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series

Appraisal & Revalidation for Doctors

***A Practical Guide for Medical
Managers***

2nd Edition

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Preface

Appraisal was first introduced for NHS consultants in the UK around 2002, with GPs and specialty doctors following shortly after. It was intended to form the basis of professional development and, at the same time, contribute towards Revalidation. There were, however, glitches both in terms of Appraisal and the proposed Revalidation process. Although Appraisal did get off the ground – to a mixed reaction from the medical profession – Revalidation did not. It was subject to numerous delays, before being shelved in the wake of the Shipman Inquiry and the Chief Medical Officer's decision to go back to the drawing board. The new Revalidation process, expected to be introduced for all doctors in the UK from 2012 will centre on a new system of 'strengthened' appraisal. The rationale for the use of Appraisal is simple. When adopted properly, Appraisal can be an effective platform for supporting personal and professional development. Although Appraisal is not the most appropriate tool for identifying and dealing with doctors in difficulty, it can be a useful means of having focused one-to-one discussions about performance. If the profession was able to create a cohort of highly skilled Appraisers, from a wide range of backgrounds, working within a better framework of medical management, allied to effective clinical governance, the profession would be in a stronger position to manage poor performance.

Revalidation presents the healthcare sector in the UK with a fantastic opportunity to put Quality centre stage, and to establish explicitly the link between 'performance' and Quality. For medical management, as an emerging specialty, this is a chance to define better the roles that doctors in management take at operational (Directorate and Team) level. For primary care, in particular, where there is often patchy medical management at this level, this is an opportunity to identify meaningful roles that doctors could take to lead parts of the organisation forward. Finally, doctors in management should not work in isolation from each other, or from other professional groups. There is a need for healthcare leaders of all professions to find better ways of working together to raise the bar across all clinical specialties.

We have written this paper after spending more than a decade working on issues of Appraisal and Revalidation for doctors, mainly in the NHS. It stems from dozens of training sessions and meetings with individuals and groups, and from advising on the setting up and running of Appraisal systems in organisations. We make no apology for our attempt to link Appraisal, Revalidation and Quality together. Neither do we apologise for promoting the case for enhanced medical management roles. It is clear to us that effective medical management is the key to success in both Revalidation and the wider leadership of the NHS. This paper constitutes a digest of all that we have learnt so far about these issues. We offer it as a resource for clinicians and managers alike, to use when making their preparations for Revalidation. It is intended as a handy and practical reference guide to the essential ideas and concepts involved. Over time, this document will evolve as readers share with us their own experiences and insights. We will incorporate updates into future editions.

Background – the Genesis of the Current System

The Bristol Child Heart Surgery Scandal

The origins of the current Appraisal system for senior doctors in the UK can be traced back to events at Bristol Royal Infirmary in the 1990s. Concerns had been raised by an anaesthetist about the surgical practice of an individual surgeon. He was worried about the surgeon's competence, specifically in relation to heart surgery on babies and made his concerns known to his Clinical Director, Medical Director, Chief Executive, and eventually to the Regional Health Authority. The anaesthetist was warned off making further allegations and was labelled a troublemaker - someone who rocked the boat. The surgeon in question was a senior and highly respected medical colleague within the Trust. However, concerns grew, and the anaesthetist eventually decided that he could no longer work with the surgeon. He also expressed his concerns to the families of patients, and encouraged them to go elsewhere for treatment. In time, the story burst into the public arena and reverberated across the NHS. Questions could be raised about the way concerns were handled by both sides.

The Kennedy Report

Professor Sir Ian Kennedy, a legal academic, was appointed by the Government to conduct an independent inquiry into the events at Bristol. The Kennedy Report, published in 2001, would affect every corner of the NHS. Kennedy was concerned, in particular, that the medical profession did not adequately respond to concerns about individual doctors from within the profession, by allied health professions, or by the public. In Kennedy's view, senior colleagues both inside the Trust and at a higher level ignored, or brushed off, legitimate concerns. He believed that the profession was more interested in self-protection than in protecting the public. Whilst there is merit in many of the conclusions reached by the Kennedy Inquiry, it is unfair to blame an entire profession because of the actions of a small minority of its members.

The Government was concerned about the ramifications of the Bristol scandal, and elected to take action even before Kennedy reported. The concept of clinical governance had been introduced in 1999, where NHS Trusts were given specific responsibilities to improve the quality of care they delivered. The NHS Plan (2000), relating specifically to England, created a new inspectorate for health organisations, the Commission for Health Improvement (CHI). This was later replaced by the Healthcare Commission (HCC), which was to be chaired by Sir Ian Kennedy himself. In 2009, the HCC was abolished and replaced by the Care Quality Commission (CQC), which was given wider powers that extended into the social care sector. The CQC is charged with introducing a system of licensing for health and social care organisations, and with requiring them periodically to revalidate that licence.

Interestingly, this is an organisational version of the scheme proposed for individual doctors. If a health or social care organisation fails to meet standards set by the CQC, it runs the risk of having its licence revoked, which could lead to its closure. In other words, the organisation could be 'struck off', and/or its services could be taken over.

In his report, Kennedy heavily criticised the GMC, which he saw as out of touch and non-responsive. The then president of the GMC, Sir Donald Irvine, launched proposals for a system of revalidating doctors. Working in conjunction with the Department of Health, a new system of Appraisal was designed, and launched in 2002, tying professional development to the seven headings set out in Good Medical Practice. The plan was simple. Revalidation would be a five-year cycle, with five annual Appraisals. Provided that a doctor could satisfy the GMC that they had successfully completed five Appraisals, and that there were no reported concerns, the doctor would be revalidated for another five years. The GMC introduced the concept of a portfolio of supporting information, and proposed to review this document at the end of the Revalidation cycle. The proposals were far-reaching, and widely criticised as being too cumbersome and bureaucratic.

The Shipman Inquiry

At about the same time that Kennedy was investigating the Bristol case, police were investigating Dr Harold Shipman, a general practitioner working in Hyde on the outskirts of Manchester. Concerns had been raised by undertakers in the town about the unusually high numbers of cremation forms used in the Shipman Practice. The local Health Authority largely ignored those concerns. Police subsequently arrested Shipman and he was charged with murder. The Shipman case is infamous. He is believed to have been responsible for the deaths of more than 200 of his patients. The actual number is likely to be far higher. How were Shipman's activities able to slip through the net? How was he able to get away with what he did for so long? Did no one notice? These were among the many questions raised at the time. He was known to the GMC, having previously been reprimanded for drug abuse some years before. He was also known to the local Health Authority, which had received numerous complaints and concerns from other medical colleagues, and the wider community.

Such was the scale of Shipman's crime, the Department of Health instituted an independent public inquiry, and appointed Dame Janet Smith as chair. The Shipman Inquiry was one of the biggest and most far-reaching inquiries of its kind. Smith and her Team investigated all aspects of managing doctors. The Inquiry reported that the Appraisal system introduced in 2002, and designed specifically to enable issues with individual doctors to be identified and dealt with, would have failed to identify the Shipman's activities. She was concerned that Appraisal was the wrong tool for the job and that it was inconsistently applied across the country. She believed that it would be far better to have explicit standards set out in a well-functioning clinical

governance system, supported by better performance management arrangements. Further, Smith believed that the GMC's proposals for Revalidation were simply not good enough.

Other High Profile Professional Cases

Around the same time that the medical profession was reeling from the fall-out from the Shipman case, a number of other high profile cases were coming to light, including:

- The independent investigation by a committee of inquiry into how the NHS handled allegations about the conduct of Clifford Ayling;
- The Kerr-Haslam Inquiry;
- An inquiry into quality and practices within the NHS arising from the actions of Rodney Ledward; and
- The Royal Liverpool Children's Inquiry (The Alder Hey Inquiry).

Whilst, in some of these instances, established traditions in the medical profession were found to be inappropriate, in others certain doctors had clearly deviated from medical good practice. In almost all cases, where there had been prolonged poor practice, medical managers were aware of it, and had failed to deal with problems. The gift of hindsight is powerful, and it could be argued that managers at the time did not have sufficient insight into what was going on, so that the complete picture only became apparent afterwards.

The Donaldson Report

The Smith report was hugely damning about management arrangements in the NHS - specifically medical management - and of the proposed arrangements for Revalidation, which were meant to protect the public from harm. Smith's report forced the Government to put the brakes on Revalidation. The Chief Medical Officer for England, Professor Sir Liam Donaldson, stepped in and introduced proposals of his own following extensive consultation by a Working Group. The CMO's proposals were contained in Medical Revalidation – Principles and Next Steps (the Report of the Chief Medical Officer for England's Working Group), which was subject to a wider consultation throughout the entire profession.

The Donaldson paper proposed that Revalidation be split into two parts, building on themes that were already in discussion between the GMC and medical Royal Colleges. These were:

- Relicensing, and
- Recertification

Relicensing (aka 'relicensure') would be a process managed predominantly by

the GMC asking the question, 'Is this doctor fit to practice as a medical practitioner in the UK?' Each doctor, seeking to work in medical practice in the UK, would be required to hold a valid licence to practice. This license would be linked to the GMC Register, and would need to be revalidated every five years. Doctors would be measured against standards linked to Good Medical Practice. Relicensing would only address the question of whether a doctor was fit to remain licensed and on the Medical Register.

Relicensing would not specifically ask the question of whether an individual doctor had sufficient knowledge and skill to work as a specialist or general practitioner. It was proposed that this would be addressed in a parallel process, called Recertification. This process would need to have significant inputs from appropriate medical Royal Colleges and faculties (under the umbrella of the Academy of Medical Royal Colleges). In essence, Recertification was designed to address the question, "Is this doctor fit to practice as a specialist or generalist?" There would need to be specific specialty standards, defined by each college or faculty, and inevitably these would differ from specialty to specialty. What might be appropriate for a surgeon may not be so for a paediatrician.

The GMC has subsequently opted to merge recertification and re-licensing into a single, unified, process of revalidation. At the time of writing, it was unclear how extensive would be the role to be played by colleges and faculties. However, the simplified process makes a great deal of sense. The Local Responsible Officer (LRO)

Donaldson's proposals went further and put in place provision for the appointment of Local Responsible Officers (LRO). Under these proposals, every doctor in the UK would need to relate to a single Responsible Officer, who would need to be a board level, senior doctor. The proposals were that Responsible Officers would sit between individual professionals and the GMC – with all recommendations for Revalidation being made to the GMC by the Responsible Officer (through the organisation's board). The expectation was that the Responsible Officer would, in most cases, be the Medical Director of the doctor's employing organisation. This was based on the fact that all NHS Trusts (in the secondary care sector) have been required, by statute, to appoint a Medical Director. This was not the case in the primary care sector. At this time, the majority of Primary Care Trusts (PCTs) in England had not appointed a Medical Director. Consequently, there was no culture of medical management in primary care in England. In Scotland, Wales and Northern Ireland, where NHS services are delivered through versions of Local Health Boards (where primary and secondary care sit within the same organisation) there has been much more of a culture of medical management over a longer period of time.

There was ambiguity, also, about arrangements for doctors working in the independent and charitable sectors, and in particular for single-handed practitioners. PCTs would need to appoint Responsible Officers. In Wales, Scotland and Northern Ireland, primary and secondary care are largely

integrated into Health Boards, which have Medical Directors. In Scotland, there was strong opinion that Medical Directors already hold many of the responsibilities proposed for Responsible Officers, and there was no need to create a new position.

After extensive consultation with the profession, the proposals were eventually streamlined into a single, umbrella, process of Revalidation, taking into account both licensing and certification. It would mean however, that Responsible Officers, relevant Royal Colleges and the GMC would have to work together. Nothing has been directly described about the role Clinical Directors might play in this process. In most organisations, Clinical Directors (or an equivalent figure) conduct the majority of Appraisals, and are closer to individual doctors than the Medical Director. Therefore, in the view of this author, it seems reasonable to suggest that in practice most of the work surrounding Appraisal and Revalidation would fall to Clinical Directors.

An overview map of the proposed Revalidation arrangements is set out in Diagram 1, below.

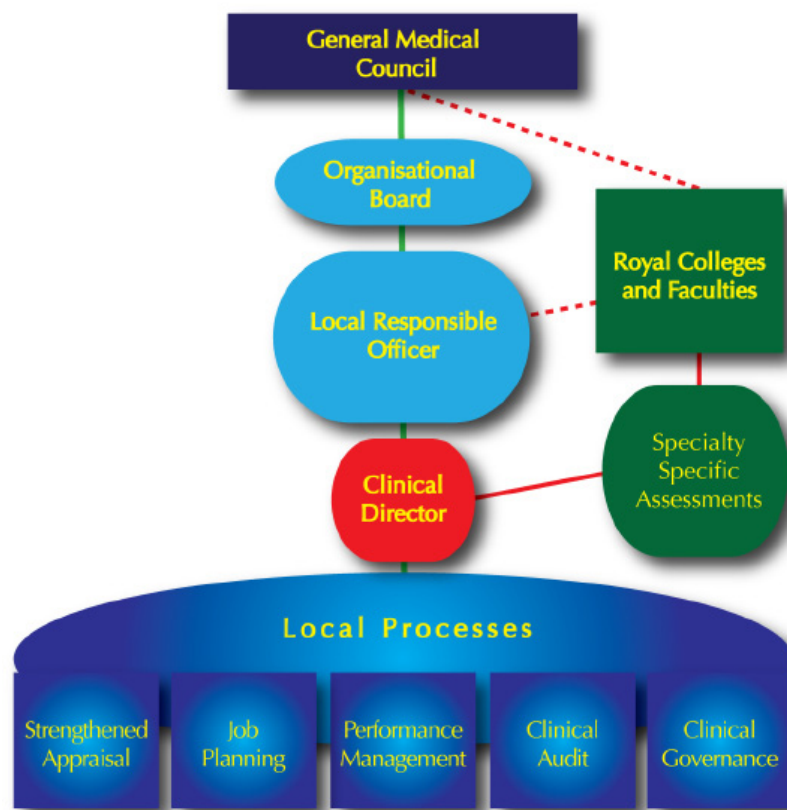


Diagram 1: The Revalidation Process

The success of Revalidation will depend on how it is operated at the level of the individual clinician. Medical managers will need to bring together a

variety of existing systems, shown in Diagram 1 as 'Local Processes'. Appraisal is just one process amongst several. Particular attention will need to be paid to performance management and clinical governance processes, to make certain that they are fit for purpose.

Responsible Officers

The new regulations concerning Responsible Officers (ROs) state that they will be charged with maintaining a focus on three main areas of work:

- **Patient Safety**, ensuring that doctors maintain and improve professional standards;
- **Effectiveness of Care**, supporting doctors' professional ethos to improve the overall effectiveness of care;
- **Patient Experience**, enabling patients and other service users to share their views on an individual doctor's fitness to practice.

In the majority of cases, Responsible Officers will need to ensure that all doctors linked to them practice safely, maintaining acceptable professional standards. Most doctors will easily demonstrate good medical practice. Responsible officers will need to promote an ethos of raising standards, and striving to deliver better health services. However, inevitably, there will be some individuals whose performance falls short of required standards. Where there are problems, there will need to be effective and fair remediation mechanisms. The emphasis will be on self-help and dealing with issues as close to the individual's workplace as possible. When remediation fails to sort out problems, Responsible Officers will be expected to refer individuals to the Regulator - very much as a last resort.

Responsible Officers, themselves, will not revalidate doctors. Their job is to ensure that there are effective local systems and make recommendations about Revalidation to the GMC. Responsible Officer Guidance issued by the Department of Health (August 2009 and updated in July 2010) states that RO's will need to issue a Positive Statement of Assurance in relation to every doctor linked to them. In so doing, they will attest to an individual's conduct and performance. This is very different to exception reporting – where one only reports when there is a deviation from the standard, and it is assumed that the absence of a problem indicates compliance. A positive statement requires a personal endorsement that the individual concerned does meet the required standards. This places a hefty burden on the shoulders of Responsible Officers, who will need to satisfy themselves that the information contained in individual portfolios and the outputs of appraisal are correct. ROs may also need to consult relevant colleges or faculties where necessary to satisfy themselves about individual doctors.

The draft Statutory Instrument (The Medical Profession (Responsible Officer) Regulations (2010)), laid before Parliament, and due to come into force in January 2011, specify that an organisation must appoint an additional responsible officer where there is a conflict of interest or an appearance of bias between the existing RO and an individual medical practitioner. Where an additional RO has been appointed, that RO and not the first one will have full responsibility in relation to the individual practitioner(s).

The GMC will make its decision whether or not to revalidate based, principally, on the recommendations of Responsible Officers. It is vital that the systems in place in organisations are robust, able to withstand audit and inspection and are fair to both individual doctors and their employing organisation.

Every Doctor Must Link to a Responsible Officer

Regulations, published in Summer 2010, state that every licensed doctor must link to a Responsible Officer. In England, the Department of Health is creating a specific and designated role. Responsible Officers will need to be senior, licensed medical practitioners, usually sitting on the executive board of a health care organisation. In Scotland, Wales and Northern Ireland, the regulations give the Health Board Medical Director responsibility for all doctors linked to them. In England, whilst it is expected that in most cases, the existing Medical Director will assume the role, in reality it can be any appropriately qualified doctor – providing they meet the requirements set out in the regulations.

The expectation is that most individual doctors will link to the Responsible Officer in the organisation where they do most of their clinical work. In the case of GPs, they will most likely relate to the Responsible Officer in the organisation that manages the appropriate Performers List. This adds a level of complexity into the mix, where doctors practice across a number of different organisations. They will only be able to relate to one Responsible Officer, who will need to liaise across multiple organisations, to be assured that the individual meets the standard in all cases. This means that information will need to flow across and in between healthcare organisations. For doctors in training, their Responsible Officer will be their Post-Graduate Dean.

All NHS organisations, the armed forces, some independent healthcare organisations and professional bodies (so-called Designated Bodies) will be approved to appoint responsible officers. To qualify, an organisation must be able to demonstrate that they have sufficiently robust processes that support revalidation. Doctors, working outside recognised organisations, will still need to relate to a Responsible Officer for the purposes of revalidation, and will need to approach one as appropriate. Members of the following specialist bodies will relate to the Responsible Officer appointed by the relevant body. These are:

- Faculty of Public Health;
- Faculty of Occupational Medicine;
- Faculty of Pharmaceutical Medicine; and
- Independent Doctors Federation

Guidance has not been issued about the arrangements for those doctors outside this structure, who work in settings where it is inappropriate to appoint an RO. Further consultation will be conducted before further guidance is issued. However, it is possible that NHS ROs may be required to take on this role. Where this is the case, they will need to be extra careful to satisfy themselves about each individual before issuing a positive statement of assurance.

Responsible Officers, themselves, must relate to an appropriate RO. Current guidance suggests that SHA Responsible Officers will take on this role in England. It is unclear what arrangements will be in place after the current NHS re-organisation is completed. In Scotland, Wales and Northern Ireland, ROs will relate to the RO at the respective devolved administration.

Role of the Responsible Officer

- Manage and maintain appropriate systems to deliver effective Revalidation, and support doctors in delivering high-quality care. Responsible officers must be able to identify and deal fairly with, all concerns relating to individual doctors. These systems will include:
 - o appraisal;
 - o performance management processes;
 - o accurate and timely information systems;
 - o supporting medical management structures and processes;
 - o effective clinical governance arrangements;
 - o robust mechanisms for generating and reviewing patient and colleague feedback; and
 - o effective monitoring and management of Serious Untoward Incidents (SUIs) and significant events.
- Maintain good working relationships with medical Royal Colleges and faculties, as well as NCAS and the GMC. To be able to seek out advice and support when needed. To be able to take and implement advice about individual doctors when given.
- Provide support to those doctors falling short of required standards, where appropriate putting in place remediation strategies.
- Providing support to those doctors that do meet appropriate standards, encouraging them to continuously improve their knowledge and skill.
- Empower medical managers throughout the organisation to contribute to the process, delegating as appropriate whilst maintaining

personal responsibility. Ensuring that medical managers support the responsible officer, coordinating appraisal, professional development and performance management in their respective teams. This is especially important in larger and more complex organisations.

- Where there are concerns about an individual doctor, a Responsible Officer will need to coordinate involvement, where appropriate, of the Royal College or faculty and/or NCAS, and ultimately make a judgement about whether to refer the individual to the GMC, taking advice as appropriate.
- To ensure that the organisation and its senior leaders are aware of the statutory duties associated with the Responsible Officer role and Revalidation in general, and that they are appropriately geared up.
- The Responsible Officer must play an active role as an executive member of the organisation’s board, and as such must maintain effective working relationships with the Chief Executive, Human Resources Director, and Director of Nursing (or equivalents) in particular, and also with other medical managers and professional leads throughout the organisation. This is shown in the diagram, below.



Diagram 2: Key Relationships of Responsible Officers

Responsible Officer Responsibilities – as Set out in Statutory Regulations

The following is a digest of the regulations set out in the Statutory Instrument relating to responsible officers, and are applicable throughout the UK. They cover every doctor linked to the Responsible Officer:

- To take all reasonably practicable steps to ensure that each doctor undergoes regular appraisal that conforms to the regulations;
- To take all reasonably practicable steps to investigate concerns about individual doctors fitness to practice raised by patients, staff or from any other source;
- Where appropriate, refer concerns about the individual doctor to the GMC;
- To ensure compliance, where an individual doctor is subject to conditions imposed by, or undertakings agreed with the GMC;
- To make recommendations the GMC about an individual's fitness to practice;
- To maintain accurate records of each individual doctor's fitness to practice evaluations, including appraisals any other investigations or assessments.

Appraisal

- To ensure that each individual doctor linked to them undergoes appropriate appraisal;
- To ensure that appraisal takes into account all available information relating to the individual doctors fitness to practice, relating to the entire breadth of practice during the appraisal period.

Specific Responsibilities Set Out in the Regulations for Responsible Officers in England

The following is a digest of the specific additional responsibilities described in the statutory regulations coming into force in January 2011, and which may be additional to the general responsibilities outlined above:

New Medical Appointments

- Ensure that medical practitioners are appropriately qualified and experienced appropriate to the work to be performed;
- Ensure that appropriate references are obtained and checked;
- Take any steps necessary to verify the identity of medical practitioners;
- In primary care organisations, manage a mission to the performers list;
- Maintain accurate records relating to the appointment.

Monitoring Conduct and Performance

- Review regularly data and information relating to general performance, including clinical indicators relating to outcomes for patients;
- Identify any issues arising from the information relating to individual doctors, e.g. variations in individual performance; and
- Ensure that the organisation takes steps to address any issues.

Responding to Concerns About Individual Doctors

- Initiate investigations with appropriately qualified investigators;
- Ensure that procedures are in place to address concerns raised by patients or staff, or any other source;
- Ensure that any investigation into the conduct performance of an individual doctor takes into account any other relevant matters within the organisation;
- Consider the need for further monitoring of the individuals conduct and performance and ensure that this takes place where appropriate;
- Ensure that the doctor who is subject to these procedures is kept informed about the progress of the investigation;
- Ensure that these procedures include provision of a doctor's comments to be sort of taken into account where appropriate;
- Where appropriate, take any steps necessary to protect patients;
- Where appropriate, make recommendations to the doctor's employer that he or she should be suspended or have conditions or restrictions placed on their practice;
- Ensure that appropriate measures are taken to address problems identified; including:
 - o requiring the doctor to undergo training or retraining;
 - o offering rehabilitation services;
 - o providing opportunities to increase the doctor's work experience;
 - o addressing any systemic issues within the organisation, which may have contributed to the concerns identified.

Further Notes About the Responsible Officer Role

- Each Responsible Officers must have been a medical practitioner for at least five years prior to their appointment.
- He or she must remain active as a medical practitioner whilst undertaking the Responsible Officer role.
- Individuals may act as Responsible Officer for more than one organisation, providing they satisfy the requirements, and have the capacity to effectively undertake the role in each organisation.
- The Secretary of State for Health has the power to appoint a

Responsible Officer in any healthcare organisation in Great Britain where that organisation has either failed to appoint a Responsible Officer, or where the proposed appointee does not meet statutory requirements. Whilst the Secretary of State has powers to appoint Responsible Officers in Wales and Scotland, they must first consult Welsh or Scottish ministers. The Secretary of State does not have powers to appoint in Northern Ireland. Secretary of State does, however, have the power to appoint Responsible Officers in Foundation Trusts in England, but must first consult with the Independent Regulator of Foundation Trusts.

- Paragraph 14(1) of the statutory instrument specifies that designated bodies must make available sufficient funds to enable Responsible Officers to discharge their responsibilities. Similarly, independent bodies that do not have a Responsible Officer and to link to one in another organisation must provide sufficient resources to enable them to carry out their role.

The Role of the Clinical Director

For Revalidation to be effective, Trusts and LHBs will need to address the key role of the Clinical Director, which is a pivotal position in clinical organisations. A Clinical Director could be a medical manager with specific, non-operational, responsibilities (say, for Appraisal). Not all NHS organisations have Clinical Directors, and it is true that where Clinical Directors are in post, their roles often differ from organisation to organisation. The term Clinical Director is used here as a catch-all for any doctor working in medical management at Team or departmental level, including Lead Clinicians, Clinical Chairs, Associate Medical Directors, Divisional Clinical Directors, etc. There is little history of PCTs appointing Clinical Directors, except in community secondary care services, and it may be inappropriate to have 'Clinical Directors' in general practice. However, for the purposes of Revalidation, elements of this role will need to be undertaken by a GP Appraiser, who will need to have a link to management and in particular to the Responsible Officer.

A Clinical Director's Twin Responsibilities

If Revalidation is to be taken seriously, and operated within the context of clinical improvement (e.g. where services get better as a result of Appraisal), which is the stated aim of both the Government and GMC, then Clinical Directors need to have explicit responsibility for Quality. This means that Clinical Directors would have two main areas of responsibility.

First, they should be responsible for the 'business' of their departments – getting the job done. Second, they should have responsibility for

‘professional’ aspects of their departments – managing the conduct, performance and behaviour of doctors. To be effective in these dual roles, especially in larger Directorates, Clinical Directors will most likely need to build substantial networks of supporting colleagues - including, in many cases, Lead Clinicians - to take more detailed responsibility for sub-specialties.

In terms of the business aspects of their role, Clinical Directors will need to build good working relationships with general managers and other professional Leads (representing other clinical specialties, e.g. nursing, allied health professions, etc). A Clinical Director with responsibility for the performance of the whole Clinical Directorate would need to account directly to the Chief Executive and Trust Board (possibly via a Director of Operations). In terms of professional aspects of the role, Clinical Directors would need to work with Appraisers, who may not be formally recognised as medical managers. A Clinical Director with responsibility for the conduct and performance of individual doctors will need to report directly to the Responsible Officer of the organisation (who may or may not be the Medical Director). In this way, Clinical Directors inevitably will be pivotal in not just managing Revalidation, but also in managing the business performance of the Trust. Clinical Directors, therefore, are indispensable in the emerging management structure. This is illustrated in Diagram 3, below.

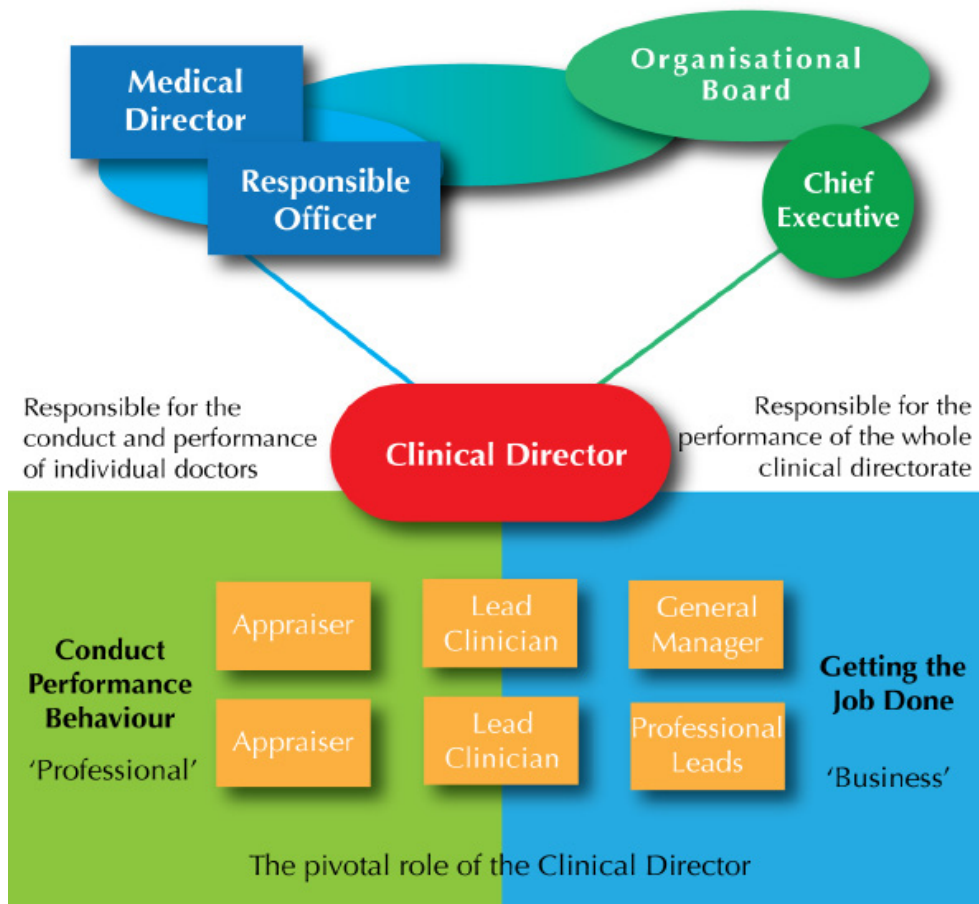


Diagram 3: The Clinical Director's pivotal management role within Revalidation

Trusts will need to have robust systems of governance and assurance for both business and professional elements of the management process. This will require partnership working throughout the organisation, as shown in Diagram 4, below. Professional lines of accountability are shown in green. Business lines of accountability are shown in red. Quality, which must sit between the business and professional strands, is shown in blue. We suggest that Quality inhabits the area where the roles of clinical leader and business leader overlap.

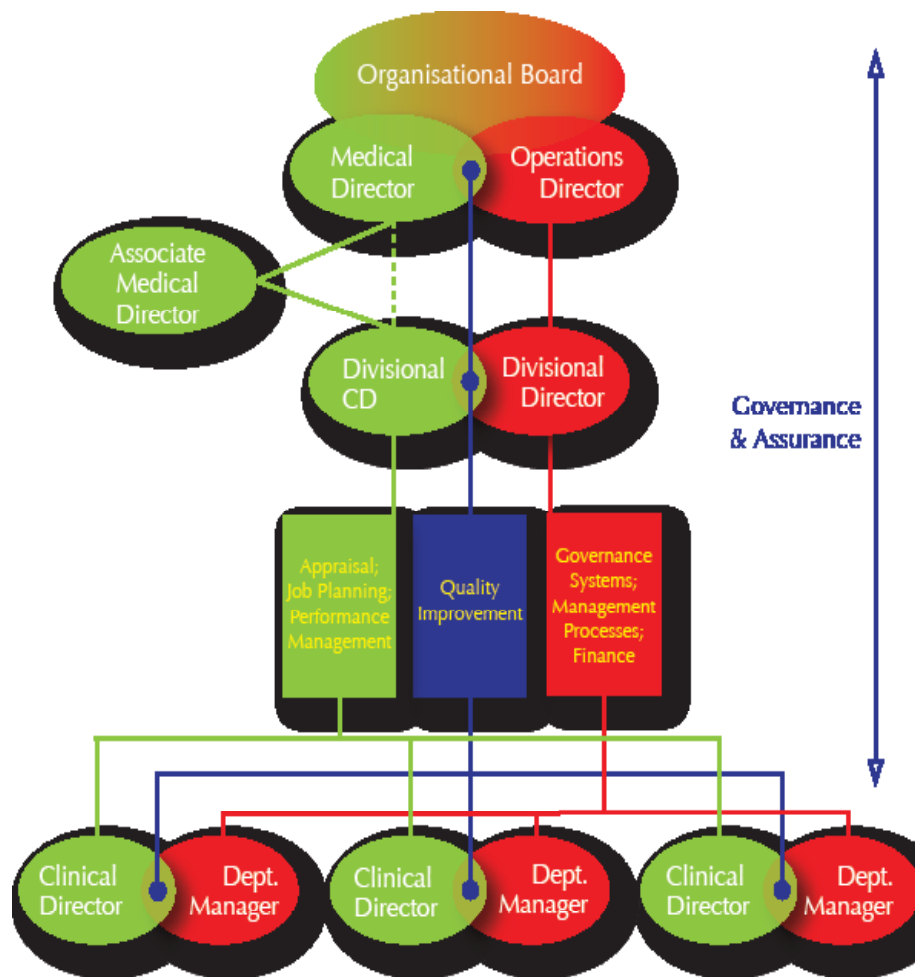


Diagram 4: Partnership working for Quality

The Revalidation Timeline

As previously indicated, Revalidation was first suggested in 1998. The current proposals to introduce Revalidation began in earnest in 2008.

- 2008: the proposed Revalidation process was piloted.
- 2009: pilots were undertaken of a proposed strengthened Appraisal system in England. Numerous pilots were undertaken across the UK. They ran for one year before being evaluated, the results of which became due in late 2010.
- 2009: Doctors were issued with licences to practice in autumn 2009. It became law in November 2009 for all medical practitioners in the UK to be in possession of a valid licence.

- 2010: Royal Colleges and Faculties agreed specialty specific standards, working through the Academy of Medical Royal Colleges. These were published on appropriate websites.
- 2011: (January) Local Responsible Officers to be appointed. Each NHS organisation, and those in the independent sector satisfying specific criteria, is required to appoint a Local Responsible Officer. Once in place, every doctor holding a licence will need to link to a named Local Responsible Officer. In Scotland, the Medical Director will undertake the role of LRO.
- 2011/2: Appraisal rolls out. Having been piloted and evaluated a new strengthened system of Appraisal will be rolled out across England and Wales. Separate arrangements will be in place for Scotland and Northern Ireland. There will need to be further testing of the appraisal tool kit.
- 2012: expected date for the beginning of the introduction of Revalidation.

Diagram 5, below summaries the timescale.

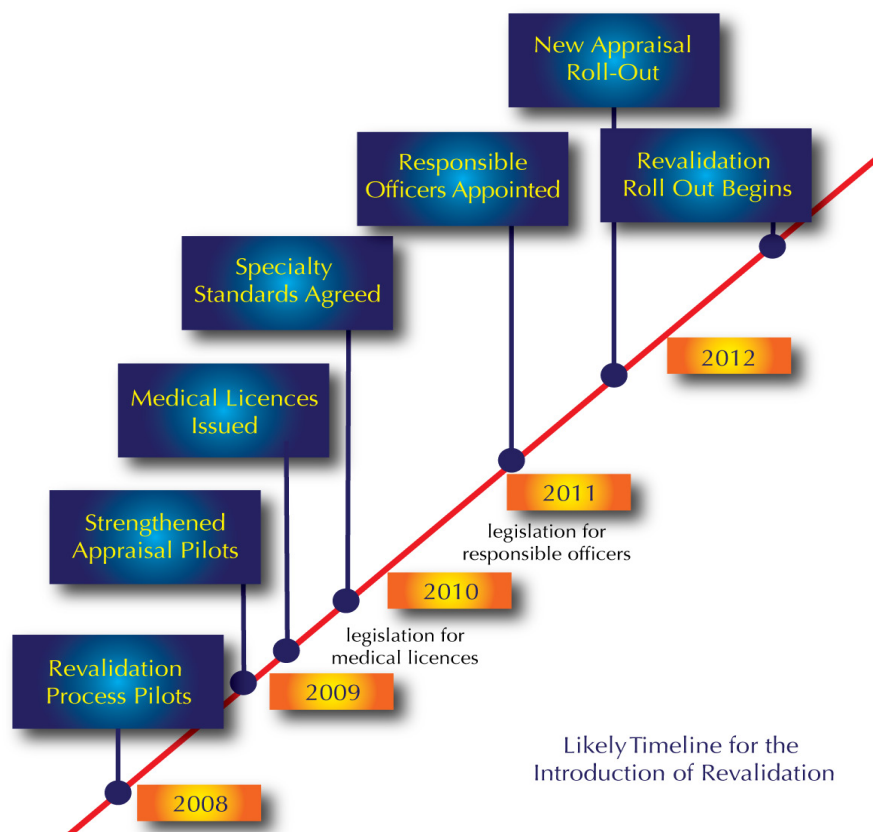


Diagram 5: The Revalidation Timeline

It is expected that there will be no big bang introduction for both Appraisal and Revalidation. Guidance from the Government and GMC indicates that

both will be rolled-out over a period of time. New Appraisal is likely to be phased in over a number of years, starting with those organisations that are geared up and prepared at the beginning, and gradually extending out to the rest. During this rollout phase, doctors working in organisations that have not adopted the new system will remain on the existing system. It is likely that they will only be able to transfer to the new Appraisal system when their organisation is ready. The Revalidation Support Team (RST) in England and Health Education Scotland have been working to support organisations as they prepare for the new system. Separate arrangements are being made in Wales and Northern Ireland.

Revalidation is expected to be launched in the late summer or autumn of 2012, even though many NHS organisations will not have the new Appraisal system in place. Expect Revalidation to take five years to be fully introduced with the profession coming on-line gradually, with around 20% being included in each year. The expectation is that doctors will be called to revalidate based on a random ballot. Table 1 below outlines the expected dates for the first tranche of Revalidation, and the subsequent five-year cycles for each. The GMC makes it clear, however, that some doctors may be required to revalidate before the five years have expired. Medical licences are valid “up to” five years. However, for the most part, doctors will participate in Revalidation according to the following schedule.

Cohort	Expected First Revalidation	Cohort Size (%)	Expected Second Revalidation	Expected Third Revalidation
1	2012	20%	2017	2022
2	2013	20%	2018	2023
3	2014	20%	2019	2024
4	2015	20%	2020	2025
5	2016	20%	2021	2026

Estimated Timetable for Revalidation Roll-Out

Note that this information may be subject to change, and is based on guidance jointly issued by the GMC and the four Departments of Health in October 2010.

The Mechanics of Revalidation

In November 2009, it became law that all doctors seeking to work in medical practice anywhere in the UK require a valid licence to practice, issued by the GMC. This covers any role or job for which the post holder is required to be a licensed medical practitioner (e.g. a hospital doctor, general practitioner, etc.). Unlicensed doctors are no longer afforded the privileges or authority associated with registration (for example prescribing drugs and certifying death). Medical licences are time-limited and valid for a period of up to five years.

This marks a significant change in the role of the GMC. Hitherto, the Council has been guardian of the Medical Register. This register is a historical record, a snapshot taken at a particular point in time, recording the qualifications and registration of each doctor. There are around 200,000 doctors listed on the Medical Register, and there has been no way of knowing from this which of these were still in medical practice, where they worked and whether they were still fit to practice. Medical licences provide an indication of which doctors are still practising, and what they do (e.g. the current specialties in which they work). They are a current record rather than a historical snapshot. The new licences are not intended to replace the Register.

Doctors may elect to remain on the Medical Register but not to hold a current licence. In such cases, they are technically still registered, but not allowed to practice. Any doctor, who fails the Revalidation process, will simply have their licence revoked or limited. They can only be removed from the Register either by applying for voluntary erasure or by being prosecuted through the GMC's Fitness to Practice procedures.

Revalidation has been re-designed as a single process covering the broad principles of both Relicensing and Recertification. Doctors need to proactively demonstrate to the GMC that they have the knowledge and skills to hold a valid licence. They must also demonstrate that their knowledge and skills are appropriate for the type and level of practice that they undertake (for example, that they are fit to practice as a consultant surgeon, a specialty doctor or a GP). At the heart of Revalidation are the following three elements:

Portfolio of Supporting Information

Individuals will be required to maintain a portfolio of evidence, which should be an accurate reflection of their entire medical practice. The portfolio should be structured around the domains and attributes set out in Good Medical Practice and the GMC core module (see below). It is expected that a doctor will update a single portfolio that will provide a framework for both Appraisal and Revalidation. As Revalidation will be a five-year cycle, the portfolio should – at any point in time and on a rolling basis – reflect the previous five years of

the doctor's practice.

There is potential for this to become a bureaucratic exercise, especially if the portfolio includes information drawn from every aspect of one's professional life. Individuals should aim to keep the portfolio as simple as possible, whilst containing sufficient information to adequately reflect and do justice to the quality of their practice. The expectation is that this document is simplified in electronic form. To this end, national bodies (e.g. the NHS Revalidation Support Team in England and Health Education Scotland) have been working on the development of appropriate electronic platforms that should plug in to organisational information systems. Doctors should be able to upload key documents at the touch of a button. The portfolio needs to be a means to an end and not an end in itself. It needs to be simple and easy to maintain and should not distract individual doctors from carrying out their medical duties.

Appraisal

Each doctor, will be required to undergo annual Appraisal in a format approved for this purpose by the GMC. In England, the Appraisal system introduced in 2002 will be replaced by a new system of 'strengthened' Appraisal, described in greater detail, below. Appraisal has also been restructured to some degree in Scotland, Wales and Northern Ireland and 'beefed up' so that it is fit for the purpose of Revalidation. To satisfy the requirements of the GMC, and to ensure that Appraisal can contribute to Revalidation, the process needs to include the GMC's attributes and domains (described below). In fact, these will need to form the core of appraisal. This is also referred to as the 'GMC Core Module'.

Not only must the appraisal be structured so that it meets the needs of the GMC, the process must be subject to robust quality assurance standards. This is described in more detail in a document published by the NHS Revalidation Support Team, '*Assuring the Quality of Medical Appraisal for Revalidation*' (also known by its acronym, AQMAR). The whole process will need to be subject to external scrutiny. Appraisers will need to be adequately trained before they will be allowed to undertake the new appraisal system, and there will need to be on-going support and development for appraisers going forward.

Organisations that satisfy the regulator that their appraisal and wider clinical governance arrangements are up to standard will be recognised as '*designated bodies*'. Individual doctors must relate to a Responsible Officer in an appropriate designated body.

The Inclusion of 'Judgement'

The appraiser will need to make a 'judgement' about the conduct and performance of the appraisee, and this will be passed up the line to the Responsible Officer/Medical Director. This 'judgement' is the fundamental difference between the old and new Appraisal systems. This element places new responsibilities on Appraisers. It is no longer good enough for an appraiser to simply act as a critical friend. It is crucial, therefore, that Appraisers are properly selected, trained and supported. This training and support needs to continue throughout the entirety of their role as Appraisers.

The whole Revalidation cycle will, for the most part, cover five years, although individuals may be called upon to submit their portfolios at any time within the period for a variety of possible reasons (e.g. if concerns have been raised, or if an individual doctor requests an earlier Revalidation). Doctors will be expected, on an ongoing basis, to create and keep up-to-date their portfolio of evidence. This portfolio will be reviewed annually as part of an Appraisal process. Appraisal will cover all aspects of an individual's medical practice (including private, charitable and medico-legal work). Appraisers will be required to report progress to a Local Responsible Officer who, in turn, will make a judgement as to the suitability of each candidate to be revalidated. Responsible Officers, themselves, will not make the decision about Revalidation. That decision rests solely with the GMC. The Responsible Officer will be required to submit a Positive Statement of Assurance for each candidate. The GMC will base the vast majority of Revalidation decisions on these recommendations from Responsible Officers.

Where the Responsible Officer has a query, and is unable to issue a Positive Statement of Assurance, the candidate cannot be revalidated. In these circumstances, Responsible Officers will need to work with the candidate (and potentially their appraiser and/or an appropriate medical manager) to put right whatever caused the query. It will, in many cases, fall to local medical managers (e.g. Lead Clinicians or Clinical Directors) to get alongside the individual, determine the causes of the problem, and work with them to put it right. It may be that external help is required. Royal Colleges and Faculties will be able to work with individuals. In addition, the National Clinical Assessment Service (NCAS) has been designing interventions that could be used. Emphasis should be placed on remediation as early as possible and as close as possible to the clinician's workplace, rather than bringing in formal and external support. Individuals should be encouraged to help themselves, or to sort out problems within clinical teams. External support, whilst available, should only be sought when local solutions have failed to have sufficient impact. The final resort, and when all other interventions have failed – or when the situation is serious enough to warrant it – will be referral to the Regulator.

When a Responsible Officer becomes satisfied that they can now issue a Positive Statement of Assurance about an individual, this will be sent to the GMC so that they can make the decision about Revalidation. If, after remedial support, it becomes clear to the Responsible Officer that the causes of concern have not, or cannot be satisfactorily addressed, this should be reported to the GMC, who will make the final decision. In some cases, an individual doctor may receive a licence that contains certain limitations that might allow them to continue practising in some areas of their work, whilst they work to put right those areas of concern.

This system of Revalidation shifts responsibility and emphasis away from the GMC to local employing bodies. The GMC will not be able to review every portfolio, and will therefore rely on the recommendations given to them by Local Responsible Officers. In larger, more complex, organisations, it will not be possible for Responsible Officers to be able to make informed judgements about individuals without the support of medical managers working in clinical Teams. Therefore, Appraisers and Clinical Directors in particular, will need to play a pivotal role in the whole process.

Doctors in Difficulty

A distinction needs to be made between doctors in difficulty and difficult doctors. The former might be described as people who, for various reasons, are struggling to perform an adequate job. The latter are often people who are difficult to work with and/or manage, for any number of reasons. Just because an individual is a pain, a thorn in the side of management, it does not necessarily mean that they are a bad doctor (although it is certainly true that dysfunction may be a sign of underlying problems). In this document, we are not interested in difficult doctors per se and this chapter deals with those doctors about whom there are some concerns regarding their professional conduct and behaviour.

A key reason for the introduction of medical Revalidation is what could be described as a failure within the Profession to adequately deal with doctors in difficulty. Many of the high profile cases mentioned earlier in this document concerned individuals who were not malicious, but aspects of their professional competence was questionable. In some cases, ego and entrenched attitudes may have got in the way of managers taking effective action. In most cases, the doctors concerned were not bad people. They were professionals who demonstrated a certain amount of bad practice that put patients at risk. It would be easy for the casual observer to bracket an entire profession with the actions of these people. However, that would be to do a terrible injustice to a large group of hard-working and dedicated people.

The Shipman Aberration

Although the case of Harold Shipman has come very much to the fore, and has in many ways overshadowed the whole Revalidation agenda, it should be remembered that he was a once-in-a-generation criminal. As a nation, we have built an entire criminal justice system with the intention of preventing, detecting and solving crime. Despite this, we still have crime. It is unlikely that the Revalidation system being introduced in the UK would have prevented Harold Shipman from carrying out his crimes, nor will it completely eradicate criminal elements from the profession. Shipman's crimes were so heinous that the likelihood of there being another Shipman in our lifetime is small – but not impossible. There are questions as to whether the process would identify some of the other cases of serious poor practice discussed earlier in this document, let alone provided mechanisms for dealing with them. It could be argued that better systems of clinical governance would do more to protect the public from poor clinical practice. The service does, however, need to bring together a series of parallel and related processes that enable Trusts and Health Boards to help doctors in difficulty, raise standards, and serve the public better. There is, in addition, a case to be made for looking at team based revalidation. Multi-disciplinary teams deliver the vast majority of clinical services in the modern NHS, where a wide range of clinical professionals provide significant inputs.

What Revalidation is About

Poor performance in doctors is not rare. There are around 200,000 doctors registered with the GMC in the UK. Of these, approximately 122,000 of whom work in the NHS. In any population of this size there will inevitably be people whose performance is deemed 'excellent', and those about whom there are concerns. The National Clinical Assessment Service, which now provides services for England, Scotland and Wales, has estimated that approximately 6% (7,000) of NHS doctors may have some problems with performance. Some of this may be the result of incompetence, and some may result from ill health. NCAS also estimates that one doctor in sixteen may be taking illegal drugs or drinking excessively. The extent to which these habits pose a serious question about an individual's ability to function as a doctor remains to be seen, but NCAS estimate that the behaviour and conduct of around 5% of doctors is so severely disrupted that it may have some effect on patient care. Therefore, to do nothing about it is to fail both individual doctors and their patients.

A case could be made that if medical leaders had taken positive action from the outset and established clear standards of behaviour and conduct – not to mention medical practice – more could have been done to prevent the Bristol scandal and many of the other cases that have hit the headlines since. It could also be argued that well-functioning support and management systems (for example, clinical governance) in health organisations would negate the

need for Revalidation, and thus save the country a fortune in unnecessary regulation and red tape.

The new system of Revalidation provides a mechanism for employers to deal more effectively with poor performance when it arises. More astute and forward-thinking organisations will put in place monitoring systems that enable poor performance to be identified and dealt with at an early stage. They need to go further than that and empower Lead Clinicians, and other medical managers working in clinical Teams to be able to take the initiative and sort out problems. Revalidation could be a fantastic opportunity to make explicit the link between 'performance' and 'Quality', and enable clinicians and managers to see them as one and the same.

Identifying Poor Performance

Any issues about a clinician's performance, behaviour, conduct or health that could impact on the quality of care provided to patients could be described as 'poor'. In essence, anything out of the ordinary that a doctor does that could put patients at risk, or that reduces the overall quality of care should be cause for concern. Although Revalidation is about the professional performance of individual doctors, it should also be recognised that most care provided in the NHS is delivered by Teams, and managers should seek to broaden the performance management systems used for Revalidation so that they encompass wider Team behaviours, conduct and performance. A team-based approach to Revalidation might do more to protect the public than focusing solely on individuals.

Indicators of Poor Performance

There are numerous ways through which poor performance can come to light, and some of these are listed below.

- **Performance Data:** usually a good indicator that something is amiss comes from the numbers of patients treated, time taken in theatre, etc. that can easily be extrapolated from operational performance data. However, be sure to compare like with like.
- **Patient Complaints:** look for themes emerging from complaints about individuals or Teams. Thoroughly understand the reasons why people complain and build detailed knowledge of any systemic causes. Look also at compliments received from patients and carers and compare and contrast them.
- **Concerns Raised by Colleagues:** when colleagues come to talk to medical managers about the conduct or performance of a doctor, it should be taken seriously. Be aware of malicious gossip, however, and make certain that you have all the facts before wading in. Make

sure you make clear to colleagues that you will not take 'off the record' feedback about people. As a medical manager, it is near impossible to deal with issues based on hearsay (unless you receive a formal complaint, it is no more than hearsay). Equally, you cannot un-know what you have learnt. So, someone telling you something 'off the record' about someone else, puts you in the difficult situation of knowing something that you can do little about. This could shift responsibility onto the medical manager and away from the individual who raised the issue. When you do hear something, or someone brings an issue to your attention, be sure to make a contemporaneous file note.

- **Litigation:** look in more detail at the underlying causes of legal action being taken against the organisation, to determine whether this is a manifestation of a deeper problem with the individual concerned.
- **Serious Untoward Incidents (SUI's)/Significant Events:** from time to time, things go wrong in clinical practice, and when it does it should trigger an event report, such as a serious untoward incident (SUI). Look for themes and repeated SUIs as an indicator of a problem. Where there are concerns that patients may be at risk from an individual's poor performance, take swift remedial action.
- **Multi-Source Feedback (MSF):** multi-source feedback such as 360° reports can be an excellent tool for identifying concerns about an individual, especially behavioural. Make certain that individual respondents are protected and that they can provide feedback confidentially without being identified. MSF is likely to be included as a mandatory component in the Revalidation process, with each individual being required to undertake a minimum of one MSF, and potentially up to three, in each five year period.
- **Outcome Data:** most healthcare organisations collect and review data around outcomes (the sort of information provided by Dr Foster Intelligence, CHKS, etc.). This data enables individuals and medical managers alike to compare like with like, and to benchmark individual performance against that of other similar clinicians elsewhere in the same field. This enables anyone concerned with Quality to determine whether their performance is within acceptable limits, or whether there should be cause for concern.

Signs and Symptoms of Doctors in Difficulty

There are many possible signs that a doctor may be in difficulty. Individually, these signs may not indicate anything other than a specific character trait, or that someone is having a bad day. However, when trends do begin to emerge, it may be legitimate to investigate further to determine whether an individual is, indeed, in difficulty. The following list is based on published information from NCAS, derived from some of the cases in which

they have been involved.

- **Anger and rage** – someone who regularly (or often) flies off the handle in an inappropriate manner. It could be argued that anger and rage should have no place in a professional working environment and this, in itself, should be dealt with. However, this kind of behaviour may be masking an underlying problem.
- **Long letters/email** – many medical managers have, at some point, been on the receiving end of a long letter of complaint from a colleague, outlining in huge detail numerous issues. The letter could be a sign that someone has come to the end of their tether and needs to off load their feelings. Alternatively, it could be a manifestation of a wider set of behavioural problems.
- **Defensive attitude** – where an individual goes on the defensive whenever questions are raised about them.
- **Blaming others** – it's never their fault, always someone else's, and they are quick to point the finger of blame at other people.
- **Sickness record and pattern of sickness** – individuals who have high rates of sickness, or sickness that follows a specific pattern (e.g. mainly Mondays).
- **Appraisal lasting less than 15 minutes, or more than two hours** – a short Appraisal may be a sign that the appraiser cannot find anything to talk about (perhaps because there is insufficient information in the portfolio – which is a problem in terms of Revalidation) or that the appraisee is uninterested. A long Appraisal may indicate that there are multiple areas for concern. Be aware that the cause of this indicator may well be as much about the appraiser as the appraisee. This is a good reason for ensuring that appraisers are properly trained and supported.
- **Dress** – dress, in itself, may not be an indicator that something is amiss. However, someone suddenly changing the way they dress, or letting their appearance slip (e.g. coming to work unshaven or looking generally dishevelled) may indicate an underlying problem. For example, it could indicate changes in their home circumstances, or could be a sign that their enthusiasm at work is waning.
- **Not attending meetings, teaching or departmental activities** – often people with difficulties refuse to attend meetings for a number of reasons. Perhaps, they claim to be 'too busy', which might indicate that they are not coping with their workload. Equally, the 'too busy' excuse may simply indicate that they don't wish to engage in a particular activity.
- **Obstructive or destructive behaviour in meetings and/or discussions** – there may, of course, be genuine reasons for obstructive behaviour (someone passionately believing in an alternative course of action).

This is often a sign of a difficult colleague (not to be confused with a doctor in difficulty). However, it's an indicator and should warrant further investigation.

- Colleagues who are fed up and unwilling to work with someone – difficult behaviour often wears down colleagues in the Team. When people start to refuse to work with someone, this should be investigated further. Is it because the person in question has an obnoxious or toxic attitude, or because colleagues are tired of covering up for their mistakes?

Cautionary Note on the Length of Appraisal.

Some people may argue that a short Appraisal could be a sign that everything is all right. Why pad out an Appraisal session when there are no problems to discuss? This somewhat misses the point. Everyone, regardless of who they are or their seniority in the organisation, can make improvements to their practice (and this as a fundamental cornerstone of Appraisal). Similarly, a long Appraisal may not be a sign of dysfunction. It could be a sign of a really powerful Appraisal session where the appraiser and appraisee are getting to grips with any number of issues. However, when an Appraisal is unduly short or long, this should be worth remarking, as it may warrant further inquiry.

Dealing with Concerns

Whenever dealing with doctors and difficulty, it is important to make patient safety and wellbeing the principal concern. Any situation where patients might be put at risk should be avoided at all costs. It may be that an individual doctor needs to be either excluded completely from work, or from specific aspects of the job that brings them into contact with certain patients or colleagues. At the same time, however, be fair to the doctor. It is all too easy to suspend or exclude somebody, in order to appear to be acting in the best interests of the service, only to find the allegations were unfounded. It is easy to ruin an individual's morale, reputation and career with a snap decision to exclude. A doctor's good standing takes years to achieve, and could take minutes to destroy. This is a tricky one, and requires great skill on the part of medical managers.

How to Deal with Poor Performance

United States President Theodore Roosevelt said, 'Walk soft, but carry a big stick'. And so it is when dealing with concerns about doctors. It is important to tread carefully, get abreast of all the facts, talk to as many people as possible, and avoid knee-jerk reactions. However, the big stick may be needed on occasions. There are a number of tools available to medical managers, and one could use either formal or informal methods, or a combination of both.

In well functioning organisations, there should be a number of processes at Clinical Team, Department, Practice, Directorate or Divisional level that can provide medical managers with the tools to deal with concerns effectively, including:

- Strengthened Appraisal (in England and Wales), and the new Appraisal systems in Scotland and Northern Ireland.
- Job Planning – in secondary care.
- Performance Management systems.
- Clinical Audit.
- Clinical Governance.

When dealing with concerns about a doctor in difficulty, identify:

- **What went wrong?** Understand, precisely, what it is that went wrong, or what is the problem. Get as many facts as possible from a wide range of sources. Go and find out for yourself the precise nature of the issue, and gather as much documentary evidence as is available to inform you. Don't just rely on feedback from individual colleagues or patients, but develop your own, in-depth, understanding of the situation.
- **Why it went wrong:** just as you would with any clinical incident, conduct a root cause analysis to determine what caused the problem or situation. Again, go and see for yourself, and don't rely solely on what people tell you.
- **What are the consequences?** Having fully understood the situation, and its causes, determine what are the consequences of the specific problem itself and of what you do about it. What will happen if you positively deal with it, or decide not to do anything? An analysis of the consequences should be the principle factor that informs you about the action to take. For example, you could deal with the situation by taking disciplinary action against the individual or individuals involved, and this might have a knock-on effect to the wider clinical service. Alternatively, you might decide not to deal with it on this occasion, and this might have a knock-on effect (now or in the future) on the service or on individuals within it. Assess the consequences of action and inaction at three levels:

- o For patients;
 - o For the individual doctor; and
 - o For the organisation.
- **What can be done to prevent it re-occurring?** Find the key lessons, and ensure that these are shared with the wider Team. Put in place mechanisms that ensure, to the best of your ability, that there is no further repetition of the situation.

When investigating what went wrong, do so in a systematic, detailed and unbiased manner. If there is a danger that an individual medical manager's approach to the investigation might be subjective, or clouded, then it might be appropriate to appoint someone else to investigate. Throughout, it is important to follow organisational procedures. If at any point it is shown that the organisation was unfair to an individual doctor, or that they failed adequately to follow organisational procedures, then it could prejudice the outcome, and be costly in terms of litigation.

Generally, you should adopt, whenever possible, a positive and supportive approach to determining the causes of problems. Promote the idea that it's not about identifying blame per se, but it is about accountability and responsibility. Individuals need to be responsible and accountable for their actions. Accountability need not necessarily mean discipline. It is possible to hold an individual to account, and sort out a situation, without resorting to disciplinary processes. However, the big stick option should always be held in reserve. In some cases, it is absolutely necessary to discipline an individual, or individuals.

Throughout the process, consider the following:

- **Act quickly:** as soon as you become aware of a problem, spring into action. Under no circumstances should you simply sit on a situation or avoid doing something about it. Problems have a tendency to get worse, and become harder to deal with the longer you leave them.
- **Wherever possible, practice limitation rather than exclusion, even in serious cases.** If it is possible to enable an individual to continue working, even if it is in a different part of the organisation, or undertaking jobs that do not bring them into contact with patients or specific colleagues, then normally this should be preferred to exclusion.
- **Wherever possible support the individuals concerned.** This could be the individual doctor who is the subject of concerns or the investigation, or those colleagues that brought it to your attention. Anyone who is involved, at any level, in the investigation (especially

anyone brought in from outside) also needs to be supported.

- It is often useful to seek help from outside the department, or from sources external to the organisation. Find a respected colleague who could guide you through the process in a confidential way, someone off whom you can bounce ideas, and who will be an honest broker. It is important that this individual is not connected to the case, and is someone who can act as a 'critical friend'. Be careful that this person does not, himself or herself, become implicated in the situation.
- External mentorship or support could also be beneficial to the individual doctor being investigated. In some cases this could be the solution to the problem. You might find it helpful to go outside the organisation, in order to maintain confidentiality, and to reduce the likelihood that the individual would lose face with their work colleagues. External support should only be brought in with the agreement of an appropriately senior manager and of the individual concerned. It is essential for mentor and mentee to negotiate and agree a clear initial 'contract' and ground rules for their relationship.

There are numerous ways to get additional support. For example, the organisation's occupational health service might be a useful way to assess the extent to which ill health might affect an individual's ability to discharge their duties as a doctor. The National Clinical Assessment Service (NCAS) have a number of both formal and informal interventions, and are hugely experienced in working with healthcare organisations with doctors in difficulty.

The Role of the Local Medical Manager

Local medical managers, for example Lead Clinicians, Clinical Directors, etc., have a crucial role to play in dealing with doctors in difficulty. There are many reasons for this. Local medical managers have a much more detailed knowledge of individuals involved. Local medical managers should work with colleagues to develop better and more robust systems for identifying poor performance as early as possible. Although Appraisal could be a useful tool for this, it is by no means the most appropriate. Far better would be more effective clinical governance systems.

Although the emphasis in Revalidation is on dealing with problems as close to the clinical workplace as possible, local medical managers need to be able to bring early concerns to the attention the Medical Director/Local Responsible Officer, but not necessarily in a way that triggers a formal response. Medical Directors need to be able to support local medical managers throughout the process. Responsible Officers need to have an indication, as soon as possible, that an individual may not be on track towards Revalidation. Such early notice would enable them to put in place remedial action, to work with the local medical manager, and to be alerted to the fact that Revalidation

may be compromised. To this end, local medical managers need to be able to make a judgement about which concerns can be dealt with entirely and informally in-house, and which need to be considered as “recorded concerns” and brought to the attention the Medical Director/Responsible Officer.

In many cases, this will require a change to the approach organisations have towards local medical managers. It is no longer good enough to dump people into these roles with no training or support. It could be argued, that it is no longer enough simply to ask clinicians to take on Clinical Director roles because it’s Buggins’ turn, or because no one else came forward. Indeed, organisations need to work harder at making local medical management roles more attractive to doctors, so that the best candidates willingly put their names forward. Becoming a Clinical Director must increasingly be seen as a legitimate and logical career move for doctors. We set out the case for this in our Clinical Leadership discussion paper, published as part of the Athena Series:

“Creating a Fresh Approach to Clinical Leadership in the NHS”; by Stuart Haines and Bob MacKenzie; 2010; BKG Athena Series. Athena Number 1.

Human Resources Support

It will become ever more important for organisations to provide better human resources support to medical managers at Team and Directorate level. This is an area that will require specific attention in primary care in England when PCTs are abolished and replaced by GP commissioning consortia. It will be important that adequate support is provided to GP Responsible Officers, Appraisers, and to those charged with managing the performance of individual GPs, many of whom are self-employed (which requires a slightly different approach).

It is now more vital than ever before to get the right doctors into the right jobs in the first place. Employing organisations will need to think about the attitudes and behaviours they are looking for in doctors before they employ them, rather than appointing according to clinical experience and skill alone. Of course, organisations will need to balance both strands, but in particular they will need to be aware of the risk of employing someone with a poor attitude, and of the effect this might have on the organisation, the service and on the Revalidation of the individual doctor.

HR professionals will need to take a more proactive role in supporting medical managers at all levels. This would include working with medical managers, who are investigating concerns, to ensure that everything is done according to best practice and in accordance with organisational policy. Most doctors do not have in-depth knowledge about the ever-evolving world of employment law.

On a macro level, employers will need to have better HR policies that cover the entire workforce. Doctors, new to the organisation, will need better induction at both organisational and local level. Organisations should consider introducing mentoring, or buddy systems for newly appointed doctors. They should build cultures there are positive, nurturing and supportive of key clinical staff. Appraisal needs to be framed in a formative and developmental way. The organisation needs to be geared up to look for early warning signs of problems, and then to be supportive of both the individual in question and the medical or general managers dealing with them

Practical Appraisal

Appraisal for doctors is not new. It has been used with doctors in training for many years, and was introduced for consultants, GPs and specialty doctors from 2002 onwards. The Department of Health's definition of Appraisal from 2002 is:

"A professional process of constructive dialogue, in which the doctor being appraised has a formal structured opportunity to reflect on his/her work and consider how his/her effectiveness might be improved.

"[It is] a positive process to give someone feedback on their, performance, chart their continuing progress and to identify development needs. It is a forward-looking process, essential for the development and educational planning needs of an individual."

*Department of Health
Advance Letter (MD) 6/02
22nd December 2002*

Appraisal has been practised widely in sectors outside the NHS throughout the world for about the last half-century or so. It is widely held there are two approaches – summative and formative - to Appraisal, and its application largely varies from organisation to organisation.

- **Summative Appraisal** tends to be an approach more aligned with performance management, where an individual is assessed against a set of predefined characteristics or standards. The outcome of a summative Appraisal tends to be pass or fail, and is often linked to bonuses and pay progression. This is a version of Appraisal often found in industry.
- **Formative Appraisal** takes more of an educational and developmental approach. It is more interested in helping an individual to develop their skills over a period of time. The output of formative Appraisal is a personal or professional development plan. Here, there tends not to be a pass/fail outcome.

Much of the discussion in the UK medical profession has been around the comparative merits of either approach to Appraisal. However, although the majority opinion appears to favour a formative approach, a combination of both approaches is probably most effective. The Appraisal system that has been in use in the NHS since 2002 has certainly been criticised for failing adequately to deal with individual problems. It was deemed to be too formative, with insufficient summative elements. However, given the understandable anxieties raised by the Shipman affair, and in the haste to

deliver Revalidation, there is a danger that Appraisal goes the other way, unduly emphasising summative at the expense of formative elements. The NHS Revalidation Support Team (RST) has made it clear throughout its documentation that Strengthened Appraisal should retain formative components for all doctors.

Appraisal can be a very useful tool that helps individuals to consider both their performance and development needs in the context of:

- Their current role;
- The evolving and changing needs their organisation;
- Developments within their specialty or the wider profession;
- Their personal needs, wants and aspirations; and
- The wider imperatives of their organisation, the NHS and the medical profession.

It is important that individuals do not view their own personal practice in isolation. Rather they must consider it in the context of what is happening all around them, both inside their organisation and looking outwards to the wider profession and health service. Appraisal should be a two-way process that primarily focuses on the individual, but also that enables individuals to provide feedback to their employer about specific aspects of their role and how they might make a contribution towards improving the wider organisation.

Appraisal gives the individual, their manager, their colleagues and their organisation an opportunity to:

- **Review the performance of an individual doctor;** looking at it in the light of local service delivery, benchmarking performance with other clinicians working in the same field, receiving feedback from colleagues (e.g. multisource feedback), considering complaints, compliments etc.
- **Consider the contribution an individual doctor makes both to the clinical service, and to the wider organisation.** It is an opportunity to think about how individual doctors might be encouraged to take on a wider role (say, as Clinical Lead in a specialty, for a project, research, medical management, expanded clinical roles, etc). In addition, or alternatively, an individual might be encouraged to take on a mentorship role, become an appraiser, publish academic papers, or engage in a raft of other activities that would contribute to the improvement of the clinical service.
- **Identify and address issues about the working environment.** This is a chance to have a discussion about issues that might prevent an individual from being more effective. This might include office space, administration support, car parking, the practicalities of a job plan, length of the working day, etc.

- **Discuss opportunities and aspirations.** This is a chance for an individual to think about how their career might evolve over a period of time. It's an opportunity to discuss new roles, additional training, new interests, etc.
- **Optimise skills and resources.** For the organisation, this is a great opportunity to get the most out of its most valuable resource – its clinicians. It's also a chance to ensure that organisational resources are aligned so that they best support clinical teams.

For the most part, doctors are extremely busy professionals, with heavy working days and tremendous responsibilities. The image that some people might have of consultants spending their days on the golf course is by and large false, and does not reflect the reality for the vast majority of hard-working professionals. Most doctors work long days that are crammed full of competing pressures. It is quite rare, in the modern NHS, for doctors to have time to stop and reflect. Appraisal, if done properly, can provide space for individuals to:

- **Stop, reflect and think about their clinical practice** – thinking especially about what they would improve it.
- **Explore their relationship with their organisation**, and whether there are aspects of it they would like to change, and whether there are areas in which they would like to get more involved.
- **Be challenged constructively by a colleague or peer.** This is especially useful if a colleague is respected by the appraisee.
- **Consider ways to improve their working life.** In some ways, this overlaps with discussions held as part of job plan reviews. Individuals might wish to think about their timetable, location of office, among other things.
- **Think about their personal strengths and weaknesses.** This is an opportunity to consider what the individual does well, and importantly how they could do things better.
- **Challenge ideas and concepts that are normally taken for granted.** As much as anything, this is an opportunity for the organisation to challenge an individual's prejudices and entrenched views. Equally, it's an opportunity for the individual to challenge the organisation's prejudices and entrenched views.
- **Discuss emerging issues and themes** pertinent to the individual and their service.
- **Express personal views and ideas.** For some individuals, this may be

the only opportunity they get at work to have a meaningful discussion with a manager about a range of issues. This could be a wonderful chance to hear their opinions, and ideas for the future.

Appraisal as a Cyclical Process

Effective Appraisal should be ongoing throughout an individual doctor's career. If we were to look at a doctor's career in its totality, from a point at age 18 where, typically, they first enter medical school, to the day they retire, it is obvious that their development needs would be different depending on the particular stage they have reached in their career. In the early stages, emphasis would be on acquiring knowledge and skill and developing a medical practice. The further into a career they get, the emphasis may shift to taking on educational roles, higher-level engagement within the profession (e.g. Royal College, professional association or BMA roles), etc. Many people think about their careers in five-year cycles, and it is probably no different for doctors.

Diagram 6, below, shows the ongoing cycle of Appraisal. Think of it as a wheel that slowly turns and continues to move forward for the life of one's career. The diagram shows a typical year. It begins with an individual reviewing their current situation, and their needs, wants and aspirations for the future. Even before the Appraisal takes place, an individual doctor should be thinking about what they want in terms of outcomes of the process. In a sense, this is a shopping list.

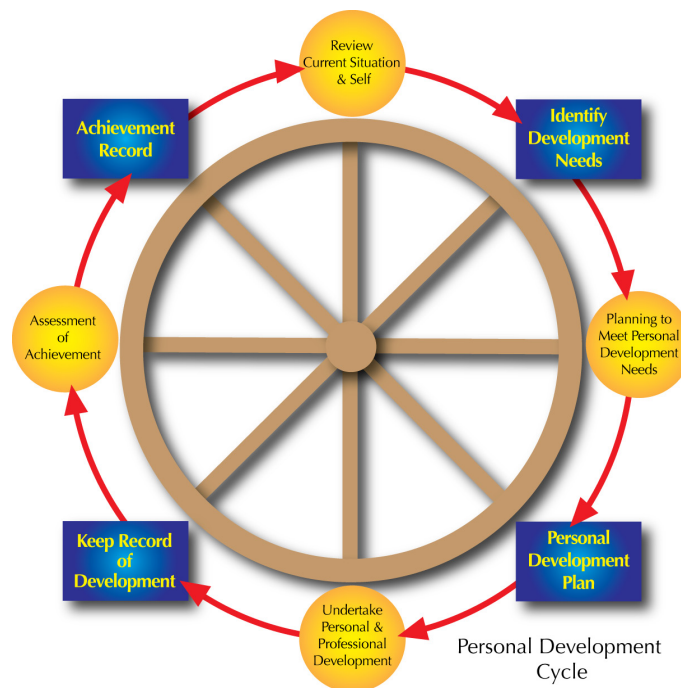


Diagram 6: The Appraisal Cycle

During the Appraisal itself, the appraiser and appraisee come together to hold a discussion about how to achieve the items on the list. Clearly, there will be additional items that the organisation wants from the individual. A successful Appraisal is a negotiation that turns an initial shopping list, along with a discussion about performance into a personal development plan. The individual takes the development plan forward, undertaking each objective in turn, and keeping a record of progress. There should then be an analysis of whether each objective resulted in the desired outcome. This takes the individual on to the beginning of the next cycle, where they review again their current situation, and think about how they might develop and move forward.

At the heart of successful Appraisal is the notion of intertwining personal and professional development, regardless of whether the emphasis is on formative or summative Appraisal. Both the appraiser and the organisation should seek to enable the individual to develop in a supportive and challenging way.

Diagram 7, below, sets out a suggested timeline for running an Appraisal for doctors. This is based on working with hundreds of doctors throughout the UK, and the feedback they have given. In the NHS, it is widely accepted that doctors require at least six weeks' notice of a meeting or event, so that they can make alternative clinical arrangements or arrange cover. Therefore, an Appraisal should be planned and scheduled at least six weeks in advance. Once the date has been set, it should not be rescheduled except in unforeseen circumstances (e.g. illness, or genuine clinical emergencies).

To enable an appraiser properly to digest the content the Appraisal portfolio, this should be shared at least a fortnight ahead of the Appraisal meeting. This is especially important when the appraiser does not have a close working knowledge of the appraisee. It is insufficient for the appraisee to present their portfolio on the day of the meeting and expect the appraiser to read it, understand it and ask meaningful and probing questions. A fundamental concept in Appraisal is the notion that there should be no surprises. Therefore, an agenda should be agreed ahead of the Appraisal session (in the diagram we suggest one week before). This agenda should be based on the individual doctor's shopping list and on specific issues that the appraiser would like to cover.

The interview itself is in fact the shortest component of the whole Appraisal process, typically lasting around 90 minutes [this figure is based on feedback given by doctors since the introduction of Appraisal in 2002]. It is important that all loose ends are tied up as soon as possible after the end of the Appraisal meeting, with the personal development plan being signed off both by the individual and the organisation. To enable a sufficient cooling-off period (where both parties can reflect on the outcome of the meeting), and to enable the appraiser to secure any necessary agreements from management for specific objectives, we suggest that a target is set to agree a development plan, and sign the Appraisal documentation no more than one week after the

Appraisal meeting.

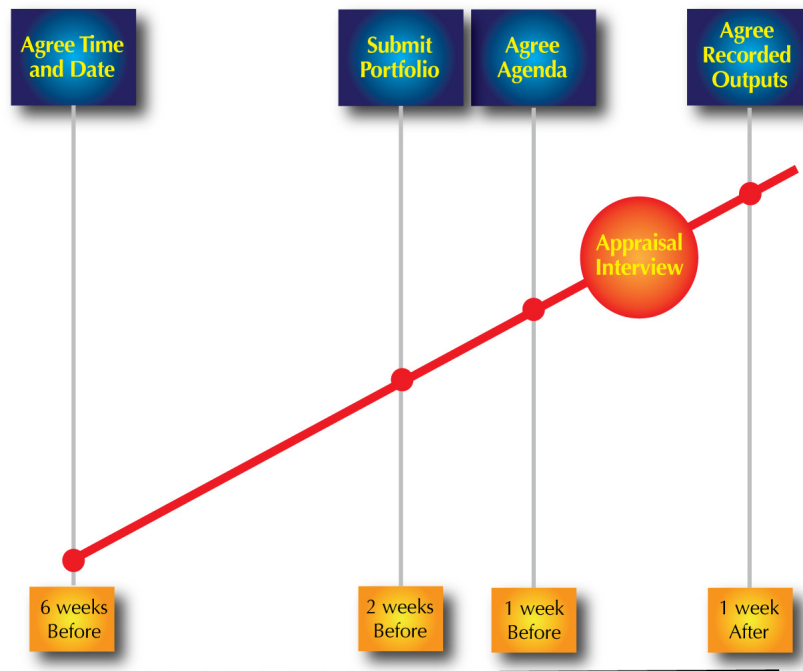


Diagram 7: Suggested Appraisal Timeline

The Skilled Appraiser

Whether Appraisal is seen as an effective professional development tool, or simply as something that contributes towards Revalidation, it is clear that the role of the appraiser is pivotal to the whole process. A skilled appraiser is someone who can make all the difference between the process working or failing. Strengthened Appraisal will place specific responsibilities on the shoulders of Appraisers. It is, therefore, crucial that the right people are appointed, trained and supported as Appraisers.

Regardless of what Appraisal is being used for, the following traits and characteristics of a skilled appraiser are essential. A good appraiser should be someone who is:

- A good listener;
- Non-judgemental;
- From a similar background (e.g. a doctor from the same specialty);
- Able to focus discussions;
- Able to provide effective and constructive feedback;
- Able to summarise often complex discussions into short written paragraphs;
- Credible in the eyes of both individual doctor and the organisation;

- Experienced as a doctor;
- Realistic;
- Honest.

The appraiser needs to be able to gain the respect of the appraisee. They must show empathy throughout the Appraisal process, come across as genuine, and act ethically. A skilled appraiser should be a good communicator. They should be skilled in negotiation, so that they can arrive at a win/win outcome for both the organisation and the individual. The appraiser needs to protect the confidentiality of the process, ensure that it is fair for both parties, and maintain the trust of both the organisation and each appraisee.

Responsibilities of the Appraiser

Appraisers are responsible for the following:

Managing the process of the interview. It falls to the appraiser to ensure at the interview passes off smoothly, that it is conducted in the right physical and psychological environment, and that the portfolio is made available to be read ahead of time, etc.

Managing the content of the interview. It is entirely possible that a medical Appraisal could be made to last all day; there is certainly a lot of material that could be covered. However, time is of the essence, and it is important that it is managed correctly and that the relatively short period of time allocated for the interview (typically 90 minutes) prioritises and covers the most appropriate issues.

Recording the agreed outcomes of the Appraisal interview. It is crucial that the recorded outcomes from Appraisal are accurate and agreed by both parties. They should accurately reflect what was discussed. The summary document of Appraisal is one of the most important features of the whole process. It's the document that's most likely to be read and reviewed by the Medical Director/Responsible Officer, and will most likely form the basis of the decision whether or not to issue a Positive Statement of Assurance. There is some debate about who should be responsible for writing up the outcome of Appraisal. Wherever possible, this should be done together by the appraiser and appraisee during (or just after) the interview.

Assisting in the planning of development needs. This is, in fact, a principal cornerstone of Appraisal. The main outcome of Appraisal is a development plan. The appraiser's responsibility is to help formulate the agreement as to what should be included in the plan. It is absolutely important that the appraisee, not the appraiser, owns their personal development plan.

Managing the Process

As previously discussed, Appraisal may be the only opportunity an individual has properly to take time out to consider their personal needs, wants and aspirations. For many, this will be the only meaningful interaction with an individual representing management. In every case, the way the Appraisal is managed will contribute to the Revalidation of their medical licence. It is therefore important to get it right. Consider the following in relation to the Appraisal process:

- **Ensure an appropriate setting:** it is important that the Appraisal interview is conducted in an environment that is conducive to open and frank discussion. It is often easiest to hold the meeting in the appraiser's office. However, this may not be the most appropriate place. The appraisee may feel intimidated, uncomfortable or otherwise unable to be completely at ease. Wherever possible, find neutral ground – a place where both parties feel comfortable and able to talk in confidence. This isn't to say that an individual's office is completely inappropriate, but do try to find a better location. Make sure the room is set out appropriately; for example, both parties should avoid sitting behind a desk wherever possible.
- **Pace the interview:** as previously described, there is a limited amount of time available for the interview itself and often a lot of material to cover. Ahead of the meeting, think about the amount of time you would like to spend on each agenda item. Throughout the meeting, keep an eye on time and ensure that the Appraisal progresses at a reasonable pace, where all agenda items are covered, and sufficient time is given to those items requiring more detailed discussion.
- **Ensure there are no interruptions:** there is nothing worse than being disturbed during an Appraisal. It breaks the train of thought, and can throw either party off track. Ensure that mobile phones/pagers are turned off, that there is sufficient clinical cover in the event of clinical issues back at base, and that office telephones are diverted to colleagues as appropriate.
- **Agree an appropriate written record:** as previously described, the principal output of Appraisal is the agreed record. This is a document that will typically be reviewed by the Medical Director/Responsible Officer, and will form the basis their decision whether to issue a Positive Statement of Assurance. In addition, the recorded outcome will sit in an individual's file for a number of years. It will also be the only record of agreed development needs and of the action plan.
- **Advise that content is confidential but outcomes may not be:** what is discussed between two people in a closed meeting is confidential between them. However, anything committed to paper or recorded electronically could become a public record and potentially available

to a wider audience. For example, it has already been described that the Responsible Officer will review the outputs. In certain cases, this document may be reviewed by representatives of a Royal College, Faculty or the GMC as part of either a response to concerns raised about individual, or a routine Quality assurance audit of the Appraisal process. It is likely that the GMC will routinely review a percentage of Revalidation applications as part of their internal processes, and this may involve a complete review of the Portfolio – including outputs from Appraisal. Be careful, therefore, about what is recorded.

The Appraiser's Approach

Consider the following when conducting an Appraisal interview:

- **Be empathic:** try to relate to the individual's circumstances, views and concerns. Demonstrate an understanding of their point of view, and where possible avoid being judgemental and dogmatic.
- **Start with something positive:** the way the interview begins will, to a large extent, sets the tone for the remainder the session. Think ahead of time about how the meeting will begin. Even if there is a difficult issue to be tackled, try to start the session with something positive.
- **Remain on side:** whenever possible, avoid the temptation to be confrontational. The appraiser should aim to work with the individual to construct a personal development plan, and help them tackle specific issues. Appraisers often find it useful to adopt coaching skills in dealing with Appraisal sessions, acting as a critical friend, and helping the individual to come to an appropriate conclusion about an issue without it becoming a fight.
- **The 80/20 Rule:** the appraiser should be listening 80% of the time, and talking for 20%, whilst the appraisee should spend 80% of the time talking and 20% listening. The Appraisal is primarily for the Appraisee, and so the majority of the time should be spent listening to what they have to say.
- **Make positive use of silence:** silence can be a powerful tool. In many ways it encourages the appraisee to keep talking. Appraisers should avoid feeling the need to fill silence with words.
- **Summarise the discussion:** when the discussion reaches natural breaks, e.g. at the end of each topic, the appraiser should relay back what they think they have heard. Not only does this demonstrate their understanding of the discussion, which helps build rapport with the appraisee, but it also provides the basis on which an agreed outcome can be constructed for the written Appraisal record. This is a powerful way to ensure that there is effective two-way communication

between both parties.

- **Probe when necessary:** if the appraiser doesn't understand a particular part of the discussion, or has queries, they should gently probe further. Avoid turning the discussion into a police-style interview, but ensure that it's conducted in an assertive way.
- **Explore blind spots:** if there are gaps in the portfolio, these will need to be addressed before the individual can progress to Revalidation. It will fall to the appraiser to explore any blind spots that exist, not least to ensure that there are no concerns about patient safety or clinical practice. Where blind spots do exist, and these are likely to affect Revalidation, these will need to be flagged up to the Responsible Officer. The personal development plan will need to include an objective covering this gap.
- **Clarify misunderstandings:** if the appraiser does not understand a particular issue, they should ask the appraisee to clarify it further, or explain it in clearer language. There should be no ambiguity at the end of an Appraisal.
- **Encourage ownership of problems:** individual Appraisers should not take it upon themselves to sort out every problem brought to them in Appraisal. If they did, they would soon become buried in problems. They should, therefore, enable the Appraisee to take responsibility for their own problems.
- **Discuss behaviour, not personality:** avoid wherever possible turning Appraisal into an analysis of an individual's personality. Instead, focus on specific aspects of their behaviour.
- **Don't be prescriptive:** don't prescribe solutions, but rather enable the individual to come up with solutions that they personally own.

Skilled Appraisers should engage in active listening skills during the Appraisal interview. At all times, the appraiser should demonstrate that they are actively engaged in the discussion, and are interested and focused. If at any point the appraiser gives the impression but they are bored or distracted, it could ruin the interview. Pay particular attention to body language throughout the meeting.

Why Things Go Wrong in Appraisal

Appraisal can be a frightening experience for some people, especially if they have been through poorly conducted Appraisals in the past. There are a number of reasons why Appraisal can go wrong, and it is worth understanding some of these when preparing the ground. Some of these include:

- **Nervous about change:** it is entirely possible that some candidates are nervous about the new Appraisal and Revalidation systems. They might be nervous if this is their first Appraisal, or if a session is with a new appraiser.
- **Nervous about the process:** people may view the Appraisal process with a degree of scepticism. Many may feel aggrieved about the fact that they are being forced to work in a system where they must report to a Responsible Officer where previously they had a degree of perceived professional autonomy. There may be scepticism about the role of the appraiser in the process, and the fact that the appraiser will be required to form a judgement about their clinical practice.
- **Perception of failure:** many people may be nervous of being perceived by the appraiser, and/or the Responsible Officer as a failure, as not good enough, or even be labelled as a doctor in difficulty. This may even be the case when it is clear that the individual is a very good and dedicated doctor.
- **Imbalance in negotiation skills:** there may be a perception that the appraiser has far more sophisticated negotiation skills than the appraisee. This may result in the appraisee's shopping list being thrown out in favour of one drawn up by the appraiser, with the appraisee feeling relatively powerless to do anything about it.
- **Disempowerment:** the individual may feel disempowered by the system, and by the belief that the Appraisal won't to make a single bit of difference to their clinical practice. In this case, the Appraisal is a waste of time in the eyes of the appraisee.
- **Illness:** the appraisee may be ill, and unable sufficiently to engage in the process.
- **Burnout:** in certain cases, the appraisee may feel overworked and burnt out. This, too, could cause them to disengage with the process.
- **Absence of rapport:** the appraiser and appraisee may have nothing in common, and therefore no rapport. If this is the case, then the best solution might be to find an alternative appraiser.

Strengthened Appraisal

A new system of strengthened Appraisal is being introduced, in one form or another, across the NHS in the UK from 2011. The reasons why Appraisal is being strengthened were addressed earlier in this document. It was felt that the existing Appraisal system, introduced around 2002, was insufficient to reassure the public that doctors were safe. In the post-Shipman furor, there was a danger that positive aspects of the existing Appraisal system would be thrown out in favour of an emphasis on much more tougher measures of performance.

The Revalidation Support Team in England states that the essence of Appraisal must remain formative for all doctors. However, there also needs to be some degree of assessment. In the new system, Appraisers will need to make a judgement about the skills, knowledge, conduct and performance on individual doctors.

One of the concerns raised by the Shipman Inquiry was the fact that there was an inconsistent approach to Appraisal between organisations. The GMC is keen to ensure that every organisation follows the same system and applies the same set of standards. Therefore, Appraisal conducted in one organisation should, as near as possible, be the same as one conducted in another part of the country.

Strengthened Appraisal seeks to encompass the following two dimensions:

- A common framework for conducting Appraisals and assessing supporting information;
- Availability of supporting information to support the Appraisal process.

In the Appraisal discussion, there needs to be a judgement about the quality and quantity of supporting information contained in the portfolio. Information in the portfolio should be sufficient for a third party to make an objective judgement about the skills and performance of the individual doctor. It should be verifiable, and reflect the entire breadth of their practice. Where an individual practices across more than one organisation, data should be gathered from all relevant organisations. The portfolio should also include verifiable information covering all roles they undertake as a doctor. This extends to any role, paid or unpaid, in which the individual works in their capacity as a medical practitioner, and would include private practice, charitable work, medico-legal practice, academic roles, medical mentoring, etc.

The employing organisation has a responsibility to make available to individual doctors good quality feedback about their performance. Indeed, individuals should not have to jump through hoops in order to get access to the information they need. There is a job of work for medical managers to come together to design information flows that provide meaningful, accurate and timely information for this process. Appraisers working in the new strengthened Appraisal system need to have the skills to challenge the

information presented to them, encourage reflection, and work with the individual to produce a personal development plan. Supporting information within a portfolio might include:

- Complaints;
- Litigation;
- Adverse incidents;
- Current GMC registration – for example, whether the individual is currently subject to fitness to practice procedures;
- Multisource feedback;
- Patient satisfaction questionnaires;
- Other pertinent documents (e.g. audits); and
- Significant event audits and personal reflection.

Such supporting information must conform to GMC, College and/or Faculty standards. As a minimum, information should be provided that addresses each domain or attribute in the GMC module.

The appraiser must show that they have reviewed and, where appropriate challenged the documentation contained in the portfolio, against standards set out by the GMC in Good Medical Practice (see below) and specialty specific standards established by individual Medical Royal Colleges and Faculties. In cases where the portfolio does not adequately demonstrate compliance with these standards, or where there are gaps, this needs to be explicitly included in the personal development plan, as this could put Revalidation at risk. There should also be evidence that the appraisee has reflected on their practice.

The GMC Core Module

In order for Appraisal to contribute to the Revalidation process, it needs to be structured around the GMC core module, which contains four domains and 12 attributes (see below). The existing appraisal systems for Consultants, GP's, Specialty Doctors, and those working in military settings were structured around the seven headings published in the old version of Good Medical Practice. When the new Appraisal system is introduced, this will change and the headings will reflect the following:

Domain 1: Knowledge, Skills and Performance

- Maintain your professional performance;
- Apply knowledge and experience to practice;
- Keep clear, accurate and legible records.

Domain 2: Safety and Quality

- Put into effect systems to protect patients and improve care;
- Respond to risks to safety;
- Protect patients and colleagues from any risk posed by your health.

Domain 3: Communication, Partnership and Teamwork

- Communicate effectively;
- Work constructively with colleagues and delegate effectively;
- Establish and maintain partnerships with patients.

Domain 4: Maintaining Trust

- Show respect for patients;
- Treat patients and colleagues fairly and without discrimination;
- Act with honesty and integrity.

Generic Essential Information

Table 2, below, is based on proposals made by the Revalidation Support Team and covers the proposed amount of generic essential information that should form the core of the Revalidation portfolio.

	Type of Information	Min. Required in 5-Year Period	Notes
1	Significant Event Review or Case Review	10	Minimum 2 per year
2	Review of Complaints and Compliments	All	
3	Formal and Informal Clinical Audit	5	Minimum 1 per year
4	Patient Feedback - Survey & Review	1	Presented by Year 5
5	Colleague Feedback (MSF) - Survey & Review	1	Presented by Year 5
6	New PDP and Review of Previous PDPs	5	Annually
7	Completion of CPD	5	Annually
8	Health Self-Declaration and Review	5	Annually
9	Probity Delf-Declaration and Review	5	Annually

Table 2: Essential information for the Revalidation portfolio

Appraiser's Statement at the End of the Appraisal Interview

At the conclusion of each Appraisal interview, the appraiser must report to the Responsible Officer the progress made. The following list, presented by the Revalidation Support Team in England, sets out what should be reported:

- **Presence or absence of immediate concerns about the doctor's fitness to practice:** the Responsible Officer will, in most cases, need to be guided by Appraisers about this. Where there are concerns, Responsible Officers will need to assess their extent, determine their likely impact on the service (e.g. whether there are patient safety issues), and identify a course of action to put things right.
- **Whether the doctor is making satisfactory progress towards Revalidation:** in the vast majority of cases, doctors should progress with ease towards Revalidation. If there are issues that might prevent or delay Revalidation, then both the individual concerned and their Responsible Officer need to be made aware of this, and an action plan drawn up. There should be no surprises at any stage during Appraisal and Revalidation, and an individual should know whether their application for Revalidation is likely to be successful.
- **Whether there is satisfactory progress with the previous years' Personal Development Plans:** personal development is one of the core aspects of Appraisal. It is essential that individuals meet objectives set out in their plan, both for professional development and for Revalidation reasons. Where an individual has not made satisfactory progress, this needs to be highlighted and remedial action taken.
- **Agreement with the Personal Development Plan that derives from the current year's Appraisal discussion:** as described, above, both the individual and their employing organisation(s) need to agree the content of the development plan coming out of Appraisal. Where there may be problems securing that agreement, whether it is on the part of the individual or their employer, this needs to be identified and rectified as soon as possible.

Multi-Source Feedback (MSF)

Multisource Feedback (MSF), also known as 360o feedback or appraisal, is increasingly becoming an important component of the Appraisal and Revalidation process. Used properly, it can be a highly effective means of enabling individuals to learn about how their performance and attitudes are perceived by a range of people.

MSF is normally set up where an individual doctor identifies around 15 people who could provide feedback about them. These should be a range of peers/colleagues, other clinical professionals, senior medical staff (e.g. Clinical Director), junior staff and often patients. Each respondent is sent a questionnaire containing both quantitative questions (e.g. a grading of performance) and space to add qualitative comments.

It is normal for an external organisation to administer the MSF process and collect feedback, sending a report to the individual. It is good practice to have Appraisers trained in handling feedback to individuals. In some cases, feedback might be difficult and even traumatic for the candidate, so it needs to be handled carefully. The aim is to provide the candidate with sufficient insight into how their conduct and performance is perceived by those around them.

The expectation is that MSF results will be included in the portfolio. There is some discussion about how many MSF reports should be included in the five-year cycle. It is likely that each individual will be required to have at least one. It is possible, the MSF survey may need to be repeated at three-yearly intervals. Evidence will need to be included that individuals have reflected on the results of MSF and that they are addressing any issues raised. Increasingly, organisations are taking the view that MSF conducted in a three-year cycle makes a great deal of sense.

Although MSF can be put in place relatively inexpensively by organisations, the system used must be approved by the GMC, and will need to be future-proofed so that it keeps up with the evolving state of Revalidation. It is good practice to have an accredited external provider who can ensure that the process runs smoothly, and that confidentiality is maintained. Although there are some very good products on the market, Trusts and Health Boards need to select one that has a sound track record, that is able to evolve alongside the Revalidation process and – crucially – one that will best serve their needs.

Glossary of Terms

Academy of Medical Royal Colleges	(AoMRC) the Academy is a body set up to bring the (more than 20) medical royal colleges together, acting as an umbrella organisation. The Academy has co-ordinated the development of specific standards pertinent to each specialty.
Appraiser	Suitably qualified doctor conducting the Appraisal process on behalf of the employing organisation/designated bodies.
Chief Medical Officer (CMO)	There are four CMOs in the UK, each acting as the professional lead for their country. They also provide medical advice to their respective devolved administrations. The CMO for England is the chief health advisor to the UK government. In England, the DH has also appointed a Medical Director for the NHS, a function previously carried out by the CMO. The CMO will act as Responsible Officer for the whole NHS in their country (a role shared in England with the NHS Medical Director).
Care Quality Commission (CQC)	Introduced as the regulatory body in England for health and social care organisations. CQC has introduced organisational licences that will need to be revalidated periodically in a system resonant of that being introduced for doctors. No health or social care organisation is allowed to operate in England without a licence issued by the CQC.
Department of Health (DH)	Government department of state that manages the NHS in England. The DH took the national lead (acting for all four home nations) in taking the legislation for Revalidation through Parliament. There are similar Departments of State covering health in Wales, Northern Ireland and Scotland.
Designated Body	Under the Responsible Officer

Guidelines designated bodies are those organisations approved to appoint a Responsible Officer and carry out Revalidation processes (including Appraisal). The boards of designated bodies will be tasked with issuing Positive Statements of Assurance to the GMC about doctors linked to them.

General Medical Council (GMC)

The regulatory body maintaining the medical register in the UK. Licenses to practice, now required by law for all doctors working in medicine across the UK, are issued and managed by the GMC. The GMC has powers to erase from the register any doctor whose practice is deemed to be unsafe (following due process). The GMC's authority and power are derived from legislation. The GMC regulates all doctors throughout the UK - with jurisdiction, therefore, in England, Scotland, Wales and Northern Ireland.

Health Education Scotland

Body working with the Scottish Government to develop the Appraisal system north of the border. HES has undertaken its own pilots and has been working closely with medical colleagues throughout Scotland on an approach that has some differences to the system being promoted by the RST in England.

Job Plan

Consultants and specialty doctors are required as part of their contract of employment to have an annually agreed plan of work, that outlines all the duties they are required to perform. The job plan details external jobs it is agreed that they perform (e.g. clinical tutor) in addition to the roles they undertake as part of their core job. Both the individual doctor and their Clinical Director review this plan annually. Job planning is not required in primary care.

Licence to Practice

It became law in November 2009 that every doctor practising medicine anywhere in the UK must hold a valid licence to practice. It is this licence

	<p>that is revalidated every 5 years.</p>
Positive Statement of Assurance	<p>Designated bodies will be required to issue a Positive Statement of Assurance to the GMC about all doctors linked to them. This document will confirm that the individual has participated in robust Appraisal and Clinical Governance processes and that there are no concerns about their Fitness to Practice.</p>
Responsible Officer	<p>(a.k.a. Local Responsible Officer) A board level appointment. Every doctor will be required to relate to a single Responsible Officer, who will manage the Revalidation process for them, and make the necessary recommendations to the GMC. The requirement to relate to a 'responsible' individual is a UK-wide requirement. However, in Scotland, this role is likely to be explicitly included as part of the role of the relevant Health Board Medical Director.</p>
Revalidation	<p>The process of ensuring that medical licences remain valid. Licences issued to doctors are valid for up to 5 years, after which the individual must demonstrate to the GMC that they remain fit to practice. This process, whilst overseen by the Council, will be managed locally by the individual doctor's employing organisation or by a relevant other Designated Body. Where the doctor is self-employed, they must relate to a recognised Designated Body.</p>
Revalidation Support Team	<p>A Team working with the DH in England to support organisations preparing for the introduction of Revalidation. The RST has expertise in Appraisal, and was largely responsible for the design of Strengthened Appraisal. RST was created out of the former Clinical Governance Support Team.</p>

Source Documents Used in this Publication

This publication brings together numerous presentations and documents collected over more than a decade of working around appraisal and revalidation. The source documents are:

The Medical Profession (Medical Officer) Regulations 2010; Draft Statutory Instrument

The Role of the Responsible Officer - Closing the Gap in Medical Regulation - Responsible Officer Guidance; Department of Health; July 2010 (Gateway Reference 14375)

Assuring the Quality of Medical Appraisal for Revalidation (AQMAR); Dr Martin Shelley and Dr Keith Judkins; NHS Revalidation Support Team; May 2009

Medical Revalidation- Principles and Next Steps; Department of Health

Appraisal in Practice; The British Association of Medical Managers; 2003

Appraisal in Action; The British Association of Medical Managers; 1999

Various presentations given by NCAS representatives at conferences, including the Scottish Association of Trust Medical Directors, February 2010.

“Creating a Fresh Approach to Clinical Leadership in the NHS”; by Stuart Haines and Bob MacKenzie; 2010; BKG Athena Series. Athena Number 1.

About the Author

Stuart Haines



Stuart Haines is a co-founder of Haines Business Systems Ltd (HBS), a multi-sector organisation, working in business and IT consultancy, business development, health leadership and retail. This business portfolio reflects the collaborative approach to running an organisation that Stuart brings to the table.

Stuart is well experienced in working in clinical leadership. For more than twelve years, he was part of the British Association of Medical Managers (BAMM), serving that organisation in the roles of General Manager, Director of Strategy, Deputy Chief Executive and latterly as an independent associate. Stuart was key in the development of the Fit to Lead programme, and in writing the underpinning medical management standards. He has designed and delivered many successful medical leadership development programmes throughout the NHS in both the primary and secondary care sectors.

Stuart built a good reputation throughout the senior medical community. He was invited to contribute to numerous national conferences and events on the subjects of medical management and clinical leadership. He was part of the Academy of Medical Royal Colleges Re-Certification Project Board, helping to shape the professional standards underpinning Revalidation and has delivered dozens of workshops on Revalidation throughout the NHS. He has a wealth of knowledge and experience around revalidation, appraisal and clinical governance, and a deep knowledge of NHS processes necessary to deliver effective regulation. His passion, though, is health-care quality. He believes strongly that quality and business management go hand in hand, and that the key to success is through effective clinical leadership.

Stuart created the innovative Business and Knowledge Gym, mainly to support and develop small and medium sized businesses. He believes that the lessons learned in healthcare leadership are relevant to small businesses, and vice versa.



Further information about the Business & Knowledge Gym, our products and services can be found at our website:

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There are other publications in the Athena Series, many available for **FREE** download, so that they may be disseminated and shared with a wider community. The Business & Knowledge Gym is committed to disseminating knowledge, and sharing best practice. All we ask is that you acknowledge the source in full.

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