NHS England All England Appraisal Network
Medical Appraisal Position Statement

Reference: MAPS S11

Supporting information for medical appraisal: the role of the designated body

Relevance:

This statement is relevant to all designated bodies in England.

Position statement:

1) In the overall interest of enhancing patient care all healthcare organisations have a role in supporting doctors to generate supporting information for medical appraisal. Information processes should be aligned to achieve this where practical.
2) In the context of NHS England's role as an individual designated body, NHS England Professional Standards Team will seek to establish a statement of intent on the alignment of such information processes in relation to doctors connected to NHS England. As this process develops, further position statements and examples of such processes will be produced.
3) In the context of NHS England's role as Senior Responsible Owner for the revalidation programme in England as a whole, NHS England Professional Standards Team will seek to establish wider debate and discussion on the implementation of this statement in England, so as to enable all designated bodies to develop in this area.
4) Input will be sought to this work from within different parts of NHS England, other designated bodies, other agencies and interested parties, as appropriate.

This position is underpinned by the following principles:

a) Every individual doctor is ultimately responsible for gathering and presenting the supporting information for their professional appraisal.

b) Any organisation, whether a designated body or not, making use of the professional service of a doctor has a duty to assure that the doctor is fit to undertake the service in question.
c) Every responsible officer is obliged, among other duties, to ensure that there are processes in place to monitor the professional practice of their doctors.
d) Every designated body is obliged to support their responsible officer in the discharge of their duties, including the resources necessary to achieve this.
e) Information flows can support the needs of the healthcare organisation and its doctors simultaneously, because organisations and doctors share the common goal of enhancing patient care.
f) Healthcare organisations and doctors also share the common aim of maximising the efficiency of information generation about medical practice, so as to maximise doctors' clinical time and minimise time spent by doctors gathering information for appraisal.
g) It is therefore reasonable and beneficial to all parties, and to the provision of high quality patient care, for information processes within healthcare organisations to be, where practical, aligned to assist doctors in their individual professional duty to generate supporting information for medical appraisal.
h) The successful development of such information processes is most likely to be achieved through a process of dialogue between a health care organisation and its doctors, and a range of other interested parties.
i) The supporting information a doctor submits at appraisal must meet the GMC requirements in *Supporting information for appraisal and revalidation*, and *Good Medical Practice Framework for appraisal and revalidation*.
j) Professional body guidance is helpful in assessing this for doctors working in a particular specialty.
k) At the current time it is the appraiser role to judge, after discussion with the doctor and, if necessary taking advice from the responsible officer, whether appropriate supporting information has been presented and whether this reflects the nature and scope of the doctor's work.
l) A degree of proportionality is appropriate when considering the scale of supporting information expected of a doctor; discussion is needed to decide if this may be mitigated by means such as allowing appropriate read-across of certain types of supporting information from one area of a doctor's scope of work to another, and/or by the submission of periodic composite reports from areas of the doctor's scope of work rather than a full portfolio from every area. For the time being, this again is a matter for the appraiser to judge.
m) It is appropriate to consider means whereby the appraiser can be assisted in reaching their judgements on these matters, whether by further clarifications of the specific expectations of supporting information, decision-making guidance for appraisers, calibration of appraiser decision-making through the All England Appraisal Network or other methods.

n) This area is complex. It requires a broad approach, combining agreed strategic vision and locally generated initiatives, and in which debate and discussion takes place with a wide range of interested parties, where central leadership has an important function but is expressed in a facilitative, consensus-seeking manner. This is the approach most likely to yield the best results for all parties, and in particular bring the greatest benefit to patient care.
o) These principles should in time be extended to apply to other healthcare professionals.

Rationale for position statement

Description and background

The GMC has defined six categories of supporting information which a doctor should present at appraisal, and descriptors of the nature of such information, in *Supporting information for appraisal and revalidation* (Box 1).

Box 1. GMC categories of supporting information

1. Continuing professional development (CPD)
2. Quality improvement activity
3. Significant events
4. Feedback from patients
5. Feedback from colleagues
6. Complaints and compliments

Production of this information will help the doctor demonstrate that their practice is to the level expected in the companion GMC guidance *Good Medical Practice Framework for appraisal and revalidation*. Specialty organisations have augmented these guidance documents with more specific guidance relevant for their members: *Supporting Information for Appraisal and Revalidation: Core Guidance Framework* (Academy of Medical Royal Colleges). A doctor is individually professionally responsible for presenting all such relevant information at their appraisal, the agreed process for which is described in the NHS Revalidation Support Team (RST) document: *Medical Appraisal Guide.*

The responsible officer regulations require responsible officers to have systems in place to monitor the professional practice of their doctors. Additionally, any organisation engaging or contracting with a licensed medical practitioner has an obligation to assure that individual's fitness to undertake the professional work they undertake. Information is central to this requirement, with the key sources of relevant information in this regard being the organisation's clinical governance processes, HR processes and processes for responding to concerns about the doctor's practice.

There are therefore both organisational and individual professional obligations to gather information about a doctor's practice. Whilst accepting the individual professional responsibility of the doctor to present all relevant information, there are several advantages to all parties if these processes can be sensibly aligned. These include, but are not limited to:

- A saving of professional time if good quality organisational information is available to a doctor to present at appraisal without them having to assemble all of it personally;
- Greater objectivity, verifiability and consistency of information which has been organisationally produced;
- Better quality appraisal, achieved by both maximising the doctor's time reviewing and reflecting on their information compared with that spent gathering it, and by having appraisal discussions informed by higher quality, standardised information;
- A new and valuable perspective on the quality of care for organisations, achieved by the alignment of their information processes to support the generation of information about doctors' practice;
- Helping doctors and their organisations to ensure that they are working productively and in line with each other, achieved through discussion about the nature of information to include locally, and then review of the information itself. This advantage can be realised primarily because healthcare organisations and doctors share the common goal of high quality patient care.

It may be beyond the remit of the organisation to gather certain types of information for the doctor (for example the doctor's organisation is unlikely to be in a position to gather all of a doctor's continuing professional development activities). However it makes good sense to align the information processes where possible. While it should be possible in the future for organisations to help gather some information in all categories, the area which has the greatest immediate overlap with existing clinical governance processes and is therefore most conducive to organisational support in this regard is that of quality improvement activity. However, in many organisations it should be possible with some adjustment to help compile organisational information on organisation-led continuing professional development, significant events and complaints/compliments; in time, the same should be possible for patient and colleague feedback.

One issue for consideration relates to the potential scale of supporting information provided by a doctor at appraisal. As described above GMC guidance describes six categories of supporting information. In any one area of a doctor's scope of work if a doctor is expected to submit only one piece of supporting information from each category, they will provide a total of six pieces. If, as is commonly the case, the doctor has several areas in their scope of work, this could be interpreted by some as

increasing the requirement in simple terms of number of items. If the doctor is expected to produce more than one item in a category, it is easy to understand that the number of items of information will soon become unmanageable. The current working understanding is that the appraiser will use judgement to decide, in conversation with the doctor, and involving the responsible officer if necessary whether the information provided is sufficient to support a judgement on fitness to practice across the doctor's whole scope of work. It would be helpful to explore in time how this judgement might be supported by guidance on what is expected for a particular area in the doctor's scope of work, and the extent to which this can be balanced by read-across from items gathered in different areas.

As an example of the sort of work that could assist in this regard, some have suggested that for a doctor listing several areas in their scope of work, where one is a main role and others are subsidiary roles (for example a doctor whose main role is as a consultant in Emergency Medicine, and who has two subsidiary roles: in medico-legal practice and as medical advisor to a local sports team), there could be an option to submit a periodic structured report from the subsidiary roles at appraisal, rather than accruing all six categories of information from each. This report could be generated by the person with clinical governance responsibility for the doctor's practice in that setting, and could describe the means whereby the doctor's fitness to work in that setting is assured. There is an existing form to support transfer of information about a doctor's practice, the *Medical Practice Information Transfer* (MPIT) form, available on the NHS England revalidation webpage. It may be that this might provide a vehicle for a doctor to bring information to their appraisal about their subsidiary roles. This is the sort of area in which discussion and testing of different approaches will help to develop a way forward.

Current approach and associated risks

The principle of organisational information being submitted at appraisal is not new. In 2007, a national conference on appraisal proposed a framework for information for medical appraisal using 'Personal' and 'Organisational' information. The GMC guidance on supporting information also makes it clear that team based information from practice is acceptable, provided the doctor reflects on its relevance to their personal practice. While in some areas of the UK there has been impressive activity in this area, there is not a system-wide approach to this in England, and the general understanding is that alignment of service information processes with medical professional regulatory processes is not widely embedded in a strategic sense.

The establishment of responsible officers and the implementation of revalidation now provide an opportunity to make progress in this area. Thinking specifically of NHS England as a single designated body connected to around 42 000 doctors, there is a clear opportunity to develop processes which will assist a great many doctors in their appraisal process. This position statement seeks to describe the principles which apply in this area, and specifically to designated bodies, in terms of their role in the

process of producing information for their doctors' appraisals, along with proposals to establish working group(s) to engage the appropriate interested parties and take this work forward, in an approach which combines strategic vision with locally generated initiatives.

References

NHS England Medical Appraisal Policy (NHS England Oct 2013): http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/04/med-app-policy-1013.pdf

NHS England Medical Appraisal Policy Annex H: Information Governance (NHS England 2013): http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/map-annex-h.pdf

Confidentiality NHS Code of Practice (Department of Health, 2003) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069253.

Information management for medical revalidation in England (NHS Revalidation Support Team, 2014) http://www.england.nhs.uk/revalidation/ro/info-docs/

Medical Appraisal Guide (NHS Revalidation Support Team, 2013) http://www.england.nhs.uk/revalidation/ro/info-docs/

Medical Appraisal Guide Model Appraisal Form (NHS Revalidation Support Team, 2012) http://www.england.nhs.uk/revalidation/ro/info-docs/

The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 http://www.legislation.gov.uk/uksi/2013/391/made.

*The Medical Profession (Responsible Officer) Regulations 2010 (*Her Majesty's Stationery Office, 2010) www.legislation.gov.uk/id/ukdsi/2010/9780111500286.

Quality Assurance of Medical Appraisers (NHS Revalidation Support Team, 2014) http://www.england.nhs.uk/revalidation/ro/info-docs/

Evidence for Medical Appraisal: Essential/Optional: Statement of the NAPCE/CGST Conference (National Association of Primary Care Educators/NHS Clinical Governance Support Team, February 2007) http://www.apce.co.uk/itemdetails.php?itemId=185

Good medical practice framework for appraisal and revalidation (GMC, March 2013) http://www.gmc-uk.org/static/documents/content/GMC_Revalidation_A4_Guidance_GMP_Framework_04.pdf

Supporting information for appraisal and revalidation (GMC, March 2012) http://www.gmc-uk.org/static/documents/content/RT_-_Supporting_information_for_appraisal_and_revalidation_-_DC5485.pdf

Medical Practice Information Transfer Form (NHS Revalidation Support Team, 2013) http://www.england.nhs.uk/revalidation/ro/info-docs/mpit-form/

NHS England medical appraisal position statements

NHS England medical appraisal position statements are a means by which issues pertinent to consistency and quality are captured, discussed and developed, so as to develop an agreed approach across all relevant parties. Issues are passed to the All England Appraisal Network (National) group in the first instance. The network develops an initial position statement based on preliminary discussion. This statement is shared for wider discussion as appropriate, then re-drafted and re-circulated. Depending on the nature of the issue, formal approval may be obtained from various bodies or relevant individuals. The degree to which a position statement has been shared and/or approved is detailed in the governance table at the end of the document.

A position statement should be seen as a fluid document to facilitate discussion and debate. It aims to capture current thinking on an issue and describe the best agreed approach available at the time. Incremental levels of sign off and approval occur after appropriate consensus-building efforts have occurred. A position statement may therefore eventually be consolidated as policy, but while it remains a position statement it remains a vehicle for debate and discussion.

NHS England medical appraisal position statement relevance

NHS England has a dual function in relation to revalidation and appraisal: firstly as a designated body in its own right, and secondly as Senior Responsible Owner for the revalidation programme in England as a whole. A NHS England medical appraisal position statement may therefore be relevant to NHS England only or to all designated bodies in England. The relevance of an individual position statement is indicated in the title of the statement. Position statements which are NHS England-only may still be of interest to other designated bodies.

Governance table

Owner	Maurice Conlon/ Paul Twomey
Email	maurice.conlon@nhs.net paul.twomey@nhs.net
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