performance.

“We’ve been involved for about the past 5 years. We’re seen as being supportive especially in relation to education and training”
Directors of HR haven’t had this at the top of our agenda. We all know it is coming but….. We weren’t involved at first – initially medical appraisal was kept separate from management processes and not linked to the organisation’s objectives. That needs to change.

1.4 Governance

The main mechanism for reporting on medical appraisal is the annual report. Three out of the four NHS boards involved in the scoping exercise produced an annual report for 2008/2009 and each generally followed the format outlined in AQMAR. However, the format and the level of detail contained in each report varied, and therefore, further work is required to develop a simple and straightforward report template. As one interviewee noted:

“I don’t think that the (annual) report is necessarily very helpful as it stands. It’s largely limited to a numerical exercise so it needs to be extended to include quality measures.”

The fourth NHS board had not yet produced a formal annual report although in February 2010 the medical director had undertaken a Board information seminar covering revalidation so that members of the Board were aware of the current position and requirements.

Generally, there was some confusion within organisations about what information exactly had been compiled and where it had been sent. Locally and centrally there needs to be a clear understanding about what is reported, the feedback and response required, and subsequent action and outcomes.

For future reporting, interviewees recognised the need for a formal annual report to be presented to the Board. It is likely this will go to the Board via one of its standing governance committees. At present, the standing committee that the NHS boards currently feed updates into is the clinical governance committee (CGC) however, there is not universal agreement on which group the annual report should be fed into.

“Medical appraisal reports get discussed at the Medical Workforce Strategy Group to ensure that appropriate links are made with clinical governance systems. It’s on the CGC radar at the moment but I would want to see this going to Staff Governance. That’s where all staffing matters should be addressed. Why should doctors be any different?”

Despite the debate around which group the annual report should be fed into, there was general agreement that it should be a substantive item on the relevant committee’s agenda and that any issues would be highlighted to the Board through a locally agreed mechanism. This might be through the committee minutes, the committee chair’s oral report or a letter.

While the interviewees expressed their intentions about future reporting, not all NHS boards have been briefed on this and there was some confusion within organisations about what exactly has gone where to date. For example, there were conflicting views about whether the annual report had actually gone to the
CGC in one NHS board and, in another, whether copies have actually been sent to the staff governance committee. Clearly there is still work to be done to ensure that good intentions are fully implemented and that Board members are sufficiently appraised of the issues involved.

Two of the NHS boards have specific policies and procedures to underpin the medical appraisal process and one has local guidance which covers broadly the same ground. While they are presented differently, they each cover the same key areas including: outlining the requirement for medical appraisal; scope, aims and responsibilities; organisational links and structures; and detail the appraisal process itself.

1.5 Action plans

Two of the three annual reports identified objectives and actions for the coming year. In summary these included actions such as: quality assuring appraisal; improving integration between appraisal and clinical governance; undertaking awareness raising sessions; increasing the quality of Form 4s (a Form 4 is designed to provide an agreed summary of the appraisal discussion including an assessment of the adequacy of the evidence submitted; agreed actions; and a PDP, establishing feedback to appraisees and appraisers on the quality of the process; a review of appraisers; and incorporating national guidance into appraisal systems as it becomes available.

In addition, one NHS board reported that it maintains a detailed action plan covering AQMAR’s four high level indicators. This includes: an assessment of its current position against each criterion and lists any action required; the timescales for addressing the action; and the individual responsible. This allows the NHS board to see “at a glance” its self-assessed state of readiness. Another of the NHS boards also had an action plan which details: actions undertaken; current status; and next steps.

1.6 Internal quality assurance

The need for internal quality assurance was generally recognised by interviewees, however, to date none of the NHS boards have made much progress on this.

So far none of the NHS boards have involved internal audit in reviewing their arrangements for medical appraisal. While several interviewees recognised that this could be a useful element, they did also highlight its limitations:

“\textit{I don't have a problem with it but we need quality assurance to cover not just process but also content and outcomes so internal audit on their own wouldn't be enough.}”

In terms of quality assurance, interviewees agreed that much will depend on the quality of the content included in Form 4s. However, some concerns were expressed about their current quality:
What appears on the Form 4 is vital along with agreed quality criteria. For example we need to know: Were the right issues discussed? Have they looked at the quantitative and qualitative evidence that’s available? Is there a PDP in place?

We need to be able to tell whether there was a robust discussion or whether it was a cosy chat

The main difficulties surrounding quality assuring the medical appraisal forms are confidentiality and concerns about how the BMA and their members will respond to this. For example, one NHS board drafted plans for quality assuring the process, proposing that this should cover:

- the organisation (process) of appraisal – proposed measures included number of appraisers, ratio of appraisers to appraisees and number of new appraisers trained per year
- content of individual appraisals – the proposal was to review 20 randomly selected appraisal folders per year and independently assess them against agreed criteria, and
- outcome of appraisals – the proposal was to have all participants completing feedback forms and identifying common development needs to ensure that these were linked to corporate learning plans.

However this was rejected locally by the BMA because the focus was on “management measures” whereas the BMA still views this as a peer review process that should be focused on the appraisee’s personal development. Consequently, the NHS board in question took it off the agenda and is monitoring the situation to see what happens nationally.

Despite this, two NHS boards had attempted limited quality assurance by reviewing Form 4. The first NHS board carried this out by scrutinising 100 random Form 4’s against each of the Good Medical Practice\(^\text{5}\) domains. Relevant evidence was submitted for each domain and actions agreed. The NHS board reported that the findings were better than anticipated. The results showed that 80% of doctors would have been given a positive recommendation for revalidation with no further scrutiny required.

The second NHS board’s quality assurance was more limited. It involved an analysis of every appraisal that was carried out over a yearly period and looked at whether the forms had been completed, signed by both the appraiser and appraisee, and whether they were dated. This resulted in a ‘quality score’ of around three out of five.

From discussions around quality assurance, it became clear that there is an urgent need to get stakeholder agreement on the fundamental issue of what is the purpose of medical appraisal now that it is the central pillar supporting

\(^{5}\text{Good Medical Practice: http://www.gmc-uk.org/guidance/good_medical_practice/contents.asp}\)
revalidation, and how it needs to link with other areas such as job planning and PDPs.

"The basic issue is around what appraisal is for – is it about an individual’s development or is it about performance?"

"Medical appraisal should be about better governance resulting in better quality of care and better outcomes for patients. Politicians aren’t serving the public well when they promote that it’s about finding ‘bad apples’"

"Medical management will have to be more involved with a mechanism to identify emerging problems so that they can advise the RO. This needs to be dealt with through leadership training and getting a shared vision about how to deal with doctors who need support"

1.7 Links with other Quality Assurance systems

Interviewees from all the NHS boards were able to point to a range of systems that could already be developed or used to inform the medical appraisal process by providing supporting evidence. These could include activity and productivity data, clinical audits, outcome data, critical incidence data, SIGN guideline implementation, compliance with standards, complaints and patient feedback data, 360 degree feedback from colleagues and patient safety review. However, interviewees reported that there is some way to go to ensure the proper systems and links are made and that the data are used effectively:

"There’s a lot of potentially useful national and local data out there – the problem is that these aren’t sophisticated enough, sufficiently joined up and stored in a useful way. Take complaints – these are stored by patient name not by clinician or clinical team"

"We have a big opportunity to help doctors improve their quality of care by providing them with the data they need so that they don’t have to source it themselves. Our aim is to have a set of triangulated data, fully accepted by clinicians and, as a default, given with their consent and enthusiasm to both parties to support medical appraisal. The evidence also has to contain nil returns for example, for complaints and critical incidents. Of course people will challenge the quality of the data but if it’s part of their medical appraisal evidence clinicians will have an interest in its quality and therefore in its input. The data will get cleaned up"
1.8 Resources

None of the NHS boards were able to quantify specific resources for medical appraisal and interviewees now accept it simply as “part of the day job” in secondary care. Appraisal is seen as a core activity for both consultant and career grades. For example, at present consultants have 2.5 supported professional activities (SPA) sessions and this is expected to cover their own appraisal and continuing professional development (CPD) needs plus any teaching, clinical audit and appraiser activities. They are then expected to reflect this in their job plan to demonstrate how they have used their SPA. However, in future, for new consultants the 2.5 will not be automatic – they will get 1.0 session and then will have to negotiate any additional time for relevant activities like being an appraiser as part of their job plan. Medical administration and HR support has also tended to be drawn from existing budgets. Resources are viewed as limited for all, but in particular there is a view that appraisers may end up doing a considerable amount of work in their own time.

“It’s important that people don’t leave it all to the very end – they need to get into the habit of collecting evidence as they go. That way it won’t be so much of a burden.”

Concerns were also raised about the equity of the existing arrangements for resourcing PDPs.

All NHS boards expect their staff to be able to get electronic access to the relevant forms for completion whether from the NHS boards’ intranet or direct from the GMC website. Staff are expected to maintain their own portfolio and no interviewees reported any serious access problems. One interviewee summed it up:

“Some might find it more difficult than others to access forms but there’s no substantive problem. The real issue is the absence of a support system to manage the process.”

In summary, NHS boards are aware of the need for commitment, but there is some way to go before medical appraisal can be considered to be embedded at local level, with adequate quality assurance and integration with local clinical governance systems.
Learning points

- Formal, structured committee in place to support executive medical directors in their RO roles.

- Clear links between CEOs and ROs regarding appraiser status and relationship to appraisee (e.g., line manager or not).

- The role of HR departments in supporting the process in providing training and establishing and managing the links between medical appraisal and performance.

- Mechanism for reporting on medical appraisal in NHS board annual reports as well-defined guidance on what level of detail needs to be reported, the feedback and response required, and subsequent action and outcomes.

- Formal dissemination for annual report to include the Board, clinical and staff governance committees.

- Having a robust action plan covering AQMAR’s four high level indicators, including: an assessment of the NHS board’s current position against each criterion, as well as action lists, individuals responsible and timescales for addressing the action. Current status and next steps would provide NHS boards with an instant position of their current status of readiness for revalidation.

- Importance of internal quality assurance systems of audit to support NHS boards when reviewing arrangements for medical appraisal.

- Stakeholder engagement and agreement to support quality assurance processes regarding content and outcome of appraisals.

- Urgent need to achieve stakeholder agreement on the purpose of medical appraisal now that it is seen as underpinning revalidation and how this needs to link to other areas such as job planning and PDPs.

- Importance for recognition of resource throughout medical administration and HR budgets to support appraisers in their role to avoid appraisers having to use their own time.
Appendix 2: Appraiser selection

The requirement

The AQMAR process requires assurance that “The responsible organisation has a process for selection of appraisers. Appraisers undertake initial training and their skills are reviewed and developed”.

Meeting the NHS board’s requirements for appraisers

The number of appraisers required depends on the size of the NHS board and how many appraisals each appraiser undertakes.

The ratios in secondary care are much lower than in primary care where it tends to be 1:22. There are contrasting views on this.

No one reported a significant shortage of appraisers to date, but there is a general opinion that this could change as the appraisal system moves from being a supportive, formative process to one linked to performance management and therefore involving a greater element of judgement. Interviewees expressed this as follows:

“We may have to think again since we have recast the purpose of medical appraisal. The original appraisers tend to be interested in education rather than performance appraisal. They may not be willing to carry on under the new environment.”

Appraiser selection

There is some disparity between primary and secondary care appraiser roles. In primary care, appraisers are volunteers with a proven aptitude for the appraisal role. In secondary care it tends to be “part of the day job” for clinical directors and clinical leads, although there are still some employees doing this on a voluntary basis.

“It’s basically a line management process. We had a problem a few years ago because a doctor insisted on being appraised by an individual in their sub-specialty. They agreed things in the development plan that didn’t match the organisation’s service needs and quite simply couldn’t be funded. It’s meaningless unless the medical appraisal and the job plan are linked. We have to accept that there is a tension sometimes between what the individual wants to do for their own development and what the service needs.”
There is an ongoing debate on whether the appraiser should be the doctor’s line manager. There are also differences of opinion about whether the appraiser should come from the same specialty or sub-specialty, although the general consensus was that this was not viewed as a big issue. Whoever ultimately carries out the appraisal, there was general acceptance among interviewees that medical appraisal must be sufficiently robust and explicitly linked with job planning.

“If you go too far down the route of having to be reviewed by someone in your sub-specialty you get into “You appraise me and I appraise you” situations that are inappropriate.”

“At the moment your medical appraisal can be done by anybody not necessarily your line manager or it can even be done by someone outside your organisation. We need to stop running parallel job planning and medical appraisal systems and have the line manager responsible for the whole thing.”

Appraiser training

In contrast to the national primary care approach where appraisal training is developed and delivered nationally by NES, appraisal training for secondary care has always been a local NHS board responsibility. The larger organisations have all developed and delivered courses for both appraisers and appraisees.

“We provide training to appraisers and appraisee’s but its pretty short – something like half a day. Appraiser training is expected but not mandatory at the moment.”

However, the SGHD have tasked NES to develop and undertake national training pilots for secondary care and, as a result, any local initiatives tend to be on hold for the time being. In view of budget constraints, NES has developed its secondary care appraisal training differently from its existing primary care courses. The primary care course currently runs over 3 days, but for secondary care training it is 1 day for experienced appraisers and 2 days for new appraisers. NES has also held a selection event for prospective tutors who will be responsible for delivering the training in future. The current cohort of tutors is approximately 14, supplemented by a number of GPs. NES has actively attempted to get a spread from across NHSScotland, however there is an awareness that there has been no involvement in the process from any of the island NHS boards. Future funding is uncertain and will dictate what is achievable in the future. Pilots were funded by NES from its existing budget, with NHS boards contributing by releasing their staff and funding travel and subsistence.
Generally, interviewees welcomed this national approach but there were also some concerns:

“We’ve developed local courses for secondary care but we’re not progressing them because of the NES pilots. I accept that training is required but there’s no point comparing it with the GP approach as we simply don’t have the resource. There’s a real opportunity cost so we need to be sure that the content and the time it takes is worth it. We’ll review the situation when our people come back from the pilot courses.”

“It’s crucial that NES pick up the training to ensure consistency across Scotland. Their primary care training has been a success – it’s a pity that they didn’t pick up on secondary care as quickly. My preference is that NES not only develop the materials but that they also deliver the courses – that’s the only way to achieve consistency.”

“I’m a bit sceptical about national initiatives like this. The ideal for us would be an ability to tap into NES resources for developing materials and for NES to quality assurance courses run locally because we need to closely align training to local board requirements. I would like more of a partnership approach.”

In terms of the pilots, it is still early days but NES reports that of the 18 people booked onto one course, five dropped out before it started “because of service requirements” and the course finally ran with 10 people. This does raise questions about the priority that prospective attendees and their NHS boards attach to training. It is perhaps worth noting this is in stark contrast to primary care whereby the role of an appraiser is a separate job for which they get paid and the fall-out rate is very low.

**Indemnifying appraisers**

Some interviewees have started to consider the risks associated with medical appraisal and revalidation recommendations. For example, they can see ROs and appraisers being held to account if someone that they have appraised and/or recommended for revalidation is subsequently found not to be fit for practise. Alternatively, there are concerns that if an RO does not make a positive recommendation for revalidation, they may be challenged by the doctor in question.

“What does my signature actually mean? Am I indemnified and if so when does it kick in? If there’s another Shipman do I appear in court too if I’ve signed his revalidation form?”

“Our appraisers will be covered by our employer’s liability in relation to dealing with our NHS board appraisees. I haven’t thought about how that works if they appraise any non-employees.”
Monitoring/developing appraiser performance

In terms of training, so far NES has only given feedback direct to the individuals and not to their employers. However, NES recognises that in future employers might also require direct feedback.

None of the NHS boards interviewed currently have robust arrangements in place to assess the quality of appraisers.

“I’m not sure that we do review their performance. We need to remember that completing a medical appraisal course doesn’t mean you are any good at it in practice.”

“We do look at the quality of Form 4s and in future we hope to be able to use the Form 5 feedback forms.”

In summary, there is a need to agree what minimum dataset should be collected and reported in relation to appraisers. Selection tends to be job dependent, but there is an expectation that initial training will become mandatory and that participants will be required to “pass” the course. Interviewees also expect the new appraisal documentation will help as it includes feedback forms, which could be analysed to facilitate an element of quality assurance.
Appendix 3: Appraisal discussion

The requirement

The AQMAR document requires assurance that “The appraisal is informed by a portfolio of verifiable supporting information that reflects the whole breadth of the doctor’s practice and informs objective evaluation of its quality. The discussion includes challenge, encourages reflection and generates a Personal Development Plan (PDP) for the year ahead.”

Appraisal activity

The numbers to be appraised vary significantly across the organisations involved in this study. In 2009 the figures were:

<table>
<thead>
<tr>
<th>NHS board</th>
<th>Fife</th>
<th>GG&amp;C</th>
<th>Grampian</th>
<th>Shetland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>268</td>
<td>1,445</td>
<td>607</td>
<td>11–13</td>
</tr>
</tbody>
</table>

Even in relation to this very basic information, there is considerable variation between how the NHS boards collect data on what number of doctors have been appraised and how this is presented in their annual report. For example:

One NHS board provides separate data for their two Divisions (Acute and Primary Care), but does not always provide a breakdown between staff groups. Another NHS board provides a breakdown across four staff groups (consultants, associate specialist, staff grades and clinical assistants), but provides no divisional breakdown. Another NHS board only differentiates between consultants and non-consultant career grades.

Thus, even producing limited information requires a series of manual calculations in an attempt to compare like with like. Even so, we cannot be certain that figures are comparable because for that we would need to be sure firstly, that all NHS boards use precisely the same definition of what constitutes a ‘completed’ medical appraisal and secondly that they adhere to the same timescales for ensuring appraisals have been carried out. Interviewees highlighted these issues:

> Some people have actually done the appraisal but haven’t completed the documentation – we need to address this. We need to agree some basics like when to shut the door at the year end

It must also be taken into consideration that there are a number of reasons why a doctor may not undergo appraisal as this can go someway to explaining why an NHS board may not achieve a 100% appraisal rate among its clinician workforce. Valid reasons for not undergoing appraisal in any year could be:

- maternity leave
- long term sick leave
- moved to another job
- retired
new appointment, and
still on ‘old’ consultant contract.

The NHS boards are keen to drive up the numbers who are participating in medical appraisal and some NHS boards have turned to incentives to encourage their staff to participate.

Overall, the view seems to be that a culture change is taking place but that it is very much a work in progress.

“We’ve considered the sticks but haven’t followed through on them so far. We’re waiting to see what happens nationally as there’s no point pushing through local arrangements if a national approach is pending”

“Appraisees tend to welcome the opportunity to reflect on their current practice and they do want feedback so they do take the filling in of the Form 4s seriously”

A further issue relates to what denominator should be used in any calculations to monitor the effectiveness of the appraisal system, ie determining the number of doctors who should have had an appraisal in a given year. None of the annual reports make it clear, but it is likely that the numbers only cover the NHS board’s employees and this raises the difficult subject about how NHS boards are expected to deal with locums and other non-employee doctors who operate in their area and require an appraisal in order to be revalidated. There is concern around this issue because of the proposal that the RO should also cover doctors primarily operating within their area and would involve NHS board appraisers undertaking appraisals for people who are not employed by the NHS. This represents a risk to their organisation and raises indemnity issues. NHS boards are also concerned about how they can assure themselves about the revalidation status of short-term locums in the absence of a national register.

“There is no equivalent of the primary care ‘host board’ for locums so they’ll be potentially disadvantaged in terms of revalidation”

“This is a huge issue – the theory is that the agencies have to organise this for their employees so technically we ought to be able to hold them to account but….. What we really need is a national bank for locums but no one seems to be picking thorny issues like this up”

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6 These ‘other’ doctors include those operating independently on the high street and Forensic Medical Examiners.
It’s fine if locums are here for months but most aren’t. They come and go very quickly and they might just do a shift. We are under real pressure if we need someone in a hurry. The reality is that supplies are drying up and using them is risky. We need a national register so that we can have assurance about people we draw from it when we need someone and also that we can give feedback to

“I wouldn’t be happy if our staff were appraising outsiders – I think that this is one for the GMC”

“This business of being responsible for doctors in our area is just not on. Lots of locums don’t even work for agencies and then there are the ones operating in the high street - we can’t have a clue about them. It’s very risky but the GMC haven’t thought this through”

The discussions with SGHD representatives confirmed that these issues are recognised and the current thoughts are:

- **Short term**
  - The individual doctor will relate to the RO in the area that they do most work and the individual is responsible for making contact with the RO and making arrangements to ensure that they have sufficient evidence to present when the time comes for revalidation.

- **Longer term**
  - For those working in large independent hospitals, the RO will be in that organisation’s headquarters.
  - For those working in smaller independent hospitals, they should look to the GMC and their Royal College.
  - NHS boards should draw on an NHSScotland Bank of Locums to address temporary staffing needs. (Action being taken on this is pending an Audit Scotland report expected in autumn 2010).

The SGHD expectation is that any doctor not falling into one of those categories (eg individual high street practitioners) is unlikely to be revalidated.

**Variation across specialties**

None of the annual reports provide any breakdown of different specialties’ participation in medical appraisal and their relative readiness for revalidation. However, interviewees did have views on which they thought were furthest ahead and why:

“The biggest influence seems to be the Royal Colleges and how far they’ve developed their framework of requirements. For example, I think anaesthetists and obstetrics & gynaecology are furthest forward”
Evidence to support appraisal

Revalidation is dependent on medical appraisal and its supporting evidence. Without sufficient, robust evidence the RO cannot be assured that the individual doctor is fit to practise and, therefore, will not be able to make a positive revalidation recommendation to the GMC. Much will depend on the quality of the Form 4.

In terms of the supporting evidence, interviewees expressed concern that, to date, the agenda has generally been set by the appraisee, ie it has largely been up to them to decide what evidence to bring to an appraisal and there are concerns surrounding this:

“There are some well kept portfolios with good supporting evidence but there’s a danger that the appraisee doesn’t have or doesn’t bring all the evidence to an appraisal – they control the agenda.”

“Hopefully, NES training will put appraisers in the driving seat in future.”

Interviewees also expressed opinion on the variations in availability of evidence for doctors across different specialties, which may present some challenges, however there were some suggestions on how these challenges can be addressed:

“Surgeons and anaesthetists are ahead – they are used to using data and providing evidence and they come in with copious amounts of it.”

“Even for mental health there are some data available like referrals, contacts, discharges, suicides and prescribing. The Royal College requires members to undertake 360 degree appraisal and undertake a structured reflection of selected critical incidents / significant events with a colleague to discuss the lessons learnt. By using multiple approaches like this, you get triangulated evidence. Other colleges need to adopt a similar approach.”

In terms of what constitutes adequate evidence, the Academy of Medical Royal Colleges (AoMRC) has:

“asked all of the colleges to define specialty specific standards for recertification and to identify the methods and evidence that could be used by doctors to demonstrate that they have achieved the standard”.

However, a number of interviewees expressed concerns about progress in this area:

7 http://www.aomrc.org.uk/revalidation.aspx
The Royal Colleges seem to be moving away from the principle of “single process and dual outcome” (i.e., re-licensing by the GMC and recertification by the Royal Colleges) because some are having difficulty coming up with specific standards. Without these, it will be more difficult to agree evidence requirements.

Finally, there was also a request not to underestimate informal networks in terms of evidence not only in the smaller NHS boards but in the large ones also:

“Informal processes are strong here because we work together, sharing ward rounds. We know about complaints, incidents and performance issues so we don’t rely so much on formal processes.”

In summary, there is an urgent need for agreement on what the minimum dataset for medical appraisal should be and to agree common definitions and timescales so that we can be sure that NHSScotland is comparing like with like. In addition, there is a need to give NHS boards greater clarity about how to deal with non-employees such as locums and about what supporting evidence will be acceptable to the GMC and the Royal Colleges. There is also a need to agree and put in place quality assurance arrangements that go beyond the ability to assess processes and allow ROs to be assured about the content and outcomes from appraisal. Despite the fact that there is still much to be done, most interviewees reported that the required culture change has begun.
Appendix 4: System infrastructure

The requirement

The AQMAR document requires assurance that “The management of the appraisal system is effective and ensures that all doctors linked to the responsible organisation are appraised annually.”

Feedback on the appraisal system

To date, the feedback on the medical appraisal process has been anecdotal as few appraisers and appraisees have chosen to fill in available feedback forms. Only one of the NHS boards interviewed had undertaken a survey but that was in 2006-2007.

Interviewees did provide their own opinion on how doctors view appraisal.

“GPs tend to be more positive about the process because they’ve stuck to the original ethos – secondary care see it more as a tick box process to benefit management rather than the individual”

The new appraisal documentation includes feedback forms for both appraisees and appraisers. They are designed to support internal quality assurance and should be sent back to the medical director/director of public health. Making this mandatory for ‘enhanced medical appraisal’ is thereby highly desirable.

Support systems

To date, NHS boards have used their own documentation based on national requirements. However, standardised appraisal documents have been drafted by the National Appraisal Leads Group and submitted to the Delivery Board (Scotland) for approval. Interviewees welcomed this development.

“We need a national approach because we need to benchmark and to be able to identify any outliers. We all need to be recording the same minimum dataset and using the same definitions or benchmarking will be meaningless”

Systems are predominantly paper based. Appraisees are responsible for keeping their own portfolio and medical directors have arrangements to store the Form 4s securely. However, paper-based systems are not easy to analyse, and subsequently requires that the information for the annual report is produced manually.

Any support system to manage the process had also initially been regarded as a local responsibility. The larger NHS boards had, therefore, been looking at developing their own IT solutions. However, this has now changed since NES was tasked with commissioning the work to adapt the existing primary care SOAR\(^8\) system for use in secondary care.

\(^8\) Scottish Online Appraisal Resource.
The overall effect of the national initiative has served to stall any local NHS board activity in this area.

"We had been looking at developing software to support revalidation but we've stalled pending the outcome of the SOAR work."  

"The HR system - currently out for procurement - will have some flags for revalidation. But we need a system to hold the detail – objectives, job plans, PDPs and such like. We might be able to tweak our existing senior management system which is web-based, cheap and cheerful."

In terms of what people are looking for from such a system, interviewees expressed the following views:

"We need something that makes it easy for people to participate in the process, eg by allowing them to store and draw down their evidence as well as something to support the organisation’s needs."

"It needs to go beyond telling us that an appraisal was done and allow us to record and analyse for example; numbers and percentages; objectives and achievements that can be categorised by themes; PDPs to ensure they are driven by service needs and to allow us to support a corporate response to education and training needs; and feedback to allow us to quality assure both quality issues and quality of the appraisal. It also has to have built in security and confidentiality measures so that people get only appropriate access to personal data in line with information governance requirements."

However, there is a concern that developments in areas to support medical appraisal are not being communicated to the wider NHSScotland community. A number of interviewees were not aware of the national work being undertaken on the SOAR system.

"We provide the blank forms electronically for doctors to complete. Other than that, I'm not aware of any support system. But we certainly need one."

Those interviewees who were aware of the current national initiative also expressed some concerns regarding it.

"If the SOAR solution is delayed we need an interim system that moves us towards greater consistency. Even within our own area we have differences and people 'doing their own thing.'"

In summary, expectations are high in relation to the two key national initiatives; the development of standardised, national appraisal documentation; and the adaptation of the current primary care SOAR system to support secondary care revalidation. These will provide a suitable template and support system for identifying, recording, storing and analysing the agreed minimum dataset. Any
local initiatives in these two areas have stalled pending the delivery of the national appraisal documentation and the secondary care version of SOAR.