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AN ROINN

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

MÄNNYSTRIE O

**Poustie, Resydènter Heisin
an Fowk Siccar**

Northern Ireland Secondary Care Medical Revalidation Project

November 2009

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1 INTRODUCTION

This report details the findings of the Northern Ireland Secondary Care Medical Revalidation project.

2 BACKGROUND

The concept and underlying principles of revalidation were set out in the Chief Medical Officer for England's consultation document *Good Doctors, Safer Patients* and adopted in the UK Government's White Paper on professional regulation, *Trust Assurance and Safety-The Regulation of Health Professionals in the 21st Century*¹ (February 2007).

The Department of Health, Social Services and Public Safety Northern Ireland (DHSSPSNI) has established the *Confidence in Care* programme to implement the recommendations of the White Paper.

Every doctor who wishes to hold a license to practise will be required to participate in revalidation, the process which will ensure the doctor is up to date and fit to practise medicine.

The process has three elements:

- 1 Relicensing-To confirm that licensed doctors practise in accordance with the General Medical Council's (GMC) generic standards
- 2 Recertification-For doctors on the specialist register or GP register, to confirm the standards appropriate for their speciality
- 3 To identify for further investigation and remediation, poor practice where local systems are not robust enough to do so, or do not exist.

The report of the Chief Medical Officer for England's Working Group, *Medical Revalidation-Principles and Next Steps* was published July 2008².

The report emphasises that revalidation will be based on evidence drawn from local practice, evaluated in the appraisal process and should be supported by robust systems of clinical governance.

The process will depend on the quality, consistency and nature of appraisal to ensure the confidence of patients and doctors. The report also recommends that key aspects of this process will need to be piloted, evaluated and adapted prior to implementation of revalidation.

¹ Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century: TSO February 2007

² Medical Revalidation-Principles and Next Steps <http://www.dh.gov.uk/publications>

The GMC have identified several categories for pilots including:

(i) Readiness reviews

The focus of these pilots will be to review the state of readiness of clinical governance systems required to support revalidation

(ii) Testing the Good Medical Practice (GMP) Framework

These pilots will focus on how the GMP Framework integrates with existing appraisal systems and how evidence or supporting information can be generated to support revalidation.

3 AIM OF THE PROJECT

The primary aim of this project is to test the Good Medical Practice Framework (GMP) and to identify how supporting information can be generated to evidence the doctor is meeting the domains and attributes specified in the framework.

The GMP framework can be found in Appendix 1 of this report.

4 OBJECTIVES

To meet the aim of the project, key objectives were identified under three headings: GMP Framework, Supporting Information and Medical Appraisal. The objectives associated with each are outlined below.

4.1 GMP Framework

1. Test the use of the Good Medical Practice Framework within appraisal in secondary care

4.2 Supporting Information

2. To test how supporting information can be collated in a range of clinical specialities
3. To identify additional information that may be required by doctors to demonstrate he or she meet the standards of GMP
4. To identify the time taken to collate supporting information and any additional resources which may be required
5. To test and evaluate the use of Multi-Source Feedback (MSF)
6. To identify groups (e.g. clinical academics) that may find it difficult to provide supporting evidence required to meet the standards and how this can be addressed

7. To identify meaningful methods of patient/carer consultation.

4.3 Medical Appraisal

8. To identify potential improvements to the appraisal process in secondary care in Northern Ireland for the purposes of revalidation.
9. To establish a baseline of medical appraisal in secondary care.

5 METHODOLOGY

A steering group was established in September 2008 to oversee the project and is chaired by Dr Paddy Woods, Deputy Chief Medical Officer, DHSSPS.

Membership of the steering group:

Dr Paddy Woods (Chair)	DHSSPS
Joyce Cairns	DHSSPS
Jane Lindsay	DHSSPS
Dr Anne Kilgallen	Western HSC Trust
Dr Mike Mannion	Northern HSC Trust
Dr Tony Stevens	Belfast HSC Trust
Mr Charlie Martyn	South Eastern HSC Trust
Dr David Stewart	RQIA
Dr Paddy Loughran	Southern HSC Trust
Christine McGowan	Beeches Management Centre
Dr John Jenkins	Northern HSC Trust
Prof J Watson	Previously of Northern Board
Dr W McConnell	Previously of Southern Board

Following discussion between the DHSSPS, GMC and the five Health and Social Care Trusts it was agreed that the NI project will primarily consist of testing the GMP framework and identify how the supporting information required can be generated.

It was, however, recognised that a baseline audit of medical appraisals completed was also required, building on the work previously undertaken by the Regulation, Quality and Improvement Authority (RQIA) and DHSSPS (Naftalin Report, 2006).

Concurrent to the NI Project Pilot is the testing of a multi source feedback (MSF) tool devised by the Beeches Management Centre and based on the 4 domains of GMP. This piece of work was led by Christine McGowan.

Project management was provided by Jane Lindsay, DHSSPS and Rhian Williams, GMC.

5.1 Project Participants

The specialties covered in the project were agreed as:

- South Eastern Trust: Emergency Medicine
- Southern Trust: Mental Health
- Western Trust: Respiratory Medicine and Obstetrics and Gynaecology
- Belfast Trust: Critical Care, Elderly Care and Trauma and Orthopaedics
- Northern Trust -Radiology
- Medial Managers
- Clinical Academics

The project surveyed a total of 100 doctors, who were asked either concurrent to their appraisal, or retrospectively if appraisal has been undertaken, to detail the supporting information they had available and ascertain which domains and attributes of the GMP framework were satisfied by this information.

The appraisal element of the project ran from April to July 2009.

Dr Steven Wilkinson, University of East Anglia, was commissioned to assist the project management team in developing the survey tool, undertake the online survey and focus groups and report the findings.

The key findings from this report are detailed in the next section of this document. Dr Wilkinson's full report can be viewed on the Confidence in Care Programme website at:

http://www.dhsspsni.gov.uk/index/hss/confidence_in_care.htm

6 RESULTS AND ANALYSIS

6.1 Number of Participants – Online Survey

The survey was successfully emailed to 90 doctors, and was undeliverable to 10. The project team subsequently emailed the survey link to medical directors in each participating Trust for distribution to participants via internal email systems.

In total 59 (from a possible 100) responses to this survey were received. 77.8% of respondents (n42) completed the questionnaire after they had completed their appraisal for this appraisal cycle. 18.5% (n10) used the GMC Framework to develop their portfolio for their last appraisal. 57.4% (n31) did not and 24.1% (n13) were unsure.

6.2 Focus Groups

A focus group exercise was developed and conducted at participating Trusts. The format for the focus groups and the schedule of events was forwarded to participants ahead of the scheduled event.

The focus groups were conducted according to schedule and in some cases were followed by a GMC revalidation information event. Included in this exercise were two interviews with key informants. One interview covered the focus group format, while the other did not.

The numbers of participants in each of the participating trusts/organisations are tabulated below. It was not possible to schedule a focus group within one of the participating trusts (Southern). Numbers of participants were also affected by pandemic flu planning.

Trust/Organisation	Number of Focus Group Participants
Belfast	8
South Eastern	3
Northern Ireland Medical and Dental Training Agency	1*
Western	6
Northern	1**

* Conducted as an Interview not using the focus group format

** Conducted as an Interview using the focus group format

Total number of Focus Group Participants – 19

7 SUMMARY OF KEY FINDINGS

Key findings, discussion and recommendations will be presented against the objectives of this project.

7.1 Objective 1: Test the use of the Good Medical Practice framework within appraisal in Secondary Care

In the online survey, respondents were asked to rate the following statements on the GMP Framework on a 6 point scale (where 1 was the lowest and 6 was the highest):

1. *'I found the framework a helpful tool for collecting information'*: mean score 3.31 (respondents n 31)
2. *'I found the domains were clear'*: mean score 3.12 (respondents n34)
3. *'I found the attributes covered all aspects of my practice'*: mean score 3 (respondents n36)

Comments made in relation to the above statements included:

It was repetitive, difficult to decide what section supporting information should go into, Trust unable to provide data/data is unreliable, some sections were ambiguous, terminology is confusing, the Domains overlap, and it did not cover all aspects of practice.

80.6% said that the information they collected was similar to the information they provided previously at appraisal.

66.7% felt that it was not easy to access electronic information about themselves from the Trust.

55.6% felt that there were not specific types of supporting information for their specialty.

Further comments made on the GMP Framework in the survey included the following:

- *Not convinced that this process is any better than what has been used in the past.*
- *The 360 degree feedback mechanism is of little / no value*
- *Some training sessions may clarify specific sections that are unclear.*
- *The new framework is a major step forward.*
- *Now the documentation by way of the appraisal forms needs to be updated.*
- *I really have no performance indicators or outcomes.*
- *Much information should be available from 360 feedback*

Summary of discussion regarding the Framework during focus groups:

- The document was found to be a useful tool and suggestions were made as to how this tool could be further developed.
- MSF is very useful for covering every aspect of the domains in the framework.
- The new framework is a major step forward.
- It has been suggested that a fourth column be considered – providing a traffic light indication of the presence of relevant data for each of the attributes

7.2 Discussion and Recommendations

- 7.2.1 The White Paper *Trust Assurance and Safety* invited the GMC to translate *Good Medical Practice* into an effective framework against which individual doctors' practice can be appraised and objectively assessed. It is widely agreed that GMP will provide a standardised module to be incorporated in all appraisal systems to support relicensing.
- 7.2.2 While it is reassuring that 80.6% of respondents said the information they collected for this exercise was similar to that previously provided at appraisal, there is some uncertainty regarding specialty specific information that will be required. Specialty specific information from the Academy of Medical Royal Colleges is pending and should provide further clarification.
- 7.2.3 It is evident that further guidance regarding the use of GMP would be valuable and assist organisations to integrate the framework into their existing appraisal systems, training programmes and documentation.
- 7.2.4 The availability and quality of Trust generated information is also noted and the information collated supports anecdotal information received prior to commencement of this project.

Recommendations

- 1. Information regarding GMP be considered by the GMC**
- 2. Work scheduled to commence locally to establish method of integrating GMP into appraisal systems/documentation**
- 3. Work to continue locally to ascertain how improvements can be made to the quality and quantity of data provided to doctors from existing IT systems.**

7.3 Objective 2: To test how supporting information can be collated in a range of clinical specialities.

Respondents to the online survey were asked to specify from a list, the type of supporting information included in their portfolio and its source. These are listed in descending order by volume:

7.3.1 **Self generated** (260 items)

CPD folders, audit activity, job plans, registration certificates, multi disciplinary team meetings, indemnity documents, complaints, mandatory training, private practice statements, team based information, research statements, registration with a GP and vaccination records

7.3.2 **Trust generated** (104 items)

Length of stay, process/outcomes, re-admission rates, near miss incident reports and infection rates

7.3.3 **Generated elsewhere** (42 items)

PMETB training survey feedback.

During the focus groups participants were asked to rate the type of supporting information as either mandatory or supplementary to their appraisal portfolio.

7.3.4 **Mandatory** (agreed by all focus groups):

- Multi Source Feedback
- CPD folder
- Past Appraisal Form 4 (including CPD)
- Records of mandatory training
- Registration Certificate

7.3.5 **Both Mandatory and Supplementary**
(agreed by all focus groups):

- Declaration of Probity
- Declaration of Health
- Multi Disciplinary Team examinations
- Workload records
- Statement of satisfactory private practice
- Indemnity documentation
- Participation in Multi-Disciplinary Team meetings
- Record of complaints (to include timing and nature of responses)
- Audit Activity
- Process/Outcome data (relevant to speciality e.g.- Length of stay, Re-admission rates, Post operative infection rates. Team based information)
- Job Plan
- Risk Information (to include near miss/risk reports and action taken to address/reduce risks)

7.3.6 **Supplementary**
(agreed by all focus groups):

- CV
- Vaccination records
- Analysis of PMETB trainee survey (where appropriate)
- Evidence of registration with a GP
- Statement of satisfactory research practice.
- Testimonials from patients

7.4 Discussion and Recommendations

7.4.1 Multi source feedback was regarded as mandatory and given the highest priority for inclusion in the appraisal portfolio. This will be further discussed in Objective 5.

7.4.2 It is evident that while a document type may be available and included in an appraisal portfolio, availability does not necessarily correspond with the priority given. For example, audit activity was indicated as being the second most used information type yet was not regarded as mandatory data in every case. Discussions during focus groups, and with the project steering group, both indicate the need for further clarification on the frequency and type of audit information that may be required.

7.4.3 Multi disciplinary team data was rated as the third most used source of data and team based information rated sixth. Both were considered mandatory for appraisal portfolios. This reflects new models of care delivery, resulting in fewer health care professionals working in isolation.

7.4.4 The CPD folder was rated fourth and a mandatory source of information for appraisal portfolios. This item was mostly self generated. Testing of online tools to assist with the compilation of CPD information is currently being undertaken nationally and it is hoped this process may relieve some of the administrative burden in preparing for appraisal.

7.4.5 The job plan was rated as the fifth most used form of data yet was not regarded as mandatory for all portfolios. Anecdotal evidence has previously suggested a lack of clarity regarding the separation of job planning from the appraisal process. This will need to be clarified in the context of implementing an enhanced model of appraisal that will support revalidation.

7.4.6 Process / outcomes and length of stay were rated as the eighth most used form of supporting information and as mandatory. Again, concerns were expressed regarding the reliability of, and access to, this information.

Recommendations

- 1. That consideration be given to the outcomes of ongoing work by Medical Royal Colleges in relation to supporting information required for the recertification element of revalidation**
- 2. That work commence locally on a 'key data set' which can be provided for the appraisal portfolio and reviewed in the context of these findings**
- 3. That the purpose and function of job planning and appraisal be clarified in the context of an enhanced appraisal system to support revalidation**
- 4. That concerns relating to the reliability and accessibility of supporting information from Trust IT systems be shared with relevant colleagues and Departments**

7.5 Objective 3: To identify additional information that may be required by doctors to demonstrate he or she meet the standards of GMP

Focus groups asked participants to allocate the type of supporting information against the attributes in GMP. The following table shows how many times each information type was indicated:

Information Type	Frequency
Multi Source feedback	indicated 84 times
Audit activity	indicated 71 times
Complaints	indicated 68 times
Multi-disciplinary team meetings	indicated 57 times
CPD folders	indicated 54 times
Job plan	indicated 45 times
Team based information	indicated 41 times
Near miss incident reports	indicated 40 times
Process/outcomes	indicated 39 times
Length of stay	indicated 38 times

Mandatory training	indicated 31 times
Readmission rates	indicated 27 times
Indemnity documents	indicated 27 times
Infection rates	indicated 23 times
Registration certificate	indicated 23 times
Vaccination records	indicated 18 times
Private practice statement	indicated 17 times
PMETB training survey	indicated 14 times
Registration with a GP	indicated 13 times
Research statement	indicated 12 times

7.6 Discussion and Recommendation

- 7.6.1 While the above table does not provide ‘additional’ types of supporting information, there is value in demonstrating that the information currently contained in the appraisal portfolio of participants in this project can be mapped to the GMP framework.
- 7.6.2 However, further clarification on the quality of the information provided is necessary, as is guidance for appraisers to aid decision making within the appraisal process. Again, outcomes from work ongoing by Medical Royal Colleges will inform this issue for those doctors on a speciality/GP register.

Recommendation

That these findings are considered by the GMC in the context of policy development, relating to use of the GMP framework.

7.7 Objective 4: To identify the time taken to collate supporting information and any additional resources which may be required

The online survey asked respondents to indicate the time they spent preparing for appraisal and how they used this time.

Time taken to prepare ranged from 0-46 hours with the mean 8.7, mode 4 and median 6 hours.

How this time was used (by % of total time spent):

- Searching and gathering documents 42.5%
- Preparing forms and the portfolio 30%
- Writing, typing or dictating 12.5%
- Analysing 9%
- Reading 6%

7.8 Discussion and Recommendation

7.8.1 There is potential to reduce the amount of time spent preparing for appraisal by the use of previously referenced online portfolio tools currently being developed and piloted. The use of a key data set available to doctors may also reduce the time spent on searching and gathering documents.

7.8.1 Further clarification on the priority and type of supporting information required may also reduce the time spent collating information for appraisal portfolios.

Recommendation

The merit of online tools to assist in development of appraisal portfolios is to be considered when outcomes of pilots are published.

7.9 Objective 5: To test and evaluate the use of MSF

Background to MSF

Participants in the focus groups were asked to review multi source questions to identify those that were regarded by doctors as useful in providing information for appraisal. The Beeches Management Centre (BMC) MSF tool was used as a template because this tool had been previously piloted in HSC Trusts and therefore was likely to be known by focus group participants.

The Royal College of Psychiatry tool which was used by the Southern Health and Social Care Trust was found to be well received and formed a sound basis for the appraisal discussion.

The BMC MSF tool also had some responder feedback which formed part of this project. A set of questions that corresponded with the 4 Domains in the Framework document was established. The findings from this exercise are reported separately and can be found in Appendix 2.

7.9 Discussion and Recommendations

- 7.9.1 MSF was identified as being key to appraisal and mandatory within the appraisal portfolio. MSF was also the most frequently indicated information type which demonstrated attributes across the domains of GMP.
- 7.9.2 The use of MSF for doctors is still in its pilot stage and much remains to be learned and understood about how this tool may continue to be developed and how it may contribute to the process.
- 7.9.3 Information gathered in this project would suggest that the absence of MSF places a higher demand on other supporting information.
- 7.9.4 Findings from the testing of the BMC tool demonstrated that completion was not overly time consuming with 69% completing the survey within 10 minutes, with 25% of those completing it within 5 minutes. 89% of respondents reported no difficulty in accessing a computer.
- 7.9.5 There are a number of MSF tools being developed that may vary in quality. The GMC are currently devising principles and criteria that must apply to any patient and colleague questionnaires used in the revalidation process in order to validate its fitness for purpose. MSF principles, criteria and accreditation will be included in the GMC's revalidation consultation, which will commence in early 2010.

- 7.9.6 Questions also remain regarding the frequency of MSF required within a revalidation cycle and it is hoped the above principles and criteria may clarify this.

Recommendations

- 1. That the information collated in this project be used by the GMC to inform policy decision in relation to the use of MSF as a type of supporting information for revalidation**
- 2. Clarification to be sought to identify frequency of MSF required within a revalidation cycle.**
- 3. Following dissemination of principles, criteria and accreditation MSF tools to be made available in each HSC Trust in Northern Ireland.**

7.10 Objective 6: To identify groups (e.g. clinical academics) that may find it difficult to provide supporting evidence required to meet the standards and how this can be addressed

Due to time constraints this objective was not met.

7.11 Recommendation

That further work is undertaken to establish the supporting information requirements of this group

7.12 Objective 7: To identify meaningful methods of patient/carer consultation.

7.13 Discussion and Recommendation

7.13.1 *Medical Revalidation-Principles and Next Steps* lists several key principles that should underpin revalidation, one of which is that it 'should include within it a strong element of patient and carer participation and evaluation'.

7.13.2 Unfortunately this objective was not met during this project for patient and carer feedback. Further work is required to examine these systems within the context of medical revalidation.

7.13.3 Within the survey and focus groups, the use of patient feedback was mentioned. However, no processes for acquiring meaningful feedback were suggested or developed. One impediment identified is the system of a 'shared list' which has resulted at times, in a fragmented care pathway with different doctors having responsibility for care during the patient's journey. This may result in difficulty collecting feedback on individual doctors.

Recommendation:

That the information provided be considered in the context of the Confidence in Care Stakeholder Engagement Programme and shared with the NI Patient and Client Council.

7.14 Objective 8: To identify potential improvements to the appraisal process in secondary care in Northern Ireland for the purposes of revalidation.

Focus group participants were asked to consider how the existing appraisal systems could be improved. Based on the feedback from this exercise, the following measures (shown in descending priority order) were suggested:

- Accurate & sufficient Trust Generated Data (including Complications, Outcomes & Complaint outcomes) (63) *
- Appraiser/Appraisal Preparation time (49)
- MSF (provided by Trust) (18) *
- Realistic, Funded Personal Development Plan (15)
- More Explicit use of SPA to be geared to Appraisal (15) *
- Clear Guidance (template) on Mandatory/ Supplementary Data (14) *
- Meaningful Appraisal Meeting (challenging behaviors and ideas) (13)
- Documentation on-line (electronic) (13) *
- CPD – Must be financed by trust and reviewed at Appraisal (6)
- Appraisal Domains and GMP to be aligned (5) *
- Clarity on Audit requirements (4) *
- Improve Process (Paperwork/office space /time) (3)
- Specialty Specific Appraisal (3)
- Specialty Specific MSF (2)
- Review discussions during year (1)

*Many of these suggestions have been addressed and recommendations made as a result of outcomes relating to previous objectives stated in this report.

Participants at focus group felt that the Medical Royal Colleges appear interested in actively engaging in the process of appraisal, rather than

have no say in the system as it evolves and that College guidance has been effective.

Participants also felt that there was a lack of clarity as to the purpose of appraisal for example; is it a management tool, a form of reassurance for the public or to identify the development needs of doctors?

7.15 Discussion and Recommendation

7.15.1 Discussion during the focus groups indicated a lack of clarity of the purpose of appraisal. This was also highlighted during discussion of these findings with the project steering group, who agreed this was unsurprising given the transition currently being undertaken.

7.15.2 Initially, medical appraisal was a formative process and is now perceived as moving towards a summative process, as the information presented by a doctor at appraisal will inform the decision making of the responsible officer in making a recommendation to the GMC for relicensure.

7.15.3 It is therefore essential that the existing appraisal systems, that form part of the governance requirements for HSC organisations, are quality assured and sufficiently robust to support revalidation. Key aspects of local appraisal systems in secondary care to be addressed include:

- Uptake of appraisal
- Clear lines of accountability for uptake and quality of appraisal
- Appraiser selection, skills, training and support
- Uptake of appraisee training
- Appraisal of locum doctors
- Use of IT systems to support appraisal preparation/processes
- Use of 'key data' set in appraisal

Recommendation

That the Confidence in Care Revalidation workstream considers the suggested improvements to the appraisal process in the context of work planned to commence on appraisal in 2010

7.16 Objective 9: To establish baseline of medical appraisal in secondary care

Annual appraisal for doctors is a requirement under contract in the NHS and was a key recommendation in *Supporting Doctors, Protecting Patients* (2001)³. The White Paper *Trust Assurance and Safety* (2007) has positioned appraisal as the cornerstone of revalidation.

Consultant appraisal was introduced in 2001; General practitioners in 2009 and for Trust non-consultant grade staff in 2003.

Previous reviews of appraisal levels in secondary care have been undertaken, firstly by Dr Nick Naftalin in 2006 and by the Regulation and Quality and Improvement Authority in 2008.

Both reports highlighted areas of good practice and compliance but also noted that levels of consultant, non-consultant grade and locum doctor appraisal were at times, patchy and inconsistent.

The audit undertaken for the purposes of this project, and to inform the development of the NI model for revalidation was undertaken in March 2009. It found that some progress has been made in this area and that the Trusts who provided data are striving to meet the target of 100% compliance in undertaking yearly appraisals.

There is, however, improvement required and the Confidence in Care Programme Board are giving consideration as to how this is may be best achieved within the broader remit of performance indicators for HSC organisations.

7.17 Recommendations

- 1. That Chief Executives and Medical Directors in HSC Trusts continue to monitor the uptake of medical appraisal within the context of their quality and governance frameworks.**
- 2. Within the context of revalidation the Confidence in Care Programme Board will take steps to improve accountability in this area.**

³Supporting Doctors, Protecting Patients
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalassets/dh_4042802.pdf

8.0 NEXT STEPS

The GMC have identified criteria that organisations will need to satisfy in relation to readiness to support revalidation. These include:

- All necessary legislation is in place
- Doctors have a license to practice
- Responsible officer in place
- Effective system of clinical governance in place
- Effective system of appraisal based on GMP framework in place
- Specialist standards are embedded in local appraisal processes
- Local processes ready to deliver necessary recommendations with appropriate quality assurance arrangements in place
- MSF tools based on professional standards are available and ready for use by doctors locally

The DHSSPS Confidence in Care Revalidation and Tackling Concerns Locally and Nationally workstreams have in place project plans that detail the key milestones achieved to date, and also work scheduled to take place, in preparation for the implementation of revalidation.

This includes:

8.1 Responsible Officer

- Consultation on Responsible Officer (RO) legislation
- Stakeholder engagement
- Publication of guidance
- Capacity building, recruitment, training and support for RO's
- Development of 'key data' set

Remediation and Rehabilitation

- Baseline assessment of readiness
- Gap analysis of the priority areas of work
- Fitness to Practice workshop
- Patient/Client workshop

8.2 Revised System of Appraisal

- Readiness reviews of primary and secondary care
- Appraisal documentation and systems workshop
- Patient/Client workshop
- Capacity building for medical managers
- Development of 'key data' set
- GMC/RQIA Project in 2010 to review appraisal system and governance structures in the context of revalidation.

The findings and recommendations contained in this project report will be considered in relation to the relevant workstream and also be shared with the GMC UK Revalidation Programme Board and other key interest groups.

APPENDICES

Appendix 1 – GMC Good Medical Practice Framework

Domain 1 – Knowledge, Skills and Performance

Numbers following generic standards in this framework refer to paragraph numbers in GMP, except where preceded by MfD which refers to our booklet *Management for Doctors*; or Research which refers to *Research: the role and responsibilities of doctors*

Attributes	Generic Standards	Possible sources of evidence
Maintain your professional performance	<p>All doctors</p> <ul style="list-style-type: none"> ⌚ Maintain knowledge of the law and other regulation relevant to practice (13) ⌚ Keep knowledge and skills up to date (13) ⌚ Participate in professional development and educational activities (12). ⌚ Take part in regular and systematic audit (14) 	Evidence from training or assessment of skills; CPD Audit Validated tools for feedback about doctors' practice
Apply knowledge and experience to practice	<p>All doctors</p> <ul style="list-style-type: none"> ⌚ Recognise and work within the limits of your competence (3a) <p>Doctors with management, teaching or research roles</p> <ul style="list-style-type: none"> ⌚ Follow appropriate national research governance guidelines (71) ⌚ Apply the skills, attitudes and practice of a competent teacher/trainer (16) ⌚ Work effectively as a manager (MfD 12, 17) <p>Doctors with clinical roles</p> <ul style="list-style-type: none"> ⌚ Adequately assess the patient's conditions (2a) ⌚ Provide or arrange advice, investigations or treatment where necessary (2b) ⌚ Prescribe drugs or treatment, including repeat prescriptions, safely and appropriately (3b) ⌚ Provide effective treatments based on the best available evidence (3c) ⌚ Take steps to alleviate pain and distress whether or not a cure may be possible (3d) ⌚ Consult colleagues, or refer patients to colleagues, when this is in the patient's best interests (2c, 3a, 3i, 54,55) ⌚ Support patients in caring for themselves (21e) 	Evidence from training or assessment of skills CPD Audit Validated tools for feedback about doctors' practice
Keep clear, accurate and legible records	<p>All doctors</p> <ul style="list-style-type: none"> ⌚ Keep clear, accurate and legible records (3f) ⌚ Make records at the same time as the events you are recording or as soon as possible afterwards (3f) <p>Doctors with clinical roles</p> <ul style="list-style-type: none"> ⌚ Record clinical findings, decisions, information given to patients, drugs prescribed and other information or treatment (3f) 	Anonymised records

Domain 2 – Safety and Quality

Attributes	Generic Standards	Possible Sources of Evidence
Put into effect systems to protect patients and improve care	<p>All doctors</p> <ul style="list-style-type: none"> ⌚ Respond constructively to the outcome of audit, appraisals and performance reviews (14e) ⌚ Take part in systems of quality assurance and quality improvement (14) ⌚ Comply with risk management and clinical governance procedures ⌚ Co-operate with legitimate requests for information from organisations monitoring public health (14i) ⌚ Provide information for confidential inquiries, significant event reporting (14g) <p>Doctors with management roles</p> <ul style="list-style-type: none"> ⌚ Make sure that all staff for whose performance you are responsible, including locums and students, are properly supervised. (17) ⌚ Ensure systems are in place for colleagues to raise concerns about risks to patients (45) <p>Doctors with clinical roles</p> <ul style="list-style-type: none"> ⌚ Report suspected adverse drug reactions (14h) ⌚ Ensure arrangements are made for the continuing care of the patient where necessary (40, 48) 	Information collected for folder Validated tools for feedback about doctors' practice CPD – reflective practice
Respond to risks to safety	<p>All doctors</p> <ul style="list-style-type: none"> ⌚ Report risks in the health care environment to your employing or contracting bodies. (6) ⌚ Safeguard and protect the health and well-being of vulnerable people, including children and the elderly and those with learning disabilities. (26,28) ⌚ Take action where there is evidence that a colleague's conduct, performance or health may be putting patients at risk. (43,44) <p>Doctors with clinical roles</p> <ul style="list-style-type: none"> ⌚ Respond promptly to risks posed by patients ⌚ Follow infection control procedures and regulations 	Information collected for folder
Protect patients and colleagues from any risk posed by your health	<p>All doctors</p> <ul style="list-style-type: none"> ⌚ Make arrangements for accessing independent medical advice when necessary. (77) ⌚ Be immunised against common serious communicable diseases where vaccines are available (78) 	Statement about registration with GP, appropriate immunisation etc – verifiable if need arises Validated tools for feedback about doctors' practice

Domain 3 – Communication, Partnership and Teamwork

Attributes	Generic Standards	Possible Sources of Evidence
Communicate effectively	<p>All doctors</p> <ul style="list-style-type: none"> ⌚ Communicate effectively with colleagues within and outside the team (41b) ⌚ Explain to patients when something has gone wrong (30) <p>Doctors with management roles</p> <ul style="list-style-type: none"> ⌚ Encourage colleagues to contribute to discussions and to communicate effectively with each other (MfD 50) <p>Doctors with clinical roles</p> <ul style="list-style-type: none"> ⌚ Listen to patients and respect their views about their health (22 a 27a). ⌚ Give patients the information they need in order to make decisions about their care in a way they can understand. (22b, 27) ⌚ Respond to patients' questions (22c, 27 b) ⌚ Keep patients informed about the progress of their care (22c) <ul style="list-style-type: none"> ⌚ Treat those close to the patient considerately. (29) <ul style="list-style-type: none"> ⌚ Pass on information to colleagues involved in, or taking over, your patients' care (40, 51-53) 	Validated tools for feedback about doctors' practice
Work constructively with colleagues and delegate effectively	<p>All doctors</p> <ul style="list-style-type: none"> ⌚ Treat colleagues fairly and with respect (46) ⌚ Support colleagues who have problems with their performance, conduct or health (41d) ⌚ Act as a positive role model for colleagues (41) <ul style="list-style-type: none"> ⌚ Ensure colleagues to whom you delegate have appropriate qualifications, experience (54) <p>Doctors with management roles</p> <ul style="list-style-type: none"> ⌚ Provide effective leadership (MfD 50) 	Information for folder
Establish and maintain partnerships with patients	<p>Doctors with clinical roles</p> <ul style="list-style-type: none"> ⌚ Encourage patients to take an interest in their health and take action to improve and maintain it (4, 21f) <ul style="list-style-type: none"> ⌚ Be satisfied that you have consent or other valid authority before you undertake any examination or investigation, provide treatment or involve patients in teaching or research. (36) 	Information for folder Validated tools for feedback about doctors' practice

Domain 4 – Maintaining Trust

Attributes	Generic Standards	Possible Sources of Evidence
Show respect for patients	<p>All doctors</p> <ul style="list-style-type: none"> ⌚ Implement and comply with systems to protect patient confidentiality. (37) <p>Doctors with research roles</p> <ul style="list-style-type: none"> ⌚ Respect the rights of patients participating in research. (Research 2, 5) <p>Doctors with clinical roles</p> <ul style="list-style-type: none"> ⌚ Be polite, considerate and honest and respect patients' dignity and privacy (21a, b, d) ⌚ Treat each patient fairly and as an individual (38-39, 21 c) 	Validated tools for feedback about doctors' practice Policy/evidence about ending professional relationships with patients
Treat patients and colleagues fairly and without discrimination	<p>All doctors</p> <ul style="list-style-type: none"> ⌚ Be honest and objective when appraising or assessing colleagues and when writing references (18-19) ⌚ Respond promptly and fully to complaints. (31) <p>Doctors with clinical roles</p> <ul style="list-style-type: none"> ⌚ Provide care on the basis of the patient's needs and the likely effect of treatment (7-10) 	Validated tools for feedback about doctors' practice CPD, e.g. completion of equalities training Folder, evidence from complaints
Act with honesty and integrity	<p>All doctors</p> <ul style="list-style-type: none"> ⌚ Ensure you have adequate indemnity or insurance cover for your practice (34) ⌚ Be honest in financial and commercial dealings (73) ⌚ Ensure any published information about your services is factual and verifiable (60, 61) ⌚ Be honest in any formal statement or report, whether written or oral, making clear the limits of your knowledge or competence. (63-65, 67-68) <p>Doctors with research roles</p> <ul style="list-style-type: none"> ⌚ Obtain appropriate ethical approval for research projects (Research 5). ⌚ Be honest in undertaking research and reporting research results (71 b) ⌚ Ensure that your research is audited regularly. (research 43) <p>Doctors with clinical roles</p> <ul style="list-style-type: none"> ⌚ Inform patients about any fees and charges before starting treatment (72a) 	Validated tools for feedback about doctors' practice Practice leaflets etc

Appendix 2 – Beeches Multi-Source Feedback Report

**Northern Ireland Medical Revalidation
Project
Multi Source Feedback Report**

DRAFT

November 2009

EXECUTIVE SUMMARY

1. In October 2009 a GMC revalidation pilot project was conducted in Northern Ireland to test the GMC's Good Medical Practice Framework and identify how the supporting information for appraisal could be generated against the framework's 12 attributes. One of the project objectives was to test and evaluate the use of multi-source feedback (MSF) as a key source of supporting information.

2. This report is an addendum to the main report and summarises outcomes from an on-line survey and focus group discussions with pilot participants in relation to MSF. It also provides information from a pilot of an on-line MSF questionnaire developed for Health and Social Care Trusts in Northern Ireland.

3. In relation to MSF the main findings were:
 - a. The MSF items contributed to some of the GMP Framework's attributes more effectively than others. However framing of the right questions may overcome this for most attributes. The possible exception is Attribute 9 " establish and maintain partnerships with patients" It is recommended that further work is undertaken to develop patient feedback data to contribute to this attribute.
 - b. Participants' ratings of the usefulness of individual MSF questions show that some development of the questionnaire is required to remove duplicated, low scoring and poorly worded questions.
 - c. The majority of respondents to the BMC survey completed the questionnaire in less than 10 minutes and had no difficulties accessing the on-line tool, navigating the website or understanding the instructions.
 - d. Good practice in the use of MSF tools should be applied to the any MSF tool particularly in relation to training appraisers to facilitate feedback discussions and having clear guidelines at Trust level for the operation of the system.

4. The report concludes by recommending a further review of MSF following the next appraisal cycle to assess its usefulness in informing appraisal discussions and development plans. There should also be an ongoing review of the BMC system in light of any emerging guidance from the GMC on MSF tools.

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Appendix 1 Focus Group rankings of MSF questions

Appendix 2 Results of BMC survey

Introduction

This report presents the findings from the Northern Ireland Medical Revalidation Project and addresses the pilot project objective:

- To test and evaluate the use of MSF (Multi Source Feedback)

This report has been developed by Dr Steven Wilkinson, Centre for Applied Research in Education – University of East Anglia, (UEA) and Christine McGowan, Beeches Management Centre, (BMC).

BACKGROUND

The White Paper, “Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century” published in 2007, includes the following;

2.11the renewal of a doctor's licence to practise will be on the basis that the doctor has engaged in an annual appraisal satisfactorily, ... the doctor has participated in an independent 360-degree feedback (also known as 'multi-source' feedback) exercise in the workplace; and that any issues concerning the doctor's conduct or practice have been resolved to the satisfaction of the medical director or responsible officer and the regional GMC Affiliate

In July 2008, the Chief Medical Officer for England's Working Group published “Medical Revalidation-Principles and Next Steps”. This report emphasises that revalidation will be based on evidence drawn from local practice, evaluated in the appraisal process and supported by robust systems of clinical governance. The report recommends that aspects of the process will need to be piloted, evaluated and adapted prior to implementation.

The GMC is also developing specific guidelines and principles for the use of multi-source feedback (MSF) in appraisal.

Following discussions between the DHSSPS, GMC and the Trusts it was agreed that a Northern Ireland (NI) revalidation pilot project would be conducted which would primarily consist of testing the GMC's Good Medical Practice (GMP) Framework to identify how the supporting information required for appraisal could be generated. This Framework consists of 4 performance domains, with 12 attributes which describe key aspects of a doctor's behaviour.

Concurrent to the NI Pilot Project, was the testing of a web based MSF system based on the 4 domains of the GMP Framework. This system was developed by the Beeches Management Centre and the 5 Trusts in NI and is referred to in this report as the BMC MSF tool.

This report focuses on the use of multi-source feedback in appraisal and collates the findings from the NI Pilot Project in relation to MSF (which included feedback regarding the use of both the Royal College of Psychiatry MSF tool and the BMC MSF tool) and the findings from the pilot of the BMC MSF tool.

MULTI SOURCE FEEDBACK

Multi-source feedback, also referred to as 360 feedback, has been used for many years in non-health sectors. The process, which is often computer-aided, collects the opinions of a group of individuals who have experience of the subject in the workplace. In the medical setting, this group might include peers, senior and junior medical colleagues, managers, support staff, allied health professionals and patients. These individuals rate the subject across a number of domains. There may also be an opportunity to offer free text comments. Usually, responses are anonymous.

Multi-source feedback was indicated as a key 'type' of information against the GMP domains by participants in the NI Pilot Project.

The BMC MSF tool

In 2008 the Beeches Management Centre, in conjunction with the 5 Trusts in Northern Ireland, developed an on-line MSF tool for use by doctors in Northern Ireland.

The MSF questionnaire had 30 items mapped against the 4 GMP domains. It also had three narrative questions, where respondents could explain low scoring items and summarise the doctor's key strengths and areas for development.

The questionnaire was administered through a web based system which all Trusts in Northern Ireland have access to.

BMC trained administrators in each Trust to co-ordinate the administration of the on-line system and also trained appraisers participating in the pilot, in facilitating a 360 feedback session.

The BMC MSF site can be accessed at www.beeches360.com

METHODS AND METHODOLOGY

The Methods used to collect data in this project included:

- an on-line survey distributed to 100 doctors from the pilot project target group
- a series of focus groups and interviews involving members of the target group
- on-line feedback collected by BMC relating to the BMC MSF tool

Originally the NI Pilot Project sought to establish how MSF information was being used in Appraisal meetings. However, initial discussions indicated that the use of MSF was still at a very early stage. It was agreed that it was too soon to discuss the functionality of the tool, when doctors had only started gaining access and familiarity with it.

However, it was possible to gain impressions about how this tool may address aspects of the GMP Framework. This was achieved by asking respondents to the on-line survey if they used MSF as a type of information, and if they did, to indicate how this information type contributed to attributes within the domains.

In addition, the focus groups were asked to look at a series of questions that had been developed from the Framework domains, and indicate how useful they thought each question would be regarding their appraisal.

BMC collated on-line feedback from those completing the on-line MSF tool.

The outcomes of these methods are discussed below.

ON-LINE SURVEY

In total – 59 (from a possible 100) responses to the on-line survey were received. Six of these respondents were from Mental Health and therefore could have experience with the RCP MSF tool, while the balance of the respondents had experience with the BMC MSF tool.

The following are the responses to the survey questions relating to Multi Source Feedback;

Q7. The following is list of 'Types of Information'. Please indicate if you have information of this type in your portfolio by selecting from the 'source' options.

	Generated by myself	Generated by my Trust	Generated elsewhere
Multi-source feedback	39.1% (9)	34.8% (8)	4.8% (8)

Total of 23 responses.

Q9. Domain 1 Knowledge Skills and Performance. Please indicate where the following information types contributed to the attributes within this domain.

	1 Maintain your professional performance	2 Apply Knowledge and experience to practice	3 Keep clear, accurate and legible records.	Response Count
Multi-source feedback	90.0% (18)	70.0% (14)	55.0% (11)	20

Q10. Domain 2 Safety and Quality. Please indicate where the following information types contributed to the attributes within this domain.

	1 Put into effect systems to protect patients and improve care	2 Respond to risks to safety	3 Protect patients and colleagues from any risk posed by your health	Response Count
Multi-source feedback	83.3% (15)	50.0% (9)	66.7% (12)	18

Q11. Domain 3 Communication, Partnership and Teamwork. Please indicate where the following information types contributed to the attributes within this domain.

	1 Communicate Effectively	2 Work constructively with colleagues and delegate effectively	3 Establish and maintain partnerships with patients	Response Count
Multi-source feedback	95.8% (23)	91.7% (22)	66.7% (16)	24

Q12. Domain 4 Maintain Trust. Please indicate where the following information types contributed to the attributes within this domain.

	1 Show respect for patients	2 Treat patients and colleagues fairly and without discrimination	3 Act with honesty and integrity	Response Count
Multi-source feedback	90.9% (20)	95.5% (21)	90.9% (20)	22

Discussion

While there was a relatively low indication of the use of MSF (less than half of the 59 respondents answered these questions), it is interesting to note respondents felt that MSF would contribute to all 4 domains. However, it appears that MSF contributed to some attributes more than others.

The tables above show that >90% respondents indicated that MSF contributed to the following attributes:

- Maintain professional practice
- Communicate effectively
- Work constructively with colleagues and delegate effectively
- Show respect for patients
- Treat patients and colleagues fairly and without discrimination
- Act with honesty and integrity

FOCUS GROUP – RANKING OF MSF QUESTIONS

There was an exercise during the pilot focus groups to review the usefulness of MSF questions. The domains within the GMP Framework were developed into a set of questions. These were the same questions used in the BMC MSF tool. (No focus

group participants were from Mental Health)

Participants were asked to agree a score for each question on a scale of 1-8 (one being the lowest - eight being the highest) regarding how useful each question would be in providing information for appraisal. Appendix 1 is an aggregate of all focus groups feedback on this task.

Discussion

The rankings by focus group members indicated that some development of this tool would be necessary. This would involve taking out the duplicated, lowest scoring and the poorly worded questions. Adjusting the question set based on this feedback, the revised list of questions is as follows.

In comparison with other doctors, to what extent does this doctor . . .

A1 Maintain and Develop Clinical Skills?

A1 Maintain sufficient breadth of clinical knowledge?

A1

Assess and Diagnose?

A2 Provide effective treatments?

A2 Make timely decisions?

A2 Encourage and support others?

A2 Teach Effectively?

A3 Keep clear, accurate and legible records?

A4 Take part in systems of quality assurance and quality improvement?

A5 Manage risk within own skills and competence?

A6 Perform unimpaired by ill health?

A7 Communicate effectively with colleagues?

A8 Work effectively in teams?

A8 Demonstrate appropriate leadership?

A8 Manage time effectively?

A8 Demonstrate trustworthiness?

A9 Communicate effectively with patients and their relatives?

A10 Protect the dignity and privacy of patients?

A10 Demonstrate respect for confidentiality?

A11 Apply objectivity in the assessment of the performance of others

A12 Demonstrate honesty?

A12 Accept personal responsibility for own decisions?

ANALYSIS

MSF was discussed in both the focus groups and via the on-line survey. As suggested earlier, two items of data can provide an indication of how MSF might be able to address specific attributes within the Framework. Respondents to the on-line survey indicated where MSF contributed to each attribute and the focus groups evaluated questions derived from the attributes. In the table below, the attributes have been numbered 1-12. The on-line survey score is the number of respondents who indicated that MSF could contribute to each of the attributes. The question score is the aggregate mean from the questions derived from each attribute (note – the same number of questions were not developed for each attribute, therefore an aggregate of the mean is used in this comparison).

Key
A1* Maintain your professional performance
A2 * Apply knowledge and experience to practice
A3 * Keep clear accurate and legible records
A4 * Put into effect systems to protect patients and improve care
A5 * Respond to risks and safety
A6 * Protect patients and colleagues from any risk posed by your health.
A7 * Communicate effectively
A8 * Work constructively with colleagues and delegate effectively
A9 * Establish and maintain partnerships with patients
A10 * Show respect for patients
A11 * Treat patients and colleagues fairly and without discrimination
A12 * Act with honesty and integrity

Attribute	On-Line Survey Score	Adjusted Question Score*
A1	18	30.6
A2	14	30
A3	11	30
A4	15	30
A5	9	31
A6	12	30
A7	23	30
A8	22	29
A9	16	27
A10	20	30.5
A11	21	28
A12	20	31

(*from a possible highest of 32)

This table shows the general level of correspondence between those who indicated MSF could contribute to informing each attribute and the aggregate score given for the usefulness of the questions developed from the attributes in the focus group exercise. After the focus group exercise, this question list was adjusted to eliminate the lowest scoring, duplicated and poorly worded questions. The scores shown in this table are the aggregated scores from the adjusted list of questions (from a possible maximum score of 32 for each question).

This table shows a slight variation in the perception and/or experience of survey respondents regarding the contribution of MSF to each domain. In particular A2 – A6 scored the lowest in the on-line survey. However, this table also shows that the forming of the right questions for each domain may overcome this. The only possible exception may be with regard to A9 – ‘Establish and maintain partnerships with patients’, which scored the lowest in both the question score and quite low in the on-line feedback. This may suggest the inclusion of ‘Patient Feedback’ data to adequately meet this attribute.

FEEDBACK ON BMC MSF TOOL

The Beeches Management Centre developed a short on-line questionnaire which all respondents completing the BMC MSF tool were invited to complete. 81 respondents completed the feedback questionnaire. A summary of the feedback from this survey indicates the following;

- 98% found the BMC MSF site and survey process easy to understand and negotiate
- 94% agreed/strongly agreed that the instructions on how to complete the questionnaire were clear
- 69% completed the survey within 10 minutes (and 25% of those within 5 minutes). 26% of respondents took up to 15 minutes.
- 89% reported no difficulty in accessing a computer to complete the survey. Those who experienced difficulty resolved the problem by completing the survey at home.
- 90% of respondents experienced no technical difficulty with the survey.

Respondents highlighted a number of issues relating to the questionnaire and survey process. There were some initial difficulties in accessing the survey which were resolved by the system administrators. Respondents felt there was some ambiguity with certain questions and they suggested ideas for further development. In particular it was suggested that the survey be developed to include items on handling stress, leadership and management, and communication skills, including interdepartmental communication.

Respondents also raised concerns about the general value of multi-source feedback.

The complete feedback report is at Appendix 2

FINDINGS AND RECOMMENDATIONS

Based on the feedback from the NI Pilot Project and the BMC survey of MSF respondents, the following is a summary of the key findings and recommendations.

1. The feedback from the focus groups and the BMC survey suggested a number of amendments to the MSF questions.

Recommendation: The BMC MSF tool is amended to reflect feedback from pilot participants

2. Feedback from the focus groups indicated particular issues relating to Attribute 9 “Establish and maintain partnerships with patients”. Doctors felt that supporting information for this attribute needed to be strengthened.

Recommendation: The pilot Steering group should consider how best to develop patient feedback data to adequately meet this attribute

3. The BMC survey showed that most respondents had no difficulties completing the BMC questionnaire on-line. This was due in part to the training undertaken within Trusts on administering the system.

Recommendation: All Trusts should identify sufficient system administrators to facilitate access to the BMC system and to be the initial port of call for any queries doctors may have about the system.

4. Although the pilot was not able to comment on how MSF was being used during appraisal, it is recognised best practice to ensure that anyone facilitating MSF feedback should be trained to do so.

Recommendation: All MSF feedback facilitators should receive training in their role and the principles and techniques of facilitating effective feedback sessions.

5. Feedback from focus groups indicated that some respondents were unsure about the purpose and process of MSF.

Recommendation: All Trusts should have clear guidelines for MSF, which set out the purpose of MSF; use of MSF in appraisal and revalidation; key roles and responsibilities; access to MSF systems; confidentiality of information.

6. As outlined in the Background Information section above, the GMC is currently developing principles and criteria for all MSF tools.

Recommendation: The BMC tool should be reviewed on a regular basis to ensure it meets the emerging requirements from the GMC.

7. The pilot was unable to assess the usefulness of MSF in informing appraisal discussions because insufficient respondents had had the opportunity to bring their MSF reports to their appraisal meeting.

Recommendation: There should be a further review of the BMC MSF tool following the next appraisal cycle, to assess how useful it was in informing the appraisal discussion and content of the personal development plan.

Appendix 1 – Focus Group rankings of MSF questions

Domain 1 – Knowledge, Skills and Performance

Attributes

A1* Maintain your professional performance

A2 * Apply knowledge and experience to practice

A3 * Keep clear accurate and legible records

In comparison with other doctors, how do you rate this doctor's ability to . . .

	Lowest							
Highest	1	2	3	4	5	6	7	8
A1 Maintain and Develop Clinical Skills							1	3
A1 Maintain sufficient breadth of clinical knowledge							2	2
A1 Participate in Self Development activities					1	2		1
A1 Assess and Diagnose							1	3
A2 Provide effective treatments				1				3
A2 Make timely decisions						1	1	2
A2 Teach Effectively						1	3	
A2 Find opportunities to train others						1	1	2
A2 Encourage and support others						1	2	1
A3 Keep clear, accurate and legible records							2	2

Domain 2 – Safety and Quality

Attributes

A4 * Put into effect systems to protect patients and improve care

A5 * Respond to risks and safety

A6 * Protect patients and colleagues from any risk posed by your health.

In comparison with other doctors, to what extent does this doctor . . .

	Lowest							
Highest	1	2	3	4	5	6	7	8
A4 Take part in systems of quality assurance and quality improvement						1		3
A5 Manage risk within own skills and competence							1	3
A6 Maintain good personal health? *					1		1	2

A6 Prevent others from suffering the effects of their personal health problems? *

1

3

(* These questions were regarded as poorly worded)

Domain 3 – Communication, Partnership and Teamwork

A doctor must

A7 * Communicate effectively

A8 * Work constructively with colleagues and delegate effectively

A9 * Establish and maintain partnership with patients

In comparison with other doctors, to what extent does this doctor . . .

Lowest

Highest

	1	2	3	4	5	6	7	8
A7 Communicate effectively with colleagues?								2
2								
A8 Work effectively in team							2	2
A8 Demonstrate appropriate leadership?						1	1	
2								
A8 Manage time effectively?							1	1
2								
A8 Respond promptly to calls, beepers and messages? *						1	1	1
1								
A8 Demonstrate trust in others						1	2	1
A8 Demonstrate trustworthiness							1	
3								
A9 Listen and respond to patients and their relatives					1			2
1								
A9 Respect the view of patients and their relatives					1			2
1								

(* This question was regarded as being poorly worded)

Domain 4 – Maintain Trust

Attributes

A10 * Show respect for patients

A11 * Treat patients and colleagues fairly and without discrimination

A12 * Act with honesty and integrity

In comparison with other doctors, to what extent does this doctor . . .

	Lowest							
Highest	1	2	3	4	5	6	7	8
A10 Treat patients and their relatives with courtesy? *						1	1	2
A10 Protect the dignity and privacy of patients?						1		3
A10 Demonstrate respect for confidentiality?						1		3
A10 Put aside personal belief in pursuit of best professional practice?						3		1
A11 Apply objectivity in the assessment of the performance of others						1	2	1
A12 Demonstrate honesty							1	3
A12 Accept personal responsibility for their own decisions							1	3

(* These questions were regarded as being too similar to 3.6/3.7)