

Report by Dr Steve Wilkinson (UEA)

**Northern Ireland Medical Revalidation
Pilot Project**

November 2009

EXECUTIVE SUMMARY

1. It was agreed that a GMC Revalidation pilot project would be conducted in Northern Ireland primarily to test the GMP framework and identify how the supporting information required could be generated. Additional project objectives included; identifying additional evidence; identifying potential improvements to the appraisal process; to establish a baseline understanding of participation in medical appraisal; to identify the time taken to collate supporting information; to test and evaluate the use of Multi-source Feedback; to identify groups that may find it difficult to provide supporting evidence; and, to identify methods of meaningful patient/carer consultation.

2. The Framework document is intended as a generic tool for all doctors, however it is recognized that information requirements may vary among specialties and groups. The Framework document was regarded as a useful tool and with some further development would assist doctors in creating information for appraisal and revalidation.

3. It was also found that document types that are currently available and used in appraisal are not necessarily those that are regarded as being of high priority for appraisal portfolios. Additionally, the items that are used the most in appraisal portfolios are predominantly self generated. There is potential to reduce the amount of time taken to prepare for appraisal and to increase the level of higher priority data that can be used. There is also scope for individuals to introduce data into their portfolio that reflects their role and work, which may lay outside recommended lists of suggested data. It would be difficult to establish a definitive list of all potential and useful data.

4. There is scope to improve the appraisal process and the appraisal experience. While a great deal of effort is being made to ensure the system is fit for purpose, improvements can also be made in ensuring there are meaningful and accountable outcomes.

5. MSF surveys were found to be efficient and effective tools for providing information at appraisal – described in the Framework. It was also found that the presence of MSF in a portfolio reduces the need for large amounts of supporting information.

6. Two of the project objectives were not achieved and one only partially achieved. Only a partial understanding of participation in appraisal is known. Additional work is

also needed in what supporting evidence may be required for those in specialty groups and in identifying methods of meaningful patient/carer consultation.

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Introduction

1. This report presents the findings from the Northern Ireland Medical Revalidation Project. This report has been developed by Dr Steven Wilkinson, Centre for Applied Research in Education – University of East Anglia, (UEA), Jane Lindsay Department of Health, Social Services and Public Safety (DHSSPS), Christine McGowan, Beeches Management Centre, (BMC) and Rhian Williams General Medical Council (GMC).

BACKGROUND

Provision and regulation of healthcare in Northern Ireland

2.1. The Department of Health, Social Services and Public Safety for Northern Ireland (DHSSPSNI) established the Health and Social Care Board (HSCB) on 1 April 2009. There are 5 Health and Social Care Trusts responsible for all healthcare services provided in hospitals, clinics, nursing and residential homes:-

Belfast Trust, Northern Trust, Southern Trust, South Eastern Trust and Western Trust

Confidence In Care Programme And Work-streams

2.2. The DHSSPS established the Confidence in Care Programme to take forward the work emanating from the Department of Health White Paper “Trust Assurance and Safety” and outstanding recommendations from the DHSSPS report “Improving Patient Safety: Building Public Confidence”.

2.3. There are four work streams within the Programme encompassing the work emanating from seven national working groups, one of which is ‘Medical and Non-Medical Revalidation’.

Medical and Non-Medical Revalidation:

2.4. The aim of this work stream is to establish and harmonize a new system of medical and non medical revalidation, building on work undertaken nationally, to improve professional standards and provide assurances to both professionals and the public.

Revalidation

2.5. In future all licensed doctors will be required to demonstrate periodically that they are up to date and fit to practice through a process called Revalidation. The GMC is planning to introduce the licence to practise, the first step towards implementing revalidation, on 16 November 2009.

2.6. Revalidation has three specific purposes:

To confirm licensed doctors practise in accordance with the GMC's generic standards (relicensure);

To confirmed licensed doctors on the GP and specialist registers meet the standards appropriate for their specialty (recertification); and

To identify for further investigation and remediation, poor practice where local systems are not robust enough to do this or do not exist.

2.7. The report of the Chief Medical Officer for England's Working Group (Medical Revalidation-Principles and Next Steps) was published July 2008. 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.

2.8. It is important that aspects of the revalidation are piloted and tested to ensure they are fit for purpose. 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.

2.9. More information on revalidation can be found on the GMC's website at <http://www.gmc-uk.org/doctors/licensing/revalidation/index.asp>

Northern Ireland project

2.10. Following discussions between the DHSSPS, GMC and the Trusts it was agreed that the NI project would primarily consist of testing the GMP framework and identify how the supporting information required could be generated. It was, however, recognised that a baseline of levels of medical appraisal was also required, building on the work previously undertaken by RQIA and DHSSPS (Naftalin Report, 2006).

Multi Source Feedback

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

2.12. The substantial findings relating to the BMC MSF tool will be reported separately. References made to MSF tools in this report refer to a range of tools used by doctors.

PROJECT OBJECTIVES

3. The objectives of the NI Revalidation Project were:

A. To test how the GMP framework sits within current appraisal systems in secondary care (*This document has come out of the GMC work-stream 3. 'Develop standards and a framework for appraisal and assessment based on Good Medical Practice' and translates 7 Good Medical Practice headings into 4 practice Domains**)

B. To test how supporting evidence can be collated in a range of clinical specialities.

C. To identify additional evidence that may be required by doctors to demonstrate he or she meet the standards of GMP

D. To identify potential improvements to the appraisal process in secondary care in Northern Ireland for the purposes of revalidation.

E. To establish a baseline of (*i.e. participation in*) medical appraisal in secondary care (in Northern Ireland)

F. To identify the time taken to collate supporting information and any additional resources which may be required

J. To test and evaluate the use of Multi-source Feedback (*The GMC Revalidation Work-stream 4 seeks to validate MSF tools and agreed principles and criteria that must apply to any patient and colleague questionnaires used in the revalidation process.**)

K. 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.

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

(*GMC Revalidation Work Streams can be located at http://www.gmc-uk.org/doctors/licensing/revalidation_board_projects.asp - November 2009)

PROJECT TARGET GROUP

4. The specialties which were covered in the project were identified and agreed with the five Trusts, as follows:

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

Queens University Belfast (QUB) – clinical academics

METHODOLOGY AND METHODS

5.1 The methodology used in this project was Grounded Theory

Grounded theory (GT) is a systematic qualitative research methodology in the social sciences emphasizing generation of theory from data in the process of conducting research.

It is a research method that operates almost in a reverse fashion from traditional research and at first may appear to be in contradiction of the scientific method. Rather than beginning by researching and developing a hypothesis, the first step is data collection, through a variety of methods.

(http://en.wikipedia.org/wiki/Grounded_theory - October 2009)

5.2 The Methods used to collect data in this project included an on-line survey distributed to 100 doctors from the project target group, a series of focus groups and interviews involving members of the target group, the use of existing data, and on-line feedback collected by BMC relating to Multi Source Feedback (MSF). Alongside this, a smaller group of clinical academics were to examine how the supporting information could be collated within their speciality.

PROJECT DELIVERABLES

6.1 This report forms the deliverable output for this project – however some wider understandings of Appraisal and associated documentation were achieved through steering group meetings and focus group exercises. Additionally, the project steering group gained greater understandings of the wider management challenges within revalidation. These were incidental but no less significant outcomes.

6.2 This report was originally to be provided by the end August 2009. However this date was extended to allow for a greater response and higher level of participation accounting for the summer break. This extension also allowed doctors time to learn more about revalidation by holding meetings, engaging in discussion and asking questions. The GMC supported these activities through providing information events within trusts during the conduct of this research.

REPORT STRUCTURE

7. This report provides a summary of each of the data methods separately, and then provides a discussion of the findings collectively. Findings from this research and recommendations from these findings are then made.

PART ONE - ON-LINE SURVEY

8.1. An on-line survey was developed using SurveyMonkey.com®. A blank copy of the survey can be found at Appendix (A) This survey was piloted within the steering group and further developed. The survey was sent out to 100 email addresses on the 19th May 2009. Undeliverable email addresses were amended and the survey was sent out again on 3 further occasions in June, August and September inviting non-respondents to participate. It is known that the survey remained undeliverable to c.10 email addresses. The last response was received on the 28th September 2009. The Survey was closed on the 7th October 2009.

Outcomes from the Survey.

8.2. A download of the survey showing quantitative responses to questions can be found at Appendix (B)

8.3. The Qualitative responses to this survey and some analysis of these can be found at Appendix (C)

Summary

8.4. 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.

8.5. 51 people responded to the questions regarding the time it took them to prepare for Appraisal and to indicate how they used this time. The time taken to prepare ranged from 0 – 46 Hours with the mean 8.7, mode 4 and median 6 Hrs. From the responses it can be surmised that respondents claim they spent 42.5% of the time searching and gathering documents, 30% of the time preparing forms and the portfolio, 12.5% of their time writing, typing or dictating, 9% of their time analysing and 6% of their time reading*.

(*These are approximate figures based on a semiotic text analysis – see Appendix C).

8.6. Respondents were asked to select from a list a 'type' of information they included in their portfolio – and to also indicate if this was generated by themselves, the trust or elsewhere. The greatest amount of information was self generated (260 items) followed by trust generated, (104 items) and then elsewhere (42 items).

8.7. Item 'types' that were mostly self generated included; 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; vaccination records; near miss incident reports; and multi source feedback (listed in descending order by volume). Length of stay; process/outcomes; re-admission rates; near miss incident reports; and infection rates were mostly generated by the trust (listed in descending order by volume). The one type of information that was mostly generated elsewhere was the PMETB training survey feedback.

8.8. Additional information types that respondents identified were,

Specific infection rates

Private practice statements

*360*appraisal by Royal college*

Statements around relationships with colleagues and patients

Declarations re health and probity

Details of service deficits

Risk Management activities.

Workload

Thank you cards/letters

Teaching sessions

CV

Feedback from students and patients

Publications and grant awards

QUB confirming contribution to teaching and management

Feedback from conferences organisers about contribution

Membership documentation for learned societies

Colleague comment and letters
Statement on working relationships

8.9. Information types contributed towards demonstrating attributes across the 4 domains. 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 time |
| 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 |

8.10. Types of data relating to individual attributes of the framework are shown at Appendix B.

8.11. On a 6 point scale where 1 was the lowest and 6 was the highest, respondents gave a mean score of 3.31 (respondents n31) to the statement 'I found the framework a helpful tool for collecting information'. Reasons given for why it was not found to be useful included;

It was repetitive

It was difficult to decide which section supporting information should go into

Trust was/is unable to provide data

Data is unreliable

8.12. On a 6 point scale where 1 was the lowest and 6 was the highest, respondents gave a mean score of 3.12 (respondents n34) to the statement 'I found the domains were clear'. Reasons given for why they were not found to be clear included;

Some sections were ambiguous

The terminology is confusing

The domains essentially overlap.

Much of the domains inter-link.

8.13. On a 6 point scale where 1 was the lowest and 6 was the highest, respondents gave a mean score of 3 (respondents n36) to the statement 'I found the attributes covered all aspects of my practice'. Reasons given for why it was felt they did not cover all aspects included;

One size does not fit all

They didn't cover other attributes of the job

It does not cover academic roles

8.14. 80.6% (n29) said that the information they collected was similar to the information they provided previously at Appraisal. 66.7% of respondents (n24) felt that it was not easy to access electronic information about themselves from the trust. 55.6% (n20) felt that there were no specific types of supporting information for their specialty.

8.15. Further comments made on this 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 need to be updated.

I really have no performance indicators or outcomes.

Much information should be available from 360 feedback.

PART TWO - FOCUS GROUPS

9.1. A focus group exercise was developed (Appendix D) and conducted at participating trusts. The format for the focus groups and the schedule of events was forwarded to participating trusts ahead of the scheduled event. The focus groups were conducted according to schedule and in some cases were followed by an open GMC information event. Included in this exercise were two interviews with key informants. One interview covered the focus group format, while the other did not.

Focus Group Outcomes

9.2. The outcome of the focus group exercise and some analysis of this data can be found at Appendix D.

Summary

9.3. The numbers of participants in each of the participating trusts/organizations are listed below. It was not possible to schedule a focus group within one of the participating trusts (Southern). However, this trust discussed the issues central to this research and reported these in an email (Appendix F). These views broadly correspond with the views of colleagues from other trusts – reported below. Numbers of participants were also affected by pandemic flue planning.

| | |
|---|------|
| Belfast Trust – | 8 |
| South Eastern Trust - | 3 |
| Northern Ireland Medical and Dental Training Agency – | 1 * |
| Western Trust - | 6 |
| Northern Trust | 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

9.4. Exercise 1 sought to identify those documents that were key to an appraisal. The documents that all focus groups agreed are Mandatory for an Appraisal Portfolio include;

- Multi Source Feedback
- CPD folder
- Past Appraisal Form 4 (including CPD)

- Records of mandatory training
- Registration Certificate

9.5. The documents that were regarded as both Mandatory and Supplementary by all focus groups include;

- 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)

9.6. The documents that all focus groups agree are Supplementary for an Appraisal Portfolio include;

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

9.7. Exercise 2 sought to discover how appraisal could be improved. Based on the feedback from this exercise, the following measures could be considered to improve Appraisal for doctors. These are shown in descending priority order - the score given to each as an outcome of the Nominal Group Technique (see appendix D) is also shown.

- Accurate & sufficient Trust Generated Data (including Complications, Outcomes & Complaint outcomes) (63)
- Appraisee/Appraisal Preparation time (49)
- MSF (provided by Trust) (18)
- Realistic, Funded Personal Development Plan (15)
- More Explicit use of SPA (expand) 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)

9.8. Exercise 3 sought to review a set of multi source questions to identify those that were regarded by doctors as useful in providing information for appraisal. An analysis of this exercise can be found at Appendix D.

9.9. In addition to the feedback from the focus groups Beeches Management Centre (BMC) collected feedback from survey responders during pilots conducted in 2008/09. In total c700 people completed MSF surveys for doctors and of these 79 responded to the feedback questionnaire about the MSF tool. A summary of this feedback is reported in Part 3 below. This report is at Appendix (E)

9.10. Exercise 4 set out some stimulus questions and responses to these and other discussion throughout the focus groups was noted. The following summarises these discussion points;

9.11. Summary of discussion regarding appraisal

- There remains a degree of uncertainty about what appraisal is for.
- Colleges are interested in actively engaging in the process other than have no say in the system as it evolves. College guidance has been effective.

9.12. Summary of discussion regarding MSF

- MSF 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.
- The absence of MSF places a higher demand on other supporting data.

9.13. Summary of discussion regarding other data

- The development of portfolios remains an individualized and often time consuming activity. This time factor could be reduced with an on-line portfolio and with the trust providing necessary data about an individuals practice within the trust.
- The current system of 'Pooled Waiting List' management raises issues regarding information about or from patients.
- Appraisal has increased the time it takes to compete other requirements (such as CPD & Audit) as they are now more accountable within the revalidation process.
- The quality and skills of the appraiser is key to the success of this system.

9.14. Summary of discussion regarding the GMC framework

- 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.

9.15. In addition to the focus group meetings, two further interviews were undertaken. While the notes from both interviews have been incorporated into the focus group feedback – one additional question remains. 'Does joint appraisal apply for associate deans as it does for clinical academics?' This implies that the appraisal be a joint meeting between the deanery, the trust and the appraisee – where the appraisee has a substantial role within the deanery and the trust and where there is significant advantage in having these roles appraised together.

9.16. Exercise 5 reviewed the Framework document. (The Framework attempts to provide a set of Domains which contain Attributes, each of which have associated standards for performance and suggests where evidence of this performance might be found.) Participants were asked to discuss and suggest amendments. These suggestions have been summarised at Appendix D and provided to the GMC.

9.17. The response to this tool by focus group respondents was varied. Some found it helpful and well constructed. Others felt it was in need of further development.

PART THREE - MULTI SOURCE FEEDBACK

10.1. Multi Source Feedback was indicated as a 'type' of information in the on-line survey and discussed widely in the focus group sessions. (see notes above).

10.2. In addition to this, BMC undertook a review of an MSF tool under pilot in trusts in NI. A summary of the feedback from this multi source feedback survey indicates the following;

10.3. The BMC feedback suggests that 69% are completing the survey within 10 minutes (and 25% of those within 5 minutes). 26% of respondents are taking up to 15 minutes.

10.4. 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.

10.5. 90% of respondents experienced no technical difficulty with the survey.

10.6. There were a range of concerns expressed about this survey. These addressed issues relating to accessing the survey and the format of the survey and also confidence in the survey itself. Some ambiguity with certain questions were raised and ideas for areas of further development. In particular it was suggested that the survey be developed to include issues of attitude and communication skills.

10.7. The full survey report can be found at Appendix E.

PART FOUR - READINESS REVIEW

11.1. A readiness review was undertaken to establish the current situation regarding Appraisal completions in each of the Trusts in Northern Ireland.

11.2. A baseline audit of appraisal was conducted. While this was incomplete (i.e. not all trust responded at the time of compiling the report) it was evident that appraisal has not been uniformly applied throughout Northern Ireland trusts. While there were some examples of consistent high levels of completion and inclusion – there were also some of very low levels of both.

11.3. This review is unpublished and remained a work in progress at the time of producing this report.

DISCUSSION

Objective

- A. To test how the GMP framework sits within current appraisal systems in secondary care

Discussion

12.1. The GMP framework was discussed in the on-line survey and in the focus group and interview discussions. While the framework was not widely used in the appraisals of the survey group, (<50%) it was rated 3.31 on a six point scale, as a helpful tool for collecting information. Supporting comments suggested it was found by some to be repetitive, unclear and there were issues regarding suggested supporting data. It is unknown if these views were held by those who actually used the tool. It is also important to differentiate between feedback that addressed the Framework, and that which was more broadly focused on the supporting data suggested by the tool (in the 'Possible Sources of Evidence' column). However, this feedback suggests that there is scope to improve this tool.

12.2. The Domains appear to be the key area where greater clarity can be achieved.

12.3. The Attributes discussion highlights the difficulty in developing a generic tool (for all specialities). This suggests that the form could be further developed to accommodate more specific Attributes. However, a careful balance needs to be struck between designing a 'generic' tool and including 'specific' Attributes. A tool that is too generic may not provide sufficient guidance and one that is too specific may exclude people within certain specialisms.

Objective

- B. To test how supporting evidence can be collated in a range of clinical specialities

Discussion

12.4. What is evident is that while a document type may be available and included in a portfolio, availability does not necessarily correspond with priority. For example, multi source feedback was identified as being a type of information that addresses more of the attributes than does any other type of information. It was also regarded as mandatory and the highest priority for

information in the portfolio – however, it is not universally available to everyone at this stage. This item was also mostly self-generated. This suggests that the full potential of the contribution to appraisal and revalidation of MSF is yet to be realised.

12.5. Audit activity was indicated as being the second most used form of all information types included in the portfolio and yet it was not regarded as mandatory data in every case. This item was mostly self-generated. There was also discussion regarding a lack of guidance or clarity from Royal Colleges and professional bodies on the issue of audits. As each college and professional body introduces guidance on certification and recertification it is anticipated that greater clarity and guidance on audits may also become available.

12.6. Multi disciplinary team data was rated as the third most used source of data and was regarded by some as mandatory for inclusion in the portfolio. This item was mostly self-generated. This may indicate an emerging interest in ‘team based’ appraisal and/or a developing interdependence or inter-reliance on team members and systems.

12.7. The CPD folder was rated as the fourth most used form of data and regarded as mandatory for all portfolios. This is also likely to be reinforced through the recertification process. This item was mostly self-generated, however it is known that some assistance with this may be forthcoming in the near future as on-line processes are developed.

12.8. While the job plan was rated as the fifth most used form of data it was not regarded as mandatory for all portfolios. This may be a further indication of the need for clarity around the purpose of Appraisal and its links to revalidation. While it was suggested that this item was mostly self-generated, it remains a governance process within employing trusts. Therefore, the extent to which the document is ‘self-generated’ may vary from trust to trust.

12.9. Team based information was rated as the sixth most used form of data and rated as mandatory for some portfolios. Near miss incident reports were rated as the seventh most used form of data and rated as mandatory for some portfolios. These items were mostly self-generated. Greater clarity on

what 'outcome' data may be relevant for appraisal and revalidation has the potential to inform trust governance systems of more specific information needs. There is potential that this form of information can be provided by trusts for appraisal and thereby reduce the burden on doctors to locate this information for themselves.

12.10. Process/outcomes and length of stay was rated as the eighth most used form of data and regarded as mandatory for some portfolios. This form of data was also regarded as often being difficult to access and not always reliable. Respondents also indicated that they spent a considerable amount of appraisal preparation time locating this data – which may contribute to its relatively low usage. This data was mostly generated by the trust. Appraisal and revalidation has increased the importance for this data to be firstly - valid and reliable and secondly – provided for appraisal.

12.11. Mandatory training was rated as the ninth most used form of data and was regarded as mandatory for all portfolios. The relatively low use of this data may imply that it is either not made available or not routinely included into portfolios. This item was mostly self-generated, which was surprising, noting that mandatory training records should be a governance process. This is an example of data that may be provided for appraisal, however, has its origins in governance and appraisal holds it into account. It is important to be able to differentiate between an appraisal that informs practice and performance, and one that provides accountability for governance systems. This differentiation needs to be understood by appraisers.

12.12. Readmission rates were rated as the tenth most used form of data and as with Process/Outcome data was regarded as mandatory for some portfolios. This data was predominantly generated by the trust. As with outcome data, provision of this information for appraisal may reduce the preparation burden.

12.13. Indemnity documents were rated as the eleventh most used form of data and were regarded as mandatory form some portfolios. This data was mostly self-generated. However, these may be regarded in the same way as 12.11 above.

12.14. Infection rates were rated as the twelfth most used form of data and as with Process/Outcome data was regarded as mandatory form some portfolios. This data was mostly generated by the trust. (see 12.10 above)

12.15. The registration certificate was rated as the thirteenth most used form of data and was regarded as mandatory for all portfolios. This data was mostly self-generated – which can possibly be interpreted as self-provided. While it is recognised that registration information is important, it is pre-requisite for employment and therefore the presence of this document can be expected. The extent to which it informs the appraisal discussion is not clear.

12.16. Vaccination records were rated as the fourteenth most used form of data but only regarded as supplementary to the portfolio. This data was regarded as being mostly self-generated. Discussion regarding the inclusion of this information raised some issues regarding confidentiality and patient choice. This data may be regarded in the same way as 12.15 above.

12.17. A private practice statement was rated as the fifteenth most used form of data and regarded as mandatory for some portfolios. This was regarded as being mostly self-generated. It is clear how this document may inform the appraisal discussion in that it should provide the full scope and range of the doctors practice. The presence of this data may 'imply' that a broader practice is included within the appraisal – however, it may also suggest further data may be important regarding additional practice undertaken outside of the main employment contract. This introduces further levels of ambiguity and scope for interpretation regarding what this further information might be and how it might be provided and discussed. Clarity on this may be necessary.

12.18. The PMETB training survey was rated as the sixteenth most used form of data and regarded as supplementary to the appraisal portfolio. This data was generated elsewhere other than the trust. In discussion it was suggested that this data is readily available – however many doctors have not accessed it.

12.19. Registration with a GP was rated as the seventeenth most used form of data and was regarded as supplementary to the portfolio. This data was self-generated. This data may be regarded in the same way as 12.15 above.

12.20. A research statement was rated as the eighteenth most used form of data and was regarded as supplementary to the portfolio. This was self-generated. Additional information for those engaged in research may include ethics approval documentation and grant applications.

12.21. Additional data that was not included in the survey list of data types – but was suggested in focus group included; self-declarations of health and probity, workload records and testimonials from patients. While self-declarations and workload records were regarded as mandatory for some portfolios, patient testimonials was regarded as supplementary. It is apparent that the data that is necessary and central to any particular appraisal may be in part down to the judgment of the appraiser and appraisee.

Objective

- C. To identify additional evidence that may be required by doctors to demonstrate he or she meet the standards of GMP

Discussion

12.22. This objective was addressed both in the survey and in the focus groups. As discussed in objective B above focus group respondents identified self-declarations in health and probity, workload records and testimonials from patients as additional information, however testimonials from patients were seen as supplementary data.

Survey respondents identified the following;

Specific infection rates,

Private practice statements

360*appraisal by Royal college

Statements around relationships with colleagues and patients

Declarations re health and probity

Details of service deficits

Risk Management activities.

Workload.

Thank you cards/letters

Teaching sessions

CV

Feedback from students and patients.

Publications and grant awards

QUB confirming contribution to teaching and management
Feedback from conferences organisers about contribution
Membership documentation for learned societies
Colleague comment and letters
Statement on working relationships

12.23. Common to both the focus groups and the survey respondents were declarations of health and probity, workload records and testimonials from patients.

Objective

- D. To identify potential improvements to the appraisal process in secondary care in Northern Ireland for the purposes of revalidation.

Discussion

12.24. Potential improvements to the appraisal process were discussed predominantly in focus groups and interviews. A suggested list of improvements includes;

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

12.25. There is scope to improve the appraisal process and the appraisal experience. While a great deal of effort is being made to ensure the system is fit for purpose, improvements can also be made in ensuring there are meaningful and accountable outcomes.

Objective

- E. To establish a baseline of medical appraisal in secondary care

Discussion

12.26. A baseline audit of appraisal has been conducted. While this was incomplete (i.e. not all trust responded at the time of compiling the report) it was evident that appraisal has not been uniformly applied throughout Northern Ireland trusts. This suggests more work is needed to embed appraisal in NI.

Objective

- F. To identify the time taken to collate supporting information and any additional resources which may be required

Discussion

12.27. The time taken to collate the supporting information and additional resources was addressed in the survey. The feedback indicated that it took an average of 8.7 hours to prepare for an appraisal. From the responses it can be surmised that respondents claim they spent 42.5% of the time Searching and Gathering Documents, 30% of the time preparing forms and the portfolio, 12.5% of their time writing, typing or dictating, 9% of their time Analysing and 6% of their time reading*.

(*These are approximate figures based on a semiotic text analysis).

12.28. There is potential to reduce the amount of time taken to prepare for appraisal and to increase the level of higher priority data that can be used (as discussed above).

Objective

- J. To test and evaluate the use of MSF

Discussion

12.29. MSF was discussed in both the focus groups and via the BMC on-line feedback. It was found that MSF surveys in general were not overly time consuming, provided a valuable contribution to the information used in appraisal and were generally accessible.

Objective

K. 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.

Discussion

12.30. This objective was to involve specialty groups (in particular clinical academics) in identifying supporting evidence particular to their role. This work was not undertaken and therefore not completed. However, there has been the report of a discussion on this issue, notes for which are included in Appendix F.

12.31. What is not known is if Deans and Associate Deans are to be appraised in the same way as clinical academics (i.e. one appraisal meeting incorporating both the clinical and academic activities and roles). Clarity on this would be helpful.

12.32. Further work is needed to establish what supporting evidence may be required for those in specialty groups or who are working outside of a managed working environment.

Objective

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

Discussion

12.33 This objective was not addressed at all during this project. Within the survey and focus groups, mention was made of the use of patient feedback – however processes for gaining it were not suggested. One complication that was identified was the ‘shared list’ system operating in NI. This system fragments the care pathway and different doctors can be responsible for providing different levels of care at different stages. This may lead to problems in collecting feedback on individual doctors – however this is yet to be tested. This issue remains unresolved in the context of this project and in the wider context of appraisal and revalidation.

FINDINGS AND RECOMMENDATIONS

Findings

13.1. Regarding the Framework document

a The Framework document is intended as a generic tool for all doctors, however it is recognized that within this, information requirements may vary among specialties and groups.

13.2. Regarding the Appraisal Portfolio

b Document types that are currently available are not necessarily those that are regarded as being of high priority for Appraisal portfolios.

c The items that are used the most in appraisal portfolios are predominantly reported as being self-generated.

d There is potential to reduce the amount of time taken to prepare for appraisal and to increase the level of higher priority data that can be used.

e There remains scope for individuals to introduce data into their portfolio that reflects their role and work, which may lay outside recommended lists of suggested data.

f Further work is needed to establish what supporting evidence may be required for those in specialty groups.

13.3. Regarding the Appraisal

g There is scope to improve the appraisal process and the appraisal experience. While a great deal of effort is being made to ensure the system is fit for purpose, improvements can also be made in ensuring there are meaningful and accountable outcomes.

13.4. Regarding MSF

h MSF surveys are not overly time consuming and are generally accessible.

i The presence of MSF in a portfolio reduces the need for large amounts of supporting information.

Recommendations

13.5 Regarding the Framework document

i The purpose of the Framework document needs to be clarified (i.e. who is the audience? and how should it be used?)

- ii. The Framework document could be further reviewed. For example, the format of the document could be shown in a way that clarifies the links between the Domains, Attributes and Standards and more direction about the supporting evidence would be helpful.
- iii Training in the use of the Framework should be considered.

13.6 Regarding the Appraisal Portfolio

- iv A minimum data set should be established for all appraisal portfolios and additional data should relate to the individuals job and role (and be supported by guidance from the respective royal colleges or professional bodies.)
- v. A further project should be set up to identify the supporting evidence that may be required for those in certain specialty groups (including clinical academics).
- vi. A separate project should be established to investigate appropriate ways of gaining and including patient feedback in the appraisal of doctors in NI.

13.7. Regarding the Appraisal

- vii Assuring the Quality of Medical Appraisal (published by the Revalidation Support Team – July 2005) provides a method for reviewing internal appraisal systems. In concert with this, Trusts should consider
 - identifying Trust generated data that can be provided to doctors for appraisal portfolios
 - identifying a time and space allocation for the appraisal meeting
 - providing MSF surveys (as per para 2.11 “Trust, Assurance and Safety – the Regulation of Health Professionals’, Feb 2007 p39)
 - ensuring the outcomes of appraisal are addressed and/or embedded
 - ensuring sufficient availability and uptake of training for all doctors and appraisers.
- viii In order to engage all doctors in Appraisal consideration should be given to providing incentives to participate at Trust level.
- ix Induction training should be provided for all doctors in NI at Trust level. Additional training for appraisers should also be provided.
- x The appraisal process for Deans and Associate Deans with respect to joint appraisal needs to be clarified.

13.8. Regarding MSF

xi MSF surveys and systems be introduced across NI.

Xii MSF surveys continue to be monitored to ensure they are efficient and effective.

Dr S. Wilkinson (on behalf of the project team) -November 2009