NHS Education for Scotland **NES/18/15**

AGENDA FOR THE ONE HUNDRED AND THIRTY-EIGHTH BOARD MEETING

Date: Thursday 8th March 2018
Time: 10.15 a.m.
Venue: Meeting Rooms 1 and 2, Westport 102, Edinburgh

1. Apologies for absence

2. Declarations of Interest

3. Chair's Introduction

4. Chief Executive's Report NES/18/16 (Enclosed)

5. Decision on taking one item in Closed Session at the end of the meeting

6. Minutes of the One Hundred and Thirty-Seventh Board Meeting NES/18/13
To approve the minutes of the meeting held on 24th January 2018. (Enclosed)

7. Actions from previous Board Meetings NES/18/14
For review. (Enclosed)

8. Matters arising from the Minutes

9. Governance and Performance Items

a. Finance Report *(A. McColl)* NES/18/17
To receive and endorse. (Enclosed)

b. Organisational Performance Report *(D. Cameron)* NES/18/18
To receive and endorse. (Enclosed)

c. Staff Governance Committee: 8th February *(S. Douglas-Scott)* NES/18/19
To receive a report and the minutes. (Enclosed)

10. Strategic Items

a. National Boards Delivery Plan *(D. Cameron)* NES/18/20
For consideration. (Enclosed)

b. Operational Plan 2018/19 and Financial Plan *(D. Cameron and A.McColl)*
Drafts for consideration and approval.

(i) Annual Operational Plan — NES/18/21(a) (To Follow)

(ii) Financial Plan — NES/18/21(b) (Enclosed)

c. Remote and Rural Healthcare Educational Alliance (RRHEAL) — NES/18/22
For consideration. *(S. Irvine and P. Nicoll)* (Enclosed)

d. Medical Revalidation *(S. Irvine and B. Reid)* — NES/18/23
For consideration. (Enclosed)

11. Items for Noting

a. Partnership Forum: 18th January *(C. Lamb)* — NES/18/24
To receive a report and the minutes. (Enclosed)

b. Training and Development Opportunities for Board Members — NES/18/25
For information. (Enclosed)

12. Any Other Business

13. Date and Time of Next Meeting

Thursday 19th April 2018 at 10.15 a.m.

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March 2018
DF/tn

CHIEF EXECUTIVE'S REPORT

Caroline Lamb, Chief Executive

March 2018

1 INTRODUCTION

The agenda for our Board meeting today contains substantive items for discussion on the National Boards Delivery Plan, Our Annual Operational Plan and Financial Plan, the Remote and Rural Healthcare Educational Alliance (RRHEAL) and Medical Revalidation.

2. ANNOUNCEMENTS

This is Lindsay Burley's final meeting as Chair of the NES Board as her term of office ends on 31 March. I would like to thank Lindsay for her very significant contribution to the organisation over the last 16 years and on behalf of all of you, wish her all the very best for the future.

The Board will wish to congratulate Christopher Wroath, who received the 'Digital Leader' award at the Holyrood Digital & Health Care Awards on 20 February. This award recognises the considerable contribution that Christopher has made to the digital transformation in NES and his contribution more widely to Digital Health and Care across the public sector. It is also acknowledgement of the profile that NES now has in this area.

3 STRATEGIC UPDATE

National Boards Delivery Plan

Development of the National Boards Delivery Plan continues to move at pace, in advance of submitting it to Scottish Government by the end of March 2018. Donald Cameron has been leading on production of this plan. A summary of the emerging plan (item 10a) has been submitted to this and all other National Board meetings for information and discussion prior to the submission deadline.

NHSScotland Business Systems

I chaired the first meeting of the NHSS Business Systems Portfolio Management Group (BSPMG) on 29 January. NES and NSS are co-leading a programme which seeks to transform NHSS Business Systems into a national, modern and user-friendly digital service that provides better access to a single source of data and analytics. The meeting was attended by key stakeholders from Scottish Government and NHSS Boards. Overall governance arrangements for the programme are in the process of being finalised; this will form one of the key deliverables in the National Boards Delivery Plan.

Corporate Parenting

At the last Board meeting we received a report on Corporate Parenting including the NES Action plan. There was some discussion at this meeting about monitoring of progress against delivery of the plan. In subsequent discussion at the Executive Team we have agreed that we need to align the monitoring of this work; in relation to performance management, quality, and our responsibilities as an employer; with our existing arrangements. We will therefore ensure that performance against the action plan is reported as part of our corporate performance management arrangements, through the Finance and Performance Management Committee; with quality and

staff governance arrangements being picked up as appropriate by the Education and Research Governance Committee and the Staff Governance Committee.

4 MEDIA INTEREST AND COMMUNICATIONS

In Quarter 3 of 2017 (Oct-Dec), we issued 166 Tweets and 99 Facebook posts, reaching an average of about 2,300 and 2,000 people for each of these. Top tweets were on the following subjects: work and study in Scotland, the new NMAHP Director announcement and GPs talking about their role in a rural setting. Best performing Facebook posts were on the subjects of: Transforming Roles, General Practice nursing, NES vacancies, and antibiotic resistance.

Finally for 2017, since the last Board meeting we have concluded our analysis of the Christmas social media 'NES Baubles' campaign. Looking at Twitter activity, we increased the total number of impressions (probable views) by 72% compared to last year. Better design and more use of animation has probably been a factor as has learning lessons on scheduling and inclusion of popular topics like medicine, dementia, leadership etc.

From January 2018 onwards, we have issued news releases about increased emergency training for GPs, hospital doctors, nurses and paramedics in remote and rural areas of Scotland, and also about a new educational framework for GP Pharmacy Technicians. We have also used Facebook ads to support recruitment to the International Medical Trainee Fellowship and Dental traineeships.

Behind the scenes, the Corporate Communications team have been supporting colleagues from several areas in improving their video production and editing skills, so that they can reduce spend on external agencies and improve the quality of the learning materials they or we produce together.

5 DIGITAL

The development of functionality to support objective setting for Executive and Senior Manager Appraisal (Turas Appraisal) has been completed and will be available for use by 1 March. The next NES personal review and planning (PRP) cycle is due to commence in April 2018 and this this cycle will be completed using Turas Appraisal. To ensure that staff in NES are well prepared a detailed communications plan is underway.

The Turas Learn Team are currently working on a variety of areas including developing the course booking functionality of the system and migrating learning history from LearnPro to Learn.

The Knowledge Services consultation on subscriptions continues with internal and external staff and the impact survey for this will be live until end of February. The Educational and Research Governance Executive Group have also agreed to comment on the final report.

Turas FNP Application
The Family Nurse Partnership (FNP) is an evidence-based preventative programme which is available to clients at 10 territorial Health Boards. FNP clients are first-time, younger mothers usually aged less than 20 at conception. NES Digital are developing a new information system which will process data captured by Family Nurses in relation to their clients. It will deliver the following benefits:

- Family Nurses will have direct access to data relating to their clients. This will allow them to tailor the programme according to the unique needs of each client.
- Family Nurses will have the most important information immediately to hand (including on mobile devices), this will release time to patient care and allow them to prioritise visits to clients with greatest need
- The system will allow continuous monitoring of quality measures; issues identified relating to programme implementation will result in improvements to client care.
- The system will offer significantly improved reporting on outcomes achieved by clients and their children. This information will support further improvements to programme implementation.

Development of the system is progressing well with constructive feedback from Family Nurses. It is expected to launch in the first half of 2018.

6 DENTAL, OPTOMERY & HEALTHCARE SCIENCE

Dental

Oral Health Improvement Plan
In January, Scottish Government published the Oral Health Improvement Plan which sets out a new preventive system of care to assess patients based on risk, and address the link between deprivation and ill-health. It will see the introduction of personalised care plans which focus on lifestyle choices, for example diet, alcohol and smoking, and how these impact on health.

The document follows the publication of the consultation exercise in September 2016 which set out the current landscape in NHS dentistry and included a number of proposals for the future direction of the policy. As part of the consultation exercise there was a period of stakeholder engagement through a consultation questionnaire, roadshows for professionals and focus groups for the public. Each of these exercises proved invaluable in helping to identify the priorities for the future. The analysis of the consultation exercise was published in June 2017.

The plan has a number of themes:-

- Focus on prevention
- Reducing oral health inequalities
- Meeting the needs of an ageing population
- More services on the high street
- Improving information for patients

- Quality assurance and improvement
- Workforce
- Finance

Among its recommendations, a new scheme is proposed to meet the needs of the ageing population, enabling suitably skilled practitioners to treat people cared for in their own homes, and a Community Challenge Fund of up to £500,000 in 2018/19 will allow organisations to bid for funding to work in deprived communities and support people to practise better oral health.

David Felix has been invited to become a member of the overarching Steering Group which will oversee and prioritise the actions within the report.

Links to the report can be found here.

Dental Conference – 20 March 2018
On 20 March 2018, we are holding our National Dental Conference at COSLA in Edinburgh. This year's event will focus on the launch of the Oral Health Action Plan. It will bring together colleagues and stake holders from all areas of the Dental Workforce. The event will provide a platform to allow discussion and feedback on the Plan.

February = Oral Health Month in NES
The Healthy Working Lives group asked Directorates to lead on a topic which would improve the health of the NES workforce. In February, the Dental Directorate ran an Oral Health month. One of the main communication channels was interacting with staff via our internal online Yammer message platform. The focus of the posts was on diet and dental caries, caring for your teeth, other oral health issues and a sugar free February challenge. This initiative has been well received with many teams entering the sugar free February challenge and engaging with Yammer messages.

Healthcare Science

Quality monitoring
In early February we ran our 7th Postgraduate trainees event with around 100 attendees. We reported on our first years' experience of ARCP-type monitoring and how this has been integrated into Turas TPM. 80% of 100 eligible trainees have given satisfactory monitoring returns; we are exploring the non-compliance issues. Dr Rob Farley NES professional Lead met with HCPC and the Association of Clinical Scientists in January 2018 to emphasise to the regulator our need for the current alternative training pathways to registration.

We will be hosting new video-viva sessions for 7 clinical scientist trainees in late March 2018 in partnership with the Academy for Healthcare Science. This initiative is designed to cement Westport as a hub for final assessment and reduce travel and time costs of the process.

We are currently recruiting two further sessional Healthcare Science Principal Leads to develop our interest in NHS practitioner trainees, training department accreditation, postgraduate trainees and our CPD offer.

Continuing Professional Development
In partnership with the UK Academy for Healthcare science, we anticipate a second Study Day (North) later in 2018 on the work of the Academy, with training opportunities for clinical scientist assessors and potential registrants to the Academy's accredited register for non-HCPC grades. Our February Postgraduates Event highlighted an appetite for a range of "bite-size" CPD that we will be exploring. Recently, we revised our face-to-face *trainee's-in-difficulty* offer, with roll-out in Edinburgh and Aberdeen and Inverness: this programme links closely with our quality monitoring work and has been well received.

Dr Rob Farley has contributed to the CNO's Transforming roles agenda, where it is hoped that healthcare scientist approach to advanced practice roles might help inform NMAHP thinking; we have also worked with Scottish Government on its shared services agenda, particularly in respect of demand optimisation of laboratory diagnostic services.

7 MEDICAL

Launch of the Implementation of the Shape of Training Report in Scotland
At an event held at the Royal College of Surgeons of Edinburgh on 26 February, the Cabinet Secretary for Health and Sport formally launched the implementation of the Shape of Training Steering Group report in Scotland. In addition to a keynote address from the Cabinet Secretary, the meeting was addressed by Shirley Rogers, Director of Health Workforce and Strategic Change; Dr Emily Broadis, Scottish Clinical Leadership Fellow; Professor Ian Finlay, Chair of the UK Shape of Training Steering Group; and Professor Stewart Irvine, NES Medical Director.

Training in Paediatrics at St John's Hospital
Board members will be aware that there was a members' business debate in the Scottish Parliament on the children's ward at St John's Hospital, Livingston. The report of the debate is available on the Parliament website[1].

As part of their training programmes, there are several trainee doctors currently working within Paediatrics at St. Johns – 1 x Foundation Year 1, 3 x Foundation Year 2s and 2 x GPSTs whose training rotations include working within the unit. They are relatively inexperienced doctors, and will work differing rotas. Following decisions agreed between NES and the regional workforce planners (and which have been in place for the last few years), there are currently no middle grade (ST3 or above) paediatric trainees placed in the Unit, primarily because the out of hours service does not support such trainees to gain the necessary training experience to contributes towards the development of the skills they need.

It is NES's responsibility to ensure that trainees are placed in locations that allow them to acquire the appropriate types and range of experiences that allow them to successfully progress through their training programmes i.e. gain the experience

[1] http://www.parliament.scot/parliamentarybusiness/report.aspx?r=11372&i=103398

and competencies that meet the standards set by the GMC. The unit has recently met with training programme directors to explore the placement of ST3 trainees for daytime experience within the unit, and further details of the experience that might be delivered to these trainees have recently been provided by the unit and are being actively considered by the training committee. Depending on the numbers of trainees available at that stage in training, it may be possible to allocate ST3 & above to the Unit for daytime experience, although it would be important to understand that the regional staffing of other units must also be taken into account.

8 NMAHP

Duty of Candour Procedure

The Health (Tobacco, Nicotine etc and Care) (Scotland) Bill, which included at Part 2 the Duty of Candour provisions, was given Royal Assent on 6 April 2016. The implementation date for the Duty of Candour provisions is 1 April 2018. Regulations in respect of the Duty of Candour provision were laid before the Parliament on 12 February 2018. These are available here.

NHS Education for Scotland (NES), Healthcare Improvement Scotland (HIS), the Care Inspectorate (CI) and Scottish Social Services Council (SSSC) have been working in partnership to develop a range of education and training resources that will support implementation of the new procedure across Health and Social Care.

All the Education and Training Resources produced have been under the banner of the four organisations and Scottish Government. This is very much a joint programme although NES has taken the lead and has undertaken any procurement activities associated with development. The following resources have been developed:

a) Duty of Candour Guide for Staff (leaflet).
b) Factsheets:
   i. Duty of Candour Procedure (Procedure)
   ii. Duty of Candour – Apology (Apology)
   iii. Duty of Candour – Monitoring and Reporting (Reporting)
c) E-learning module (module)
d) Face to Face Training Events (using case studies and scenarios)

   NES have had an overwhelming response to the events with over 2200 applications received for the 800 places available. Each event accommodates 200 participants. The events will be held as follows:

   Murrayfield Stadium, Edinburgh – Tuesday 20 February 2018
   Hilton Treetops Hotel, Aberdeen – Wednesday 21 February 2018
   Crieff Hydro, Crieff – Thursday 8 March 2018
   Hilton Hotel, Cambridge Street, Glasgow – Wednesday 21 March 2018

e) Train the Trainers pack currently being developed and will be available electronically

Scottish Government and the four partner organisations are in currently in discussion about potential funding available for education and training in 2018/19. The ethos underlying this education and training and the intention of all those involved is to maximise the impact our existing and future work has on the implementation of the Duty of Candour. We plan to create opportunities to embed key messages such as openness, honesty, learning and improvement that are the cornerstones of the new Duty.

Duty of Candour event – Aberdeen
We were delighted to welcome Catherine Calderwood (Chief Medical Officer), to our event held in Aberdeen on Wednesday 21 February. She happened to be in the area and had been keen to attend one of the events, however, her diary hadn't allowed her to attend the whole day. She was offered the opportunity to say a few words during the event and we adjusted the programme to allow this to happen. NES staff discussed with her some of the points raised by clinicians earlier in the day and from the event held in Murrayfield the previous day.

Catherine Calderwood gave a very powerful talk about her thoughts around the duty of candour. Her message was delivered through a real experience she had as a doctor. It was delivered with real compassion, emotion and demonstrated her vulnerability as a clinician when she had caused harm. The message was that we are humans, delivering care to humans and when things go wrong, we should just do the right thing and say sorry. She tweeted about the event using our #fcdoc18. She has been provided with the dates of the future events. If she attends, we will ensure that we can accommodate her within the programme.

9 PSYCHOLOGY

Psychosis
NES Psychology provided training in 'Training for trainers in Psychosocial Interventions for Psychosis' on the 1st & 2nd February 2018 to a Scottish expert cohort of trainers who will deliver the training within the local boards and lead in the implementation of this low intensity psychological intervention for psychosis. The training was co-produced with the University of Glasgow, NHS Clinicians and people with lived experience of psychosis and is aimed at mental health staff who have a keyworker role and work with people who have experience of psychosis. It consists of a digital e-learning module followed by 2-day interactive workshops. The training aims to introduce the psychosocial approach to psychosis and empower staff to engage in collaborative alliances that encapsulate optimism, recovery and hope.

Dementia
The Cognitive Rehabilitation in Dementia mobile application developed by NES has been submitted for 2 UK awards: National Technology Awards and the Advancing Healthcare Awards.

The Essentials in Psychological Care – Dementia; Training for Trainers programme was launched in January in Grampian. Positive feedback was received from attendees.

10 WORKFORCE

4th National NHSScotland Healthcare Support Workers Annual Event
'Inspirational', 'Best day of the year', 'Important'. These are just a few of the comments from delegates after attending our 4th National NHSScotland Healthcare Support Workers Annual Event on Wednesday 7 February 2018.

The theme of the event was 'Learning to Do Things Differently' and aimed to make delegates aware of how they can contribute to service improvement. Over 200 Healthcare Support Workers were welcomed to BT Murrayfield Stadium on the day. Shirley Rogers, Director of Health Workforce & Strategic Change, Scottish Government and Fiona McQueen, Chief Nursing Officer, Scottish Government both attended the event and emphasised how much they valued healthcare support staff and their appreciation for the work of these staff who 'keep the hospital doors open'.

CALENDAR

12 January: National Board Chief Executives Workshop

I attended a development workshop with the Chief Executives of the other National Boards to discuss the strategic relationship between the Regions and the National Boards and the areas where most impact can be delivered on a national level. The outputs of this meeting were a refreshed approach to the National Boards Delivery Plan.

16 January

NES Executive Team
The Executive Team discussed the 2018/19 draft budget and operational plan and corporate priorities, Realistic Medicine and the National Health & Social Care Workforce Plan (Part 2).

National Boards Health & Social Care Delivery Plan Programme Board
I attended this meeting where we discussed the progress of the National Boards Delivery Plan and future communications/engagement and the development of regional plans.

NHSScotland (NHSS) Implementation Leads Meeting
I attended this meeting at which we discussed progress towards the national and regional delivery plans and current/future national planning arrangements. Phil Raines (Scottish Government) presented a paper on 'Strengthening our Approach to Driving Transformational Change'. Dorothy Wright along with the regional HRD leads, also attended to provide a workforce update.

17 January

NHSS Chief Executives Private & Strategy Meetings
I attended these meetings where a Forensic Report, National Specialist Services Committee (NSSC) commissioning update and review of national planning arrangements were discussed. I provided an update on NHSS Business Systems work and Colin Sinclair (NSS) gave a presentation on CHI (Community Health Index) population register.

John Burns
I met with John Burns (Chief Executive, NHS Ayrshire & Arran) to discuss the CAJE (Computer Aided Job Evaluation) system. CAJE currently supports the NHSS Agenda for Change job evaluation process. The purpose of the meeting was to discuss the development of an NHSS-owned system that NES could build on the Turas platform.

NHSS Chief Executives Business Meeting
The main items of discussion at this meeting were Finance, Performance and Planning and an update from St Andrew's House on various health policy areas.

18/19 January: Scottish Trauma Network 'Planning for the Future' Launch Event

As Chair of the Scottish Trauma Network (STN) I attended this event which formally launched the STN and its aim to create a co-ordinated and inclusive system of trauma care in Scotland. I introduced the Cabinet Secretary and the work of the STN as part of the opening of the event.

19 January

Meeting with Geoff Huggins and Andrew Morris to discuss the Digital Health and Care Strategy
I attended this meeting which reviewed the findings of the External Expert Panel Report on digital health and care in Scotland. The panel, which comprised healthcare leaders from the US. Spain, Northern Ireland and England, was setup to advise the Scottish Government on the development of the Scottish Digital Health and Care Strategy and how digital technology can support Scotland's aim for high quality health and social care services that have a focus on prevention, early intervention and supported self-management.

22 January

Health & Social Care Delivery Plan National Programme Board
I attended this meeting where we discussed Public Health, Realistic Medicine, opportunities for aligning resources and planning and the delivery plan's Financial Framework.

23 January: Health Education and Improvement Wales (HEIW)

I met with Alex Howells, the newly appointed Chief Executive of the recently formed HEIW to discuss the current landscape and our future working relationship.

24 January

Workforce Data and Modelling
Christopher Wroath and I met with Sean Neil, Philip Couser (Director of ISD) and colleagues from Analytics Service Division Scottish Government to discuss future arrangements for health and care workforce data modelling. We discussed the requirement to identify additional capacity to support the NES work on the workforce data platform.

Marion Bain
I met with Professor Marion Bain (Medical Director, NSS) to discuss the new Public Health organisation.

NHSS Performance Teleconference
I attended a teleconference convened by Alan Hunter (NHS Scotland Director of Performance and Delivery at Scottish Government) to discuss the 2018/19 NHSS operational planning process.

Friday 26 January: NHSS Implementation Leads

I attended this meeting at which we discussed emerging issues in relation to the review of national planning arrangements and the ongoing development of the national and regional delivery plans.

29 January

National Workforce Plan (Part 2)
I met with colleagues from Scottish Government, SSSC and the Care Inspectorate to discuss the implementation of Part 2 of the National Workforce Plan, which focuses on improving workforce planning for social care in Scotland.

NHSS Business Systems Portfolio Management Group (BSPMG)
I chaired the inaugural meeting of the BSPMG which will provide oversight to the Business Systems programme of work. We discussed the Business Systems vision and roadmap, progress to date and future next steps, particularly in relation to the delivery of the programme and formal governance arrangements.

30 January

NES Executive Team
The Executive Team discussed the draft 2018/19 budget, the draft National Boards Delivery Plan and a briefing paper on the operation of Controlled Student Intake Processes (CIPs) in Scotland.

Scottish Leaders Forum Leadership Event – Collective Leadership in the Social Age
I attended part of this all-day event which explored what collective leadership means in the current environment, what barriers there are to working collectively, and looked at opportunities to help shape support for collective leadership in Scotland.

Graham Gault
I met with Graham Gault (Head of eHealth, Scottish Government) to discuss current and future plans around eRostering in NHSS.

31 January

Annie Ingram
I met with Annie Ingram (Director of Workforce, NHS Grampian) to discuss eRostering.

Alex McMahon
I met with Professor Alex McMahon (NMAHP Director, NHS Lothian) to discuss regional nursing banks and national training requirements.

1 February

PA Consulting/NSS
Christopher Wroath and I met with colleagues from PA Consulting and NSS to discuss the NHSS Business Systems programme of work, particularly in relation to overall delivery methodology.

Christine McLaughlin
I met with Christine McLaughlin (Director of Health Finance, Scottish Government) to discuss funding for the NHSS Business Systems work.

Management Steering Group
I attended this meeting where we discussed contractual arrangements for NHSS staff and received workforce updates on various NHSS staffing groups.

6 February: Managed Agency Staffing Network (MASNET)
I chaired this meeting where we received updates on the Nursing and Medicine regional banks and discussed current spend analysis. We also discussed the MASNET future operating model and remit as funding is due to end later this year.

7 February

Elective Care National Programme Board
I attended this meeting where we discussed the Elective Centre programme, target operating models and the Elective Centre Advisory Group recommendations on Elective Centre Scenario Planning. I also presented an item on Workforce Planning.

National Boards Collaboration – Chairs & Chief Executives Workshop
The National Boards Chairs and Chief Executives met to discuss progress on the National Boards Delivery Plan. The Chairs received updates on the strategic approach to collaboration taken so far and the shared infrastructure being assembled for collective work between the eight national boards. We also identified governance and financial implications associated with the delivery plan's development.

9 February: NHSS Implementation Leads

I attended this meeting where we discussed the ongoing progress of the National Boards Delivery Plan. Christopher Wroath and Colin Tilley (Programme Director, NES) also attended to give a demonstration of NES's new Supply Side Workforce Data platform.

12 February: eRostering Workshop

I chaired this workshop, attended by various NHSS stakeholders and colleagues from PA Consulting, to discuss a national approach to eRostering in NHSS. We reviewed the eRostering case for change and identified concerns, challenges and opportunities associated with this work.

13 February

NES Executive Team
The Executive Team discussed budget, operational planning and corporate priorities for 2018/19.

National Boards Health & Social Care Delivery Plan Programme Board
I attended this meeting at which we received various updates on the development of the National Boards Delivery Plan, including updates on the Financial Framework and stakeholder communications.

NHSS Chief Executives Private Meeting
I attended this meeting and presented a briefing paper on NES's position regarding Postgraduate Medical Training Whistleblowing which was prepared by Stewart Irvine. Other substantive items on the agenda included an update from Healthcare Improvement Scotland, a Safe Staffing presentation from Alex McMahon (NHS Lothian) and a paper on Scottish Government's new Duty of Candour arrangements.

14 February: NHSS Chief Executives Strategy & Business Meeting
I attended these meetings where we discussed NHSS Information and Intelligence, with reference to the new Public Health body and the Digital Health and Care Strategy and arrangements for national, regional and local information and intelligence support.

15 February: Phil Raines & Peter Donachie

Christopher Wroath and I met with Phil Raines and Peter Donachie (Scottish Government) to discuss how we can jointly establish the best fit between the National Boards Plan and the emerging Health and Social Care Digital Strategy.

19 February

Sean Neill
I met with Sean Neill (Scottish Government) to discuss Part 3 of the National Workforce Plan, which will focus on the Primary Care workforce. We discussed additional GP recruitment in particular and NES's role in supporting this.

Olivia McLeod
I met with Olivia McLeod (Director for Children and Families, Scottish Government) to discuss the Leadership for Integration organisational and leadership development programme. The aim of the programme is to build capacity and capabilities of primary care and social care professionals to work effectively at locality level and within integrated partnerships to deliver integrated models of care.

Geoff Huggins
Christopher Wroath and I met with Geoff Huggins (Director of Health & Social Care Integration and Digital Health and Social Care at Scottish Government) to discuss the National Boards Delivery Plan, specifically in relation to the Digital Health and Care Strategy.

Anna Fowlie
I met with Anna Fowlie (Chief Executive, SSSC) to discuss education and training opportunities for social care support staff.

20 February

Digital Health & Care Scotland Conference
I was a member of an expert panel at a session which looked at the next steps for delivering Scotland's new Digital Health and Social Care Strategy. Pennie Taylor**,** Journalist and Broadcaster chaired the panel. We discussed how the strategy plans to impact on the way health and care services are delivered in Scotland.

Holyrood Digital Health & Care Awards
I attended the first annual Scottish Digital Health & Care Awards which celebrated excellence and innovation in the growing digital health and care sector in Scotland. The awards aim to recognise the achievements of those individuals and teams working in the health and social care sector whose creativity and innovation continues to put Scotland at the forefront of the digital revolution in healthcare and improves the life chances and quality of patients across the country and beyond.

Our Director of Digital, Christopher Wroath, received the 'Digital Leader of the Year' award, which recognised his role in creating the conditions and culture required to deliver health and social care services digitally on a national level.

21 February: Developing the Public Health Priorities for Scotland – Engagement Event

Scottish Government and COSLA were the co-hosts of this event in Aberdeen which aimed to establish public health priorities for Scotland as part of a wider programme of Public Health reform.

22 February: PA Consulting

Christopher Wroath and I met with colleagues from PA Consulting to discuss the next steps in relation to the eRostering workstream as part of the overall NHSS Business Systems programme.

23 February: NHSS Implementation Leads

I attended this meeting and gave a presentation on NHSS Business Systems, including progress to date and proposed governance arrangements. Dorothy Wright also attended with HR and workforce planning colleagues to give an update on national and regional workforce narratives.

RISK REGISTER

There are no changes to the risk ratings on the register, however the narrative has been updated to reflect the publication of the 2018/19 Scottish Budget and our current financial position.

Key Corporate Risks - March 2018

			Currrent Period						Last Period	
	Brief Description	I x L	Inherent Risk	I x L	Residual Risk		Notes	Appetite	I x L	Residual Risk
	Strategic/Policy Risks									
1	Retaining a strong focus on the importance of education and training through structural change	4 x 4	**Primary 1**	**4 x 4**	**Primary 2**		The Health and Social Care delivery plan published in December 2016 clearly sets out the requirement for organisations to work together differently in order to support the delivery of health and care in the future. We have had supportive feedback from SG in relation to our LDP		**4 x 4**	**Primary 2**
2	Signifiifcant pressure on budgets for 2017/18 and beyond	5 x 5	**Primary 1**	**4 x 4**	**Primary 1**		The Board has approved a draft budget for 2017/8 which includes a relatively high level of unidentified savings to be delivered from programmes of work within NES, and also through collaboration across the National Special Health Boards. The Scottish Government budget was published in December 2017 and has a flat cash settlement for NES which will clearly be very challenging. The 2018/19 draft budget has been submitted to the March Board for approval	**Open**	**4 x 4**	**Primary 1**
3	Lack of capacity and continuity at SGHD	4 x 4	**Primary 1**	**3 x 3**	**Contingency**		High inherent risk due to staffing reductions at SGHD which risks the loss of some corporate memory which is important in UK wide discussions. Increasingly NES is the repository for this level of expertise and experience. There is an opportunity for us to demonstrate this through joining up some of the data we hold, and through working with other organisations, such as NSS.		**3 x 3**	**Contingency**
17	Approach to workforce development is driven by HEE without due attention to requirements and views of the devolved nations	4 x 4	**Primary 1**	**3 x 4**	**Primary 2**		High inherent risk due to size of England as compared to other nations and extent of cross border flow. In response to this NES continues to work with the other devolved nations, with SG and to meet regularly with HEE.		**3 x 4**	**Primary 2**
18	Challenges in managing changing relationships with partner organisations	4 x 4	**Primary 1**	**3 x 4**	**Primary 2**		The changing environment will also drive shifts in our relationships with existing partners and identify new partners. Of particular importance will be our ability to craft collaborative relationships which play to each of our stregnths, with the other national NHS Boards, and to build supportive relationships with the emerging regional structures.		**3 x 4**	**Primary 2**
	Operational/Service Delivery Risks									
4	Ability to continue to support core business and respond to new demands in an agile and responsive manner.	5 x 5	**Primary 1**	**3 x 4**	**Primary 2**		We continue to experience pressures in maintaining core business in the face of increasing demands, and in the face of our Senior staff being asked to take on more national roles. We continue to review areas where we have the potential to release capacity and to use our workforce resource differently. Equally we will press SG for additonal resources where possible.		**3 x 4**	**Primary 2**
6	Dependency on key individuals	4 x 4	**Primary 1**	**3 x 3**	**Contingency**		Over the last year we have experienced some considerable turnover in senior roles and we have demonstrated our resilience in managing this. We are also now moving forwards with the development of our 'Potential and Career Management Strategy'.		**3 x 3**	**Contingency**
7	Turbulence and lack of cohesion due to internal organisational changes	4 x 4	**Primary 1**	**3 x 3**	**Contingency**		A number of significant organisational changes have been fully implemented. The budget paper that was considered by the Board in March highlighted a number of further areas that we will now be considering, we are committed to bringing a paper on our full programme of work to a future Board meeting.		**3 x 3**	**Contingency**

Key Corporate Risks - March 2018

	Brief Description	Currrent Period I x L	Inherent Risk	I x L	Residual Risk	Notes	Appetite	Last Period I x L	Residual Risk
16	Challenges in workforce supply in some areas	4 x 4	Primary 1	3 x 4	Primary 2	We are experiencing difficulties in recruitment to a number of key medical specialties and this is making it difficult to sustain services in some areas. There is a risk that NES is blamed for some of this, equally it is an opportunity for us to promote the position that good quality training and employment environments are essential to recruitment & retention; and to think creatively and innovatively about what we can do to maximise recruitment and retention and to support the contribution of other groups.		3 x 4	Primary 2
19	We lose the integrity of some of our reporting systems as a result of the introduction of e:ESS	5 x 5	Primary 2	3 x 4	Primary 2	NES is committed to the implementation of e:ESS and we have now implemented core e:ESS. We are continuing to experience some difficulties in replicating our reporting from the new system and this is causing some issues for us. We now have a direct influence on the review of NHS Business Systems which will help to drive developments in this area.		3 x 4	Primary 2
8	Major adverse incident - impacting on business continuity	4 x 4	Primary 1	2 x 4	Housekeeping	We have significantly improved our resilience in this area through roll out of more agile working, and the recent implementation of O365 has further enhanced our capabilities here.		2 x 4	Housekeeping
	Finance Risks								
9	Risk of underspends & resulting negative perception	4 x 5	Primary 1	3 x 3	Contingency	Our January position indicates a very small underspend. We will need to manage the position carefully into the year end		3 x 3	Contingency
10	Reduction of resources puts NES into deficit	4 x 5	Primary 1	3 x 4	Primary 2	As above	Averse	3 x 4	Primary 2
	Reputational/Credibility Risks								
11	NES is unable to demonstrate that it makes a positive contribution to patient safety/patient experience	4 x 5	Primary 1	3 x 4	Primary 2	This has been identified as a key objective in our refreshed strategic framework. Work is underway to identify existing data and ways of using this to demonstrate impact. We have also considerably increased our external PR activity, particularly on social media.		3 x 4	Primary 2
12	NES does not deliver on key targets	4 x 5	Primary 1	3 x 2	Contingency	Strong measures in place to demonstrate performance against key targets and to identify and remedy areas where performance falls behind.	Cautious	3 x 2	Contingency
	Accountability/Governance								
13	Failure in Corporate Governance	5 x 5	Primary 1	2 x 2	Negligible	Very strong internal audit opinion relating to system of internal controls. Good quality reporting from all NES Committees to Audit Committee.	Averse	2 x 2	Negligible
14	Data security issue	4 x 5	Primary 1	3 x 2	Contingency	We have strong data security processes in place. Further information regarding preparation for the new General Data Protection Regulations is provided in Risk 19.		3 x 2	Contingency
19	Preparartion for GDPR	4 x 5	Primary 1	3 x 2	Contingency	We have a structured programme in place to address the new regulations and are engaging with all Directorates. Directorates are currently populating their information asset registers in preparation for GDPR coming into force from 31 May 2018. A full report was presented to the F&PM Committee at its February meeting.		N/A	N/A

IN CONFIDENCE **NES/18/13**

NHS Education for Scotland

MINUTES OF THE ONE HUNDRED AND THIRTY-SEVENTH BOARD MEETING HELD ON WEDNESDAY 24th JANUARY 2018 AT WESTPORT 102, EDINBURGH

Present: Dr Lindsay Burley (Chair)
Ms Susan Douglas-Scott, Non-executive member
Ms Liz Ford, Employee Director
Professor Stewart Irvine, Director of Medicine
Mr Douglas Hutchens, Non-executive member
Ms Caroline Lamb, Chief Executive (all agenda items except 10 to 12)
Mrs Audrey McColl, Director of Finance
Dr Doreen Steele, Non-executive member
Ms Susan Stewart, Non-executive member (via Skype link) (all agenda items except 10 to 12)
Dr Andrew Tannahill, Non-executive member (via telephone link)
Ms Carole Wilkinson, Non-executive member (all agenda items except 9c and 10 to 12)

In attendance: Mr David Ferguson, Board Services Manager (Board Secretary)
Mr Donald Cameron, Director of Planning & Corporate Resources
Ms Dorothy Wright, Director of Workforce
Mrs Judy Thomson, Director of Psychology Training (agenda item 9b only)
Ms Sarah Doyle, Principal Educator, NMAHP (agenda item 9b only)
Ms Helen Raftopoulos, Scottish Funding Council (particularly for agenda item 9c)
Mr John MacEachen, Head of Corporate Communications
Ms Alison Shiell (Senior Officer, Planning and Corporate Governance)

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Karen Wilson, Director of NMAHP, David Felix, Postgraduate Dental Dean, and Christopher Wroath, Director of Digital.

2. DECLARATIONS OF INTEREST

There were no declarations of interest.

3. CHAIR'S INTRODUCTION

The Chair welcomed everyone to the meeting.

It was noted that Susan Stewart was joining the meeting via a Skype link to the Open University offices in Milton Keynes and that Andrew Tannahill was joining by a telephone link as his train had been cancelled.

The Chair drew attention to Karen Wilson's recent appointment to succeed Colette Ferguson as Director of NMAHP. It was confirmed that Karen had now been appointed as an executive Board member. It was noted that she was unable to attend this Board meeting due to prior commitments.

The Chair advised that the following officers would be joining the meeting for particular items:

- Judy Thomson, Director of Psychology Training, and Sarah Doyle, Pricipal Educator, NMAHP – for agenda item 9b, Corporate Parenting; and
- Helen Raftopoulos, Scottish Funding Council – for agenda item 9c, Intensification of Outcome Agreements.

4. CHIEF EXECUTIVE'S REPORT (NES/18/02)

The Chief Executive introduced the report, which provided information and updates on a wide range of NES activity, highlighting the following points:

- NES's successful bid to lead on the design and branding elements associated with the celebration of the 70th Anniversary of the NHS in Scotland. A suite of tailored materials have also been created for each NHS Board.
- The Turas Appraisal team's delivery of a Minimum Viable Product, as scheduled and in line with the December 2017 deadline. Turas Appraisal will replace the current e-KSF system.
- The 'supply side data platform' proof of concept work required as part of the NES deliverables from Part One of the Scottish Government Health and Care Workforce Plan was demonstrated successfully at the start of January 2018.
- The recently published report from the Care Inspectorate, "My Life, My Care Home. The experiences of people living with dementia in care homes in Scotland", included a prominent section on oral care, which reflects favourably on the work carried out by NES.
- The recent implementation of the training requested by Scottish Government for the initial 3 cohorts of pharmacists and pharmacy technicians employed using Primary Care Funding.
- The recent launch of a mobile application supporting Cognitive Rehabilitation in Dementia.
- The successful outcome of the recent GMC National Review of Scotland. The initial feedback from the GMC (circulated to Board members in summary form) was positive and the formal reports are scheduled to be published at the Scottish Medical Education Conference in April 2018. The Board congratulated Professor Irvine and his team on this achievement.

- The recent launch by the Cabinet Secretary of the Scottish Major Trauma Network and the agreement to the funding required to establish 4 Major Trauma Centres over the next five years.

The following points arose in discussion:

- A member asked about evaluations of use and effectiveness of the distance learning pack and workbook referred to in the Pharmacy section of the report. This will be followed up outwith the meeting. **Action: DJF**
- Some discussion took place on the new GP Contract, which has recently been signed-off by the GP profession. It was noted that there are educational implications and implications for the wider workforce, particularly in primary care. It was agreed that it would be useful to bring a paper to a future Board meeting on the implications of the new GP Contract. **Action: DSI**
- In response to a question from one of the members it was advised that an update paper on the new General Data Protection Regulations (GDPR) will be produced for consideration by the Finance and Performance Management Committee, in the first instance. **Action: CW**

5. MINUTES OF THE ONE HUNDRED AND THIRTY-SIXTH BOARD MEETING HELD ON 7TH DECEMBER 2017 (NES/17/107)

Subject to a minor amendment in item 8a (Finance Report), the minutes of the previous Board meeting were approved. **Action: DJF**

6. ACTIONS FROM PREVIOUS BOARD MEETINGS (NES/18/03)

The Board noted that all of the action points were completed or were in hand.

7. MATTERS ARISING FROM THE MINUTES

There were no matters arising from the minutes which did not feature elsewhere on the agenda.

8. GOVERNANCE AND PERFORMANCE ITEMS

a. Finance Report **(NES/18/04)**

Audrey McColl introduced a paper which presented the financial results for the eight months to 30th November 2017 and indicated the anticipated forecast outturn as at 31st March 2018. The following points were highlighted:

- The forecast underspend at the end of November 2017 was £370,000, compared to October's forecast of £643,000. The new figure reflects NES's VAT liability, as discussed at the last meeting, offset by a review of other expenditure.
- The initial figures for December 2017 suggested that there had been some significant movements which, if correct, would move the forecast outturn to a

small overspend. As an interim measure, an additional level of scrutiny of purchase orders had been introduced.

- Audrey McColl was pleased to report that, following a detailed review of Provisions and Capital Spend, the net result is that the current forecast outturn for 2017/18 is now between £200,000 - £250,000. The additional scrutiny of purchase orders remains in place.

An update was provided in relation to the ongoing dispute with HMRC in relation to NES's VAT liability. At this stage, the liability is expected to be in the region of £1.7 million and this is reflected in the financial forecasts. It was noted that this could change as a result of further discussions with HMRC and NES's VAT advisers. A meeting with HMRC is scheduled for 1st February 2018.

It was noted that NES has been unsuccessful in its legal dispute with the landlords of Westport 102. The financial forecast includes a provision for NES's legal costs. There is, however, no information currently available on the level of any award of expenses.

The following points arose in discussion:

- It was noted that the funding arrangements for the replacement Mobile Skills Unit will be considered at the next meeting of the Finance and Performance Management Committee.
- It was confirmed that the forecast outturn in relation to Digital expenditure remains accurate and reliable.

Following discussion, the Board noted and was content with the information contained in the Finance Report.

b. Educational and Research Governance Committee: 14th December 2017 **(NES/18/05)**

The Board received and noted the unconfirmed minutes and a summary, which were introduced by Andrew Tannahill.

Andrew Tannahill congratulated all concerned on the positive outcome to date of the recent GMC National Review of Scotland, and commented that it reflected the considerable expertise and effort on the part of the Scotland Deanery that provided the E&RGC with assurance in respect of managing and improving the quality of medical education and training. Professor Irvine indicated that he would pass these kind comments on to colleagues.

The following points arose in discussion:

- In response to a question from another Board member, Andrew Tannahill provided clarifying information regarding the Turas Learn risk register issue referred to in section 10 of the committee minutes.
- In relation to section 8.1 of the committee minutes, it was agreed that it would be useful to provide the Board with an update on the Family Nurse Partnership Programme in due course. **Action: DJF**

c. Audit Committee: 11th Janiuary 2018 **(NES/18/06)**

The Board received and noted the draft minutes and a summary, which were introduced by Carole Wilkinson, who confirmed that she had some minor changes to suggest to the minutes.

Particular attention was drawn to the committee's agreement to extend the internal audit contract with Scott-Moncrieff for one year, with a potential for extension for a further year beyond that.

ci. Revised Risk Management Strategy **(NES/18/06(a))**

Audrey McColl introduced a paper presenting a revised Risk Management Strategy, incorporating the changes to risk appetite discussed at the December 2017 Board meeting. It was noted that the revised strategy had been reviewed and supported at the recent meeting of the Audit Committee. The following points were highlighted:

- Members were reminded that the Board had agreed that the current appetite for residual risk (after the application of mitigating controls) should be retained, but that the Board should signal greater appetite for risk during the early concept phases of new activities or ways of working.
- Particular attention was drawn to section 5.2 of the revised strategy, dealing with Board risk appetite.
- It was recognised that there is work to do in relation to putting the proposed risk appetites for new activities and ways of working into practice.

Discussion of the paper generated the following main points:

- It was agreed that the revised strategy is an accurate reflection of the discussion at the December 2017 Board meeting and the proposed new approach to risk appetites was welcomed.
- It was agreed to refine the wording of some of the descriptions of risk appetite classifications included in the table on page 13 and to seek to incorporate further clarification of the residual risk score ranges in the same table.

Subject to taking account of the points referred to in the second bullet point above, the revised Risk Management Strategy was approved. **Action: AMcC**

d. Audit Committee Remit **(NES/18/07)**

Audrey McColl introduced a paper seeking the Board's approval for proposed changes and additions to the remit of the Audit Committee, which had been recommended following a recent review by the committee.

The following points arose in discussion:

- One member queried whether the phrase "to review" is a robust enough action in governance terms.
- It was suggested that it should be clarified that the private meetings with the internal and external auditors are for the purpose of discussing any issues of concern.

Following discussion, the Board approved the proposed amendments to the Audit Committee remit and agreed that the points raised in the two bullet points above should be taken into account when the committee next reviews its remit.

Action: AMcC

e. Review of Standing Orders **(NES/18/08)**

Caroline Lamb introduced a paper which had been produced to propose some changes to the Board Standing Orders; to inform a review of the Standing Orders; and to propose a timescale for subsequent reviews. It was noted that the proposed changes and additions to the Standing Orders were indicated in the paper by means of tracked changes.

The following points were raised in discussion:

- It was clarified that the Audit Committee Handbook recommends that it is good practice to indicate the name of the Audit Committee Chair in the committee's terms of reference. The Board noted this advice but agreed instead that the names of the Chairs of all of the Board's committees should be noted in the Board membership details in the Governance Handbook.
- It was noted that the titles of the Cabinet Secretary and the Head of the Scottish Government Health Department require updating in section 3.1.
- In clause 4.1, "Deputy Chair" should read "Vice Chair".
- It was agreed to include reference to declaration of interests in section 5.
- In clause 6.1.4, "Chairmen" should read "Chairs".
- It was agreed, on balance, to retain section 6.13 (Questions).
- It was agreed to delete the phrase "...,to the extent to which accommodation permits." In clause 7.1.
- It was agreed to clarify the relationship between the Staff Governance and Remuneration Committees in clause 9.1.
- It was agreed to delete clause 9.3.
- It was agreed that clause 9.8 should be shortened to read "The Board shall appoint the Chairs of its committees."
- It was agreed to amend clause 9.9 to include reference to the minutes of committee meetings being drawn up by executive leads, rather than "...by or on behalf of the Chief Executive..."

Subject to taking account of the points raised in discussion, The Board approved the proposed amendments to the Standing Orders. **Action: DJF**

In terms of the amended Standing Orders, the next review of the Standing Orders will be scheduled for March 2021. **Action: DJF**

9. STRATEGIC ITEMS

a. Budget and planning for 2018/19 **(NES/18/09)**

Audrey McColl introduced a paper presenting an update on the development of the draft NES budget for 2018/19.

The following points were highlighted:

- The draft Scottish Budget, released on 15th December 2017, confirmed that there would be no uplift to the NES baseline recurrent budget. There will, however, be additional funding made available later in the financial year to fund the Agenda for Change pay awards.
- Identification of a range of known pressures on the NES budget for 2018/19 revealed a funding gap of around £14.8 million, although initial savings identified by directorates have reduced this gap to £12.4 million.
- The scale of the challenge associated with producing a balanced budget for 2018/19 has necessitated an iterative process.
- The previous Local Delivery Planning process will be replaced with an Annual Plan, linking into the Regional and National Delivery Plans. This will set out a number of principles to be delivered in relation to finance and wider performance, although specific guidance on what is required has yet to be received.
- In parallel, NES is also supporting the development of the draft Financial Framework for the National Boards proposition, to contribute to the implementation of the health and social care delivery plan.
- It was noted that the patient-facing national NHS Boards will receive an uplift of 1.5%, while the non-patient-facing national Boards, including NES, will receive no uplift.
- The issues requiring to be addressed include the treatment of the likely pay award to trainees, in the light of NES receiving no funding to support this.
- It was agreed that it may be helpful to take some aspects of the discussion of the draft NES budget for 2018/19 in Closed Session at the next Board meeting in March 2018.

The following main points arose in discussion:

- It was confirmed that a deficit budget for 2018/19 is not an option.
- The Board re-iterated that NES should be regarded as a patient-facing NHS Board, as a significant amount of its budget is spent on the training of a range of patient-facing professionals, and it was agreed that this point should be emphasised at every opportunity in discussions with Scottish Government.

Following discussion, the Board noted the challenging position in relation to producing a balanced budget for 2018/19 and supported the proposal to consider this further through the Finance and Performance Management Committee, and the Board meeting in March 2018. **Action: AMcC**

b. NES's Corporate Parenting responsibilities **(NES/18/10)**

Judy Thomson and Sarah Doyle were welcomed to the meeting for this item.

A paper had been circulated to provide an opportunity for the Board to note and comment on NES's Corporate Parenting Plan prior to its publication. Judy Thomson introduced the paper, highlighting the following points:

- NES's statutory duties as a corporate parent involve exercising its functions in ways which actively promote and protect the interests and wellbeing of care experienced young people.
- NES is required to plan, review and report its corporate parenting activities and to collaborate with other corporate parents, as appropriate. Corporate parenting plans and progress reports must be published. The first progress report is expected in April 2018.
- Corporate parenting is an organisation-wide responsibility and there is positive engagement across the NES directorates.
- NES's Corporate Parenting Plan has been approved by the Executive Team and the Senior Leadership and Management Team and Board members' comments will be welcomed. The plan is considered to be brief but comprehensive.
- There are implications for the NES workforce and the education and training of healthcare professionals.
- Online materials for health and social care staff will be hosted in Turas Learn. It will be important to ensure that these materials are as accessible as possible.
- Digital learning materials, including videos, have been developed in association with Who Cares? Scotland (WC?S).
- Reporting on this workstream is through the Person-Centred Care, Participation and Equality and Diversity Leads Network (PEDLN) and scrutiny is provided through the educational governance process.

Discussion of the paper resulted in the following main points:

- Members acknowledged the importance of the corporate parenting role towards supporting a severely disadvantaged population group and reducing health inequalities.
- It was clarified that NES's corporate parenting role was the responsibility of the organisation as a whole, with the Board playing an important governance role.
- The general content of the plan was endorsed, but one member felt that it was somewhat lacking in terms of targets, timescales and impact.
- It was noted that health literacy is not NES's prime locus.
- There is a need to re-focus NES's workforce priorities in line with this agenda and to mainstream this activity in the operational plan.
- One member suggested that it might be useful to identify where NES's wider responsibilities in relation to reducing health inequalities fit in relation to planning and performance monitoring.
- It was suggested that appropriate governance/monitoring responsibilities in relation to corporate parenting might be shared between the Educational and Research Governance Committee and the Staff Governance Committee, reporting to the Board on those aspects relevant to their respective remits.

Following discussion, the Board approved NES's Corporate Parenting Plan for publication and it was agreed that Caroline Lamb would come back to the Board on the governance/monitoring aspects. **Action: CL**

Judy Thomson and Sarah Doyle were thanked for their useful paper and contributions to the discussion.

c. NES/SFC Joint Work: Intensification of Outcome Agreements **(NES/18/11)**

Helen Raftopoulos was welcomed to the meeting for this item. She introduced a paper which had been circulated to provide an update on specific health-related outcomes which are included in the "intensification" of the Scottish Funding Council (SFC) outcome agreement process. The following points were highlighted;

- As requested by the Board in August 2017, the specific outcomes for medicine include widening access and increasing the pool of applicants who may stay and work for the NHS and care sectors in Scotland.
- Work is already in hand in relation to a number of the specific outcomes.
- The profile in relation to meeting the outcomes has been raised to the level of Institution Principals.
- It will be important not to overload the outcome agreements process.
- There has been a mixed response to a letter sent in December 2017 informing the institutions of the specific health-related outcomes. Ministers are, however, content with the arrangements and supportive of the ways in which any concerns are being addressed.

The following points arose in discussion:

- One member queried whether the paper adequately captured all the responsibilities placed on Universities in relation to widening access generally.
- Susan Stewart declared an interest in relation to the Open University's nursing programmes and asked why there were no actions assigned to the nursing and midwifery outcomes in the paper .In response, Helen Raftopoulos advised that discussions are ongoing with Scottish Government with a view to developing a series of nursing and midwifery actions by April 2018.
- It will be important for Scottish Government to remain openly supportive of developments, in the face of the pressures likely to be exerted by some institutions.
- It would be possible for Scottish Government to claw back funding from institutions which fail to meet targets.
- NES is well placed to influence the intended move towards greater collaboration across the medical schools in Scotland.

Following discussion, the Board noted the paper and thanked Helen Raftopoulos for her attendance and useful contribution.

10. ITEMS FOR NOTING

a. Training and development opportunities for Board members **(NES/18/12)**

The Board noted a paper providing information on upcoming training and development opportunities for Board members.

b. National Health and Social Care Workforce Plan, Part 2

The Board noted this paper.

11. ANY OTHER BUSINESS

There was no other business.

12. DATE AND TIME OF NEXT MEETING

The next Board meeting will take place on Thursday 8th March 2018 at 10.15 a.m. It was confirmed that this meeting will take place in Westport 102, Edinburgh.

NES
January 2018
DJF/cl/at

NHS Education for Scotland

NES/18/14
(Enclosure)

Actions arising from Board meetings: Rolling list

Minute	Title	Action	Responsibility	Date required	Status and date of completion
Actions agreed at Board meeting on 24th January 2018					
4	OTC distance learning packs	Find out the position in relation to evaluation of these packs.	Chief Executive's Office	March 2018	The response from NES Pharmacy is appended to this list.
4	Implications of new GP Contract	Bring a paper to a future Board meeting.	Stewart Irvine	April 2018	Ongoing
4	New General Data Protection Regulations (GDPR)	Produce an update paper for the F&PM Committee, in the first instance.	Christopher Wroath	May 2018	Ongoing
8b	Family Nurse Partnership Programme (FNP)	Arrange to provide the Board with an update.	Chief Executive's Office	March 2018	An update on the FNP Turas App is included in the CE's Report to the March 2018 Board meeting.
8ci	Revised Risk Management Strategy	Take account of the discussion points in finalising the revised strategy	Audrey McColl	April 2018	Ongoing
8d	Revised Audit Committee Remit	Take account of the discussion points when the Audit Committee next reviews its remit.	Audrey McColl	January 2019	Ongoing
8e	Review of Standing Orders	Revise the Standing Orders in line with the discussion points and schedule the next review for March 2021.	David Ferguson	February 2018	Standing Orders revised on 7th February 2018. Next review of Standing Orders on 'bring forward' for action.
9a	Budget for 2018/19	Produce a paper for the F&PM Committee, en route to the March Board meeting.	Audrey McColl	February 2018	Paper on agenda for March 2018 Board meeitng.
9b	Corporate Parenting Plan	Arrange for the plan to be published.	Judy Thomson	March 2018	Ongoing
9b	Corporate Parenting Plan	Advise the Board of the governance/monitoring arrangements put in place for implementation of the plan.	Caroline Lamb	March 2018	An update on Corporate Partenting governance is provided in the CE's Report to the March 2018 Board meeitng.

Minute	Title	Action	Responsibility	Date required	Status and date of completion
Actions agreed at Board meeting on 26th October 2017					
8d	Committee Chairing Arrangements from 1st April 2018	Arrange for committee records and lists to be updated, in due course.	David Ferguson	March 2018	In hand – on 'bring-forward' for action.
9b	Mental Health Strategy	Actions, as necessary, following approval of the recommendations in the paper. Arrange for the NES/SSSC Steering Group to consider the upskilling of the existing health and social care workforce, using a flexible model. Arrange for the Executive Team to consider how NES can become even more influential and foster the right connections.	Judy Thomson Colette Ferguson (now Karen Wilson) Colette Ferguson (now Karen Wilson)	Ongoing Ongoing Ongoing	Ongoing Ongoing Ongoing
Actions agreed at Board meeting on 3rd August 2017					
8a	Progress against Strategic Outcomes 2014-19	Include specific examples of how staff have used impact guidance in next year's report (page 7) Share the progress report with NES staff and ask for feedback/future case study suggestions	Donald Cameron	August 2018	Ongoing

1. **How the impact of these long-distance learning packs will be evaluated?**

Prior to the development of the distance learning pack 'Effective Management of Over-the-Counter (OTC) Consultations (Phase 1) and the workbook 'Improving the Quality of Over-the-Counter (OTC) Consultations' (Phase 2), a large research exercise was undertaken as part of the Translation Research in a Dental Setting (TRiaDS) programme of research (www.triads.org.uk) within the Pharmacy profession (TRiaDS-P).

The need to improve the quality of the management of over-the-counter OTC consultations in the community pharmacy setting had been identified by the Consumer Association, Which? in several studies, the most recent of which was published in 2013. TRiaDs-P therefore conducted semi-structured interviews, using the Theoretical Domains Framework (TDF), with personnel working in community pharmacies across Scotland. The interviews explored participants' knowledge of current guidance for managing consultations, the skills required to elicit information and barriers and facilitators associated with this behaviour. The results informed the content of both these NES resources to improve information gathering by community pharmacy personnel.

Both resources will be/were evaluated in two ways, firstly by the shared TURAS MCQ knowledge assessment which they attempt on completion of the learning. There is a pass mark, which must be attained. Learners are also asked to rate the pack on a 1-5 scale and give any freetext comments.

Secondly, the learners are asked to complete a questionnaire measuring: -

- Perceived confidence prior to and after completion of the pack
- Perceived knowledge prior to and after completion of the pack
- Perceived likelihood of changing their management of OTC consultations because of completing the pack.

2. **Whether these learning packs were issued electronically/in hard copy – if hard copies are being sent, are there any plans to issue the packs electronically in future?**

These resources were targeted to medicine counter assistants (MCAs) working in community pharmacies across Scotland. The resources were issued in hard copy (1 copy per pharmacy as requested by Scottish Government) as this staff group does not have ready access to IT facilities in the workplace. However, an electronic copy of the resource will also be made available on TURAS Learn and staff are advised of this for additional support.

NES **NES/18/17**

Item 9a **(Enclosure)**

March 2018

NHS Education for Scotland

Board Paper Summary

1. Title of Paper

Finance Report to 31st January 2018.

2. Author(s) of Paper

Audrey McColl, Director of Finance
Keith Douglas, Head of Finance Business Partnering

3. Purpose of Paper

To present the financial results for the ten months to 31st January 2018 and to indicate the anticipated forecast outturn as at 31st March 2018.

4. Key Items

The year to date position is an underspend of £3.4m. This has been attributed mainly to timing differences such as budget phasing or reprofiling of activity. This will be kept under close review in the final two months of the year.

The forecast underspend at the end of January is £258k which is an acceptable position at this stage in the financial year. This is a reduction in forecast underspend, from December, of £14k and is predominately the net impact of;

- Additional underspend in Psychology due to late receipt of data from Boards (£95k)
- Additional savings from posts vacant whilst recruitment is underway (£371k)
- Additional funding in support of the Medical Education package (£280k)

Offset by;

- Contribution to the National Boards £15m efficiency target - £500k
- Additional costs of the e-Rostering project - £50k

- Increased costs in NMAHP mainly driven by higher than anticipated cohort numbers for the Advanced Nurse Practitioner programme - £81k
- Increased costs for the UK wide recruitment system, Oriel, amounting to £60k.

We have agreed with Scottish Governement that the slippage on capital spend for the procurement of the new mobile skills unit can be carried forward into 2018/19.

5. Educational Implications

This report sets out the financial impact of the on-going activity of the organisation in the delivery of its strategic objectives. Areas where we see significant movements may also indicate issues with the achievement of operational delivery targets.

6. Financial Implications

It is essential that we have effective mechanisms to ensure appropriate financial information is available for decision making at all levels of our Governance structures.

7. Which NES Strategic Objective does this align to?

An improved organisation

8. Recommendations

The Board is asked to note the information contained in this report.

AMcC

KD

February 2018

Finance Report to 31st January 2018

1. Anticipated Revenue Funding

NES receives both Core and Non-Core Revenue allocations from Scottish Government (SG). Boards are not able to offset underspends against one limit to offset overspends in the other. The NES core 'baseline recurring' budget for 2017/18 was originally £420 million. The table below reflects the updated position as at January 2018.

Table 1: Anticipated Revenue Funding

Core Revenue	Baseline Recurring	Earmarked Recurring	Non Recurring (In-Year)	Total Core Revenue
	£'000	£'000	£'000	£'000
Confirmed	423,353	4,777	16,737	**444,867**
Anticipated	45	307	647	**999**
Totals	**423,398**	**5,084**	**17,384**	**445,866**

Non Core Revenue	AME	Depreciation	Total Non Core Revenue
	£'000	£'000	£'000
Confirmed	(616)	1,214	**598**
Anticipated	0	0	**0**
Totals	**(616)**	**1,214**	**598**

Total Revenue	446,464

The in-year movements in 'baseline recurring' funding (ie from £420m to the £423.4m shown in the table) is made up of £2.7million in relation to expansion posts in Foundation Medical Training Grades, £610k in relation to the NMAHP Education Outcomes Framework, and £80k for the ScIL programme.

The allocations of £999k still to be confirmed are:

- £376k for Dental VT (after the return of the Dental Act Levy)
- £130k for Quality Improvement
- £185k for Psychology – split between Paediatrics (£100k) and Trauma (£85k)
- £100k for Dental Outreach (Dundee/Glasgow).
- £208k – various smaller allocations

We continue to liaise with the SG to ensure confirmation of the outstanding sums.

The funding required for 'non-core' expenditure relating to Depreciation and movements in Provisions have all been confirmed.

2. Summary Financial Position

2.1 Revenue Summary

As at 31st January 2018, the year to date position is an underspend of £3.4million, with a forecast year-end underspend of £0.25million.

Most of the YTD underspend is because of timing differences and these should be eliminated as we move towards the year-end. The table below reflects the current financial position and forecast by Directorate as at 31st January 2018.

Table 2: Summary Revenue Position as at 31st January 2018

MONTHLY REPORTING FOR JANUARY 2018 **Period 10**

Directorate	Year to Date			Full Year				
	Current Budget	Outturn	Variance	Current Budget	Forecast*	Variance	Variance last month P9 summary table	Variance movement from P9
Quality Management	65,357	65,175	182	78,347	78,329	18	39	**21**
Strategic Planning and Directorate Support	5,705	5,587	118	6,786	6,838	-52	-19	**32**
Training Programme Management	211,596	210,972	624	255,730	254,595	1,135	1,032	**-103**
Professional Development	4,249	3,698	551	6,542	6,527	15	-46	**-61**
Pharmacy			0			0	0	**0**
Medical Total	**286,907**	**285,431**	**1,476**	**347,405**	**346,289**	**1,116**	**1,005**	**-110**
Dental	37,097	36,889	208	44,688	44,498	190	236	**46**
NMAHP	8,836	8,452	384	11,548	11,547	1	113	**113**
Psychology	14,188	13,796	392	17,399	17,333	66	-29	**-95**
Healthcare Sciences	2,042	2,036	6	2,404	2,401	3	-11	**-14**
Optometry	775	760	16	959	952	7	16	**9**
Digital	7,728	7,026	702	9,405	9,349	57	99	**42**
Workforce	3,618	3,427	192	4,641	4,540	101	38	**-63**
Finance	1,733	1,707	25	2,120	2,141	-21	-25	**-4**
Properties	3,148	3,061	87	3,744	3,818	-74	-56	**18**
Facilities Management	532	508	24	640	614	26	10	**-16**
Planning (incl OPIP)	947	937	9	1,131	1,134	-3	-6	**-3**
Net Provisions (excluding AME & Depreciation)	2,514	2,648	-134	380	1,590	-1,210	-1,119	**91**
NES Total (revenue)	**370,064**	**366,678**	**3,386**	**446,464**	**446,206**	**258**	**272**	**14**

More details on individual lines shown is this table are provided in Section 4.

2.2 Capital Summary

In addition to revenue, NES has planned Capital expenditure of £2,254k for the following*:*

	Budget	***Forecast***	***Variance***
	£'000	***£'000***	***£'000***
Mobile Clinical Skills Unit (MSU) Replacement	*300*	*62*	*238*
Turas development programs	*1,762*	*1,790*	*(28)*
Other Equipment & Contingency costs	*192*	*191*	*1*
Total	***2,254***	***2,043***	***211***

There has been total capital slippage of £371k. We have used £160k to pull forward the procurement of a Digital Data Centre from 2018/19. This will replace out of warranty hardware with a flexible fit for purpose solution that will deliver sufficient capacity, availability, expandability, continuity, security and also act as a model for future infrastructure standards. This will directly support the business continuity planning and disaster recovery work underway at present. More importantly, it will offer better value for money for the organisation, as well as increased performance, availability, and comparable ease of use to the existing equipment which is important to immediately support our teams.

We have requested that the balance of £211k is carried forward to next year to enable completion of the purchase of the Mobile Skills Unit. The unit was ordered in December but only the chassis is likely to be received by the end of March.

3. Key risks to achievement of Financial Targets

To deliver outturn in line with budget for 2017/18 the risks below need to be managed:

- The forecast figures reflect current discussions with SG that some specific allocations for key projects can be returned to SG if they are not spent in full before 31 March. If this treatment was to change the potential impact on the forecast would be a further underspend of £228k in Digital and £134k in Workforce.
- Some directorates have a high YTD underspend compared to the year end forecast figures. Finance Managers are working closely with Directorates to ensure any changes are highlighted immediately.
- Within Workforce we have anticipated a full recharge of the costs of carrying out PVG and Tier 2 checks for NHSS. However, the pay cost element of this has been queried and discussions to resolve this are ongoing. The part of the

recharge which could be considered a risk is £100k, which would reduce our forecast underspend.

- Work is also ongoing to understand the impact of any accounting adjustments such as the annual leave accrual or the provisions for fixed term contract redundancy liability.

4 Directorate Analysis

Year to date variances and full year forecasts are shown by Directorate in Table 2 above. The material variances are discussed below.

4.1 Medical Directorate

At a consolidated level Year to Date (YTD), the Directorate is reporting an underspend of £1,476k (last month £1,327k) and a full year forecast of a £1,116k underspend, an increase of £110k from December.

An increased underspend in Professional Development of £61k, arising from reduced spend on the Scottish Improvement Leader Programme, is offset by small cost increases, across a range of activity, in both Quality Management and Strategic Planning and Directorate Support of £21k and £32k respectively.

The overall increase in underspend relates mainly to Training Programme Management where the forecast underspend has increased by £103k since December. These movements are detailed in Table 3:

Table 3: TPM Significant variance

	Variance Under/ (Over) spend		
	Forecast £'000	Prev Forecast £'000	Variance £'000
Training Grades:			
Training Grade GP Pay costs	775	798	(23)
Trainee Support costs	358	401	(43)
Hospital Training Grade posts	(38)	(271)	233
	1,095	**928**	**167**
Other budget areas:			
ePortfolio	73	26	47
Fellow Programmes	75	86	(11)
Other	(108)	(8)	(100)
	40	**104**	**(64)**
Total TPM	**1,135**	**1,032**	**103**

The £167k increased underspend in Training Grades is mainly a combination of increased costs for;

- GPST1 posts (£66k)
- GP Maternity Leave (£47k)
- Increased costs for the national recruitment system – Oriel (£60k)

Which are offset by additional income received for the gap between the Levy on overseas Medical students and the cost of the medical education package of £280k.

4.2 Dental

The YTD underspend of £208k (£493k last month) is largely the result of the following three factors with pay and other smaller underspends forming the balance.

- underspend of £135k on Dental Care Professional (DCP), Continuous Professional Development (CPD), Clinical Effectiveness, Priority Groups and Dental Outreach activity;
- receipt of an additional £32k of income;
- underspend on training grade activity of £12k.

In terms of the full year forecast the current projection is for an underspend of £190k (compared to £236k in December). Around £103k of this relates to underspends to on the projects and programmes noted above. £40k of which relates to the Smile-on project not going ahead and £57k as a result of delayed training courses. The remaining underspend is from pay savings (vacant posts being filled at lower grades) and additional income.

4.3 NMAHP

The YTD position is an underspend of £384k (last period £445k) of which £208k is a timing delay on invoicing within the Practice Education programme.

The full year forecast is an underspend of £1k. This has moved since December when an underspend of £113k was projected. This movement is largely the net impact of ;

- An underspend in the Women, Children, Young People & Families programme, driven by lower than expected volumes of trainees and fewer attendees within the Family Nurse Partnership educational programme - £66k
- Additional costs in Post Registration activity due to larger than anticipated cohorts within the Advanced Nurse Practitioner programme - £81k.
- Savings from posts vacant whilst recruitment takes place now transferred to provisions - £74k

- Additional development costs for training modules in Infection prevention and control - £13k.

4.4 Psychology

Psychology are reporting a YTD underspend of £392k (£290k in December), mainly caused by underspend on project and programme activity, the majority of which is timing differences.

The full year forecast is an underspend of £66k (£29k overspend in December). This £95k movement is the net impact of;

- a Training Grade post has been on long term sick and NES was not notified therefore the cost continued to be included in the forecast (£44k)
- underspend in Therapies (£84k)
- Underspend in Cognitive Behaviour Therapy Training because of lower than anticipated cohort volumes. (£61k)

Offset by movements in anticipated costs of £115k spread across several project areas.

4.5 Digital

Digital is showing a YTD underspend of £702k (prior month £763k) which is split between pay (£503k), non-pay (£182k) and additional income of £16k.

Pay - Vacant posts represent £386k of the pay underspend with the balance being made up of restructuring funds not required (£78k) and appointments below budget/reduced hours (£39k).

Non-pay is £182k underspent mainly related to the e-Health initiative, £96k and the SOAR project, £51k.

By year-end, the forecast underspend is expected to reduce to £57k (£99k in the prior month). This includes an assumption that underspends on specifically funded projects of £228k will be returned to SG and carried forward into 2018/19.

The forecast year-end underspend of £57k is made up of;

- Underspend of £141k on pay primarily caused by delays in recruitment. It should be noted that posts are being filled and this underspend has fallen by £40k this month
- Underspend of £25k on project activity.

Offset by an anticipated overspend of £108k on non-project activity, the most significant of which, related to a planned salary recharge which did not take place (£52k) and increased costs for eLibrary content (£30k).

4.6 Workforce

Workforce is reporting a YTD underspend of £192k (December - £165k).

The YTD underspend is made up of three elements:

- underspend on pay of £163k (being the net impact of vacant posts and maternity leave less the cost of agency cover);
- lower spend than anticipated on project activity (£188k) – the budgets for much of this activity did not fully recognise the extent of 'backloading' of planned activity.
- an adverse variance of £159k on income. Most of this relates to budgeted income for PVG & Tier 2 costs of £181k that has not yet been recharged. This impact is offset by unplanned income of £23k.

An underspend of £101k is anticipated by year end as compared to £38k in December. The movement of £63k since December is caused by three factors;

- an increase in income being anticipated for PVG costs (£25k),
- lower costs associated with filling vacant posts (£22k), and
- cost reductions in O&LD spend due to a stop on non-committed costs last month.

As noted above a considerable amount of OD spend is assumed in the final months of the year. The SG has confirmed that any underspend for Implementation Leads Support activity can be carried forward into 2018/19.

4.7 Properties

The YTD underspend is £87k (£105k in Dec). The YTD underspend arises in respect of timing differences across a number of property costs.

The year-end forecast is an overspend of £74k, a £18k increase from December. £56k of the forecast overspend relates to the estimated NES legal costs in respect of the recent dispute about Westport building costs while the £18k increase is a result of the final reconciliation of the 2016/17 service charges for Westport.

4.8 Net Provisions

Net Provisions is made up of the following:

- central corporate charges for depreciation, amortisation and the Apprenticeship Levy;
- savings targets to be met by Directorates, e.g. vacancy savings,
- top-slicing of external income to cover overheads, and
- other provisions (such as those for redeployment and Fixed Term Contract (FTC) termination payments and potential claims).

The year to date variance on Provisions is an overspend of £134k.

The projected variance is a £1.2m overspend. This is related to various items, including an increase in the provision for fixed term contract liability, the cost of the VAT implications related to e-Library services, an increase in the allowance for the apprenticeship levy, a reduced amount allocated for topslice income, and increased vacancy savings to date.

This is an increase of £0.1m in the period. This is mainly due to the additional contribution of £500k to the National Boards collaborative savings target partly offset by recognition of additional savings from posts vacant whilst recruitment is taking place of £371k.

5.0 Recommendations

Board members are invited to note the information contained in this report.

AMcC

KD

February 2018

NES **NES/18/18**
Item 9b **(Enclosure)**
March 2018

NHS Education for Scotland

Board Paper Summary

1. Title of Paper

Performance Management Report following 31st December 2017 progress updates.

2. Author(s) of Paper

Karen Howe, Planning and Corporate Governance Manager

Lynnette Grieve, Planning and Corporate Governance Manager

Donald Cameron, Director of Planning & Corporate Resources

3. Purpose of Paper

This paper provides the Board with an overview of NES performance, against the targets set out in our Operational Plan for the third quarter of the reporting year 2017/18. This report therefore sets out to give an overview of performance against each of the individual performance targets.

The report focuses on reporting by exception, giving more detail on key performance targets which are assessed as being Red or Amber - which equate to not being delivered in accordance with the original plan.

Note: This quarter the report is shown in spreadsheet format, containing two separate spreadsheets: (1) details of all red and amber targets, along with desired outcome (all desired outcomes not shown are green); (2) breakdown of targets by directorate.

In assessing performance against all targets, NES uses a RAG (Red, Amber, Green) rating system. Definitions are shown below:

- **Red** – progress against this target/outcome has not been satisfactory. The target will not be achieved and/or there has been major deviation from deliverables.

- **Amber** – progress against this target/outcome has not been fully satisfactory. Deliverables may now be behind schedule, but overall outputs / programme objectives are expected to be completed.

- **Green** – progress against this target/outcome has been satisfactory. The target is expected to be delivered on schedule and/or better than expected.

4. Key Issues

The overall summary of NES' performance against the targets contained within the Operational Plan at the end of the third quarter of 2017/2018 is set out in the table overleaf (this table included all open and closed targets):

Strategic Theme	No of Performance Targets	Red	Amber	Green
An excellent workforce	111	8	6	97
Improved quality	98	2	3	93
New models of care	132	5	6	121
Enhanced educational infrastructure	65	2	6	57
An improved organisation	114	2	16	96
TOTALS =	**520**	**19**	**37**	**464**

5. Recommendation(s) for Decision

The recommendation is to note the current performance of NES.

March 2018

Strategic Theme 1 - An Excellent Workforce

(8 red, 6 amber, 97 green)

Starting year	Number	Directorate	State	Scope	Strategic theme	Description
2017/ 2018	TAR0001064	Dental	Closed	External	An Excellent Workforce	Provide an ePortfolio for DCPs in place by August 2017. Discussions already started with Digital Group, this will provide equity for students as well as a QA (Quality Assurance) system for trainees' delivery of safe patient care (A8337-05).
2017/ 2018	TAR0001027	Dental	Closed	External	An Excellent Workforce	Liaise with the Digital Group team in the development of an appropriate system during the period 2017/18 to replace the portal system for management of the study day programme including course bookings (A8405-02).
2017/ 2018	TAR0001025	Dental	Closed	External	An Excellent Workforce	Liaise with the Digital Group team in the development of an appropriate system during the period 2017/18 to replace the portal system for recruitment of HTVT trainees and trainers (A8342-02).
2017/ 2018	TAR0001021	Dental	Closed	External	An Excellent Workforce	Liaise with the Digital Group team in the development of an appropriate system during the period 2017/18 to replace the portal system for recruitment of vocational trainees and trainers (A8344-02).
2017/ 2018	TAR0001106	Medical	Closed	External	An Excellent Workforce	Ensure TURAS TPM module for PSU is in place and has appropriate functionality to support workload. A8143-03
2017/ 2018	TAR0001101	Medical	Closed	External	An Excellent Workforce	By August 2017 successfully deliver a CPD programme and recruit up to 20 on the programme, utilising anticipated Scottish Government funding of £16k. A8316-01

2017/ 2018	TAR0001005	Medical	Closed	External	An Excellent Workforce	Undertake a review of the simulation training requirements in curricula and develop a policy for allocation of funding to ensure equity for trainees by March 2018 (A8140-02).
2017/ 2018	TAR0001080	Medical	Closed	External	An Excellent Workforce	Deliver a new TURAS Quality Module in conjunction with NES Digital Group. A8101-01
2017/ 2018	TAR0001592	Medical	Closed	External	An Excellent Workforce	By September 2017 deliver the actions in the GMC Visit 2017 agreed plan in conjunction with Quality and PD workstreams, including a curriculum mapping exercise to record all NHS Board capacity. A8144
2017/ 2018	TAR0001011	Medical	Open	External	An Excellent Workforce	By December 2017, deliver a Scottish Careers Fair, or alternative career events, and presence at the BMJ (British Medical Journal) Careers Fair. Deploy associated Digital Group tools and support materials to ensure an enhanced careers policy and resources (A8138-01).
2017/ 2018	TAR0001102	Medical	Closed	External	An Excellent Workforce	By March 2018 have recruited 12 Community Hub Fellows utilising anticipated Scottish Government Funding of £700k for the Community Hub. A8316-02

2017/ 2018	TAR0001009	Medical	Open	External	An Excellent Workforce	By March 2018 ensure the automated data download from ORIEL (UK recruitment portal) to the Training Programme Management (TPM) system on TURAS (our Digital Group platform) is progressed to minimise bulk transfer and delay in processing (A8136-04).
2017/ 2018	TAR0001008	Medical	Open	External	An Excellent Workforce	By March 2018 ensure Scottish requirements for recruitment in ORIEL are included in the HEE development plan; manage prioritisation against budget for functionality requests to ensure best value; budget for payment to HEE for ORIEL contract, GP and inter-deanery transfer (IDT) costs (A8136-03).
2017/ 2018	TAR0001087	Medical	Open	External	An Excellent Workforce	By September 2017 deliver the actions in the GMC Visit 2017 agreed plan in conjunction with Quality and PD workstreams, including a curriculum mapping exercise to record all NHS Board capacity. A8144
Strategic Theme 2 - Improved Quality				(2 red, 3 amber, 93 green)		
2017/ 2018	TAR0001179	Dental	Open	External	Improved Quality	Provide up-to-date evidence-based recommendations for dental professionals (SDCEP): a) scope the updating of Management and Treatment of Periodontal Disease guidance; b) update Drug Prescribing for Dentistry guidance in line with BNF(British National Formulary) and BNFC (British National Formulary for Children). A8348-04
2017/ 2018	TAR0001119	NMAHP	Open	External	Improved Quality	Undertake required processes and activities that will enable Investing in Volunteers to be re-awarded. A8087-02

2017/ 2018	TAR0001174	Workforce	Open	External	Improved Quality	Increase capacity and capability within the Organisational and Leadership Development team to deliver Digital Group learning interventions in Quality Improvement. A8620-06
2017/2018	TAR0001204	Workforce	Open	External	Improved Quality	Work with stakeholders to develop and test collaborative processes and interventions that will increase OD capability and capacity in support of transformational change by March 2018, including the development of consistent approaches, joint working and shared services across National Health Boards and NHS Scotland. A8626-01
2017/ 2018	TAR0001181	Dental	Open	External	Improved Quality	Respond to the implications of the new Scottish Government Oral Health Plan consultation and prepare a strategy for guidance development to address the implications by March 2018. A8348-06
Strategic Theme 3 - New Models of Care (5 red, 6 amber, 121 green)						
2017/ 2018	TAR0001218	Dental	Closed	External	New Models of Care	Portal Transition to ensure that the following areas for development are user tested and requirements are met: course booking/audit/marketing/reporting/evaluating. A8377-03
2017/ 2018	TAR0001214	Dental	Open	External	New Models of Care	Make available to 150 practices, a Digital Group package of verifiable CPD through Healthcare Learning packages via Smile-on. A8382

2017/ 2018	TAR0001330	NMAHP	Open	External	New Models of Care	Design and delivery of training for 50 learning disability staff in positive behavioural support. A8052
2017/ 2018	TAR0001240	Dental	Open	External	New Models of Care	Dental School data exchange - a central data point for data collection on current dental students. Data provided either directly to our systems or by secure sharing or other method. Includes individual level data. A8332-03
2017/ 2018	TAR0001211	Medical	Closed	External	New Models of Care	Migrate all CPD Connect portal based services to TURAS in 2017/18, improving the infrastructure for accessing CPD Connect educational resources to increase customer satisfaction and support a 10% increase in PBSGL memberships and course attendances. A8509
2017/ 2018	TAR0001234	Dental	Open	External	New Models of Care	Provide support to the Dental Undergraduate Bursary Scheme in collaboration with Student Awards Agency for Scotland and Scottish Government. A8378-01
2017/ 2018	TAR0001231	Medical	Open	External	New Models of Care	By March 2018 ensure reviewed and agreed funded baseline establishment. Develop management plan for review of unfunded 2014-2016 planned expansion (58) and 2017 expansion (21) as well as unfunded FY (90) and LTFT expansion (22) and 100 GPST. A8145-02

2017/ 2018	TAR0001213	Medical	Open	External	New Models of Care	Provide a national education event on general practice nursing as part of the Scottish Medical Education Conference for 50 delegates in May 2017. Advertise and select 18 nurses in June 2017 for the national GPN (General Practice Nurse) Programme. Bi-annual newsletter created, designed and disseminated. A8227
2017/2018	TAR0001283	Medical	Open	External	New Models of Care	All Scotland psychiatrists (trained and in-training) who require AMP certification will be able to access Digital Group and local face to face teaching to an agreed standard. A8164-02
2017/2018	TAR0001282	Medical	Open	External	New Models of Care	All AMP (Advanced Medical Practitioner) certificated Scotland psychiatrists will be able to access refresher training on a regular cyclical basis. A8164-01
2017/ 2018	TAR0001235	Dental	Open	External	New Models of Care	New system for data collection from all DUBS recipients (approx 2000). Users to update own information to include post-registration employment information, and % NHS earnings. Automated reports and user reminders. A8378-02

Strategic Theme 4 - Enhanced Educational Infrastructure (2 red, 6 amber, 57 green)

2017/ 2018	TAR0001341	Digital Group	Closed	External	Enhanced Educational Infrastructure	Engage and coordinate implementation and continuous improvement of the evidence summary service by NHS Board Librarians. A8528-02
2017/ 2018	TAR0001360	Medical	Closed	External	Enhanced Educational Infrastructure	Ensure required functionality is in place to support plans, agreed and prioritised by SOLG. Plan submitted: 1) Vacancy Manager integration to TURAS; 2) Quality Module (TURAS); 3) SMT to TURAS; 4) ePortfolio v3; 5) Pharmacy requirements; 6) CPD Connect. A8133-05
2017/ 2018	TAR0001353	Digital Group	Open	External	Enhanced Educational Infrastructure	Continued Development of TURAS Learn platform with extended features as per TURAS Learn Product road map that will enable internal stakeholders to onboard their eLearning content to make accessible to their users and to be able to track and record their progress with management reports. A8464-03
2017/ 2018	TAR0001352	Digital Group	Open	External	Enhanced Educational Infrastructure	Development of TURAS Digital Group Platform, training management, career management in line with plan approved by Digital Group Delivery Board. A8464-02

2017/ 2018	TAR0001393	Workforce	Open	External	Enhanced Educational Infrastructure	Review equality and diversity planning and performance management. Oversee the rollout of equalities data and intelligence using TURAS, embedding the use of data in quality management and equality impact assessment, reviewing implementation as part of the PEDLN annual review and advising on further developments and improvements. A8399-02
2017/ 2018	TAR0001359	Medical	Open	External	Enhanced Educational Infrastructure	Support customer transition from ePortfoliov2 to v3 in accordance with Digital Group scheduling making the best use of technical resources and closely monitoring financial implications; begin negotiations with external customers for migration by March 2018. A8133-04
2017/ 2018	TAR0001358	Medical	Open	External	Enhanced Educational Infrastructure	Ensure required staff and contractor resource to support operational migration from ePortfoliov2 to v3 via Digital Group directorate and commercial partnership arrangements by monitoring contractor usage and closing to new customers March 2017. A8133-03
2017/ 2018	TAR0001354	Digital Group	Open	External	Enhanced Educational Infrastructure	Development of TURAS Analytics and Datawarehouse infrastructure to provide efficient TURAS platform wide analytics and operational reporting to internal and external stakeholders as per requirements generated by stakeholders. A8464-04

Strategic Theme 5 - An Improved Organisation (2 red, 16 amber, 96 green)

2017/ 2018	TAR0001461	Finance	Closed	Internal	An Improved Organisation	Identify information needs and respond to information requests from Finance and Procurement colleagues to provide the relevant information from all available systems to allow full analysis for financial monitoring and planning. A8493-02
2017/ 2018	TAR0001460	Finance	Closed	Internal	An Improved Organisation	Production of a monthly KPI (key performance indicators) dashboard for the Finance and Procurement function, reporting actual outcomes against target to identify areas for improvement. A8493-01
2017/ 2018	TAR0001444	Digital Group	Open	Internal	An Improved Organisation	Develop an improved Digital Group content development service based on agreed standards on a single unified environment which ensures continuity during the Digital Group Transformation. A8466
2017/ 2018	TAR0001466	Finance	Open	Internal	An Improved Organisation	Develop a suite of standard request templates for users of the service desk so that the information reported on calls is complete at the outset, which will enable all responses to be provided quicker i.e. within 3 working days of initial log. A8492-02
2017/ 2018	TAR0001443	Digital Group	Open	Internal	An Improved Organisation	Review and evolve existing policies and procedures for support of cloud based services through the formation of a single Digital Group service desk. A8473
2017/ 2018	TAR0001464	Finance	Open	Internal	An Improved Organisation	Review the information needs from the TURAS trainee management system data for the purposes of financial planning and forecasting to identify any required reporting changes. A8493-05

2017/ 2018	TAR0001518	Finance	Open	Internal	An Improved Organisation	Continued development of new Service Desk and Room booking system systems (together with Digital Group team) and then roll out and implement for use to all our sites. A8339-02
2017/2018	TAR0001437	Digital Group	Open	Internal	An Improved Organisation	Launch new corporate identity guidelines for the organisation, along with a programme of workshops and promotion, inviting feedback from stakeholders through a Digital Group survey within 12 months of launch. A8627-01
2017/ 2018	TAR0001463	Finance	Open	Internal	An Improved Organisation	Provide monthly trend analysis data based on VARs for each budget area for Budget Holders and Finance Managers, tailored to the needs of the Directorate and amended within 10 working days of the request from Finance Managers. A8493-04
2017/ 2018	TAR0001493	Planning & Corporate Resources	Open	Internal	An Improved Organisation	The corporate Business Continuity Plan (BCP) tested and fully implemented by end June 2017. A8254-05
2017/2018	TAR0001487	Finance	Open	Internal	An Improved Organisation	Finance Induction handbook to be reviewed and updated by end of September 2017 which will include links to procedure notes and be available on Yammer for all finance staff to use. A8484-05

2017/ 2018	TAR0001483	Finance	Open	Internal	An Improved Organisation	All line managers will fulfil the requirements of the revised self-assessments in relation to the Manager's Passport which will be re-launched in January 2017. Requirements for development will be built into their PDPs for 2017/18. A8484-01
2017/ 2018	TAR0001457	Finance	Open	Internal	An Improved Organisation	All journals, accruals and pre-payments are posted in line with the reporting timetable for each month. A8494-04
2017/2018	TAR0001480	Finance	Open	Internal	An Improved Organisation	Ensure 2017/18 budget letters are issued to all budget holders within two weeks of Board approval. A8486-02
2017/ 2018	TAR0001456	Finance	Open	Internal	An Improved Organisation	Sales ledger invoice requests are processed in line with agreed targets and aged debt processes are followed to ensure that outstanding invoice reminders are sent out as per set procedures. A8494-03

2017/ 2018	TAR0001474	Finance	Open	Internal	An Improved Organisation	All monthly control reconciliations will be carried out in line with agreed timetables for monthly reporting. A8488-01
2017/ 2018	TAR0001446	Digital Group	Open	Internal	An Improved Organisation	Review and evaluate ISO27001 information security standards for the Digital Group Group to ensure full ISO27001 re-certification. A8471-02
2017/ 2018	TAR0001473	Finance	Open	Internal	An Improved Organisation	Provide quarterly updates on the delivery of TURAS and/or Business Intelligence actions to meet the information and reporting needs of the Finance Business Partnering team for the purposes of financial planning and forecasting. A8491-05

RAG status of individual target	Comments	Desired Outcome
Red	This project was to be "piggy backed" onto the v3 ePortfolio for vocational training, introduction of which has now been delayed by Digital till August 2018. This target is closed - this update is from a previous quarter.	Contributing to an increase in knowledge and skills in the DCP workforce to improve care and oral health.
Red	NES uses an AGILE process for prioritising digital developments on a cross-directorate basis. This work has not been prioritised for completion during 2017/18, therefore this target will be closed. This target is closed - this update is from a previous quarter.	A well trained dental workforce in Scotland to improve public access to NHS dental services through quality assured training programmes.
Red	NES uses an AGILE process for prioritising digital developments on a cross-directorate basis. This work has not been prioritised for completion during 2017/18, therefore this target will be closed. This target is closed - this update is from a previous quarter.	A well trained dental workforce in Scotland to improve public access to NHS dental services through quality assured training programmes.
Red	NES uses an AGILE process for prioritising digital developments on a cross-directorate basis. This work has not been prioritised for completion during 2017/18, therefore this target will be closed. This target is closed - this update is from a previous quarter.	A well trained dental workforce in Scotland to improve public access to NHS dental services through quality assured training programmes.
Red	NES uses an AGILE process for prioritising digital developments on a cross-directorate basis. This work has not been prioritised for completion during 2017/18, therefore this target will be closed. This target is closed - this update is from a previous quarter.	Improved retention through development of a national Deanery support for performance issues to improve outcomes for trainees and improve equity of support across regions.
Red	Numbers recruited to this was very poor . We have not repeated this initiative this year. This target is closed - this update is from a previous quarter. This target is closed - this update is from a previous quarter.	Initiatives to improve retention of Scottish medical school graduates, and support the improvement of recruitment of doctors to training programmes. Initiatives to support recruitment to General Practice. Management of international recruitment and visa sponsorship.

Red	NES Medicine Simulation Collaborative established - bringing together simulation leads from the centres and health boards. Regular review of updates on progress towards foundation simulation training and future simulation requirements. Priorities will be increasing the number of trained simulation trainers which will require funding. No budget for this activity at this time. This target is closed - this update is from a previous quarter.	Successful progression through medical training programmes to provide a pipeline for the consultant and GP appointments required by NHSScotland utilising study leave funding and national initiatives for simulation.
Red	NES uses an AGILE process for prioritising digital developments on a cross-directorate basis. This work has not been prioritised for completion during 2017/18, therefore this target will be closed. This target is closed - this update is from a previous quarter.	An improved medical training environment through quality management (QM), quality improvement (QI) and educational governance.
Amber	The work to ensure consistent processes continues and is expected to be ongoing both before and after the GMC visit. Review of new ARCP policy is being undertaken. Work completed. GMC visit 11/12 December. This target is closed - this update is from a previous quarter. (This target is also a duplicate of TAR0001087 and will not show in future reports)	A plan for delivering the Training Programme Management component of the planned GMC Visit 2017 through consistent Scotland Deanery single processes and policies.
Amber	Decision taken that Scotland Deanery would not attend the BMJ Careers Fair due to funding constraints. Not aware of plans for a Scottish Careers Fair to take place before 2017. The Scotland Deanery and SMT websites are continually being developed - they are a vital resource in providing potential future employees with the information that they need. We continue to work with the NES Communications team in maintaining and developing our social media presence as a key method for engaging with potential medical staff.	Enhance the standing of Scottish Medical Training (SMT) and improve careers and recruitment/retention strategies to attract non-training grade doctors to live and work in Scotland and promote Scotland as a destination for career development.
Amber	The Community Hub Fellowships continue with 9 Fellows currently in NHS Boards, including one on maternity leave.	Initiatives to improve retention of Scottish medical school graduates, and support the improvement of recruitment of doctors to training programmes. Initiatives to support recruitment to General Practice. Management of international recruitment and visa sponsorship.

Amber	There were some delays in the download ahead of the beginning of the training year (August 2017) which led to some teams having to manually enter data onto Turas, however we understand that these teething problems have now been resolved and we expect future downloads to be fully automated and successful. No problems encountered for R1 R and R2.	Ensuring recruitment of trainees to agreed UK standards, utilising funding to expand training numbers, making the best use of resources.
Amber	Proposed costings for 2017/18 discussed at MDRS Programme Board Oct 17 and out to four nations for sign off. costings received and in negotiation.	Ensuring recruitment of trainees to agreed UK standards, utilising funding to expand training numbers, making the best use of resources.
Amber	The work to ensure consistent processes continues and is expected to be ongoing both before and after the GMC visit. Review of new ARCP policy is being undertaken. Work completed. GMC visit 11/12 December.	A plan for delivering the Training Programme Management component of the planned GMC Visit 2017 through consistent Scotland Deanery single processes and policies.
Red	Drug prescribing update published June 2016, further update in preparation. Scoping of update of management of periodontal disease not yet progressed due to higher priority work in providing advice on Antibiotic Prophylaxis against infectious endocarditis.	Improved quality of care by increasing compliance with guidance, evidence-based recommendations and regulatory standards; by the production of guidance, informing the development of effective education.
Red	Further discussion and agreement is required to determine where this work is best positioned within NES to ensure impact across all directorates. The Investors in Volunteering award currently held by NES expires in May 2018. The process for re-award takes approximately 9 month to achieve therefore we will not achieve it in this current financial year. We need to 1) agree where this work sits in NES then 2) negotiate with Volunteer Scotland to continue to use the Invertors in volunteering status and logo whilst we 3) work toward the re-award	To support the achievement of NES responsibilities and meet governance requirements in relation to person-centred care and health and social care integration.

Amber	Organisational change within O&LD team has just been completed so there is no progress update at this time. This target will be progressed throughout 17/18 as the team members adjust to new roles and responsibilities. Team members still adjusting to new roles and responsibilities - staff changes due to maternity leave and vacancies have impacted upon the team's ability to progress this issue. This target has been de-prioritised for the moment and continues to be kept under review.	Improved access to learning, better identification of training needs, enhanced confidence in participating in development discussions, easier to use guidance and system.
Amber	8 x OD Associates selected through an initial round of commissioning involving regional/ national Board OD representatives. After an introductory event in early Jan, commissioning by reps with payment by NES using SG funds can commence. Due to regions' stages of development and other work pressures affective participant availability, unlikely that full allocation of funding provided by SG can be used in Q4. Chief Executive aware and confirming with Board Reform / HSCDP Lead whether funding carry over is possible.	Organisational Development which helps NHSS staff perform to their potential and align their individual performance with organisational aims.
Amber	Awaiting publication from Scottish Government of the new OralHhealth Plan for Scotland expected January 2018	Improved quality of care by increasing compliance with guidance, evidence-based recommendations and regulatory standards; by the production of guidance, informing the development of effective education.
Red	NES uses an AGILE process for prioritising digital developments on a cross-directorate basis. This work has not been prioritised for completion during 2017/18, therefore this target will be closed. This target is closed - this update is from a previous quarter.	A CPD programme for Dentists and Dental Care Professionals.
Red	Smile-on packages not being progressed, this target can be removed. This target should have been removed last quarter as n ot being progressed. Fundes being utilised in another way (Employment of a Learning Technologist) fixed term.	Access to a package of digital CPD for 150 practices per year.

Red	This target was set before an evaluation of previous training was undertaken. Evaluation findings strongly indicate this target should be revised and a more strategic approach undertaken, with attention to infrastructures and sustainability. This has been discussed and agreed with SG and wider partners. We have been undertaking alternative activities to support existing trainers to sustain and embed their activities by supporting networking activities.	Better cross-sector reach of multi-professional education to improve quality of care and quality of life outcomes for people with a learning disability through increased knowledge and skills and enhanced impact assessment to inform future developments.
Red	No work was progressed following previous meeting with Digital to discuss Dental School data transfer. Discussions will be opened again in early 2018 with a view to recapping on requirements and developing an entry for the Digital backlog. The Digital development schedule is full until March 2018, so any work is unlikely to commence before April 2018.	Support workforce planning for health and the interface between health and social care in Scotland.
Red	NES uses an AGILE process for prioritising digital developments on a cross-directorate basis. This work has not been prioritised for completion during 2017/18, therefore this target will be closed. This target is closed - this update is from a previous quarter.	Migrate all CPD Connect PORTAL based services to TURAS.
Amber	Digital have ruled out any bespoke development work to support DUBS in the current financial year. However, they are currently investigating third party software options as an alternative to developing bespoke software in-house. We are waiting for an update on the early investigations and if the feedback is positive we will seek a fuller picture on cost and delivery timelines	Identification of compliance or non-compliance with terms of the Dental Undergraduate Bursary Scheme (DUBS) for all participants from 2006 - SG requirement.
Amber	Work ongoing to ensure establishment is recorded in Turas TPM. Budget letter not yet issued from SG confirming funding, so status now changed to amber pending this confirmation. Budget letter still not received. Status remains amber.	More accurate and timely data on which to base workforce numbers for recruitment, succession planning and modernisation.

Amber	New Programme Leader commences on January 11th 2018 working 80% with the Programme and 20% with NMAP. This is a new contract/job description and will need embedding. A new post of 18.75 hrs commences on January 11th 2018 working in CPD Connect to run GPN CPD short courses, previously run by the present Programme Leader. This is a new post and will need embedding. This new team will present challenges as they form a collaborative working environment and may also present challenges to the present administrative assistant. The present cohort of 2017_18 GPN Programme has reduced to 16 participants due to extenuating circumstances, all four have deferred until August 2018. The present programme needs to be rewritten in order to reflect the new GMS contract and this will be the primary first job of the new Programme Leader, which will represent a critical number of input hours in order to prepare the new programme for August 2018. The programme Board Chairman is aware of these changes and the next Programme Board meets with the Examination Board on 20th December 2017. Presently the Portfolios are being marked for the 2016_17 cohort for which there are 19 participants whose results hope to be ratified and completed with certificate in April 2018.	A fully accessible 15 month quality assured work based General Practice Nursing (GPN) Programme to better prepare registered nurses for a career in GPN.
Amber	"Train the Trainers" courses run in December and various update "Train the Trainers" courses also run. Final touches being put to on-line material for launch in New Year. Part Two courses and trainers to be identified for 2018 and will then be advertised via Royal College of Psychiatrists and Portal.	Improved education for clinicians delivering healthcare in psychiatry in respect of the Mental Health Act to become and maintain their status as Advanced Medical Practitioner (AMP) psychiatrists.
Amber	A number of trainers were trained during December to deliver Part Two. These courses will be advertised and delivered in 2018	Improved education for clinicians delivering healthcare in psychiatry in respect of the Mental Health Act to become and maintain their status as Advanced Medical Practitioner (AMP) psychiatrists.
Amber	Digital have ruled out any bespoke development work to support DUBS in the current financial year. However, they are currently investigating third party software options as an alternative to developing bespoke software in-house. We are waiting for an update on the early investigations and if the feedback is positive we will seek a fuller picture on cost and delivery timelines	Identification of compliance or non-compliance with terms of the Dental Undergraduate Bursary Scheme (DUBS) for all participants from 2006 - SG requirement.

Red	This target needs to be closed as NES no longer supporting this work. This target is closed - this update is from a previous quarter.	Health and social services staff have ready access to expert support in finding digital knowledge resources, using digital tools to share knowledge, and applying knowledge to practice. This contributes to improved workforce capability and capacity in delivering care and support and ultimately to safer, better quality care based on evidence.
Red	NES uses an AGILE process for prioritising digital developments on a cross-directorate basis. This work has not been prioritised for completion during 2017/18, therefore this target will be closed. This target is closed - this update is from a previous quarter.	Management of functionality and systems during digital transformation to ensure core business continuity. Prioritisation of essential additional functionality to meet Government priority initiatives, statutory and regulatory requirements for core business. Oversight of delivery of required agreed functionality with user sign off.
Amber	Content process in place and content is making its way onto the system.	A continuously improving digital development methodology, single unified digital platform and service support which ensures continuity during the Digital Transformation.
Amber	Despite the pressures of suboptimal delivery conditions the team and the wider organisation have been committed to finding a resolution which has meant that the TURAS Appraisal MVP was delivered on time and that we are on course to deliver general release by March 2018. Turas People development work continues with no major issues.	A continuously improving digital development methodology, single unified digital platform and service support which ensures continuity during the Digital Transformation.

Amber	We have agreed that data will be established in a core module of Turas . Some data on trainees is currently available in trainee module but full specification is yet to be established. Data protection issues will require further exploration, as will interface between existing systems holding data (eg, eESS). Draft specifications for data exist but may require expansion in response to differential attainment pilot and scoping for reasonable adjustments passports. Digital has been asked to hold a discovery workshop for stakeholders across NES to establish updated data and analysis requirements to inform Turas development.	Governance and performance management of EandD support to achieve our equality outcomes and mainstream equality and diversity so that we can increasingly demonstrate the positive impact of our equalities work. All business areas of NES receive high-quality advice and support to build capacity for delivering equality outcomes and mainstreaming equality in their work.
Amber	Awaiting transition plan so maintaining hold position. Amber status therefore remains./ work now underway to reduce commercial partnership activities and move bwck to inhouse management.	Management of functionality and systems during digital transformation to ensure core business continuity. Prioritisation of essential additional functionality to meet Government priority initiatives, statutory and regulatory requirements for core business. Oversight of delivery of required agreed functionality with user sign off.
Amber	Current configuration of staff continues pending confirmation of migration so amber status remains. Amber status remains.	Management of functionality and systems during digital transformation to ensure core business continuity. Prioritisation of essential additional functionality to meet Government priority initiatives, statutory and regulatory requirements for core business. Oversight of delivery of required agreed functionality with user sign off.
Amber	Some issues have been identified with lead time and accuracy of some reports. Action is being taken to remedy this.	A continuously improving digital development methodology, single unified digital platform and service support which ensures continuity during the Digital Transformation.

Red	To be closed and add ref to TAR0001462. This target is closed - this update is from a previous quarter.	A corporate finance function which supports integrated systems for financial decision making and control.
Red	To be closed as this is a duplicate of TAR0001471. This target is closed - this update is from a previous quarter.	A corporate finance function which supports integrated systems for financial decision making and control.
Amber	Corporate Digital infrastructure teams are about to undergo Azure training.	A more efficient and effective delivery of complex support requirements for all users of our NHS facing cloud based services, including both the learning management and virtual learning components of the NES Digital Platform.
Amber	First draft of the forms have been completed and the next steps to look at the tasks and workflow in order for the forms to be developed on the system will be completed in Q4.	Financial transactions processed and staff paid within an effective control environment in compliance with national payment targets.
Amber	The single service continues to take shape with an increased focus on daily and weekly reporting to increase quality. We move to fixed term posts to ensure the service desk is robust in the medium term with the aspiration that these will become full time posts after Organisational Change completes in 2018	A more efficient and effective delivery of complex support requirements for all users of our NHS facing cloud based services, including both the learning management and virtual learning components of the NES Digital Platform.
Amber	Progress has been made with the payment report but there are still outstanding issues and requirements to be actioned. Progress update has been sent to Digital and a meeting is to be arranged to progress the outstanding work as a matter of urgency. Labels have now been added to identify funding streams but there are still issues outstanding.	A corporate finance function which supports integrated systems for financial decision making and control.

Amber	SNOW projects have been prioritised, with Room Booking System slipping slightly. Development work still on track for end 17/18 FY but some slippage on those sites transferring from current room booking system. DDEC and GDEC have now went live with provisional dates/preparations being firmed up for EDEC and CfHS to go live in Q4 FY17/18.	Improved corporate facilities management support services through continuous improvement and the delivery of the NES Facilities Management Strategy.
Amber	New design/brand guidelines in place and being used. Workshops delayed due to staff changes and organisational change. Survey rescheduled for 2018/19.	To provide high quality design products to support NES strategic aims and objectives, primarily to help support quality education for the NHSScotland workforce.
Amber	The Consolidated trend analysis for 2017/18 continues to be provided, along with responding to all information requests from Finance and other business areas. However, areas for further trend analysis have not been identified. The Analyst Manager post is currently vacant and therefore MIS will liaise with the Head of FBP/FM for Modelling and Planning to identify if there are areas they require further analysis on.	A corporate finance function which supports integrated systems for financial decision making and control.
Amber	The management response has been sent to the Auditors and we are awaiting the final report. Once we have this, it will go to Audit Committee and I will start to work on their recommendations with a view to publishing this within the next six months or less	Improved alignment of corporate planning, governance and performance improvement with service needs, national policy and NES impact and improvement objectives.
Amber	The Induction handbook has been developed to include links to procedures and provides basic information on the Governance & Operational Team. Sections for the Analyst and Finance Manager teams have yet to be incorporated. It is planned to have these in place by the end of February 2018.	By having a robust recruitment process and ensuring that staff are appropriately trained and motivated, retention rates can be improved and the objectives of the team are more likely to be met. This will include the Day to day management of staff; including staff meetings; JDR's; PDP and 1 to 1s focused on agreed individual and team objectives linked to strategic objectives.

Amber	Not all follow up meetings have been completed due to focus on Operational Planning meetings. These will be scheduled to take place before the end of January 2018.	By having a robust recruitment process and ensuring that staff are appropriately trained and motivated, retention rates can be improved and the objectives of the team are more likely to be met. This will include the Day to day management of staff; including staff meetings; JDR's; PDP and 1 to 1s focused on agreed individual and team objectives linked to strategic objectives.
Amber	There have been instances of journals being posted after the deadline during this quarter. These instances have been investigated and any process improvement opportunities identified and implemented.	Financial transactions processed and staff paid within an effective control environment in compliance with national payment targets. Detailed analysis of monthly transactions through the finance system to ensure that the financial position is reported accurately to support decision making within Directorates and across NES. Analysis of transactions as required for reporting within the annual accounts will provide assurance to the external auditors that the figures present a true and fair view of the financial performance of NES for the year.
Amber	Budget letters have been agreed for all directorates except Medical. Discussions have been taking place with managers in that directorate but letters still need to finalised. This has been scored at amber on the basis that all other letters have been agreed (green) and only Medical are outstanding (red) but a red assessment could equally be justified.	A robust budget setting process ensures an appropriate allocation of corporate resources, facilitates transparency and ensures approval is obtained appropriately. It supports congruence across all activities to the strategic plan and facilitates early recognition of budget issues to allow appropriate action to be taken.
Amber	Over the 3 month period to Nov 17, 91% of sales invoices were raised within 3 days of receipt of the fully completed Sales Invoice Request Form and 99% of sales invoices were raised within 5 days. This has improved from the previous quarter and in the month of November, 100% of invoices were raised within 3 days. Customer Reminder Letters were run and sent out each week in line with timetable.	Financial transactions processed and staff paid within an effective control environment in compliance with national payment targets. Detailed analysis of monthly transactions through the finance system to ensure that the financial position is reported accurately to support decision making within Directorates and across NES. Analysis of transactions as required for reporting within the annual accounts will provide assurance to the external auditors that the figures present a true and fair view of the financial performance of NES for the year.

Amber	Due to the late receipt of information from NSS that is required for the payroll control account reconciliations, there was a short delay in their completion. This has been addressed and the information will be provided earlier in future months.	Financial systems have controls in place which ensure accurate delivery of statutory reporting obligations, and information to support decision making and provide assurance of financial control across the organisation.
Amber	ISO27001 implementation action plan is complete, but now needs to be implemented. Ongoing discussions regarding the feasibility of consultancy support to complete by end of March.	To significantly improve information governance and security with a commensurate increase in confidence in NES and the wider NHS for our cloud based services.
Amber	After a meeting with the Digital team the requirement was refined to the point where a development 'sprint' was agreed. At the time of providing this update there had been no outcome from this. The Finance representative on the prioritisation group is pursuing this on our behalf.	A responsive finance function that provides a quality focussed and responsive service to the rest of the organisation ensuring financial information is available when required and statutory responsibilities are met.

RAG Status of desired outcome
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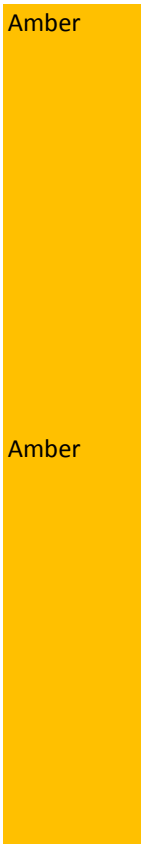
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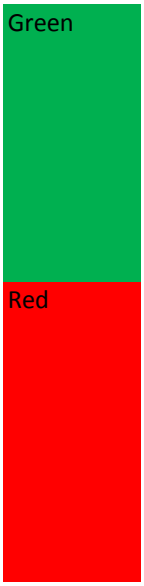
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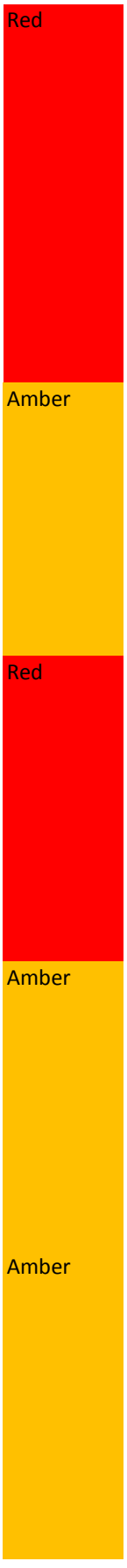
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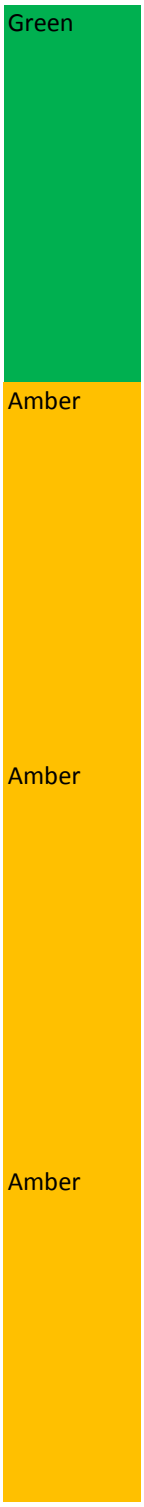
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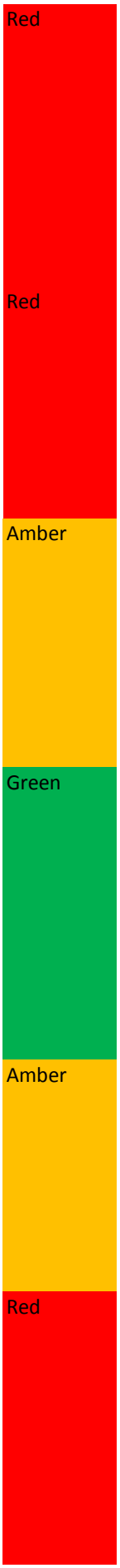
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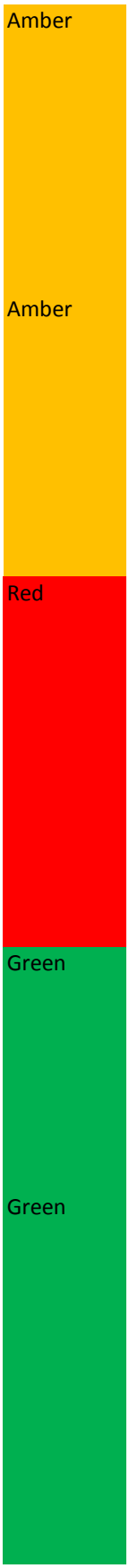
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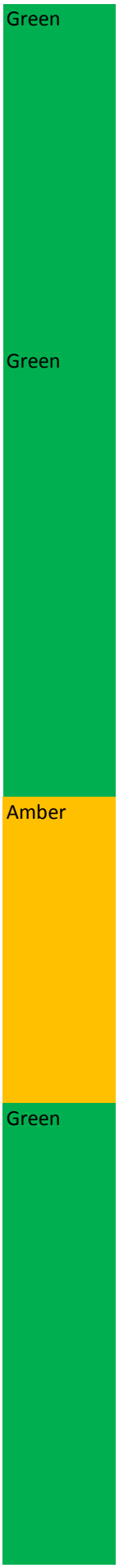
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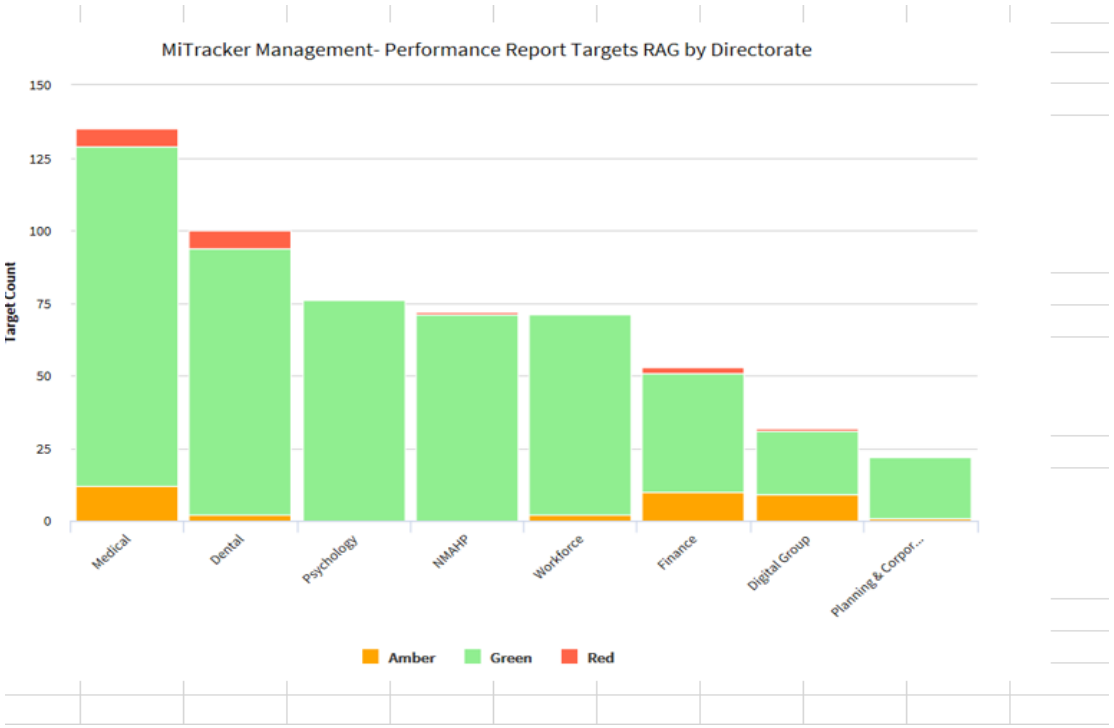

MiTracker Management- Performance Report Targets RAG by Directorate
Target Count
150
125
100
75
50
25
0
Medical
Dental
Psychology
NMAHP
Workforce
Finance
Digital Group
Planning & Corpor...
Amber
Green
Red

Directorate	Red	Amber	Green
Dental (Inc. Healthcare Science and Optometry)	8	3	71
Digital	1	7	23
Finance	2	10	41
Medical (Inc. Pharmacy)	6	12	106
NMAHP	2	0	63
Planning and Corporate Resources	0	2	19
Psychology	0	0	74
Workforce	0	3	67
TOTALS = 520	**19**	**37**	**464**

NES **NES/18/19**
Item 9c **(Enclosure)**
March 2018

NHS Education for Scotland

Board Paper Summary: Staff Governance Committee Minutes

1. Title of Paper

Minutes of Staff Governance Committee meeting held on 8th February 2018: copy attached.

2. Author(s) of Paper

David Ferguson, Board Services Manager

3. Purpose of Paper

To receive the unconfirmed minutes of the Staff Governance Committee meeting held on 8th February 2018.

4. Items for Noting

Item 7 – OD, Leadership and Management Development

The Staff Governance Committee received interesting and informative presentations on the 'Learning and Management Zone' of Turas Learn and 'Leadership Links' (formerly the Managers Development Network).

Item 8 – Turas Appraisal

The Staff Governance Committee received a useful update paper on the development and application of Turas Appraisal, which will replace the e-KSF system in April 2018.

Item 10 – Sexual Harassment in the Workplace

The Staff Governance Committee received a thought-provoking paper on this topic and endorsed NES's existing policies and processes and the proposed actions set out in the paper.

Item 11 – Workforce Metrics

The Staff Governance Committee received a helpful presentation providing an update on the development of Management Information Workforce Data. The metrics prepared for the committee's next meeting in April will be in a new dashboard format.

Item 12– EU citizens working in NHSScotland

The Staff Governance Committee held an interesting discussion on discussions with Scottish Government and in the service on the collection of

staff data in the context of the UK exiting the EU in March 2019. The committee was not in favour of collecting information which is unnecessary and would risk isolating or stigmatising a group of staff.

Item 13 – Review of Staff Governance Committee Remit

The Staff Governance Committee reviewed its remit and agreed one change, which is shown as a tracked change in the Appendix to the minutes (see also the recommendation at section 5 below).

The committee also agreed to suggest one change to the remit of the Remuneration Committee.
(Post-meeting note: This change was subsequently approved by the Remuneration Committee members by e-mail and so this amended remit will also be recommended to the Board for approval (see section 5 below)).

Item 17a – Vote of thanks to Committee Chair

As this was Susan Douglas-Scott's last meeting as committee Chair before she retires from the Board at the end of May 2018, the Staff Governance Committee thanked her for her excellent contribution as Chair.

5. Recommendations

Item 13 – Review of Staff Governance Committee Remit

(i) The Staff Governance Committee agreed to recommend one change to its remit, as noted in the tracked change in Appendix One of the minutes.

(ii) The Staff Governance Committee also agreed to recommend a change to the remit of the Remuneration Committee, as noted in the tracked changes in Appendix Two of the minutes.

NES
February 2018
DJF/dw/sds

Unconfirmed

NHS Education for Scotland **NES/SGC/18/07**

Minutes of the Fifty-Ninth Meeting of the Staff Governance Committee held on Thursday 8th February 2018 at Westport 102, Edinburgh

Present: Susan Douglas-Scott, non-executive Board member (Chair)
Liz Ford, non-executive Board member
Susan Stewart, non-executive Board member
Andrew Tannahill, non-executive Board member

In attendance: Dorothy Wright, Director of Workforce/Executive Secretary
Lindsay Burley, NES Board Chair
Caroline Lamb, Chief Executive (agenda items 7 to 18 only)
Christine McCole, Head of Service, HR
Ameet Bellad, Senior Specialist Lead (Workforce) (agenda item 11 only)
Anne Campbell, Principal Lead (OL&D) (agenda item 8 only)
Elaine Lawther, Principal Lead (OL&D) (particularly for agenda item 7)
Kristi Long, Senior Specialist Manager (Workforce)
Tuija Tengvall, Specialist Lead (O&LD) (particularly for agenda item 7)
David Ferguson, Board Services Manager

1. Chair's welcome and introduction

The Chair welcomed everyone to what would be her last meeting in the Staff Governance Committee Chair before her retiral from the NES Board in May 2018.

2. Apologies for absence

Apologies were received from David Cunningham (BMA).

3. Declaration of interests

There were no declarations of interest in relation to the items on the agenda.

4. Minutes of meeting held on 9th November 2017 (NES/SGC/17/37)

The minutes of the previous meeting were approved, subject to showing David Cunningham as 'Present', rather than 'In attendance'. **Action: DJF**

5. Action list from meeting held on 9th November 2017 (NES/SGC/17/38)

It was noted that all of the action points had been completed or were in hand.

6. Matters arising from the minutes

a. Item 15: Any other business – Starting time of future meetings

It was agreed that future meetings of the committee will start at 10.00 a.m., subject to a review of this arrangement in due course. **Action: DJF**

7. OD, Leadership and Workforce Development

Elaine Lawther and Tuija Tengvall were welcomed to the meeting for this item.

Elaine gave a brief presentation on the 'Leadership and Management Zone' of Turas Learn. This included a video overview of the zone, 'Be The Best You Can Be'. The following points were highlighted:

- The Leadership and Management Zone complements Turas Appraisal.
- There are similar zones for Estates and Facilities; Business and Admin; and Quality Improvement.
- The NHS Scotland Leadership and Management Development Framework is constructed in layers and offers a variety of pathways and resources.
- A Minimum Viable Product (MVP) in relation to the Health and Care Leadership pathway was launched on 1st February. Online resources (videos, blogs, articles and events) are available within 3 clusters.

The following points arose in discussion:

- Although all of the current resources have been developed in-house, there is scope to incorporate resources from a number of other sources, including the wider NHS and care sectors.
- It was noted that the system is capable of detecting the interests of online users and it was suggested that it would be useful if it could be developed to a point where it also detected gaps in users' interests.

Tuija then gave a brief presentation on 'Leadership Links' (formerly the Managers Development Network), which has provided much of the resources for the Learning and Management Zone to date. The following points were highlighted:

- Feedback from an initial workshop suggests that 'Leadership Links' has been well-received so far.
- 'Leadership Links' provides a blended approach and offers bite-size learning (webinars, workshops and resources).
- Online networking is encouraged and facilitated via a 'People Connect' button on the system.

Further discussion followed, resulting in these main points:

- Uptake of the webinars has been encouraging and there is scope to improve the uptake further.
- The Turas platform is beginning to gain traction in the wider health and care communities.
- It was acknowledged that the branding of the Turas platform and its applications needs to be sensitive to the needs of both the health and care sectors.

Elaine and Tuija were thanked for their interesting presentations and their helpful participation in the discussion. It was agreed that it would be useful to provide the members with a link to the 'Leadership and Management Zone' on Turas.

Action: EL

8. Turas Appraisal: Update (NES/SGC/18/02)

Anne Campbell was welcomed to the meeting for this item. She introduced a paper presenting an update on the development and application of Turas Appraisal, which is the replacement application for the e-KSF system across the NHS in Scotland when the current contract runs out on 31st March 2018. The following points were highlighted:

- Work has progressed well on the development of the Turas Appraisal application and the Digital team were commended for their excellent work in delivering according to a challenging timescale. This commendation will be conveyed to the team concerned. **Action: DW**
- The new functionality will be available for the majority of Agenda for Change staff from 2nd April.
- The data transfer from the e-KSF system has proved challenging, partly due to the quality of data stored there, and some 'workarounds' have been required.
- Stakeholder engagement has produced some useful user feedback. Examples of this feedback were provided in an Appendix to the paper.
- Close attention has been paid to information governance compliance issues.
- Accessibility standards will be met.
- Robust arrangements have been put in place for user support and training following implementation.
- NES's 2018/19 personal review and planning cycle will be completed using Turas Appraisal.

Discussion of the paper produced the following main points:

- Some concern was expressed regarding those staff in NHSScotland (for example a number of ancillary staff) still without NHS e-mail addresses. It was pointed out that Turas Appraisal will be accessible from personal devices, although it will require a cultural shift for the use of personal devices at work to be universally welcomed in NHSScotland.

- It was confirmed that user feedback will be used to inform the iterative development of Turas Appraisal.

The committee was pleased to note the encouraging progress in relation to the development and implementation of Turas Appraisal and thanked Anne for her helpful paper.

9. Mapping NES leadership behaviours to NHSScotland Values (NES/SGC/18/03)

Christine McCole was welcomed to the meeting for this item. She introduced a paper providing the committee with an assurance that the NES leadership behaviours align to the NHS Scotland Values. The following points were highlighted:

- Attention was drawn to the table defining how NES's Ways of Working align to NHS Scotland Values and how NES's Leadership Behaviours align to the NES Ways of Working.
- Values-based recruitment is currently being piloted in NES and feedback on the pilot will be provided in due course.

The following points arose in discussion:

- One member considered that not all of the NHS Scotland Values are truly represented in the NES Leadership Behaviours. 'Compassion' was cited as an example and it was accepted in discussion that this is not adequately covered in the 'Engaged and Engaging' leadership behaviour. It will be useful to reflect on this point when considering the feedback from the values-based recruitment pilot.
- It was pointed out that the NES leadership behaviours had been developed by the staff. It was, however, accepted that an accompanying narrative about NES might be helpful.
- It was emphasised that the leadership behaviours apply to all NES staff.

Following discussion, the committee noted the paper.

10. Sexual Harassment in the Workplace (NES/SGC/18/04)

Kristi Long was welcomed to the meeting for this item. She introduced a paper describing NES's current arrangements for preventing and responding to potential sexual harassment, benchmarked against the EHRC's guidance on policy and implementation, and proposing further action to be taken to support awareness-raising and facilitation of discussion around sexual harassment within a wider focus on NHS Values, ways of working and organisational culture. The following points were highlighted:

- Similar papers have already been discussed by the Partnership Forum (PF) and the SLMT. The PF has endorsed the action plan proposed in the paper.

- Sexual harassment in the workplace is covered in NES's wider Dignity at Work Policy.
- The high-profile #MeToo campaign has highlighted the need to raise staff awareness of these issues.
- It was acknowledged that this is one of a number of gender inequality issues.
- The intention is for the PEDLN group to consider the operationalisation of the points in the action plan.

Discussion of the paper generated the following main points:

- In view of the high profile accorded to sexual harassment in workplaces, it was very timely to review our approach and profile it is accorded in NES. It may be useful to explore the Equally Safe Employer accreditation for NES.
- It will be important to focus on and engage the trainees, particularly the GPSTRs, who are NES employees but work in GP practices and Boards to ensure joined-up and consistent messages.
- This subject might usefully be covered in the NES corporate induction programme.
- Further consideration will now be given to refining approaches in NES and any communication strategy, as appropriate.

Following discussion, the committee endorsed NES's existing policies and processes and the proposed actions set out on pages 4 to 5 of the main paper.

Action: KL

11. Workforce Metrics

Ameet Bellad was welcomed to the meeting for this item. He gave a brief presentation, 'Management Information Workforce Data', covering the following main areas:

- The workforce data solution developed: Data sources through to data consumption
- Usage of data: Snapshots of the dashboard
- NES People & OD Dashboard: A balanced scorecard mechanism, with metrics (aligned to the Staff Governance Standards) to support a sustainable workforce.
- Next steps: Talent Analytics Maturity Model. NES has progressed to Level 3 - Advanced Analytics.

The following points were highlighted during the presentation:

- NES has started on the journey of democratising the data.
- The metrics are used by the HR Business Partners in discussions with their Directorates.

The following points arose in discussion:

- It was hoped that the dashboard approach will be useful for the committee in relation to their governance role. An early prototype of the dashboard should be available for the next meeting.
- It will be important, in terms of the colour coding in the dashboard, to ensure that the links are accessible to those with colour blindness.
- It was confirmed that the data protection issue relating to access to information derived from small cohorts has been addressed.

Following discussion, the committee thanked Ameet for his useful presentation and looked forward to receiving the new-style metrics at the next meeting.

Action: AB

12. EU citizens working in NHSScotland (NES/SGC/18/05)

Dorothy Wright introduced a paper updating the committee on discussions with Scottish Government and in the service on the collection of staff data. The following points were highlighted:

- This issue has arisen as a result of the UK exiting the European Union in March 2019 and the Scottish Government would like to find a way of collecting or reporting data using a variety of data sources.
- This matter was discussed at the last Partnership Forum meeting in January.
- The message from staff is that sharing their ethnicity is fundamentally an issue of trust relating not only to NES as their employer but also to wider government bodies. While there may be trust within NES, the wider picture is challenging.

Discussion of the paper resulted in the following main points:

- Members agreed that this is an issue for the Scottish Government to address, in association with the trade unions.
- Members did not support collection of data on EU citizenship unless there was a clear rationale and use for the data. They raised concerns about the potential for isolating or stigmatising individuals.

Dorothy thanked the committee for its consideration of this challenging issue and NES would continue to work with the service and Scottish Government to find a way forward.

13. Review of Staff Governance Committee Remit (NES/SGC/18/06)

Dorothy Wright introduced a paper provided to inform the committee's annual review of its remit, to ensure that it remains appropriate. The current remit of the Remuneration Committee was provided for reference.

In the second bullet point of the existing Staff Governance Committee remit, it was agreed to amend "…Gender, Race, Disability and other diversity…" to read "…Equality and Diversity…". Subject this change, the committee was satisfied with its current remit. The Board will be asked to approve this change to the remit when the minutes of this meeting are submitted to the March Board meeting. For this purpose, the amended remit, with the change tracked, will be included as an Appendix to these minutes. **Action: DJF**

On an associated point, it was agreed to suggest to the Remuneration Committee that the references in its remit to "Senior Managers" should be clarified and re-worded **Action: DW**

(Post-meeting note: The suggested change to the Remuneration Committee remit was approved subsequently by the members of that committee by e-mail and so that amended remit (with the change(s) tracked) will also be included as an Appendix to these minutes and recommended to the Board for approval.) **Action: DW**

14. Policy Tracker

Members received the Policy Tracker as at January 2018 and noted that everything was on track.

15. Managing Health, Safety and Wellbeing Committee minutes

Members noted the minutes of this committee's meeting held on 31st October 2017.

16. Change Management Programme Board (CMPB) minutes

Members noted the minutes of the CMPB meeting held on 11th December 2017.

17. Any other business

a. Vote of thanks to Committee Chair

As this had been Susan Douglas-Scott's last meeting as committee Chair, the committee thanked her for her excellent contribution as Chair.

Dorothy Wright thanked Susan for her support to herself and her team.

Susan thanked the committee for its kind words and indicated that she had enjoyed her time on the committee. She also thanked Jenn Allison for her support as the former administrative secretary to the committee. It was noted that this role had been taken over by David Ferguson, following a recent review of committee-servicing responsibilities.

18. Date and time of next meeting

It was confirmed that the committee's next meeting will take place on Thursday 26th April 2018 at the new earlier time of 10.00 a.m.

NES
February 2018
DJF/dw/kl/sds

Staff Governance Committee **Appendix One**

Remit

The Staff Governance Committee is a standing committee of the Board, with the primary purpose to monitor the development and maintenance of a culture throughout NHS Education for Scotland (NES) where delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the organisation, built on partnership and collaboration.

The specific responsibilities of the Staff Governance Committee are:

- to monitor and evaluate strategies and implementation plans relating to people management;
- to review the implementation of policies, procedures and practices through regular and routine scrutiny of statistics in relation to ~~Gender, Race, Disability and other diversity~~Equality and Diversity strands and ensure that the outcomes of these reviews are published;
- to monitor the operation of processes and progress against agreed action plans to ensure that momentum of delivery against the national Staff Governance Standard is maintained;
- to propose and/or support any policy amendment, funding or resource submission to achieve the full Staff Governance Standard;
- to monitor NES compliance with all staff governance information required for national and statutory obligations for monitoring;
- to monitor compliance of staff governance activities with statutory duties, NHSScotland policy and NES priorities in relation to equality and diversity;
- to monitor benefit realisation processes of major initiatives, e.g. pay modernisation;
- to monitor trends and performance in relation to sickness absence management, recruitment and staff turnover and recommend actions as appropriate;
- to receive an Annual Report on the work of the Remuneration Committee at the last meeting in the calendar year, in order to give the Board assurance that systems and procedures are in place for the proper operation of performance management;
- to receive the minutes of the NES Health, Safety and Welfare Committee;
- to receive any recommendations from the Partnership Forum;
- to provide staff governance information for any internal control purposes; and to ratify NES HR policies and procedures on behalf of the Board.

Remuneration Committee

Remit

The Remuneration Committee is accountable to the Board through the Staff Governance Committee for the discharge of its remit:

i. to agree all terms and conditions of employment for ~~Senior Managers of the~~the Chief Executive and direct reports to the Chief Executive ~~Board~~, including job description, job evaluation, terms of employment, basic pay, performance pay and bonuses and benefits;

ii. to agree objectives for ~~Senior Managers of NES~~the Chief Executive and direct reports to the Chief Executive, normally before the start of the year in which performance is assessed;

iii. to monitor the performance of ~~Senior Managers of NES~~the Chief Executive and direct reports to the Chief Executive, in accordance with their performance plans;

iv. to review submissions from the Chief Executive for the terms of any Settlement Agreement which is outwith the provisions of our Organisational Change and Redeployment Policy or is outwith the severance terms set out in NHSScotland terms and conditions of employment;

v. to review and endorse the award of severance arrangements under the terms of the NES Redeployment Procedures and outwith any organisation wide Voluntary Severance and Early Retirement Scheme;

vi. to conduct regular reviews of NES policy for the remuneration and performance management of ~~Senior Managers~~the Chief Executive and direct reports to the Chief Executive, in the light of any guidance issued by NHS Scotland;

vii. to delegate responsibility to a sub-group of the committee to act as the Appeals body for ~~Senior Managers and Directors of NES~~the Chief Executive and direct reports to the Chief Executive who have a grievance concerning their terms and conditions of service; and

viii. together with the Chief Executive of NES, make recommendations regarding the citation of doctors and dentists to the Scottish Advisory Committee on Distinction Awards, General Dental Practitioners under CRUMP discretionary progression arrangements and consultant discretionary point progression.

The remit of the Committee will be reviewed annually.

~~Approved by the NES Board on 7 December 2017~~

NES **NES/18/20**

Item10a **(Enclosure)**

March 2018

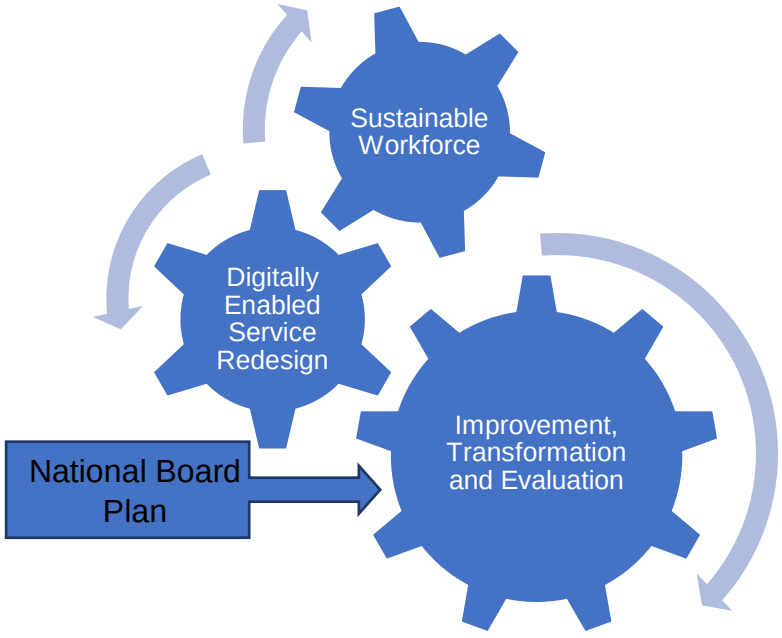
National Board Plan 2018-23

Summary for Board Meetings

Introduction

The National Board Plan 2018-23 will be submitted to Scottish Government at the end of March 2018. This paper provides a summary of the emerging plan for Board meetings prior to the submission deadline and is to endorse the general principles and direction of travel. Further engagement with Scottish Government, regions, territorial boards and social care partners will be required before the plan is finalised and workstreams which will involve Boards collaborating to deliver the plan will require further discussion and sign-off at future Board meetings to ensure the appropriate governance of investment and resource decisions.

As national boards we will support the *Health and Social Care Delivery Plan,* providing services that meet changing national, regional and local needs. Our plan will be closely aligned with regional plans and will support Scottish Government policy including the *National Clinical Strategy, Realistic Medicine* and the *Everyone Matters: 2020 Workforce Vision.* The plan will bring together collaborative teams to meet the challenges described in the regional plans and from our own analysis, helping to tackle the challenges of health inequalities, an ageing population and restricted budgets. The plan will involve developing new areas of collaborative work, distinct from 'core business' and underpinned by national evaluation, improvement and transformation services.



Underpinning this plan are the following principles; we will

- use existing capacity and capability wherever possible
- focus on potential impact and added value
- focus on priorities where we can achieve most by working together
- not limit our level of ambition
- work in partnership across health and social care

1. Improvement, Transformation and Evaluation

The national boards have a wealth of resources which can be better linked and made available to support transformational change. The plan will aim to develop national improvement, transformation and evaluation services to support all aspects of the *Health and Social Care Delivery Plan,* underpinned by new national planning arrangements. These services will help develop more integrated partnership approaches to service delivery and strengthen support for transformational change through a collaborative operating model supported by data and analytics and evaluation expertise.

This will involve developing national improvement, transformation and evaluation services which

- bring together expertise and capacity to support transformational change alongside the development of a culture of continuous improvement
- provide self-service data and modelling tools for planning, improvement and change and a ‘virtual laboratory’ for scenario testing
- bring together research and evaluation expertise to support system wide improvement and transformation which also spreads learning
- maintain a strong focus on public health and supports the transition to a new public health landscape underpinned by population health intelligence and data and modelling tools

Some of the benefits that are expected to accrue from this approach are

- accelerating the shift in the balance of care and reduced pressure on services
- higher quality care at less cost

- an integrated and accessible national framework for change
- better sharing of good practice and effective models of change
- better alignment of workforce, service and financial plans
- better service planning supported by data over a longer timescale
- a better understanding of the evidence base for effective change
- a joined-up approach to public health at a national and local level
- improved access intelligence and data and modelling tools

2. **Digitally Enabled Service Transformation**

Digital innovation is a key enabler of service transformation and will be a constant theme across the plan to support the *Digital Health and Care Strategy*. Digitally enabled services will help people manage their own health and ensure staff have the skills to deliver digital solutions and use data to improve standards, freeing up clinical time to focus on complex cases and cases where direct clinical input is required.

This will involve helping to drive service redesign in conjunction with users at national, regional or local levels (supported by national improvement, transformation and evaluation services) which

- improve elective and outpatient care to ensure people are directed into the most appropriate care pathway
- provide triage and specialist paramedic practice support which relieves the pressure on primary and unscheduled care
- provide digitally enabled unscheduled mental health services which complement local services and improves access to professionals
- provide alternative care pathways for older people into community services
- help to deliver the *Digital Health and Care Strategy,* providing consistent digital architecture and a national approach to information governance
- provide national cloud-based business systems which enable more effective shared services models, reduce cost and improve analytics
- develop a workforce confident with providing digitally enabled services

Some of the benefits that are expected to accrue from this approach are

- care pathways that better meet people’s needs and free up resources

- services that are easier for people to use and don't waste time and money
- reduced acute out-patient demand though less face to face consultation
- reduced demand on primary and unscheduled care and less acute referrals
- public engagement that creates ownership of digital and its benefits
- common technologies that can be built and procured once
- people more able take control of their own health and wellbeing
- the ability to more easily scale up proven digital innovations
- a more digitally ready workforce around the clock easily accessible services

3. A Sustainable Workforce

Redesigned services will require a reshaped workforce supported by data that enables workforce planners to model demand and projected supply. The plan will have a strong workforce element to help improve workforce planning, recruitment and retention, attraction and education and training.

This will involve helping to develop national workforce initiatives, (supported by national improvement, transformation and evaluation services), which

- improve workforce planning with a better match between supply and demand along with new guidance, a data platform and training
- provide *eRostering* to improve staff deployment and help employees to better manage their working lives
- develop recruitment, attraction and employee engagement through a *Digital Portal* and enhanced employer brand
- put in place a new national approach to youth employment
- establish national education and training commissioning along with guiding principles for *Recognition of Prior Learning* (RPL)
- roll out a national cloud-based learning management system
- strengthen leadership, talent management and performance appraisal and develops national support to work with local systems
- deliver national models of employment and employment policies

Some of the benefits that are expected to accrue from this approach are

- better workforce planning over a longer timescale and upskilled planners

- better alignment of workforce, service and financial plans
- employees better able to manage their own working lives
- improved recruitment, retention, talent management and staff engagement
- better awareness and opportunities for young people
- better recognition, transferability and access in relation to learning
- an enhanced talent pool and improved succession planning
- increased leadership capacity and capability for transforming services
- improved employment transferability to support national and regional models

4. Financial Framework and Investment Case

We recognise the continuing financial challenge for the whole system and the importance of a robust financial framework to support the plan. The financial framework will outline the consolidated financial position of the national boards over the next five years and the economic impact of delivering the work in the plan.

The financial framework will be based on developing a culture of sharing risk and cost underpinned by a commitment to value for money (return on investment) in the delivery of core individual operations and collaborative work. The overarching aim is to create capacity and capability to support the health and social care system and manage the ever-increasing demands for services and the associated workforce challenges. The investment case to support the plan will be based on the principle that we will utilise existing national infrastructure to reduce the pressures on individual organisations and achieve economies of scale.

NES **NES/18/21(b)**

Item 10b(ii) **(Enclosure)**

March 2018

NHS Education for Scotland

Board Paper Summary

1. Title of Paper

Draft NES budget for 2018/19

2. Author(s) of Paper

Audrey McColl, Director of Finance

3. Purpose of Paper

To present the draft Budget for 2018/19 to the Board

4. Key Issues

The draft Scottish Budget, released on the 15th December 2017 and approved on 21st February, confirmed that there would be no uplift to the NES baseline recurrent budget. However, we have been advised that given the UK Government budget commitment to 'funding pay awards for NHS staff on the Agenda for Change (AFC) contract', we should assume that central funding will be provided to meet the additional costs of the SG pay policy for AFC Grades above the first 1%. This funding position cannot be absolutely confirmed until the summer.

The total amount that we would have to find from the NES budget to cover all cost pressures stands at £14.9m. This arises from the AFC pay award, incremental progression for AFC staff, pay awards for those not on Agenda for Change terms and conditions (mainly the trainee cohorts), inflationary pressures across our non-pay budgets and an anticipated contribution of £2.5m to the £15m efficiency target applied collectively to National Boards. In addition, we have an underlying recurrent deficit of £3.2m which in previous years we have met on a non-recurrent basis.

Initial savings and additional income identified by directorates of £2.5m have reduced this gap to £12.4m. Further proposals contained in this paper would reduce the gap to £0.7m, however this would mean increasing our underlying recurrent deficit to £7.3m, which is offset by in-year non-recurrent savings to reduce the overall gap. This would enable longer term measures to be developed to reduce this deficit.

5. Educational Implications

The draft budget underpins the activities that we have included in our Annual Operational plan. This has been drafted based on Directorate submissions to the planning system and reflects the key priority areas which will contribute to the implementation of the Health and Social Care Delivery Plan.

6. Financial Implications

We will start the 2018/19 financial year with an unidentified savings target of £0.7m, which will be managed throughout the year to ensure our financial targets are met.

7. Which NES Strategic Objective(s) does this align to?

The budget underpins the achievement of all our strategic objectives

8. Impact on the Quality Ambitions

The education and training that NES provides/commissions, and which is supported by this budget, is designed to impact on all the Quality Ambitions.

9. Key Risks and Proposals to Mitigate the Risks

The total cost pressure of £14.9m represents a very high proportion (30%) of the 'discretionary' element of NES spend – that is the amount which we can directly influence (excluding commitments to training grade salaries etc). Were we to try to cover all these pressures, we would need to reduce activity across all infrastructure and other headings by around a third.

As a consequence of the funding settlement (no uplift) provided to NES, this paper sets out the case that NES is not in a position to provide any uplift in the level of payments we provide to Boards for the salary support of trainees, or for the support costs we provide for medical and dental undergraduate placements (ACT). As a result, we are effectively passing

on the cost pressures in these areas to Boards. Given that these costs are directly supporting front-line clinical staff delivering patient care, there is a risk that this position will impact on Boards' provision of safe, effective and person-centred care.

It is also clear that we have, over recent years, absorbed and in-part mitigated substantial cost pressures arising from the need to support more training grades – particularly in medicine. However, our assessment is that our capacity to absorb this growth is now exhausted, and any further growth in training grades will explicitly require to be supported with appropriate resources, including infrastructure support.

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10. Equality and Diversity Impact Assessment

The funding settlement may result in a decision to cease activity in some areas. Where this is necessary we will need to carry out an equality impact assessment.

11. Recommendation(s) for Decision

The Board is asked to;

- Note and comment on the proposed actions to reduce the budget gap in 2018/19.
- Review and approve the draft budget for 2018/19, including an unidentified savings target of £0.7m
- Note the proposals for longer term actions to reduce the underlying deficit position.

A McColl

February 2018

1. Background and National Context

The Scottish Budget was published on 15th December 2017 and approved on 21st February 2018. The total draft budget for Health and Sport is £13,584m (an increase of £373m on 2017/18) which includes Capital of £351million.

The draft budget included a cash terms uplift for Territorial Health Boards of 1.5% for 2018/19. In addition to this, those Boards furthest from NHS Scotland Resource Allocation Committee (NRAC) parity will receive a share of £30 million, which will mean that no Board is further than 0.8% from NRAC parity in 2018/19.

The Special Health Boards have been considered separately with the patient facing Boards (Scottish Ambulance Service, NHS24, Golden Jubilee and The State Hospital) receiving a cash terms uplift of 1%. If appropriate, they will also have received an NRAC parity adjustment.

The remaining four national Boards (NHS National Services Scotland, Healthcare Improvement Scotland, NHS Health Scotland and NHS Education for Scotland) will receive no uplift to their baseline recurrent budgets. Details of the draft budgets are shown in Table 1 below.

Table 1 – Budget Figures for National Boards

National/Special Boards	**2016/17 £m**	**2017/18 £m**	**2018/19 Draft Budget £m**
NHS Waiting Times Centre	46.5	51.9	54.0
NHS Scottish Ambulance Service	218.5	229.3	237.9
NHS National Services Scotland *****	293.4	324.7	328.2
Healthcare Improvement Scotland	15.5	24.7	24.7
NHS State Hospital	34.3	34.4	34.8
NHS 24	64.6	65.2	66.3
NHS Education for Scotland	**408.7**	**420.0**	**420.0**
NHS Health Scotland	18.2	18.4	18.4
Total Special Boards	1,099.7	1,168.6	1,184.3

* The NSS increase relates to the NSD element of their budget only.

The £420.0 million reflected above for NES, does not include £3.4million of funding which was transferred to the NES baseline during 2017/18, therefore the total baseline funding for 2018/19 is £423.4m. These funding allocations related to £2.7million for the Foundation Expansion in Medical Training posts; £80k for the SciL Programme; and £600k for the NMAHP Educational Outcomes Framework.

2. NES Context

As members will be aware a significant amount of the NES budget is committed to paying the salaries of doctors, dentists, clinical psychologists and others while they are in training.

In recent years a large proportion of the total uplift received by NES has gone towards funding the pay increases of trainees across the service as detailed in the table 2 below.

Given the combination of the increase in employers Superannuation contributions in 2015/16, the removal of the Employers NI rebate in 2016/17 and the recent announcement of a zero uplift to the NES budget, it is no longer sustainable for NES to fund pay increases to clinical training grades.

Table 2 - ALL TRAINEES (Pay only)	**2015/16**	**2016/17**	**2017/18**	**2018/19 estimate**
Total uplift to the NES baseline budget	1%	1%	1%	0%
Value of the budget uplift	**£4m**	**£4m**	**£4.1m**	**nil**
Cost of pay increase for all trainees	£2.5m	£2.6m	£3.1m	£5.4m
Impact of increase in ER pension costs	£3.0m			
Impact of the removal of the ER NI Rebate		£5.6m		
Total Pay Related Pressures	**£5.5m**	**£8.2m**	**£3.1m**	**£5.4m**
Impact on the NES baseline budget	**(£1.5m)**	**(£4.2m)**	**£1m**	**(£5.4m)**
Cumulative impact and 2018/19 estimate	**(£1.5m)**	**(£5.7m)**	**(£4.7m)**	**(£10.1m)**

Cumulatively, in recent years, the uplift received has not fully covered the Training Grade pay pressures. During this same period, NES has had recurrent efficiency targets of £1million (2015/16) and non-recurrent targets of £3 million (£0.5m in 2015/16 and £2.5m in 17/18) applied to its budget.

As at 2017/18, the underlying recurrent deficit on the total NES budget was £3.2m, reflecting the fact that all areas of the NES budget have contributed to the management of this increasing pressure.

3. Approach to Budgeting

Whilst preparing the initial draft budget, the full extent of the challenge facing NES was unknown. For 2018/19, the Executive team agreed a different approach to budgeting. A Priorities framework was agreed at the start of the planning process based on the implementation of the Health and Social Care delivery plan.

As part of creating their operational plan Directorates considered each of their activities against the framework to identify the key element it supported. If no direct link could be established then the activity was flagged. It was agreed that these activities would not necessarily cease but that a discussion could then take place as to the most appropriate course of action.

Directorates were not issued with detailed indicative budgets but were asked to submit the most cost-effective budget which enabled them to deliver their required outcomes. The only caveat was that the recurrent budget requested for 2018/19 should not exceed the 2017/18 budget, after absorbing the assumed pay increase of 2%. At this stage, no adjustments were made for vacant posts or for the recruitment lag factor which has been implemented in the last 2 years.

Planning closed on the 1st December. On the 15th December the Draft Budget was announced confirming a zero uplift for NES and an increase in the potential pay award. Throughout December and early January, the Finance team have been meeting with individual directorates to review their initial submissions.

4. Cost Pressures Identified

As a result of the published draft budget, total Cost Pressures of £14.9m were identified as detailed below;

Table 3 – Cost Pressure Analysis

Cost Pressure	**£'000**
Pay costs	
Training Grades Boards	4,741
Training Grades NES	611
Pay award for NES non TG Staff (AFC, CRUMP, etc)	550
NES Staff Incremental Drift	192
SLAs with Other Boards	333
Modern Apprenticeship Levy	26
Underlying recurrent gap	3,201
Other Non-Pay Pressures:	
eLibrary Services additional VAT	550
eLibrary Services Price Inflation	165
Property Costs (incl rates, Service Charges)	303
HCS Training Posts	188
Digital	361
Psychology Increased Tuition Fees	144
Other Inflationary pressures	1,071
SG Efficiency Target - contribution to the National Boards' Savings Targets	2,500
Total Pressures	**14,936**

4.1 Pay Cost Assumptions

The Scottish Government has set out its 2018-19 pay policy, which recommends a 3% pay increase for public sector workers earning £36,500 or less and a cap of 2% on the increase in the pay bill for staff earning more than £36,500. In addition, there will be a cap on the pay increase for highest paid, with a maximum cash increase of £1,600 for those earning above £80,000. Although the pay settlement for NHS staff will be subject to the NHS pay reviews process we have used this as the basis for our calculations. Total pay related pressures across all directorates – including Training Grade pay pressures (see below) - is £6.5 million.

4.1.1 **Training Grade Pay Pressures**

A significant amount of the NES budget is committed to paying the salaries of doctors, dentists, clinical psychologists and others while they are in training.

The anticipated pressures as a result of the 2018/19 pay policy on the Training Grade element of the NES recurrent budget is a total of £5.4m. Table 4 below reflects the pressure across the different Directorates.

Table 4 – Pay Award Impact on Training Grades:

Budget Area	TGs Pay Award £'000	NES GP Trainees	Total TG Pay Awards
Dental	230	0	230
Healthcare Sciences	20	0	20
Medical	4,289	611	4,900
Psychology	194	0	194
Workforce	8	0	8
TOTAL Training Grades	*4,741*	*611*	*5,352*

4.1.2 **Other Pay Pressures**

Table 5: Pay Pressures from Non-TG posts

Pay element	Pay Award £'000
NES Directly employed staff	550
NES Staff Incremental Drift	192
SLAs with Other Boards	333
Modern Apprenticeship Levy	26
TOTAL non TG Pay Pressure	*1,101*

The total impact on the costs of Non-TG staff directly employed by NES reflected in Table 5 above, is £742k for 2018/19. This includes the impact of the Pay Award and Incremental Progression across all directorates. It is also forecast that an additional £333k will be incurred in relation to pay costs within Service Level Agreements (SLAs) with other boards. The Modern Apprenticeship levy increase was based on the 2017/18 paybill costs.

Additional pressures of £150k could be incurred against the Modern Apprenticeship levy as a result of the impact on NES of becoming the Lead Employer for GP Trainees for the duration of their training and not just when they are in a Practice Location. Final agreement on whether this funding comes directly from Boards or from Scottish Government has not yet been reached.

4.2 Underlying Recurring Gap (£3.2 million)

In recent years as the pressure on the recurrent liability for Trainees has increased, NES has reported an increasing underlying deficit between recurrent and non-recurrent funding. NES will not be able to close this gap during 2018/19, however measures for delivering balance will be explored within the year and ahead of the budget setting exercise for 2019/20. This current pressure is reflected within Provisions.

4.3 Other Non-Pay Pressures

4.3.1 e-Library Services (£715k)

We are currently in dispute with HMRC as to whether all the services we purchase under the current eLibrary contract qualify for VAT recovery under the Contracted Out Services (COS) rules. As there is no definite resolution we are reflecting increased costs of £550k in respect of the annual VAT charge. There is also an additional cost pressure of £165k in respect of the Inflation uplift on the contract.

4.3.2 Property Costs (£303k)

Contractual lease and service charge rises across all properties, coupled with Rate increases have added £210k of cost pressures to the 2018/19 budget. The loss of the recent court case against the Landlords accounts for £34k of the costs. Also included here is £77k in respect of backlog maintenance costs.

4.3.3 Other non-pay Pressures (£1,071k)

Non-Pay costs across all directorates will be subject to price inflation pressures and contractual price increases.

4.3.4 Contribution to the National Boards' Savings Target

SGHD wrote to the Chief Executives of the eight National Health Boards on 15th December 2016 informing them of the need to deliver, collectively, £15m of recurrent savings, through efficiencies and closer joint working. As part of this requirement, in 2017/18 NES contributed non-recurrent savings of £3.0m. There is an expectation that in 2018/19 the National Boards will deliver the £15m collaboratively on a recurrent basis which would mean a recurrent reduction to our baseline.

However, as the collaborative programme of work is still developing there is not sufficient clarity to allocate the anticipated savings to specific efficiency programmes, therefore a general contribution of £2.5m has been reflected as a cost pressure within Provisions.

4.4 **Medical Education Package**

A decision has been taken by the Scottish Government that non-EEA overseas medical students attending Scottish Universities should make a contribution towards the costs of their clinical teaching within the NHS in Scotland in the form of an Associated Cost of Teaching (ACT) levy. This levy commenced in August 2016.

The Scottish Government has directed that the income raised from the introduction of the levy be used to fund a set of measures known as the 'Medical Education Package'. The components of this package are;

- Widening access places – 50 additional undergraduate medical places;
- A Graduate Entry Programme ScotGEM, delivered in partnership between Dundee and St Andrews Universities – first intake 55 students;
- A return of service bursary scheme for the ScotGEM programme and;
- A pre-medical entry programme.

It is recognised that the total cost of the Medical Education Package is projected to be more than the funding raised by the Levy, however the Scottish Government has agreed that additional funding will be provided each year to cover this gap, which rises to approximately £9m by 2020/21.

The additional funding required for 2017/18 has been received.

Table 6: Medical Education Package 'Gap' Funding

	2016/17	2017/18	2018/19	2019/20	2020/21
Anticipated gap in Funding for the Medical Education Package	£0.06m	£0.52m	£2.25m	£4.83m	£9.19m

5. Current Position

In order to stay within a flat-cash budget Directorates would need to have absorbed the total cost pressures of £14.9 million. The table below highlights progress made to date where savings and additional income totalling £2.5 million have been identified leaving a recurrent gap of £12.4 million.

This has been split between Training Grades and Other Directorate costs. The Training Grade Total of £5.6 is comprised of Pay of £5.4million, and non-Pay of £0.2million.

Table 7: Overall budget

Directorate	Total Cost Pressures £'000	Savings Identified £'000	Additional Income £'000	Remaining Balance £'000
Dental	(230)	17	0	(213)
Healthcare Sciences	(208)	0	0	(208)
Medical Training Programme Mngt	(4,900)	0	0	(4,900)
Psychology	(253)	0	0	(253)
Workforce	(8)	2	0	(6)
Training Grades TOTAL	***(5,599)***	***19***	***0***	***(5,580)***

Directorate	Total Cost Pressures £'000	Savings Identified £'000	Additional Income £'000	Remaining Balance £'000
Dental excl TG	(122)	164	91	133
Healthcare Sciences excl TG	(33)	0	0	(33)
Optometry	(11)	29	11	29
Digital	(1,162)	155	68	(939)
Medical Professional Development	(554)	44	209	(300)
Medical Quality Mngt	288	6	0	293
Medical Training Programme Mngt excl TG	(9)	80	0	71
Medical Directorate Operational Support	(495)	86	0	(409)
Medical TOTAL	*(770)*	*216*	*209*	*(345)*
NMAHP	(367)	408	0	41
Psychology excl TG	(117)	152	0	34
Workforce excl TG	(89)	70	23	5
Planning	(60)	13	0	(47)
Properties	(331)	140	0	(284)
Facilities Management	(39)	19	0	72
Finance	(77)	95	0	18
Procurement	(9)	0	0	(9)
Provisions - Depreciation	0	291	0	291
Provisions -Corporate Charges (incl Apprenticeship Levy)	(426)	0	0	(426)
Provisions - CNORIS	(23)	0	0	(23)
Provisions - Income Contribution	0	0	300	300
Provisions - Vacancy	0	7	0	7
Provisions - Contribution to Nationals Savings	(2,500)	0	0	(2,500)
Provisions - Underlying recurrent deficit	(3,201)	0	0	(3,201)
Provision TOTAL	(6,150)	298	300	(5,552)
NON Training Grades Totals	(8,009)	1,411	532	(6,067)
Total	**(14,936)**	**1,778**	**702**	**(12,457)**

Most Directorates have identified savings from a variety of sources including restructuring and removal of posts where vacancies exist, renegotiating contracts, and implementing efficiency programs.

6. Proposed Measures to reduce the Gap

6.1 Trainee Pay

Given the significant Trainee cost pressures absorbed in previous years, and the zero percent uplift to the NES baseline in 2018/19, it is proposed that we freeze our contribution in cash terms to the Boards, for all Trainee salaries. The additional cost to Boards will be £4.7million as £0.7million of the total relates to GP Trainees whilst they are employed by NES.

The largest element of this relates to Medical Trainees. We currently pay Boards between point 2 and 3 of the scale for trainees however, the actual salary costs for some trainees are below this level. Initial results from analysis carried out to quantify how much this difference is suggests that we currently overpay Boards for the salary and ER on-costs element of medical trainees pay, by approximately £2.3m.

It is recognised that there may be a perception that NES is passing the problem to another part of the system, however as detailed in section 2, further absorption of additional cost on this scale, in the context of a zero % uplift is not possible. It should be noted that all territorial Boards received an uplift of at least 1.5% which is more favourable than had been anticipated.

6.2 Recruitment Lag

We will continue the policy implemented in 2016/17, that savings from posts, vacant whilst recruitment is undertaken, will be removed as a contribution towards the overall budget position. Based on the savings realised during 2016/17 and 2017/18, we expect that this could be in the region of £1.7m.

6.3 Training Grade

As in previous years it is recognised that there will be training grade funding which can be recycled *on a non-recurrent basis*. This arises from; posts which are filled on a Less Than Full Time basis (LTFT) where funding for the unfilled part of the post is not paid to Boards; GP posts which are vacant during the practice based element, where NES is the employer and from the price differential between the rate currently paid for a filled training post compared to the rate paid to Boards when the post is vacant.

Any anticipated available funding is first allocated to existing training grade pressures

Table 8: Offsetting the Recurrent Gap

	£m
Total anticipated training grade funds available on a non-recurrent basis	9.7
Reallocation to other specific training grade pressures such as funding of ST expansion posts, Remedial posts and post CCT double running.	4.8
Balance available on a non-recurrent basis to support existing recurrent budget gap (detailed in table 2, page 5)	**4.9**

6.4 Medical and Dental ACT (Additional Cost of Teaching)

It should be noted that the current budget gap assumes that there is no uplift to ACT. This is funding which is made available towards the direct teaching cost of undergraduates within the NHS.

In previous years we have passed on to Boards the uplift NES received apart from 2015/16 when we reduced the amount we paid to Boards by 1%, although we provided some transitional support to allow this to happen over a 2 year period. During 2015/16 there was an increase to the Employers pension contribution rate which resulted in a cost pressure on training grade salaries of £3m. The reduction in ACT funding was the result of a decision, at that time, to protect the basic salary budgets associated with Training Grades (including making provision for full pay pressures).

The only exception proposed is the ACT for the additional ScotGem posts, agreed as part of the Medical Education package funded from the levy on overseas Medical Students. The Levy on overseas Dental students is collected by NES but returned to Scottish Government.

6.5 UK Consequentials for Agenda for Change Pay Award

Since the Draft budget was published we have been advised that given the UK Government budget commitment to 'funding pay awards for NHS staff on the Agenda for Change contract', we should assume that central funding will be provided to meet the additional costs of the SG pay policy for Agenda for Change Grades above the first 1%. This funding position cannot be absolutely confirmed until the summer.

It should be noted this does not cover any element of incremental progression for those staff who have not yet reached the top of their pay scale.

6.6 Position after proposed measures to close the budget gap

The Table below reflects the cumulative impact of these items.

Table 9: Unidentified Funding Gap

	Recurrent	Non-Recurrent	Total
Description	**£m**	**£m**	**£m**
NES cost pressures	(12.4)		(12.4)
Plus SG estimated savings target	(2.5)		(2.5)
Total potential budget gap	**(14.9)**		**(14.9)**
Freeze Training Grade Payment rate	4.7		4.7
Revised total Gap	**(10.2)**	**0**	**(10.2)**
Directorate savings/additional income	2.5		2.5
Application of Recruitment Lag		1.7	1.7
Non Recurring TG funds		4.9	4.9
Potential funding for AfC staff	0.6		0.6
NMAHP Pay Costs	(0.1)		(0.1)
ACT income removed	(0.1)		(0.1)
Revised Unidentified Gap	**(7.3)**	**6.6**	**(0.7)**

As can be seen from the above, despite identifying recurrent savings of £2.5m, the majority of the measures to reduce the budget gap are non-recurrent in nature, and still leave an unidentified savings gap of £0.7 million.

7. Actions to close the remaining gap (£0.7m) and reduce the underlying recurrent deficit.

During the 2017/18 budget setting process we stated that we would aim to reduce the underlying recurrent deficit during 2017/18 in order to be better placed to meet the challenges ahead. This has not been achieved.

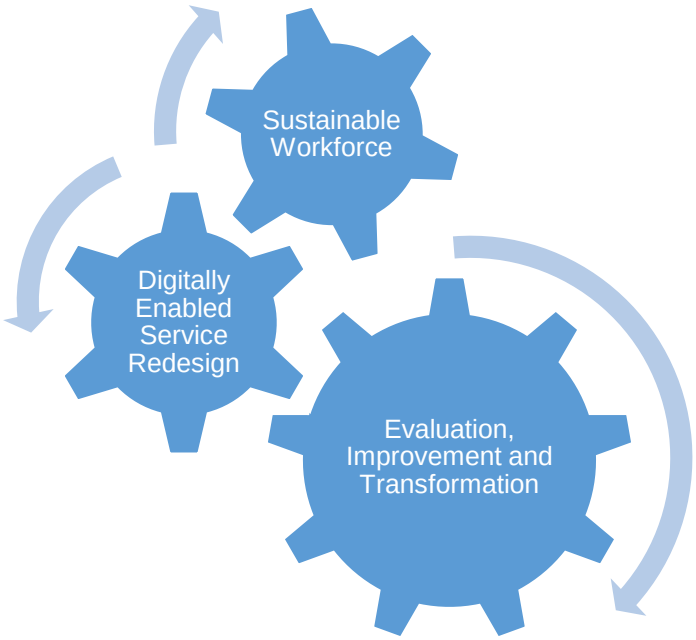
7.1 NES Improvement Programmes

As part of the 2017/18 budget setting process the Executive team agreed 4 improvement programmes which aimed to support the reduction of the underlying recurrent deficit. Although progress has been made, no cash releasing savings have been made to date. Whilst recognising that the pace of these initiatives can be increased, it is accepted that the quantum of the savings achievable from these programmes alone, is not of the scale required.

7.2 National Board Collaborative Activity

Whilst progress has been made in a number of areas, the specific areas progressed to date may not deliver significant recurrent savings to the NES budget in 2018/19. The National Boards are actively working to identify additional proposals to generate these savings.

The National Board Collaborative proposition has been refocused as shown below;



These are the key areas where the national Boards can provide support to meet technological, demographic and societal changes.

7.3 Tools to identify further savings opportunities

We will have to start the year with an unidentified savings target. The financial environment is unlikely to improve; therefore we need to identify potential areas now where we can do things differently (more efficiently), scale back or stop activity. Early identification will enable any risks to be identified and incorporated into an appropriate exit strategy, if required.

7.3.1 **Budget Analysis**

We have mapped the 2018/19 budget submissions across activity categories such as ;

Trainee costs – split by Direct costs, Supervision and Education, Strategic Management, Governance and Quality and Improvement and Admin support of Programmes.

Non-Trainee Health Workforce – split by Direct cost, Supervision and Education, Strategic Management, Training provision and Admin support of Programmes.

The purpose of this work is to raise questions. Why does ‘x’ cost more than ‘y’? After investigation it may be that the delivery method is very different. If that is the case, what can be learned from the more cost-effective method.

It has been agreed that the Senior Operational Leadership Group will work through this data and identify potential opportunities for review by the Executive team.

7.3.2 **Priorities Framework**

As discussed in section 3, each activity in the 2018/19 operational plan was mapped to an item in the priorities framework. The Senior Operational Leadership Group will use this Framework to review the detailed data in the budget analysis and screen any potential opportunities they identify, from a risk perspective.

8.0 Sustainabilty - 2019/20 and Beyond

It has been highlighted above that training grades, particularly within Medicine, impact significantly on the NES budget. There are several different elements to this;

a) Absorbing increases in pay related costs without a commensurate increase in funding. For 2018/19, we have proposed to deal with this by freezing the amount we pay for trainee salaries.

b) Managing an increased number of training posts which although considered part of the training establishment, are not recurrently funded. In recent years we have managed this through the reallocation of various elements of training grade funding, such as the use of Less Than Full Time Fractions (LTFT). For 2018/19, we plan to continue this approach as detailed in section 6.3 above.

c) For 2019/20 and beyond, we need to review the current policy that where a medical training post (with recurrent funding) is vacant, the funding is still passed to the Board. This was agreed for a ‘transition period’ whilst changes as a result of ‘Modernising Medical Careers’ bedded in. Medicine is the only professional group, of the many funded by NES, where there is any payment for vacant training posts. The Medical directorate are currently developing proposals for how this vacancy factor could be managed differently to support initiatives that would enhance recruitment and retention and the redesign of services which may need to involve the upskilling of broader staff groups. This is a complex exercise as vacancies are not spread evenly across Boards.

Proposals for how these areas could be addressed in future years will be discussed with the Board at the May 2018 planning day.

9.0 Summary

If the proposals contained within this paper are approved, we will start 2018/19 with an unidentified savings target of £0.7m although the underlying recurrent deficit will have increased from £3.2m to £7.3m.

NHS Education for Scotland

Board Paper Summary

1. Title of Paper

Remote and Rural Healthcare Educational Alliance (RRHEAL) – 10 Years On

2. Author(s) of Paper

Pam Nicoll

3. Purpose of Paper

This paper provides an overview of the progress of RRHEAL in relation to the original and current NES objectives and highlights examples of key achievements of RRHEAL over the last ten years. This work continues to support remote, rural and island practitioners to deliver safe, and effective care to people living in remote and rural communities.

4. Key Issues

The extant Scottish remote and rural healthcare strategy and action plan document *"Delivering for Remote and Rural Healthcare (2008)*[1]*"* states access, rural specific content and support for remote and rural learners as the key issues to be addressed by RRHEAL. The action plan emphasised remote and rural learners' need for increased opportunities to access learning in a range of ways using modern technology with learning relevant to the range of competences required by new roles and the context in which they must be practised. RRHEAL led on the Remote and Rural Implementation Group (RRIG) Workforce and Education Subgroup to deliver on these aims from 2008 until the programme ended in 2010.[2]

RRHEAL holds a unique position in Scotland as a coordinating force between education providers and the remote and rural healthcare workforce. RRHEAL has a specific overview of developments in each of these areas and maps priority education, training and workforce requirements. RRHEAL's methods of partnership working and functional collaboration have resulted in RRHEAL increasingly being able to provide other NHS Boards, Higher and Further Education establishments, third sector, partner agencies and the Scottish Government with remote and rural healthcare educational intelligence, resources and guidance.

5. Communications Plan

A Communications Plan highlighting RRHEAL 10th Anniversary, work and partnerships has been produced and shared with NES Communications Team.

[1] www.scotland.gov.uk/Resource/Doc/222087/0059735.pdf
[2] www.nospg.nhsscotland.com/wp-content/Final_Report_RRIG_Oct101.pdf

7. Which NES Strategic Objective(s) does this align to?

The design and delivery of remote and rural inclusive education effectively supports many of our key outcomes particularly:

1. A demonstrable impact of our work on healthcare services.
2. An excellent learning environment where there is better access to education for all healthcare staff.
3. A range of development opportunities for support workers and new and extended roles to support integration.
4. Improved and consistent use of technology with measurable benefits for user satisfaction, accessibility and impact.
5. Consistently well-developed educational support roles and networks to enable education across the workplace.
6. An effective organisation where staff are enabled to give their best and our values are evident in every day work.

8. Recommendation(s) for Decision

The Board is asked to note the content of this paper and to be assured of the role that NES has in providing educational support to multi professional remote, rural and island practitioners, NHS Boards, health and social care organisations.

NES
February 2018
Pam Nicoll

Remote and Rural Healthcare Educational Alliance (RRHEAL) – 10 Years On

1. Introduction

1.1 The purpose of this paper is to provide the NHS Education for Scotland Board with an overview of key areas of achievement of the Remote and Rural Healthcare Educational Alliance (RRHEAL) since it was established in January 2008. The paper will provide a brief description of the ongoing contribution RRHEAL makes to remote and rural practice and highlight the added value to NHS Education for Scotland in continuing to support the education and professional development of remote and rural health and social care practitioners.

2. Background

2.1 The Remote and Rural Healthcare Educational Alliance (RRHEAL) was developed by NHS Education for Scotland (NES) following extensive consultation with NHS Boards, frontline staff and partnership agencies and endorsed by the Scottish Government in 2008. RRHEAL provides practical educational assistance to remote and rural NHS Boards and is a linking force between healthcare services and education providers across Scotland.

2.3 RRHEAL has been structured to be a sustainable resource and to be of value supporting the current and future remote and rural healthcare workforce education needs. RRHEAL is focussed on the development and delivery of accessible, affordable and sustainable education solutions that meet the changing needs of the remote and rural healthcare workforce. RRHEAL has established a strong working national alliance infrastructure and has developed a range of education networks for the healthcare workforce in remote, rural and island areas throughout Scotland.

3. RRHEAL Key Objectives:

3.1 Produce educational products of high utility to both healthcare staff and education providers.

3.2 Champion the use of rural–proofing methodologies by NES, NHS, and all healthcare education partner agencies.

3.3 Champion Remote and Rural education on Scottish, UK and international platform.

3.4 Assist in development of optimised technology support for rural-learner access and improved access to education for and from rural areas.

3.5 Raise the profile of working within remote and rural healthcare posts, and as a career enhancement.

3.6 Map existing and new remote & rural education programmes - identifying educational needs gaps and providing streamlined access to remote and rural education information and knowledge for front line staff.

3.7 Develop and manage an effective Remote & Rural Education Networks.

3.8 The extant Scottish remote and rural healthcare strategy and action plan document *"Delivering for Remote and Rural Healthcare (2008)*[1] *"*states access, rural specific content and support for remote and rural learners as the key issues to be addressed by RRHEAL. The action plan emphasised remote and rural learners' need for increased opportunities to access learning in a range of ways using modern technology with learning relevant to the range of competences required by new roles and the context in which they must be practised. RRHEAL led on the Remote and Rural Implementation Group (RRIG) Workforce and Education Subgroup to deliver on these aims from 2008 until the programme ended in 2010.[2]

3.9 RRHEAL holds a unique position in Scotland as a coordinating force between education providers and the remote and rural healthcare workforce. RRHEAL has a specific overview, of developments in each of these areas and maps priority education, training and workforce requirements. RRHEAL's methods of partnership working and functional collaboration have resulted in RRHEAL increasingly being able to provide other NHS Boards, Higher and Further Education establishments, third sector, partner agencies and the Scottish Government with remote and rural healthcare educational intelligence, resources and guidance.

4. Deliverables

4.1 Remote and Rural Inclusive Education Programmes

4.1.1 RRHEAL have developed a wide range of education programmes and resources over the last ten years. These programmes and learning resources have been developed primarily to meet the needs and contexts of remote and rural practitioners but have also been found to be of value to practitioners within more urban settings. RRHEAL education programmes and resources have been developed in conjunction with a wide range of NES partners from across Directorates NHS Boards, and external health and education partners. RRHEAL also provide advice and guidance to other agencies who wish to develop remote and rural appropriate or inclusive education, training or learning packages. RRHEAL developed the NES Remote and Rural Inclusive Education Policy and Guidance[3] to assist with this process.

4.1.2 The full range of RRHEAL educational resources, programmes and guides are now available for use via the RRHEAL Turas Learn site[4]. The following examples of RRHEAL programmes of work are given by way of highlighting the variety of different resources that have been developed to date in response to priority needs across a broad range of disciplines.

Examples :

4.1.3 *Child Health/Paediatric*[5]*:* RRHEAL has rural proofed a wide range of paediatric programmes in conjunction with NES Child Health such as the *Core Level Paediatric Emergency Care Programme*. This programme has been taken up by over 2500 healthcare staff across Scotland. RRHEAL also worked with NES Child Health colleagues to develop the *Assessment of The Acutely Ill and Injured Child; Skills Maintenance Resource*.[6] This popular "at distance

[1] www.scotland.gov.uk/Resource/Doc/222087/0059735.pdf
[2] www.nospg.nhsscotland.com/wp-content/Final_Report_RRIG_Oct101.pdf
[3] http://www.nes.scot.nhs.uk/about-us/equality-and-diversity/inclusive-education-and-learning/guidance-inclusive-education-remote-rural.aspx
[4] https://learn.nes.nhs.scot/786/rrheal
[5] https://learn.nes.nhs.scot/792/rrheal/child-health
[6] https://learn.nes.nhs.scot/793/rrheal/child-health/early-recognition-and-assessment-of-the-sick-child

reusable tool" supports multiprofessional healthcare practitioners who may encounter a sick child and demonstrates the correct steps in early identification and assessment. RRHEAL have also worked extensively with the ScotsSTAR Paediatric Retrieval Service and the Children's Hospice Association Scotland (CHAS) to develop a range of specialist resources to support remote and rural practice in these key areas.

4.2.4 *Maternal Health* [7]**:** RRHEAL in collaboration with NES Maternal Health colleagues have developed a variety of resources to support remote and rural practitioners such as the Scottish *Multiprofessional Maternity/Pregnancy Induced Hypertension* resource*, the Postpartum Haemorrhage and Pregnancy Induced Hypertension* resources*.* These audio visual educational resources use simulation to depict the assessment, recognition and early intervention required of practitioners in a rural setting.

4.2.5 *Rural Community Teams*[8]*: The Wheelchair Assessment Tool* [9]supports a right first-time approach to referral and provision of wheelchairs within rural community settings.

4.2.6 *Healthy Ageing*[10]*:* RRHEAL resources within this area include rural proofing of *Managing Frailty in Remote and Rural Settings*, *Falls Preventions* "at distance" Programme and *Enhancing Well-being in Dementia in Remote and Rural Healthcare Teams*.

4.2.7 *GP Acute Care Rural Fellowship* [11]-RRHEAL worked with NES Medical colleagues to develop the GP Acute Care Competencies framework and this is now offered as an option with the NES GP Rural Fellowship programme.

4.2 Championing the Use of Rural –Proofing Methodologies

4.2.1 In addition to implementing and testing a range of different rural proofing methodologies RRHEAL have developed a range of reports and guides to assist NES, NHS, healthcare education partner agencies and the Scottish Government to be able to produce remote and rural inclusive education resources and learning events. In this way RRHEAL have been able to influence the production of a much larger range of remote and rural proofed education resources than those that are specifically produced by the RRHEAL team each year.

Examples :

4.2.2 *NHS Education for Scotland Remote and Rural Inclusive Education Policy*[12]

4.2.3 Quality assurance (QA) guide for distributed education [13]

4.2.4 *Scottish Rural Health Partnership (SRHP)*[14]**-** RRHEAL has led on the development of the "Scottish Rural Health Partnership" since 2010. The SRHP was originally established with a

[7] https://learn.nes.nhs.scot/1230/rrheal/maternal-health
[8] https://learn.nes.nhs.scot/1231/rrheal/rural-teams
[9] https://learn.nes.nhs.scot/1586/rrheal/rural-teams/nhs-highland-wheelchair-referral-process
[10] https://learn.nes.nhs.scot/887/rrheal/healthy-aging
[11] http://www.nes.scot.nhs.uk/education-and-training/by-discipline/medicine/general-practice/gp-fellowships.aspx
[12] http://www.nes.scot.nhs.uk/about-us/equality-and-diversity/inclusive-education-and-learning.aspx
[13] https://learn.nes.nhs.scot/1533/rrheal/education-networks/education-networks-resources/quality-assurance-qa-guide-for-distributed-education
[14] http://www.rrheal.scot.nhs.uk/what-we-do/scottish-rural-health-partnership.aspx

small group of expert education and research partners to increase production of training, education and research for the remote, rural and island health and social care workforce. Membership includes NES/RRHEAL University of Stirling, University of Highlands and Islands, University of Aberdeen, NHS24, NHS Highland and Highland Council. The SRHP recently achieved funding and resource support via the University of The Highlands and Islands and is currently recruiting staff and establishing a new structure.

4.3 Championing Remote and Rural Education on Scottish, UK and International Platform

4.3.1 RRHEAL have been and continue to be partners within a range of national and international remote and rural healthcare projects. RRHEAL have been able to present work at conferences nationally and internationally within UK, USA, Australia, and Europe to promote NES remote and rural education. Within Scotland RRHEAL have provided input within the Scottish Government's *Remote and Rural Implementation Group, Being Here*[15] *and most recently the Scottish Rural Medical Collaborative*[16].

4.3.2 RRHEAL have participated with a range of international remote and rural programmes and projects and have established a working network of international remote and rural healthcare colleagues with whom RRHEAL can exchange knowledge and resources**.** This has included working with colleagues from remote and rural Canada, Australia, Japan, Venezuela, Norway, Sweden and Iceland.

Examples :

4.3.3 *Western Australia Centre for Rural Health & RRHEAL, University of Western Australia Masterclass*[17]

4.3.4 *Making it work: Recruitment and Retention of Remote & Rural Healthcare Workers Northern Peripheries Project*[18] 2016-2018. This is the second part of a large scale seven-year programme of international partnership working to follow on from 2010 WHO report into recruitment and retention of rural healthcare workers[19]. RRHEAL have been providing remote and rural healthcare education input within both projects since 2010. The projects aim to identify and test the key challenges and solutions to recruitment and retention of remote and rural healthcare staff across the partnership countries. The Scottish Group are working alongside colleagues from Iceland, Norway, Canada and Sweden to implement and publish a set of strategic and practical tools and recommendations for use across all countries.

4.4 Technology Enhanced Learning (TEL)

4.4.1 RRHEAL were tasked with assisting in the development of optimised technology support for rural-learner access and improved access to education for and from rural areas. RRHEAL began to deliver on this from early on in 2009 as a key means through which remote and rural staff could be given affordable, accessible and sustainable education of high quality. RRHEAL developed the *Remote and Rural Education Platform*[20] in 2010 as a practical streamlined

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[15] http://www.nhshighland.scot.nhs.uk/News/Pages/BeingHerenewsletternowavailableonline.aspx
[16] https://news.gov.scot/news/improving-gp-recruitment-and-retention
[17] https://sctt.org.uk/recorded-webinar-rural-healthcare-using-technology-increase-access-services/
[18] http://rrmakingitwork.eu/
[19] http://whqlibdoc.who.int/publications/2010/9789241564014_eng.pdf
[20] http://www.rrheal.scot.nhs.uk/

online resource of tailored education information for remote and rural learners with analytics demonstrating a consistent level of usage and time on site by users throughout each year. More recently RRHEAL have become early adopters and testers of *NES TURAS Learn* and have now established and launched the *RRHEAL Turas Learn*[21] resource to replace the original RRHEAL platform. RRHEAL are currently working with NES Digital colleagues to develop a TURAS Learn site tailored to the needs of Rural Health & Social Care Support Worker Education in conjunction with NHS Highland.

4.4.2 RRHEAL have worked alongside health, social care and education partners to develop a range of TEL resources, guides and programmes to meet staff needs. Some of this work has involved adaptation of existing NHS Board training or education resources to ensure better use of technology to support learning and efficiency. Other programmes have focussed on supporting health and social care staff themselves to develop their digital skills and confidence in using technology well to both access ongoing educational support and deliver services.

Examples :

4.4.3 *Promoting Inclusive and Accessible Education through Technology Enabled Learning: Report on RRHEAL supported work with Care at Home/Care Home Staff in Western Isles and Highland* [22]

4.4.4 RRHEAL *Videoconferencing (VC) quick start guide* [23]

4.4.5 RRHEAL have also produced and delivered the first *TEL Programme for NHS Learning & Development Staff*[24]in Scotland. This programme enables staff within NHS Boards who have a learning, development or training role to become confident in using digital technology to deliver, create and enhance their staff training programmes. The programme was designed by RRHEAL and University of Highlands and Islands in 2016 and the third cohort of staff within NHS Highland are currently undertaking the programme. RRHEAL currently chair the *Digital Highland Islands Group* which is an alliance of education, health, local authority and third sector partners all working to promote digital inclusion across the area.

4.5 Raising the Profile of Remote and Rural Healthcare Posts.

4.5.1 RRHEAL has worked through the programmes and projects highlighted here to support enhanced and improved remote and rural recruitment. The main role for RRHEAL has been to work to ensure appropriate education programmes and opportunities are accessible to the existing and future workforce and that these are publicised to emphasise the career and educational support opportunities that are available for remote and rural practitioners.

4.6 Mapping of Educational Needs

4.6.1 RRHEAL has developed both formal and informal systems to ensure that remote and rural priority education and training needs are identified and shared with colleagues**.** In this way RRHEAL can help identify gaps in provision and work with each of the remote, rural and island Boards to identify common denominators and solutions to best meet the needs. Key NHS Board contacts, staff and partner agencies raise enquiries with RRHEAL via a range of contact

[21] https://learn.nes.nhs.scot/786/rrheal
[22] Supporting Technology Enabled Learning June 2016
[23] https://learn.nes.nhs.scot/2692/rrheal/education-networks/education-networks-resources/videoconferencing-vc-quick-start-guide
[24] RRHEAL TEL L&D Programme Evaluation Report 2017 RRHEAL TEL L&D NHSH Programme Outline

routes and from regular liaison meetings. RRHEAL manages all enquiries and programmes in accordance with an established administration programme in order that each item can be tracked and monitored until completion. An example of information gathered from this enquiry and programme process is given in Appendix 3.

4.7 RRHEAL Education Networks

4.7.1 RRHEAL have developed a range of high quality "at distance" education networks [25]. Each of these networks offers a technology enabled learning package to accompany live real-time video conferenced monthly education sessions. The sessions provide graded educational content that is either profession specific or multi professional. Sessions attract thirty to forty participants on average across eight to ten different geographical remote and rural locations.

Examples :

4.7.2 *RRHEAL Rural General Hospital VC Education Network*[26]

4.7.3 *RRHEAL VC Education Network* [27]

4.7.4 *RRHEAL High Dependency /Critical Care for rural Practitioners Network.*[28]

4.7.5 *RRHEAL Rural GP Education Network Pilot*[29]

5. Summary

5.1 This paper provides an overview of the progress of RRHEAL in relation to the original and current NES objectives and highlights examples of key achievements of RRHEAL over the last ten years. RRHEAL work continues to support remote, rural and island practitioners to deliver safe and effective care to people living in remote and rural communities.

5.2 The Board is asked to note the content of this paper and to be assured of the role that NES has in providing educational support to remote, rural and island practitioners, NHS Boards, health and social care organisations.

The Remote and Rural Healthcare Education Alliance

RHEAL 10 Year Anniversary - Inclusive Education for Remote and Rural Teams
#RRHEAL10
RRHEAL Turas Learn https://learn.nes.nhs.scot/786/rrheal

[25] https://learn.nes.nhs.scot/902/rrheal/education-networks
[26] https://learn.nes.nhs.scot/899/rrheal/education-networks/rgh-education-network
[27] https://learn.nes.nhs.scot/1312/rrheal/education-networks/rrheal-education-network
[28] https://learn.nes.nhs.scot/1935/rrheal/education-networks/rrheal-high-dependency-critical-care-education-network
[29] RRHEAL Rural GP VC Education Network: Evaluation of initial education series

Appendix 1

RRHEAL TURAS Learn - Child Health Resources

https://learn.nes.nhs.scot/792/rrheal/child-health

Bronchiolitis and croup : part 1 bronchiolitis

Dr Shane Campbell of ScotSTAR presents a guide to winter seasonal illness in a young child, with helpful tips regarding clinical recognition and initial management and seeking early expert help when required. This work consists of 2...

Bronchiolitis and croup : part 2 croup

Dr Shane Campbell of ScotSTAR presents a guide to winter seasonal illness in a young child, with helpful tips regarding clinical recognition and initial management and seeking early expert help when required.This work consists of 2...

CHAS Palliative and end of life care for babies, children and young people in your community Download (3 MB)

Choices surrounding the place of care for this age group are broadening such that primary care teams are increasingly likely to be engaged in supporting home as a realistic option. This session will introduce the structures, services and...

CHAS Palliative and end of life care for babies, children and young people in your community. Film 1 Part 1

Choices surrounding the place of care for this age group are broadening such that primary care teams are increasingly likely to be engaged in supporting home as a realistic option. This session will introduce the structures, services and resource...

CHAS Palliative and end of life care for babies, children and young people in your community. Film 1 Part 2

Choices surrounding the place of care for this age group are broadening such that primary care teams are increasingly likely to be engaged in supporting home as a realistic option. This session will introduce the structures, services and resource...

CHAS Children's palliative care : supporting bereaved families within your local community Download (11 MB)

The death of a baby, child or young person leads to a devastating impact on the entire family and surrounding community. Professionals often feel at a loss as to how to offer support. This session will enable understanding of the nature of grief...

CHAS Children's palliative care : supporting bereaved families within your local community. Film 2 Part 1

The death of a baby, child or young person leads to a devastating impact on the entire family and surrounding community. Professionals often feel at a loss as to how to offer support. This session will enable understanding of the nature of grief...

CHAS Children's palliative care : supporting bereaved families within your local community. Film 2 Part 2

The death of a baby, child or young person leads to a devastating impact on the entire family and surrounding community. Professionals often feel at a loss as to how to offer support. This session will enable understanding of the nature of grief...

CHAS Symptom control at home for babies, children and young people at end of life (Part 1)

Symptom control at home for babies, children and young people at end of life (Part 1)

CHAS Symptom control at home for babies, children and young people at end of life (Part 2)

Symptom control at home for babies, children and young people at end of life (Part 2)

CHAS Taking a baby, child or young person home for end of life care (Part 1)

Taking a baby, child or young person home for end of life care (Part 1)

CHAS Taking a baby, child or young person home for end of life care (Part 2)

Taking a baby, child or young person home for end of life care (Part 2)

Early recognition and assessment of the sick child

This resource uses a scenario in simulation to display recognition and assessment of a sick child in a rural setting, illustrating standardised approaches and best practice when engaging with a sick child and their family/carers. This resource...

Managing the multiple trauma patient : paediatric trauma with Dr Marie Spiers Download (2 MB)

Introduction to Paediatric Trauma

Paediatric unscheduled (Tele) care project : summary update Download (2 MB)

Paediatric Unscheduled (Tele) Care Project; Summary Update

Stabilisation and management of the critically ill child prior to transfer

It can often take the retrieval team some hours to reach the referring hospital and this can be an extremely stressful time for the referring hospital staff that are looking after the child. This recorded presentation will provide useful advice...

Strengths based approaches : resources Download (2 MB)

This resource will help participants explore how: • Behaviour problems develop in preschool children • Using strength based communication skills can help to open up the doors to conversations with parents about what they can do to improve the...

Healthy Healthy Aging: Resources

Managing frailty in remote and rural settings Download (56 KB)

RRHEAL Rural GP VC Education Network 29 March 2016: Square Pegs in Round Holes:- Managing frailty in remote and rural settings - ideas for the challenges ahead Resource 1

Enhancing well-being in Dementia in remote and rural Healthcare Teams Download (4 MB)

Discusses different ways of understanding dementia, models of care, focusing on enhancing well being and managing risks.

Rural GP Rescources

RRHEAL Rural GP VC Education Network 29 March 2016: Presentation by Dr Martin Wilson, NHS Highland Download (75 KB)

RRHEAL Rural GP VC Education Network 29 March 2016: Square Pegs in Round Holes:- Managing frailty in remote and rural settings - ideas for the challenges ahead Resource 3

RRHEAL Rural GP VC Education Network 29 March 2016: Presentation by Dr Kate Dawson on Frailty in the Hebrides Download (417 KB)

RRHEAL Rural GP VC Education Network 29 March 2016: Square Pegs in Round Holes:- Managing frailty in remote and rural settings - ideas for the challenges ahead Resource 4

RRHEAL Rural GP VC Education Network 29 March 2016: Presentation by Ms Deena Dean on Frailty Case Study Download (82 KB)

RRHEAL Rural GP VC Education Network 29 March 2016: Square Pegs in Round Holes:- Managing frailty in remote and rural settings - ideas for the challenges ahead Resource 5

RRHEAL Rural GP VC Education Network 24 November 2015: Major Trauma - A remote, rural and islands response Resource 2 Download (996 KB)

RRHEAL Rural GP VC Education Network 24 November 2015: Major Trauma - A remote, rural and islands response Resource 2

RRHEAL Rural GP VC Education Network 26 January 2016: Mental Health skills based training in suicide prevention Link

RRHEAL Rural GP VC Education Network 26 January 2016: Mental Health skills based training in suicide prevention

RRHEAL Rural GP VC Education Network 29 September 2015: Rural Proofed ACS Pathways Download (9 MB)

RRHEAL Rural GP VC Education Network 29 September 2015: Rural Proofed ACS Pathways

RRHEAL Rural GP VC Education Network 24 November 2015: Major Trauma - A remote, rural and islands response Resource 1 Download (8 MB)

RRHEAL Rural GP VC Education Network 24 November 2015: Major Trauma - A remote, rural and islands response Resource 1

Appendix 2

VC Network links

- https://learn.nes.nhs.scot/1312/rrheal/education-networks/rrheal-education-network
- https://learn.nes.nhs.scot/899/rrheal/education-networks/rgh-education-network
- https://learn.nes.nhs.scot/1935/rrheal/education-networks/rrheal-high-dependency-critical-care-education-network

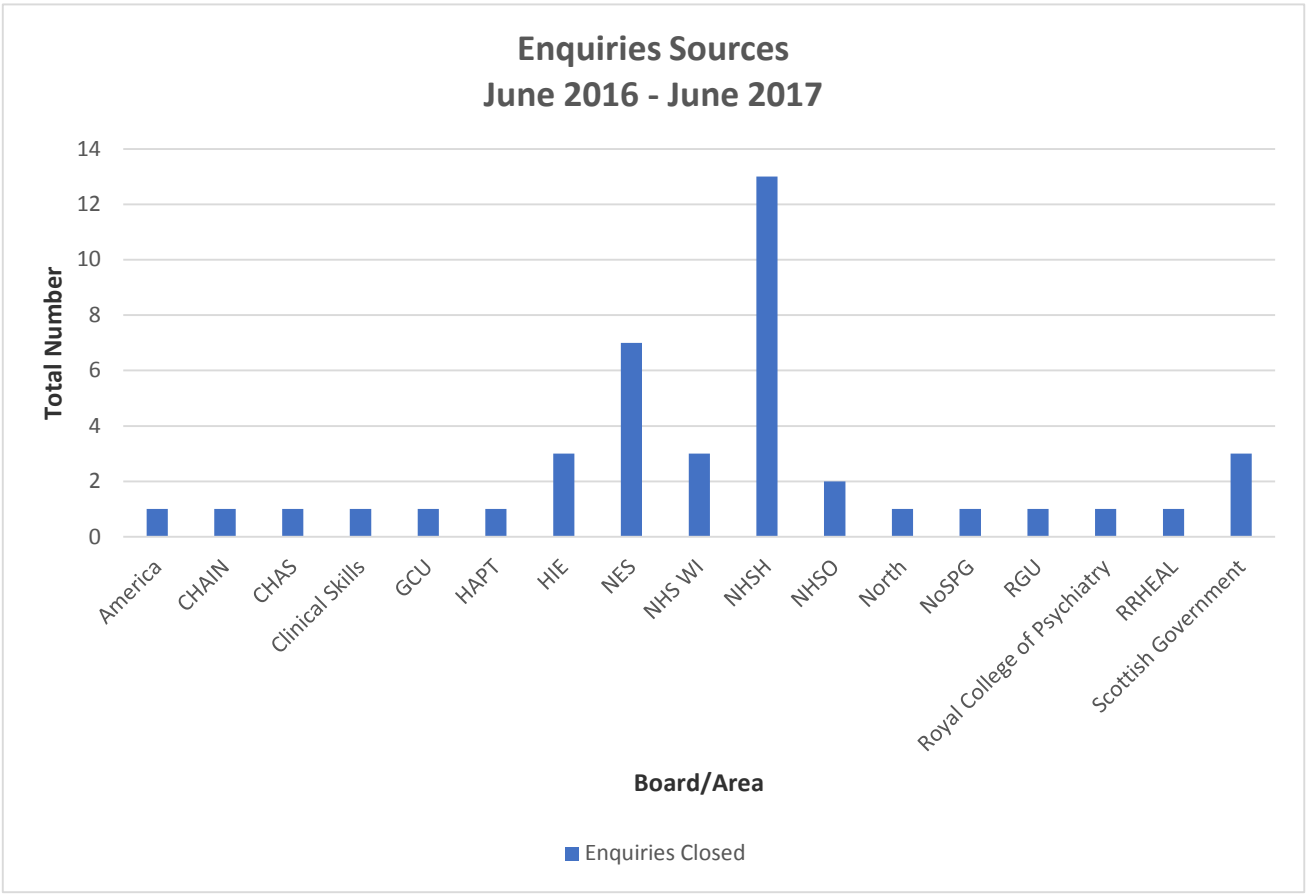
Rural GP Network link

- https://learn.nes.nhs.scot/1589/rrheal/rural-teams/rural-gp-vc-education-network

Rural ANP

- https://learn.nes.nhs.scot/1543/rrheal/rural-teams/rural-teams-reports-and-conference-contributions/remote-and-rural-advanced-nurse-practitioner

Appendix 3 RRHEAL Enquiries sample by Source



NHS Education for Scotland

Board Paper Summary

1. Title of Paper

Medical Revalidation update

2. Author(s) of Paper

Professor Stewart Irvine, Director of Medicine
Professor Bill Reid, Postgraduate Dean, South East Region

3. Purpose of Paper

a) To provide Board members with a further update on the implementation of Medical Revalidation across Scotland, with particular reference to the arrangements for the revalidation of Doctors in Training.

b) To respond to the HIS revalidation recommendation to report our revalidation activity to the NES board[1].

c) To alert the board to developments since last year, with reference to the recent review of revalidation by Sir Keith Pearson[2], and to developments in NES's role in revalidation oversight in Scotland.

4. Key Issues

a) Medical Revalidation was introduced in December 2012. This process was a watershed for the profession and patients. Revalidation has filled a key gap in the regulatory framework by requiring regular reviews and providing stronger regulatory oversight of doctors' fitness to practise.

b) Revalidation is the General Medical Council's way of regulating licensed doctors and aimed to provide extra confidence to patients that their doctors are up to date and fit to practise. Licensed doctors have to revalidate, usually every five years, by having regular appraisals that are based on the GMC core guidance for doctors, Good Medical Practice[3]. These regular checks on doctors aimed to be a world leading system that would help improve the quality of care received by patients.

c) The key role in revalidation is that of the 'responsible officer' (RO), who makes recommendations to the GMC regarding the revalidation and re-licensure of doctors. For NES, the **medical director** is the RO, and is responsible for making recommendations on all 5,700 doctors in training across Scotland – over 30% of the Scottish medical workforce.

d) Sir Keith Pearson, independent chair of the former GMC Revalidation Advisory Board, carried out a review of the operation and impact of revalidation throughout 2016, which was published in January 2017. Since then, the GMC has been working closely with

representatives from the range of organisations and groups involved in revalidation, to discuss the recommendations and develop a plan of action to implement them.

e) More recently, the realignment of HIS and its activities has meant that they are disengaging from the production of the Scottish annual overview report on revalidation. Following discussion at the most recent Revalidation Delivery Board for Scotland (RDBS, 18/12/17), it has been agreed that NES will take over this responsibility for 2017/18. Full details of the regulatory role of HIS and how that will align with our data collecting role are still being worked out, but we will have a more central role in the administration and monitoring of revalidation in Scotland in 2018.

5. Educational Implications

a) Doctors have a connection to one organisation that will provide them with a regular appraisal and help them with revalidation. This organisation is called their **designated body**.

b) Doctors need to have a regular **appraisal** based on GMC core guidance for the medical profession, Good Medical Practice. The GMC appraisal framework tells doctors, plus their appraisers and **responsible officers**, the professional values they need to show they are meeting in their everyday practice.

c) **Doctors in training** are assessed through the Annual Review of Competence Progression (ARCP) process they go through instead.

d) Doctors need to maintain a **portfolio of supporting information** drawn from their practice which demonstrates how they are continuing to meet the principles and values set out in Good Medical Practice. Doctors need to collect some of this information themselves while the rest will need to come from the organisation that is supporting them with revalidation.

e) The GMC has developed supporting information guidance tells doctors the six types of information they need to collect, including Continuing Professional Development (CPD) and feedback from patients. GMC have also agreed supplementary guidance with the four UK health departments that will help doctors understand how they can meet our requirements in the first revalidation cycle.

f) A person called a '**responsible officer'** makes a **recommendation** to the GMC, usually every five years, that the doctor is up to date and fit to practise and should be revalidated. The responsible officer is usually the medical director of the doctor's designated body. They make their recommendation based on the doctor's appraisals over the last five years and other information drawn from their organisation's clinical governance systems.

g) The GMC will receive a recommendation about a doctor from their responsible officer and will carry out a series of checks to ensure there are no other concerns about that doctor. If there are no such concerns, the GMC will revalidate the doctor. This will mean that the doctor can continue to hold their licence to practise.

6. Financial Implications

a) We were well positioned to implement and manage this important statutory process. Scottish Government, through the oversight of their Revalidation Delivery Board, have continued to fund and assist in NES's involvement both in training appraisers to a consistent standard, and also supporting the important contributions to making the process work using digital systems.

b) The medical director of NES acts as the RO for a very large number of doctors, the volume of work involved is significant, and although it has been successfully managed through the deanery structures, does require significant senior input and administrative support.

7. Which NES Strategic Objective(s) does this align to?

Medical revalidation is a statutory obligation, but one which effectively supports many of our key objectives particularly :

1 We will deliver consistent evidence based excellence in education for improved care
3 We will continue to build coordinated joint working and engagement with our partners
5 We will develop our support for workforce redesign
7 We will support education in partnership that maximises shared knowledge and understanding
8 We will develop flexible, connected and responsive educational infrastructure which covers people, technology and educational content
10 We will improve the sharing of knowledge across our organisation.

8. Impact on the Quality Ambitions

a) "The revalidation model will give greater public confidence and assurance of the competence of doctors and significant benefits in terms of quality of care and patient experience. Throughout the UK over 4000 doctors have taken part in the testing and piloting to develop a model that delivers for patients, doctors and the organisations where care is delivered."[4]

b) Appraisal is the "cornerstone" of medical Revalidation. Performed annually, it is predominantly a reflective interview between a doctor and a trained appraiser informed by available information about the whole range of that doctor's practice. It is inevitable however that appraisal will in the future involve an element of summative assessment. This is because the appraiser comes to a judgment as to whether the information presented by the doctor is sufficient for revalidation purposes. Further, Appraisal provides the essential information that is used by the Responsible Officer to recommend to the GMC that a doctor should have his/her license to practise maintained.

c) Annual appraisal is also an important component of NHS Scotland's efforts to deliver against the Healthcare Quality Strategy and to ensure continuous quality improvement. Most doctors already practise to a high standard and it was expected that they would find appraisal a helpful process for both their personal and professional development.

9. Key Risks and Proposals to Mitigate the Risks

a) Revalidation and re-licensure are high stakes decisions for the professional affected, as well as for the patients for whom they care, and the systems within which they practice.

b) Because of the large numbers of doctors for which NES is the 'designated body' and the NES medical director the 'responsible officer' under the relevant statute[5], this is a very significant responsibility.

c) The current position set out in the attached paper has been developed in partnership, through the Revalidation Delivery Board in Scotland (RDBS) and at a UK level, and builds on the already well established processes for monitoring the progress of doctors in training.

10. Equality and Diversity Impact Assessment

a) Given that revalidation is a statutory responsibility, the focus of the EQIA is not on revalidation per-se, but rather on NES's role in delivering revalidation for Scotland. In this regard, it should be noted that our approach to revalidation in Scotland builds on existing systems and processes.

b) Our concern is to ensure that we have given due regard to what needs to be done to carry out our statutory remit in a way that works to eliminate discrimination and harassment, advance equality of opportunity and to foster good relations. Due regard in this case means to actively consider any equality implications in decisions and to take relevant and proportionate action to advance those three elements of the Equality Duty. In addition, we are working to identify any equality and diversity related risks arising from this work stream and note any relevant approaches to managing these risks.

c) NES's responsibilities as the designated body for revalidation for doctors in training. The issue here will be about fair application of the existing and established ARCP system. As the (UK-wide) approach to trainee revalidation builds on existing systems, we are considering whether there is any evidence of discrimination or bias in the existing ARCP. We will also be seeking to review the adequacy of training of ARCP panellists in equality and diversity issues, and the issue of reasonable adjustments which may be required in the process. This work is now being undertaken as part of our wider work on differential attainment.

11. Recommendation(s) for Decision

The Board is asked to note the current state of play of Medical Revalidation.

NES
January 2018
DSI / WR

[1] HIS Medical Revalidation Overview 2016-17 (Link)
[2] GMC Taking Revalidation Forward (Link)
[3] GMC Good Medical Practice (Link)
[4] Statement by the 4 UK CMOs, October 2012.
[5] The Medical Profession (Responsible Officers) Regulations 2010 (Link)

Medical Revalidation – into the next 5 year cycle

1. Background

1.1 Revalidation is the process by which all doctors with a licence to practice are required to demonstrate on a regular basis that they are fit to practice and keeping up to date in the field in which they are engaged. The process is underpinned by an annual review of the individual doctor carried out in an annual appraisal, during which all aspects of the doctors' practice is discussed, their development plan is reviewed, and the evidence to show that they are remaining up to date in their scope of practice is presented and reviewed. A licence to practice, separate from the registration of a doctor on the GMC GP or specialist register is therefore becoming an indicator that the doctor concerned continues to meet the professional standards set by the GMC[1], and any standards set by Royal Colleges and Faculties in respect of specialist practice.

1.2 After a very long gestation (of around 15 years), revalidation went live in the UK in December 2012, after the The Medical Profession (Responsible Officers) Regulations 2010 came into force in January 2011[2]. Revalidation implementation was coordinated by a UK wide steering group but delivered in each of the four nations in a different way, allowing for some flexibility around local issues.

1.3 NES has contributed significantly to the Revalidation Delivery Board in Scotland from its inception in 2010, both in development of policy and implementation for trainee doctors, but also in the revalidation of the trained doctor workforce in Scotland, through both the delivery of appraisal training[3] and through the Scottish Online Appraisal and Revalidation[4] (SOAR) IT package, which has developed into the single, "one stop" portal for appraisal and revalidation in Scotland.

1.4 Sir Keith Pearson, independent chair of the former GMC Revalidation Advisory Board, carried out a review of the operation and impact of revalidation throughout 2016, which was published in January 2017. Since then, GMC have been working closely with representatives from the range of organisations and groups involved in revalidation, to discuss the recommendations and develop a plan of action to implement them.

1.5 More recently, the realignment of HIS and its activities has meant that they are disengaging from the production of the Scottish annual overview report on revalidation[5]. Following discussion at the most recent Revalidation Delivery Board for Scotland (RDBS, 18/12/17), it has been agreed that NES will take over this responsibility for 2017/18. Full details of the regulatory role of HIS and how that will align with our data collecting role are still being worked out, but we will have a more central role in the administration and monitoring of revalidation in Scotland in 2018.

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[1] Good Medical Practice 2013
[2] http://www.legislation.gov.uk/ukdsi/2010/9780111500286/pdfs/ukdsi_9780111500286_en.pdf
[3] Medical Appraisal Scotland - Annual Report (2016/2017)
[4] http://www.appraisal.nes.scot.nhs.uk
[5] Medical revalidation in Scotland: 2016–2017

2. Current Position

2.1 All doctors on the medical register will have revalidated once by end January 2018, and in Scotland we are on track to meet this target. For consultants and GPs, the scope of practice is covered in the online forms which capture a portfolio of supporting information, along with a declaration of health, probity and complaints/significant events, and various forms of feedback on performance. This constitutes the evidence that, along with a development plan and satisfactory appraisal, leads to sufficient evidence for revalidation to take place. The key elements of revalidation therefore are – consideration of wide sources of information on the practice of the individual practitioner, assisted reflection on all aspects of the scope of practice with that evidence at hand, and a positive recommendation by the responsible officer to the regulator to continue the licence.

2.2 Most licensed doctors have a connection with one organisation that will provide them with a regular appraisal and help them with revalidation. This organisation is called their '**designated body'**. Only UK organisations can be designated bodies, because the legal rules that determine this only cover the UK. A connection with this organisation ensures a doctor is always supported with appraisal and working in an environment that monitors and improves the quality of its services, regardless of how or where they practise in the UK.

2.2 In the case of doctors in training, it was felt by the GMC that they already practiced in a highly supervised and regulated environment, where they would be subject to scrutiny through the annual review process of competence and progression (**ARCP**). The evidence that trainees normally collect to demonstrate progress through training, along with the same Health, Probity and Complaints/significant events declaration provided by all doctors, provides the evidence to support their revalidation. A recommendation for revalidation is made at the time of completion of training (CCT) and/or five years after full registration. Deferral of revalidation for trainees is not uncommon, and is generally for different reasons from trained doctors, and predominantly to accommodate statutory maternity leave, or adjustment of date of CCT for curricular reasons.

2.3 NES is set out in statute as the 'designated body' for all doctors in training in Scotland and is therefore responsible for making the recommendation for revalidation in all cases for doctors in training, along with the handful of trained doctors we employ on a more than half time basis. In Scotland, the medical director is the statutory **responsible officer**, whose responsibilities are:

(a) to ensure that the designated body carries out regular appraisals on medical practitioners

(b) to establish and implement procedures to investigate concerns about a medical practitioner's fitness to practise raised by patients or staff of the designated body or arising from any other source;

(c) where appropriate, to refer concerns about the medical practitioner to the General Medical Council;

(d) where a medical practitioner is subject to conditions imposed by, or undertakings agreed with, the General Medical Council, to monitor compliance with those conditions or undertakings;

(e) to make recommendations to the General Medical Council about medical practitioners' fitness to practise;

(f) to maintain records of practitioners' fitness to practise evaluations, including appraisals and any other investigations or assessments.

2.4 Although this role sits personally with the medical director, much of the work is undertaken on his behalf by senior colleagues acting with delegated authority.

2.5 The Board is responsible (P5) for nominating or appointing the responsible officer, with the provision (P7) that the individual concerned must be a medical practitioner fully registered under the Act. The Board is also responsible (P14) for the provision of 'sufficient funds and other resources necessary to enable the officer to discharge their responsibilities'.

3. Digital Support

3.1 The adoption of SOAR as the single Scottish method of collecting evidence to feed into either trained doctor appraisal or to facilitate trainee revalidation has been a wise move. It has allowed us to provide real-time, RAG rated dashboards to allow oversight for ROs of the doctors for whom they are responsible, and also has allowed statistical analysis to be undertaken on the process, in contrast to the heavy administrative burden carried in England, with paper based forms and extensive email communications. It also has the advantage that the trainees can use the same system as they would if they remain in Scotland as a consultant or GP. It is envisaged that HEE are reviewing their trainee processes to align more closely with our approach, as it is seen to be more efficient and less onerous both for hospitals and trainees, whilst providing the same level of reliable assurance as the English system.

3.2 A policy of regular development of the package has been prevalent during implementation, and adaptations have been made to allow the GMC recognition of trainers to be recorded on the system, as well as developments to improve management of trainee revalidation.

3.3 As our digital strategy continues to be rolled out, alignment with E-portfolio and Turas is plannned. One of the rate limiting steps has been the speed at which the GMC's IT packages can respond to our data, and if the developments here continue, this will simplify data transfer with the regulator. Recent meetings with the head of IM&T in the GMC suggest alignment will continue in this way. The reliability of our current systems has meant that we have much more confidence in our data than before. The new version of SOAR delivers the facility for all doctors in Scotland to have seamless digital support to help them with all aspects of their development, including accessing material to help with CPD.

4. New developments

4.1 Sir Keith Pearson, independent chair of the former GMC Revalidation Advisory Board, carried out a review of the operation and impact of revalidation throughout 2016, which was published in January 2017[6]. Since then, GMC have been working closely with representatives from the range of organisations and groups involved in revalidation, to discuss the recommendations and develop a plan of action to implement them.

4.2 GMC have recently established the **Revalidation Oversight Group** to oversee the progress and delivery of their Taking Revalidation Forward action plan[7]. This group is chaired by the GMC Chief Executive, Charlie Massey, and includes representatives of all four UK health departments, the BMA, training bodies, primary care and employer representatives, as well as patient representatives. Sir Keith Pearson is a member of the group, acting as a specialist adviser. NES is represented by the Medical Director.

4.3 This group replaces the Revalidation Advisory Board, which was in place from 2013 – March 2017. The board provided advice to GMC about how effectively revalidation was operating and was chaired by Sir Keith Pearson.

5. Annual Reporting to HIS

5.1 An annual report on revalidation in Scotland has been collated by Healthcare Improvement Scotland, following a self-assessment questionnaire sent to each board in Scotland.[8] Despite the huge numbers of doctors in training dealt with by NES each year, the focus of our HIS return has tended to be on the few trained doctors for whom we act as a designated body, rather than on the 5,000+ doctors for whom we also act.

5.2 As can be seen, the trainees who have a connection to NES as a designated body constitute the largest single group of connected doctors in Scotland. This data was extracted from the GMC's register of medical practitioners & is not publicly available.

DESIGNATED BODY & numbers of connected doctors in Scotland in 2016			
	Frequency	Percent	Valid Percent
NHS Education for Scotland (NES)	5175	27.8	27.8
NHS Greater Glasgow and Clyde	3425	18.4	18.4
NHS Lothian	2595	13.9	13.9
NHS Grampian	1315	7.1	7.1
NHS Lanarkshire	1116	6.0	6.0
NHS Tayside	1089	5.8	5.8
NHS Highland	790	4.2	4.2
NHS Ayrshire and Arran	770	4.1	4.1
NHS Fife	700	3.8	3.8
NHS Forth Valley	622	3.3	3.3
NHS Dumfries and Galloway	376	2.0	2.0
NHS Borders	281	1.5	1.5

[6] https://www.gmc-uk.org/doctors/revalidation/9610.asp
[7] https://www.gmc-uk.org/RT Taking revalidation forward action plan DC10267.pdf 71185817.pdf
[8] Medical revalidation in Scotland: 2016–2017

NHS National Waiting Times Centre Board	124	0.7	0.7
NHS Western Isles	57	0.3	0.3
NHS Shetland	51	0.3	0.3
NHS Orkney	46	0.2	0.2
NHS National Services Scotland	40	0.2	0.2
Scottish Government	34	0.2	0.2
Medical and Dental Defence Union of Scotland	13	0.1	0.1
NHS Healthcare Improvement Scotland (HIS)	7	0.0	0.0
NHS Health Scotland	2	0.0	0.0
NHS 24	1	0.0	0.0
Glasgow Memory Clinic Ltd	1	0.0	0.0
Total	**18630**	**100.0**	**100.0**

5.3 The HIS overview report for 2016-17 is attached as an annex. The key messages are :

- Annual appraisal rates in Scotland have risen from 80% in 2011–2012 to 94% in 2016–2017.
- Appraisal rates have improved in most staff groups during 2016–2017.
- Healthcare organisations in Scotland reported that 10,992 medical doctors received a positive recommendation to revalidate between December 2012 and 31 March 2017.
- Processes for medical revalidation are established and the data reported indicates that Scotland is on track to complete the first 5-year cycle of medical revalidation by 31 March 2018.

5.4 In addition, this year, the report acknowledged the substantial amount of work undertaken by NES in appraising and revalidating doctors in training :

	2013–2014	**2014–2015**	**2015–2016**	**2016–2017**
Doctors in training	5,476	5,920	5,673	5,723
Doctors identified for revalidation	494	552	643	570
Number of doctors in training who have been revalidated	494	511	643	570

An additional cohort of 480 trainees completing 5-years in the training programme also revalidated in years 2015–2016 and 2016–2017.

5.5 More recently, the realignment of HIS and its activities has meant that they are disengaging from the production of the Scottish annual overview report on revalidation. Following discussion at the most recent Revalidation Delivery Board for Scotland (RDBS, 18/12/17), it has been agreed that NES will take over this responsibility for 2017/18. Full details of the regulatory role of HIS and how that will align with our data collecting role are still being worked out, but we will have a more central role in the administration and monitoring of revalidation in Scotland in 2018.

6. Summary

6.1 Medical revalidation has worked well in Scotland. Medical trainee revalidation in Scotland has worked especially well, with high levels of confidence both within MDET and from the regulator, that the IM&T systems we have used have been significant elements in its acceptance from all parties. Our levels of deferrals (in all doctors) are lower than other parts of the UK (13% vs 18% in England). These deferral rates are in themselves artificially high because of the way the GMC set CCT dates in their systems, and the relative inflexibility of their data handling.

6.2 With the advent of Turas, and the promise of a comprehensive API (Application Programming Interface) system, we are confident that this will become a more real time system & that these artificially high rates of deferral will fall.

Year	Number of trainees revalidated	Deferrals
2013 (from May)	461	170
2014	547	444
2015	665	482
2016	940	780

6.3 The system introduced in 2012 has widespread acceptance across Scotland. Continuous development of processes and reviews through the Scottish Government RO group, with input into the GMC's UK RO reference group, means that in general we are 'ahead of the curve', and well positioned to influence further developments.

WR / DSI
NES
February 2018

Healthcare Improvement Scotland

Medical Revalidation in Scotland 2016–2017

NHS SCOTLAND

Healthcare Improvement Scotland is committed to equality. We have assessed the performance assessment function for likely impact on equality protected characteristics as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality Act 2010). Our work on medical revalidation has been assessed as having a neutral impact. You can request a copy of the equality impact assessment report from the Healthcare Improvement Scotland Equality and Diversity Officer on 0141 225 6999 or email contactpublicinvolvement.his@nhs.net

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www.healthcareimprovementscotland.org

Contents

Key Messages

Annual appraisal rates in Scotland have risen from 80% in 2011–2012 to 94% in 2016–2017.

Appraisal rates have improved in most staff groups during 2016–2017.

Healthcare organisations in Scotland reported that 10,992 medical doctors received a positive recommendation to revalidate between December 2012 and 31 March 2017.

Processes for medical revalidation are established and the data reported indicates that Scotland is on track to complete the first 5-year cycle of medical revalidation by 31 March 2018.

Key Facts 2016–2017

11,286 (94%) doctors completed appraisal

12,978 doctors with a prescribed connection

12,008 doctors eligible for appraisal

970 doctors were not eligible for appraisal

511 doctors identified for revalidation

85% 432 doctors received a positive recommendation*

16% 81 doctors were deferred*

*Please note that the number of positive recommendations and the number of deferral requests may not add up to the total number of doctors identified for revalidation as it is possible for a doctor to have a deferral (or deferrals) and a positive recommendation within the same appraisal year.

Introduction

Medical revalidation was introduced as a legal requirement in the UK in 2012[1]. Revalidation is the process by which medical doctors are legally required to demonstrate that they are maintaining their skills, are up to date and fit to practise in order to maintain their licence and continue working in the UK. All licensed doctors are required to be revalidated every 5 years to continue practising. This process includes an annual appraisal based on the General Medical Council's (GMC's) core guidance for doctors, Good Medical Practice[2].

Doctors who do not engage with appraisal and revalidation may have their licence to practise revoked. Revalidation is not designed to be a 'pass' or 'fail' process, but one that will assure doctors' fitness to practise and assist them to identify areas for improvement. Doctors whose practice is not up to standard should be identified by the annual appraisal process. They will be offered remediation and support.

The GMC provides the oversight to medical revalidation across the UK and includes advice and support to stakeholders. In Scotland, the collaborative approach between key partners and stakeholders, including the GMC, NHS Education for Scotland (NES) and Scottish Government has contributed to the ongoing development and improvement of medical revalidation.

1 General Medical Council. General Medical Council (Licence to practice and revalidation) Regulations. 2012 [cited 2017 Nov 13]; Available from: www.gmc-uk.org/LtP_and_Reval_Regs_2012.pdf_50435434.pdf

2 General Medical Council. Good Medical Practice. 2013 [cited 2017 Nov 13] Available from: www.gmc-uk.org/guidance/good_medical_practice.asp

The role of Healthcare Improvement Scotland has included a published annual review of Scotland's medical revalidation and appraisal arrangements. The scope of our work includes any organisation registered in Scotland who employs medical doctors, such as NHS boards, registered independent hospitals and hospices, and other organisations such as the Mental Welfare Commission for Scotland. The aim of our reviews, within the 5-year cycle (December 2012 to March 2018), is to find out how well organisations are progressing with revalidation.

This report provides an overview of the medical revalidation and appraisal arrangements in Scotland 2016–2017.

Review Methodology

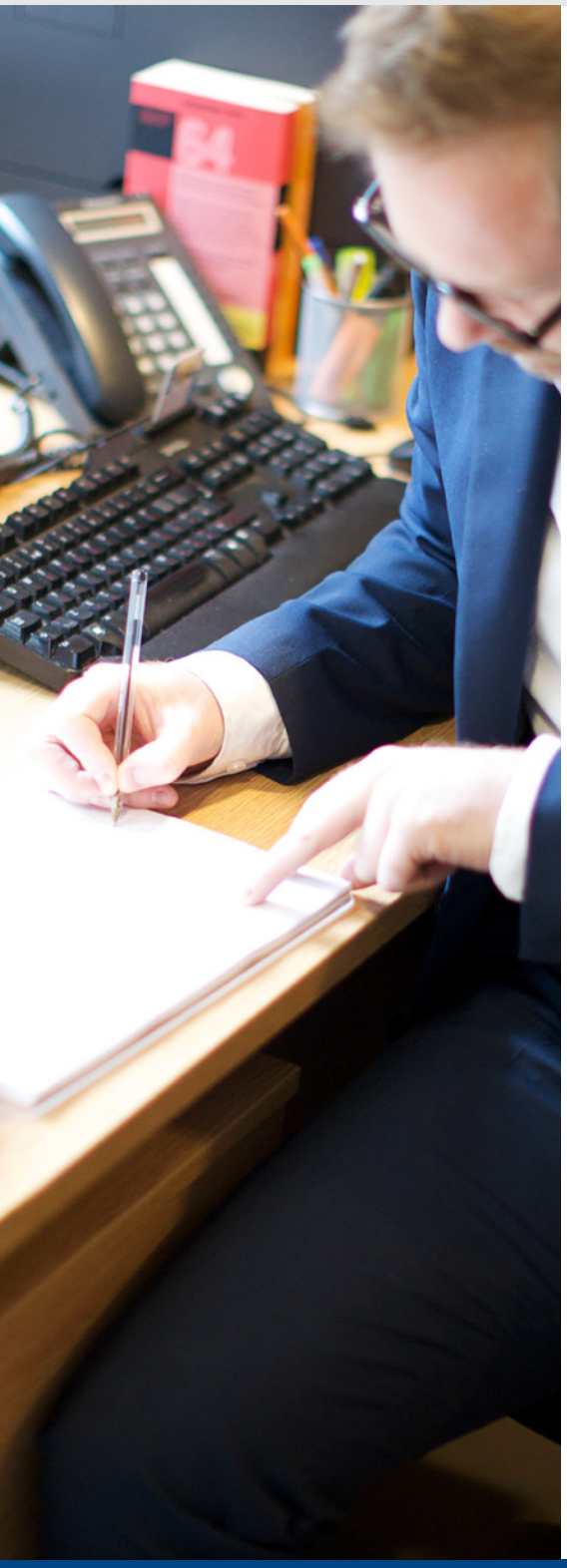
Any organisation registered in Scotland who employs medical doctors is required to be part of our annual self-assessment review. In March 2017, this amounted to 47 organisations (see Appendix 2).

We issued self-assessments to all 47 organisations in June 2017.

The self-assessment is made up of two sections: a governance section and a data section. In previous years, organisations were required to complete both sections. However, our past reviews highlighted that the organisations' governance arrangements have not, in general, changed over the years. Therefore, we asked those organisations that had previously been involved in our review to complete the data section and only to report any significant changes in governance arrangements. Three organisations were involved in the review process for the first time this year and they were asked to complete both governance and data sections.

The completed self-assessments were signed off by the organisations' Responsible Officers and Chief Executives and returned to us for analysing. Where discrepancies were found in the data, we queried these with the relevant organisations.

We convened an advisory group in October 2017 to review all of the collated self-assessment documentation. This review included consideration of annual appraisal rates, deferral rates, support and development arrangements, areas of good practice and challenges identified from the data. The data for this year's review are included in Appendix 3 – Data Tables. The group included representation from appraisal and clinical governance leads, GPs, Medical Directors, specialty and associate specialist doctors and public partners. The full membership of the advisory group is set out in Appendix 1.



Our Findings

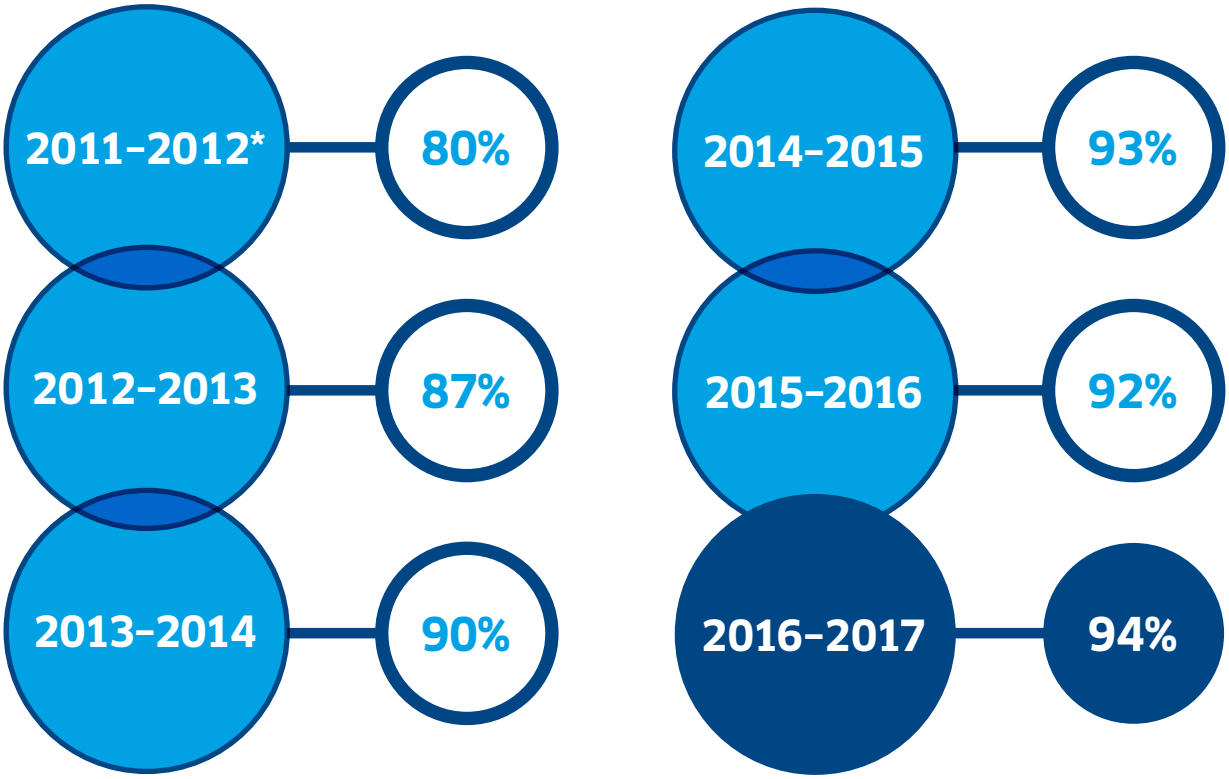
The plan set out in 2012 was to have all doctors in Scotland revalidated by 31 March 2018. The advisory group considered the progress that has been made to establish arrangements to support doctors through the appraisal and revalidation process.

Appraisal rates

The increase in overall appraisal rates was considered a significant achievement. However, it is essential for all organisations to maintain high appraisal rates. In order to achieve this, organisations have to ensure they have sufficient numbers of appraisers in place to provide appraisal services for all doctors with whom there is a prescribed connection. It is also important to build on the achievements of the first 5-year cycle to date and take forward lessons learned from any issues along the way.

Annual appraisal rates in Scotland have risen from 80% in 2011–2012 to 94% in 2016–2017 (see Figure 1).

Figure 1: Annual appraisal rates in Scotland



Although total appraisal rates have improved, there is still variation in appraisal rates for some groups of medical staff.

*Data in this group represent the period from December 2011–March 2012. Data in all the other groups represent the respective appraisal years from 1 April to 31 March.

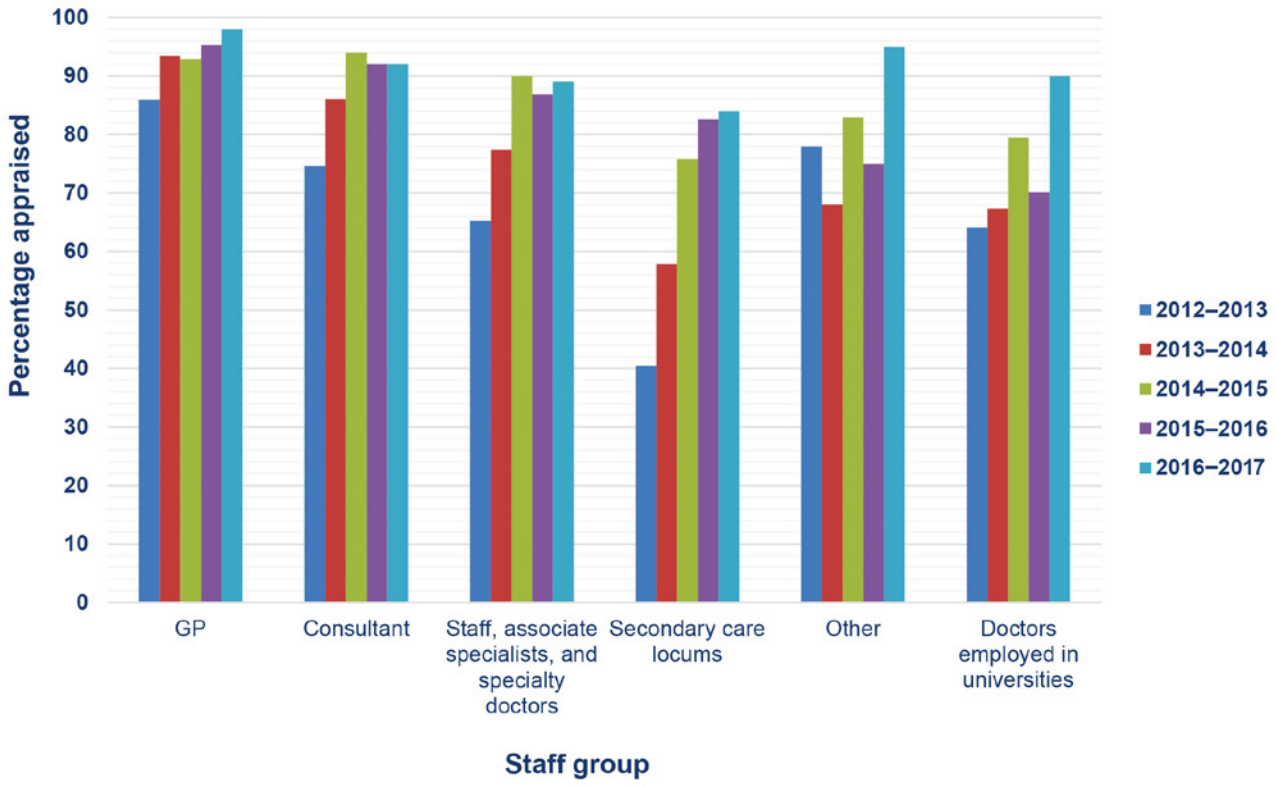
Figure 2 shows shows the number of completed appraisals in each staff group for 2016–2017. The percentage of appraised doctors in smaller staff groups will have a wider range of variation than in the larger staff groups.

Figure 2: NHSScotland appraisal by staff group for 2016–2017

Staff group	Doctors eligible for appraisal	Completed appraisals	Percentage of completed appraisals
Consultant, including honorary contract holders	5,249	4,810	92%
General Practitioner (doctors on a General Practitioner Performers List)	5,097	4,993	98%
Staff, Associate Specialists, and Specialty Doctors	1,116	996	89%
Secondary Care Locums, employed for 2 months or more, in the 12 months up to 31 March 2017	224	183	82%
Other (doctors in leadership roles, the civil service, doctors in wholly independent practice, and doctors not directly employed)	136	130	96%
University employed staff with a licence to practise	50	45	90%
Total	**11,872**	**11,157**	**94%**

Appraisal rates for 2016–2017 vary from 84% for secondary care locums to 98% for GPs. Figure 3 shows the variation in the percentage of completed appraisals by staff groups from 2012–2013 to 2016–2017.

Figure 3: Percentage of completed appraisals by NHSScotland staff groups (2012–2013 to 2016–2017)



- The percentage of doctors employed in universities who have been appraised has increased from 70% in 2015–2016 to 90% in 2016–2017.
- The group categorised as 'Other' (doctors in management or leadership roles, the civil service, doctors in wholly independent practice, and doctors not directly employed) also had a 20% increase from 2015–2016 to 2016–2017.
- The most significant increase in this first 5-year cycle was in secondary care locums, increasing from 40% in 2012–2013 to 84% in 2016–2017.

We are represented on the Scottish Government and GMC national and UK-wide groups. This provides us with the opportunity to share experiences of the process and provide input to new initiatives. The most recent group being the Revalidation Oversight Group, set up in June 2017 by the GMC following its review undertaken by Sir Keith Pearson. Taking revalidation forward, improving the process of relicensing for doctors looked at the operation and impact of revalidation since its introduction to learn from the first 5-year cycle to make it more effective in the next.

Positive recommendations to revalidate

The first group of doctors to be revalidated in 2012 were Responsible Officers and other doctors in leadership roles; 58 doctors were represented in this group. This followed with a 3-year period of revalidating the majority of doctors in Scotland, leaving the final 2 years 2016–2017 and 2017–2018 to revalidate all the doctors who had not yet had an opportunity to revalidate. This is illustrated in the reduction from 4,114 doctors in 2016 to 432 in 2017. Figure 4 shows the number of doctors with a prescribed connection in Scotland, the number of doctors identified for revalidation and from that the number of positive recommendations for 2013–2014, 2014–2015, 2015–2016 and 2016–2017.

Figure 4: Revalidation numbers and positive recommendations 2013–2014 to 2016–2017

	2013-2014	2014-2015	2015-2016	2016-2017
Number of doctors with a prescribed connection on 31 March (each year)	12,101	12,367	12,733	12,978
Number of doctors identified for revalidation (each year)	2,446 **(20%)**	4,406 **(36%)**	4,320 **(34%)**	511 **(4%)**
Number of positive recommendations (each year)	2,308 **(94%)**	4,080 **(93%)**	4,114 **(95%)**	432 **(85%)**

NES monitors doctors in training through the Annual Review of Competence Progression (ARCP) system. The GMC has confirmed this meets the requirements for revalidating trainees. Figure 5 shows the number of doctors in training in Scotland, the number of these doctors who were identified for revalidation and the number who actually revalidated across appraisals years.

Figure 5: Doctors in training

	2013-2014	2014-2015	2015-2016	2016-2017
Doctors in training*	5,476	5,920	5,673	5,723
Doctors identified for revalidation	494	552	643	570
Number of doctors in training who have been revalidated	494 **(100%)**	511 **(93%)**	643 **(100%)**	570 **(100%)**

*An additional cohort of 480 trainees completing 5-years in the training programme also revalidated in years 2015–2016 and 2016–2017. These have not been included in Figure 5 above.

A local initiative

The information provided in the box below describes the process developed by NHS Greater Glasgow and Clyde for its management of doctors in clinical fellow posts.

Appraisal for doctors in clinical fellow posts in NHS Greater Glasgow and Clyde

NHS Greater Glasgow and Clyde has more than 130 doctors called clinical fellows. This group of doctors are employed on contracts that are neither recognised training positions nor career grade posts. They have a range of experience and responsibility for direct patient care. For example, some may be taking time out of their training programme to acquire teaching or research experience and others may be employed directly for service purposes. Some of the latter group can be at a relatively early stage in their medical careers and some may be international medical graduates. Both groups are unfamiliar with the UK appraisal process.

The NHS Greater Glasgow and Clyde's appraisal quality assurance system recognised that these doctors struggled with the format and terminology of the career grade SOAR forms and often had to be deferred by the Responsible Officer because of lack of information and thereafter given help to complete the appraisal documentation.

Following internal discussion within NHS Greater Glasgow and Clyde and externally with Scottish Government colleagues, a trial process was put in place. Clinical fellows are allocated an educational supervisor who is also responsible for the doctor's annual appraisal then performed with individual educational objectives in mind. The supervisor must fulfil the GMC criteria for recognition of trainers but is not necessarily also a secondary care appraiser (this is identical to the process used for trainees in recognised training posts). Through the utilisation of study leave we have given the clinical fellows access to appropriate training portfolios which form the basis of the supporting information for the appraisal.

NHS Greater Glasgow and Clyde is currently in the process of auditing this initiative but has reported better engagement in the appraisal process by the clinical fellows and believe it has a number of advantages for the appraisee. This includes having designated supervisors, set educational objectives and access to training portfolios which they may require to use later if taking up recognised training posts. This can be a vulnerable group of doctors on contracts of variable length. Ideally, going forward, access to the trainee version of SOAR might further help them keep a more useful permanent record of their progress in clinical fellow posts.

Conclusion and Next Steps

The findings in this report reflect the ongoing commitment from stakeholders to complete the first 5-year cycle of medical revalidation in Scotland by the end of March 2018.

This report focuses on year 4 (1 April 2016 to 31 March 2017) of the initial 5-year revalidation cycle. It is expected that many of the recommendations made in our previous annual reports (www.healthcareimprovementscotland.org/medical_revalidation.aspx) are still current in this cycle. These are summarised below.

It is important that organisations have systems in place to continue to improve their annual appraisal rates.

All organisations should report annually, on progress with annual appraisal and medication revalidation, through formal local governance arrangements.

Organisations should ensure they have robust systems in place which are not person-dependant which can propose a risk to the entire appraisal and revalidation process.

Continue to share information between organisations where doctors have more than one employer.

Ensure organisations continue to check Form 4s (or relevant documentation) for all new doctors.

The advisory group noted the importance of doctors working on a lone basis in remote and rural areas and suggested that organisations should ensure that their doctors are supported throughout all aspects of the appraisal and revalidation process.

We are currently in discussions with Scottish Government about the future of the review process. We acknowledge that organisations gather information from other sources, such as the GMC's Connect and the NES SOAR system, to complete our self-assessment documentation.

The GMC is currently developing a dashboard system that will provide Responsible Officers with information about the doctors their respective organisations have a prescribed connection with. It will also provide access to some of the information previously asked for in our self-assessment documentation. In view of this, and to avoid duplication of effort, further consideration will need to be given to how the process is reviewed going forward.

Appendix 1: Acknowledgements

Healthcare Improvement Scotland gratefully acknowledges the support provided for this work. Details of all the organisations that participated are provided in Appendix 2. In particular, we would like to record our thanks to the members of the advisory group for their time, commitment and attention to detail in the analysis of this review process.

Advisory group members

Ronnie Burns	General Practitioner NHS Greater Glasgow and Clyde
Frances Dow	Lay Member
Edward Dunstan	Appraisal Lead NHS Fife
Norman Gibb	Public Partner
Sue Gibbs	Quality and Safety Assurance Lead NHS Lothian
Alison Graham	Medical Director and Responsible Officer NHS Ayrshire & Arran
Paul Knight	Director for Medical Education/ Associate Medical Director NHS Greater Glasgow and Clyde
Elizabeth Muir	Clinical Effectiveness Co-ordinator NHS Fife
Harry Peat	Training Manager NHS Education for Scotland
Sue Robertson	Specialty and Associate Specialist (SAS) Doctor NHS Dumfries & Galloway
Elizabeth Tait	Professional Lead for Clinical Governance NHS Grampian
Mike Winter (Advisory Group)	Medical Director and Deputy Responsible Officer Procurement, Commissioning and Facilities Strategic Business Unit NHS National Services Scotland

Appendix 2: All Organisations Participating in Medical Revalidation Review 2016–2017

NHS board	See data table
NHS Ayrshire & Arran	2, 3, 4, 5
NHS Borders	2, 3, 4, 5
NHS Dumfries & Galloway	2, 3, 4, 5
NHS Fife	2, 3, 4, 5
NHS Forth Valley	2, 3, 4, 5
NHS Grampian	2, 3, 4, 5
NHS Greater Glasgow and Clyde	2, 3, 4, 5
NHS Highland	2, 3, 4, 5
NHS Lanarkshire	2, 3, 4, 5
NHS Lothian	2, 3, 4, 5
NHS Orkney	2, 3, 4, 5
NHS Shetland	2, 3, 4, 5
NHS Tayside	2, 3, 4, 5
NHS Western Isles	2, 3, 4, 5
Healthcare Improvement Scotland	2, 3, 4, 5
NHS 24	2, 3, 4, 5
NHS Education for Scotland	2, 3, 4, 5
NHS Health Scotland	2, 3, 4, 5
NHS National Services Scotland	2, 3, 4, 5
NHS National Waiting Times Centre Board	2, 3, 4, 5
Scottish Ambulance Service	2, 3, 4, 5
The State Hospitals Board for Scotland	2, 3, 4, 5

Hospice	See data table
Accord Hospice	6, 7, 8
Ardgowan Hospice	6, 7, 8
Ayrshire Hospice	6, 7, 8
Bethesda Hospice	6, 7, 8
Children's Hospice Association Scotland (Rachel House and Robin House)	6, 7, 8
Highland Hospice[1]	6, 7, 8
Marie Curie, Edinburgh	6, 7, 8
Marie Curie, Glasgow	6, 7, 8
St Andrew's Hospice[2]	6, 7, 8
St Columba's Hospice	6, 7, 8
St Margaret of Scotland Hospice	6, 7, 8
St Vincent's Hospice	6, 7, 8
Strathcarron Hospice	6, 7, 8
The Prince and Princess of Wales Hospice	6, 7, 8

[1]Included in NHS Highland data.
[2]Included in NHS Lanarkshire data.

Regulated independent healthcare service	See data table
AbleMed Health Limited	9, 10, 11
Castle Craig Hospital Limited	9, 10, 11
DHI Medical Group Scotland	9, 10, 11
Glasgow Centre for Reproductive Medicine	9, 10, 11
Glasgow Memory Clinic	9, 10, 11
Surehaven Glasgow Hospital	9, 10, 11

Non-regulated healthcare service	See data table
MP Locums Healthcare Limited	12, 13, 14
TauRx Pharmaceuticals	12, 13, 14
The Private Surgeon	12, 13, 14

Organisation	See data table
Mental Welfare Commission for Scotland	15, 16, 17, 18
Scottish Government	19, 20, 21, 22

Appendix 3: Data Tables

Data Table 1: Key facts 2016–2017

Organisation type	Number of organisations	Responses	Doctors with a prescribed connection as at 31 March 2017	Doctors eligible for revalidation in 2016–2017	Doctors with a positive recommendation	Doctors deferred	Doctors due for appraisal	Completed appraisals (%)
NHS board	22	22	12,836	495	417	80	11,873	11,158 (94%)
Hospice*	14	14	58	4	3	1	54	52 (96%)
Regulated independent healthcare service*	6	6	16	3	3	0	14	10 (71%)
Non-regulated healthcare service**	3	3	32	8	8	0	31	30 (97%)
Mental Welfare Commission for Scotland	1	1	3	0	0	0	3	3 (100%)
Scottish Government	1	1	33	1	1	0	33	33 (100%)
Total	**47**	**47**	**12,978**	**511**	**432**	**81**	**12,008**	**11,286 (94%)**

*Regulated by Healthcare Improvement Scotland.

**Not regulated by Healthcare Improvement Scotland.

Data Table 2: Number of completed appraisals by NHS board for 2016–2017 compared with previous years*

NHS board	Completed appraisals						
	2010–2011 (%)	2011–2012 (%)	2012–2013 (%)	2013–2014 (%)	2014–2015 (%)	2015–2016 (%)	2016–2017 (%)
NHS Ayrshire & Arran	417 (62%)	418 (58%)	614 (81%)	648 (92%)	699 (96%)	727 (99%)	712 (96%)
NHS Borders	62 (41%)	63 (41%)	272 (94%)	228 (90%)	244 (87%)	235 (89%)	271 (95%)
NHS Dumfries & Galloway	369 (97%)	389 (73%)	372 (99%)	351 (96%)	300 (92%)	258 (80%)	296 (89%)
NHS Fife	528 (89%)	528 (83%)	563 (94%)	580 (92%)	562 (92%)	551 (84%)	557 (94%)
NHS Forth Valley	375 (82%)	414 (86%)	517 (96%)	506 (98%)	492 (95%)	516 (92%)	537 (99%)
NHS Grampian	1,016 (96%)	1,021 (90%)	1,142 (98%)	1,067 (95%)	1,114 (98%)	1,175 (98%)	1,207 (98%)
NHS Greater Glasgow and Clyde	2,256 (80%)	2,255 (83%)	2,233 (75%)	2,726 (88%)	2,735 (92%)	2,778 (94%)	2,854 (95%)
NHS Highland	663 (89%)	733 (98%)	668 (92%)	682 (92%)	699 (91%)	670 (90%)	687 (94%)
NHS Lanarkshire	770 (77%)	865 (80%)	932 (93%)	829 (82%)	916 (89%)	934 (93%)	893 (92%)
NHS Lothian	1,951 (92%)	1,946 (92%)	1,949 (91%)	1,955 (95%)	1,992 (92%)	2,021 (92%)	2,099 (95%)
NHS Orkney	25 (30%)	42 (59%)	43 (96%)	47 (90%)	59 (98%)	51 (94%)	47 (100%)
NHS Shetland	66 (93%)	45 (100%)	47 (98%)	31 (70%)	38 (84%)	42 (95%)	43 (96%)
NHS Tayside	603 (66%)	440 (43%)	730 (77%)	761 (82%)	925 (94%)	852 (89%)	732 (81%)
NHS Western Isles	70 (79%)	62 (89%)	55 (90%)	45 (74%)	53 (95%)	49 (82%)	49 (98%)
Healthcare Improvement Scotland	2 (100%)	2 (100%)	2 (100%)	1 (100%)	3 (100%)	8 (100%)	8 (100%)
NHS 24	2 (100%)	2 (100%)	2 (100%)	2 (100%)	2 (100%)	2 (100%)	2 (100%)

NHS board	Completed appraisals						
	2010–2011 (%)	2011–2012 (%)	2012–2013 (%)	2013–2014 (%)	2014–2015 (%)	2015–2016 (%)	2016–2017 (%)
NHS Education for Scotland**	9 (100%)	9 (100%)	9 (100%)	9 (100%)	7 (70%)	8 (100%)	7 (100%)
NHS Health Scotland	Not available	1 (50%)	3 (100%)	3 (100%)	4 (100%)	4 (100%)	3 (75%)
NHS National Services Scotland	49 (100%)	45 (98%)	41 (100%)	41 (100%)	37 (100%)	39 (100%)	44 (100%)
NHS National Waiting Times Centre Board	58 (73%)	58 (72%)	83 (100%)	65 (93%)	77 (85%)	95 (95%)	97 (93%)
Scottish Ambulance Service	Not available	Not available	Not available	1 (100%)	0	0	0
The State Hospitals Board for Scotland	15 (100%)	14 (100%)	13 (100%)	10 (71%)	14 (100%)	14 (82%)	13 (93%)
NHSScotland total	**9,306 (82%)**	**9,352 (80%)**	**10,287 (87%)**	**10,588 (90%)**	**10,973 (93%)**	**11,029 (92%)**	**11,158 (94%)**

*The data used in this table reflect doctors in primary and secondary care.

**NHS Education for Scotland reported that it is monitoring the 5,723 doctors in training through the Annual Review of Competence Progression (ARCP) system. The GMC has confirmed this meets the requirements for the revalidation of trainees. Trainees are not shown in this table.

Data Table 3: Number of NHS board doctors identified for revalidation in 2016–2017*

NHS board	Doctors with a prescribed connection to the organisation at 31 March 2017	Doctors identified for revalidation in 2016–2017	Positive recommendations (%)	Deferral requests (%)
NHS Ayrshire & Arran	772	28	28 (100%)	2 (7%)
NHS Borders	302	9	7 (78%)	2 (22%)
NHS Dumfries & Galloway	343	15	14 (93%)	2 (13%)
NHS Fife	664	26	23 (88%)	6 (23%)
NHS Forth Valley	568	7	6 (86%)	1 (14%)
NHS Grampian	1,324	63	56 (89%)	7 (11%)
NHS Greater Glasgow and Clyde	3,235	86	74 (86%)	14 (16%)
NHS Highland	781	27	19 (70%)	8 (30%)
NHS Lanarkshire	1,092	51	42 (82%)	9 (18%)
NHS Lothian	2,333	122	100 (82%)	27 (22%)
NHS Orkney	48	1	1 (100%)	0
NHS Shetland	46	3	2 (67%)	2 (67%)
NHS Tayside	1,069	46	35 (76%)	11 (24%)
NHS Western Isles	53	1	1 (100%)	0
Healthcare Improvement Scotland	8	0	0	0
NHS 24	2	0	0	0
NHS Education for Scotland	8	0	0	0
NHS Health Scotland	4	0	0	0

NHS board	Doctors with a prescribed connection to the organisation at 31 March 2017	Doctors identified for revalidation in 2016–2017	Positive recommendations (%)	Deferral requests (%)
NHS National Services Scotland	44	0	0	0
NHS National Waiting Times Centre Board	125	8	7 (88%)	1 (13%)
Scottish Ambulance Service	0	0	0	0
The State Hospitals Board for Scotland	15	2	2 (100%)	0
NHSScotland total	**12,836**	**495**	**417 (84%)**	**92 (19%)**

*Please note that the percentage of positive recommendations and the number of deferral requests may not add up to 100%. It is possible for a doctor to have a deferral (or deferrals) and a positive recommendation within the same appraisal year.

Data Table 4: Number of NHS board doctors identified for revalidation in 2017–2018* and their number of completed appraisals for 2012–2013, 2013–2014, 2014–2015, 2015-2016 and 2016–2017

NHS board	Doctors identified for revalidation in 2017–2018	Completed appraisals 2012–2013 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2013–2014 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2014–2015 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2015–2016 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2016–2017 (%)	Appraisals undertaken by NES-trained appraiser (%)
NHS Ayrshire & Arran	51	32 (63%)	29 (91%)	33 (65%)	33 (100%)	40 (78%)	40 (100%)	42 (82%)	41 (98%)	46 (90%)	46 (100%)
NHS Borders	8	1 (13%)	1 (100%)	3 (38%)	3 (100%)	3 (38%)	3 (100%)	4 (50%)	4 (100%)	7 (88%)	7 (100%)
NHS Dumfries & Galloway	2	1 (50%)	1 (100%)	1 (50%)	1 (100%)	1 (50%)	1 (100%)	1 (50%)	1 (100%)	1 (50%)	1 (100%)
NHS Fife	17	4 (24%)	3 (75%)	6 (35%)	5 (83%)	6 (35%)	6 (100%)	9 (53%)	9 (100%)	12 (71%)	11 (92%)
NHS Forth Valley	16	14 (88%)	14 (100%)	14 (88%)	14 (100%)	15 (94%)	15 (100%)	13 (81%)	13 (100%)	13 (81%)	13 (100%)
NHS Grampian	47	10 (21%)	10 (100%)	21 (45%)	21 (100%)	26 (55%)	26 (100%)	33 (70%)	33 (100%)	38 (81%)	38 (100%)
NHS Greater Glasgow and Clyde	98	28 (29%)	23 (82%)	50 (51%)	49 (98%)	53 (54%)	53 (100%)	58 (59%)	58 (100%)	72 (73%)	72 (100%)
NHS Highland	25	1 (4%)	1 (100%)	10 (40%)	10 (100%)	13 (52%)	13 (100%)	15 (60%)	15 (100%)	20 (80%)	20 (100%)
NHS Lanarkshire	60	13 (22%)	12 (92%)	32 (53%)	32 (100%)	39 (65%)	39 (100%)	41 (68%)	41 (100%)	42 (70%)	42 (100%)
NHS Lothian	109	23 (21%)	18 (78%)	42 (39%)	38 (90%)	59 (54%)	53 (90%)	61 (56%)	61 (100%)	97 (89%)	97 (100%)
NHS Orkney	1	0	0	1 (100%)	1 (100%)	1 (100%)	1 (100%)	0	0	1 (100%)	1 (100%)
NHS Shetland	4	3 (75%)	2 (67%)	3 (75%)	1 (33%)	4 (100%)	4 (100%)	3 (75%)	3 (100%)	3 (75%)	3 (100%)
NHS Tayside	39	2 (5%)	2 (100%)	11 (28%)	11 (100%)	19 (49%)	19 (100%)	20 (51%)	20 (100%)	25 (64%)	25 (100%)
NHS Western Isles	0	0	0	0	0	0	0	0	0	0	0

NHS board	Doctors identified for revalidation in 2017–2018	Completed appraisals 2012–2013 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2013–2014 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2014–2015 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2015–2016 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2016–2017 (%)	Appraisals undertaken by NES-trained appraiser (%)
Healthcare Improvement Scotland	0	0	0	0	0	0	0	0	0	0	0
NHS 24	0	0	0	0	0	0	0	0	0	0	0
NHS Education for Scotland	0	0	0	0	0	0	0	0	0	0	0
NHS Health Scotland	0	0	0	0	0	0	0	0	0	0	0
NHS National Services Scotland	0	0	0	0	0	0	0	0	0	0	0
NHS National Waiting Times Centre Board	6	0	0	1 (17%)	1 (100%)	3 (50%)	3 (100%)	3 (50%)	3 (100%)	4 (67%)	4 (100%)
Scottish Ambulance Service	0	0	0	0	0	0	0	0	0	0	0
The State Hospitals Board for Scotland	3	2 (67%)	1 (50%)	1 (33%)	1 (100%)	1 (33%)	1 (100%)	1 (33%)	1 (100%)	1 (33%)	1 (100%)
Total	**486**	**134 (28%)**	**117 (87%)**	**229 (47%)**	**221 (97%)**	**284 (58%)**	**278 (98%)**	**304 (63%)**	**303 (99.7%)**	**383 (79%)**	**382 (99.7%)**

*Please note that doctors identified for revalidation in 2017–2018 require five annual appraisals.

Data Table 5: Number of NHS board appraisers who have undertaken the NES national (enhanced) medical appraiser training

NHS board	Number of NES-trained appraisers
NHS Ayrshire & Arran	61
NHS Borders	61
NHS Dumfries & Galloway	5
NHS Fife	50
NHS Forth Valley	50
NHS Grampian	113
NHS Greater Glasgow and Clyde	328
NHS Highland	78
NHS Lanarkshire	80
NHS Lothian	258
NHS Orkney	5
NHS Shetland	4
NHS Tayside	99
NHS Western Isles	6
Healthcare Improvement Scotland	1

NHS board	Number of NES-trained appraisers
NHS 24	1
NHS Education for Scotland	4
NHS Health Scotland	0
NHS National Services Scotland	11
NHS National Waiting Times Centre Board	17
Scottish Ambulance Service	0
The State Hospitals Board for Scotland	3
NHSScotland total	**1,235**

Data Table 6: Number of completed appraisals by hospice* for 2016–2017 compared with previous years

Hospice	Completed appraisals						
	2010–2011 (%)	2011–2012 (%)	2012–2013 (%)	2013–2014 (%)	2014–2015 (%)	2015–2016 (%)	2016–2017 (%)
Accord Hospice	3 (100%)	2 (67%)	3 (100%)	3 (100%)	2 (100%)	2 (100%)	2 (100%)
Ardgowan Hospice	4 (80%)	3 (60%)	0	2 (100%)	0	1 (100%)	2 (100%)
Ayrshire Hospice	4 (100%)	4 (100%)	4 (100%)	4 (100%)	4 (100%)	4 (100%)	5 (100%)
Bethesda Hospice	2 (100%)	2 (100%)	2 (100%)	2 (100%)	2 (100%)	2 (100%)	2 (100%)
Children's Hospice Association Scotland (Rachel House and Robin House)	14 (100%)	14 (100%)	3 (75%)	0	0	2 (100%)	2 (100%)
Highland Hospice**	8 (100%)	8 (100%)	0	Not applicable	Not applicable	Not applicable	Not applicable
Marie Curie, Edinburgh	Not applicable	Not applicable	Not applicable	Not applicable	5 (71%)	7 (100%)	7 (100%)
Marie Curie, Glasgow	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	7 (88%)	6 (100%)
St Andrew's Hospice***	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
St Columba's Hospice	6 (100%)	5 (100%)	4 (100%)	6 (100%)	5 (100%)	4 (100%)	8 (100%)
St Margaret of Scotland Hospice	2 (50%)	3 (60%)	3 (75%)	6 (100%)	5 (100%)	4 (100%)	3 (100%)
St Vincent's Hospice	1 (33%)	3 (100%)	1 (50%)	2 (100%)	2 (100%)	1 (100%)	2 (67%)
Strathcarron Hospice	9 (100%)	9 (100%)	6 (75%)	7 (100%)	7 (78%)	10 (91%)	9 (100%)
The Prince and Princess of Wales Hospice	1 (50%)	5 (100%)	9 (100%)	10 (100%)	7 (78%)	3 (100%)	4 (80%)
Total	**54 (90%)**	**58 (92%)**	**35 (88%)**	**42 (95%)**	**39 (83%)**	**47 (96%)**	**52 (96%)**

*The hospices above are regulated in Scotland by Healthcare Improvement Scotland.

**Data for the Highland Hospice have been included in NHS Highland's data 2013–2014, 2014–2015, 2015–2016 and 2016–2017.

***Data for St Andrew's Hospice have been included in NHS Lanarkshire's data.

Data Table 7: Number of hospice doctors identified for revalidation in 2016–2017*

Hospice	Doctors with a prescribed connection to the organisation at 31 March 2017	Doctors identified for revalidation in 2016–2017	Positive recommendations (%)	Deferral requests (%)
Accord Hospice	2	0	0	0
Ardgowan Hospice	2	0	0	0
Ayrshire Hospice	5	0	0	0
Bethesda Hospice	2	0	0	0
Children's Hospice Association Scotland (Rachel House and Robin House)	2	0	0	0
Highland Hospice**	Not applicable	Not applicable	Not applicable	Not applicable
Marie Curie, Edinburgh	8	†	†	†
Marie Curie, Glasgow	7	0	0	0
St Andrew's Hospice***	Not applicable	Not applicable	Not applicable	Not applicable
St Columba's Hospice	8	0	0	0
St Margaret of Scotland Hospice	4	†	†	†
St Vincent's Hospice****	3	†	†	†
Strathcarron Hospice	10	0	0	0
The Prince and Princess of Wales Hospice	5	0	0	0
Total	**58**	**4**	**3 (75%)**	**1 (25%)**

*Please note that the percentage of positive recommendations and the number of deferral requests may not add up to 100%. It is possible for a doctor to have a deferral (or deferrals) and a positive recommendation within the same appraisal year.

**Data for Highland Hospice have been included in NHS Highland's data for years 2013–2014, 2014–2015, 2015–2016 and 2016–2017.

***Data for St Andrew's Hospice have been included in NHS Lanarkshire's data.

****Data suppressed due to the organisation having an individual(s) eligible for revalidation, and 3 or less doctors with a prescribed connection to it. Data suppression shown as †. Because of column totals, secondary suppression has been applied to data from the Marie Curie Hospice, Edinburgh and St Margaret of Scotland Hospice, both of which had doctors eligible for revalidation.

Data Table 8: Number of hospice doctors identified for revalidation in 2017–2018* and the number of completed appraisals for 2012–2013, 2013–2014, 2014–2015, 2015–2016 and 2016–2017

Hospice	Doctors identified for revalidation in 2017–2018	Completed appraisals 2012–2013 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2013–2014 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2014–2015 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2015–2016 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2016–2017 (%)	Appraisals undertaken by NES-trained appraiser (%)
Accord Hospice	0	0	0	0	0	0	0	0	0	0	0
Ardgowan Hospice	0	0	0	0	0	0	0	0	0	0	0
Ayrshire Hospice	0	0	0	0	0	0	0	0	0	0	0
Bethesda Hospice	0	0	0	0	0	0	0	0	0	0	0
Children's Hospice Association Scotland (Rachel House and Robin House)	0	0	0	0	0	0	0	0	0	0	0
Highland Hospice**	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Marie Curie, Edinburgh	0	0	0	0	0	0	0	0	0	0	0
Marie Curie, Glasgow	0	0	0	0	0	0	0	0	0	0	0

*Please note that doctors identified for revalidation in 2017–2018 require five annual appraisals.

**Data for Highland Hospice have been included in NHS Highland's data for years 2013–2014, 2014–2015 and 2015–2016.

Hospice	Doctors identified for revalidation in 2017–2018	Completed appraisals 2012–2013 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2013–2014 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2014–2015 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2015–2016 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2016–2017 (%)	Appraisals undertaken by NES-trained appraiser (%)
St Andrew's Hospice***	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
St Columba's Hospice	0	0	0	0	0	0	0	0	0	0	0
St Margaret of Scotland Hospice	1	1 (100%)	1 (100%)	1 (100%)	1 (100%)	1 (100%)	1 (100%)	1 (100%)	1 (100%)	1 (100%)	1 (100%)
St Vincent's Hospice	1	0	0	0	0	0	0	0	0	1	1
Strathcarron Hospice	2	2 (100%)	0	1 (50%)	0	1 (50%)	0	1 (50%)	0	2 (100%)	2 (100%)
The Prince & Princess of Wales Hospice	1	0	0	0	0	0	0	1 (100%)	1 (100%)	1 (100%)	1 (100%)
Total	**5**	**3 (60%)**	**1 (33%)**	**2 (40%)**	**1 (50%)**	**2 (40%)**	**1 (50%)**	**3 (60%)**	**2 (67%)**	**5 (100%)**	**5 (100%)**

***Data for St Andrew's Hospice have been included in NHS Lanarkshire's data.

Data Table 9: Number of completed appraisals* by regulated** independent healthcare service for 2016–2017 compared with previous years

Regulated independent healthcare service	Completed appraisals						
	2010–2011 (%)	2011–2012 (%)	2012–2013 (%)	2013–2014 (%)	2014–2015 (%)	2015–2016 (%)	2016–2017 (%)
AbleMed Health Limited	Not available	Not available	Not available	Not available	0	2 (100%)	0
Castle Craig Hospital Limited	4 (100%)	4 (100%)	5 (83%)	7 (70%)	7 (100%)	7 (100%)	3 (60%)
DHI Medical Group Scotland	Not available	Not available	Not available	Not available	Not available	Not available	5 (100%)
Glasgow Centre for Reproductive Medicine	Not available	Not available	Not available	Not available	Not available	1 (100%)	1 (100%)
Glasgow Memory Clinic	Not available	Not available	Not available	Not available	0	1 (100%)	1 (100%)
Surehaven Glasgow Hospital	Not available	1 (100%)	0	Not available	0	0	0
Total	**4 (100%)**	**5 (100%)**	**5 (71%)**	**7 (70%)**	**7 (88%)**	**8 (100%)**	**10 (71%)**

*The data in this table reflect doctors whose prescribed connection is to the independent healthcare service. Many doctors working in independent healthcare services often work in the NHS as well and they are not included in this table.

**Regulated by Healthcare Improvement Scotland.

Data Table 10: Number of regulated* independent healthcare service doctors identified for revalidation in 2016–2017**

Regulated independent healthcare service	Doctors with a prescribed connection to the organisation at 31 March 2017	Doctors identified for revalidation in 2016–2017	Positive recommendations (%)	Deferral requests
AbleMed Health Limited	2	0	0	0
Castle Craig Hospital Limited	6	2	2 (100%)	0
DHI Medical Group Scotland	5	0	0	0
Glasgow Centre for Reproductive Medicine	1	0	0	0
Glasgow Memory Clinic	1	0	0	0
Surehaven Glasgow Hospital	1	1	1 (100%)	0
Total	**16**	**3**	**3 (100%)**	**0**

*Regulated by Healthcare Improvement Scotland.

**Please note that the percentage of positive recommendations and the number of deferral requests may not add up to 100%. It is possible for a doctor to have a deferral (or deferrals) and a positive recommendation within the same appraisal year.

Data Table 11: Number of regulated independent healthcare service doctors identified for revalidation in 2017–2018* and their number of completed appraisals for 2012–2013, 2013–2014, 2014–2015, 2015–2016 and 2016–2017

Regulated independent healthcare service	Doctors identified for revalidation in 2017–2018	Completed appraisals 2012–2013 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2013–2014 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2014–2015 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2015–2016 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2016–2017 (%)	Appraisals undertaken by NES-trained appraiser (%)
AbleMed Health Limited	0	0	0	0	0	0	0	0	0	0	0
Castle Craig Hospital Limited	0	0	0	0	0	0	0	0	0	0	0
DHI Medical Group Scotland	0	0	0	0	0	0	0	0	0	0	0
Glasgow Centre for Reproductive Medicine	1	1 (100%)	1 (100%)	1 (100%)	1 (100%)	1 (100%)	1 (100%)	1 (100%)	1 (100%)	1 (100%)	1 (100%)
Glasgow Memory Clinic	0	0	0	0	0	0	0	0	0	0	0
Surehaven Glasgow Hospital	0	0	0	0	0	0	0	0	0	0	0
Total	**1**	**1 (100%)**	**1 (100%)**	**1 (100%)**	**1 (100%)**	**1 (100%)**	**1 (100%)**	**1 (100%)**	**1 (100%)**	**1 (100%)**	**1 (100%)**

*Please note that doctors identified for revalidation in 2017–2018 require five annual appraisals.

Data Table 12: Number of completed appraisals by non-regulated* healthcare service for 2016–2017** compared with previous years

Non-regulated healthcare service	Completed appraisals				
	2012–2013 (%)	2013–2014 (%)	2014–2015 (%)	2015–2016 (%)	2016–2017 (%)
MP Locums Healthcare Limited	Not available	Not available	5 (42%)	15 (65%)	26 (96%)
RS Occupational Health***	7 (78%)	0	7 (64%)	7 (100%)	Not available
TauRx Pharmaceuticals	Not available	Not available	Not available	Not available	3 (100%)
The Private Surgeon	Not available	Not available	Not available	Not available	1 (100%)
Total	**7 (78%)**	**0**	**12 (52%)**	**22 (73%)**	**30 (97%)**

*Not regulated by Healthcare Improvement Scotland.

**The data used in this table have been provided by the designated bodies for independent healthcare that are not regulated in Scotland by Healthcare Improvement Scotland. The data are self-reported information provided by the organisations. Each return was then validated by the evaluation panels. The data in this table reflect doctors whose prescribed connection is to the independent healthcare service.

***RS Occupational Health is no longer a designated body so no data has been requested for the 2016–2017 review.

Data Table 13: Number* of non-regulated** healthcare service doctors identified for revalidation in 2016–2017

Non-regulated healthcare service	Doctors with a prescribed connection to the organisation at 31 March 2017	Doctors eligible for revalidation in 2016–2017	Positive recommendations (%)	Deferral requests
MP Locums Healthcare Limited	28	5	5	0
TauRx Pharmaceuticals	3	2	2	0
The Private Surgeon	1	1	1	0
Total	**32**	**8**	**8 (100%)**	**0**

*The data in this table reflect doctors whose prescribed connection is to the independent healthcare service. Many doctors working in independent healthcare services often work in the NHS as well and they are not included in this table.

**Not regulated by Healthcare Improvement Scotland.

Data Table 14: Number of non-regulated* healthcare service doctors identified for revalidation in 2017–2018** and their number of completed appraisals for 2012–2013, 2013–2014, 2014–2015, 2015-2016 and 2016–2017

Non-regulated healthcare services	Doctors identified for revalidation in 2017–2018	Completed appraisals 2012–2013 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2013–2014 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2014–2015 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2015–2016 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2016–2017 (%)	Appraisals undertaken by NES-trained appraiser (%)
MP Locums Healthcare Limited	6	0	0	0	0	0	0	2 (33%)	0	6 (100%)	0
TauRx Pharmaceuticals	0	0	0	0	0	0	0	0	0	0	0
The Private Surgeon	0	0	0	0	0	0	0	0	0	0	0
Total	**6**	**0**	**0**	**0**	**0**	**0**	**0**	**2 (33%)**	**0**	**6 (100%)**	**0**

*Not regulated by Healthcare Improvement Scotland.

**Please note that doctors identified for revalidation in 2016–2017 require five annual appraisals.

Data Table 15: Number of completed appraisals by the Mental Welfare Commission for Scotland for 2016–2017 compared with previous years

Organisation	Completed appraisals						
	2010–2011 (%)	2011–2012 (%)	2012–2013 (%)	2013–2014 (%)	2014–2015 (%)	2015–2016 (%)	2016–2017 (%)
Mental Welfare Commission for Scotland	6 (100%)	6 (100%)	5 (100%)	4 (67%)	4 (80%)	4 (100%)	3 (100%)

Data Table 16: Number of Mental Welfare Commission for Scotland doctors identified for revalidation in 2016–2017

Organisation	Doctors with a prescribed connection to the organisation at 31 March 2017	Doctors identified for revalidation in 2016–2017	Positive recommendations (%)	Deferral requests
Mental Welfare Commission for Scotland	3	0	0	0

Data Table 17: Number of Mental Welfare Commission for Scotland doctors identified for revalidation in 2017–2018 and their number of completed appraisals for 2012–2013, 2013–2014, 2014–2015, 2015-2016 and 2016–2017

Organisation	Doctors identified for revalidation in 2016–2017	Completed appraisals 2012–2013 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2013–2014 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2014–2015 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2015–2016 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2016–2017 (%)	Appraisals undertaken by NES-trained appraiser (%)
Mental Welfare Commission for Scotland	0	0	0	0	0	0	0	0	0	0	0

Data Table 18: Number of Mental Welfare Commission for Scotland appraisers who have undertaken the NES national (enhanced) medical appraiser training

Organisation	Number of NES-trained appraisers
Mental Welfare Commission for Scotland	1

Data Table 19: Number of completed appraisals by the Scottish Government for 2016–2017 compared with previous years

Organisation	Completed appraisals				
	2012–2013 (%)	2013–2014 (%)	2014–2015 (%)	2015–2016 (%)	2016–2017 (%)
Scottish Government	25 (100%)	28 (90%)	32 (97%)	32 (97%)	33 (100%)

Data Table 20: Number of Scottish Government doctors identified for revalidation in 2016–2017

Organisation	Doctors with a prescribed connection to the organisation at 31 March 2017	Doctors identified for revalidation in 2016–2017	Positive recommendations (%)	Deferral requests
Scottish Government	33	1	1 (100%)	0

Data Table 21: Number of Scottish Government doctors identified for revalidation in 2017–2018* and their number of completed appraisals for 2012–2013, 2013–2014, 2014–2015, 2015-2016 and 2016–2017

Organisation	Doctors identified for revalidation in 2017–2018	Completed appraisals 2012–2013 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2013–2014 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2014–2015 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2015–2016 (%)	Appraisals undertaken by NES-trained appraiser (%)	Completed appraisals 2016–2017 (%)	Appraisals undertaken by NES-trained appraiser (%)
Scottish Government	1	1 (100%)	1 (100%)	1 (100%)	1 (100%)	1 (100%)	1 (100%)	1(100%)	1 (100%)	1 (100%)	1 (100%)

*Please note that doctors identified for revalidation in 2016–2017 require five annual appraisals.

Data Table 22: Number of Scottish Government appraisers who have undertaken the NES national (enhanced) medical appraiser training

Organisation	Number of NES-trained appraisers
Scottish Government	1

Appendix 4: Glossary

Annual Appraisal	The process of preparing, collating and reflecting on information, followed by a discussion with an appraiser at a formal, confidential meeting. The appraisal meeting between the appraisee and appraiser should take place every year. The appraisal year for both primary and secondary care has been aligned to the financial year (1 April–31 March). An appraisal is considered to be completed when the summary of the appraisal discussion and personal development plan have been signed off by the appraiser and appraisee, within 28 days of the appraisal meeting.
Designated Body	An organisation that employs or contracts with doctors and is designated in The Medical Profession (Responsible Officer) Regulations 2010, as amended by The Medical Profession (Responsible Officer) (Amendment) Regulations 2013. www.legislation.gov.uk/ukdsi/2010/9780111500286/contents
General Medical Council (GMC)	A public body that maintains the official register of medical practitioners within the UK. Its chief responsibility is 'to protect, promote and maintain the health and safety of the public' by controlling entry to the register and suspending or removing members when necessary.
Good Medical Practice	*Good Medical Practice*, published by the GMC, sets out the principles and values on which good practice is founded; these principles together describe medical professionalism in action. The guidance is addressed to doctors, but it is also intended to let the public know what they can expect from doctors. www.gmc-uk.org/guidance/good_medical_practice.asp
Independent Healthcare Provider	An NHS term for a healthcare services provider (a term which, as used in the UK, refers to an organisation, not an individual healthcare professional) that operates independently of the NHS.
Licence to Practise	To practise medicine in the UK, all doctors are required by law to be both registered and hold a licence to practise. This applies to practising full time, part time, as a locum, privately or in the NHS, or employed or self-employed. Licences are issued, renewed and withdrawn by the GMC.

Positive Recommendation	A recommendation to revalidate is a formal declaration from a Responsible Officer to the GMC that a licensed doctor remains up to date and fit to practise. The Responsible Officer has to be assured that doctors have: • met the GMC's requirements for revalidation • participated in systems and processes to support revalidation, and • collected the required supporting information for revalidation.
Prescribed Connection	The formal link between a doctor and their designated body. It is the route by which doctors are able to find their Responsible Officer. Regulation 10 and 12 in The Medical Profession (Responsible Officer) Regulations 2010 set out the 'prescribed connection' between designated bodies and doctors and these are explained in more detail in the Responsible Officer guidance. www.gov.uk/government/publications/closing-the-gap-in-medical-regulation-responsible-officer-guidance
Remediation	The overall process agreed with a practitioner to redress identified aspects of underperformance. Remediation is a broad concept varying from informal agreements to carrying out some re-skilling, to more formal supervised programmes of remediation or rehabilitation.
Responsible Officer (RO)	A licensed doctor with a least five years' experience who has been nominated or appointed by a designated body. In Scotland, Medical Directors have been appointed as Responsible Officers and they have a key role in developing more effective liaison between organisations and the GMC as the regulatory body for all doctors. They also oversee the arrangements for medical revalidation, including all methods of evaluating fitness to practise. The GMC will make the final decision on revalidation of any doctor.
Scottish Online Appraisal Resource (SOAR)	The national database used to record appraisal for trainees and doctors in primary and secondary care.

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Taking revalidation forward

Improving the process of relicensing for doctors

Sir Keith Pearson's review of medical revalidation

January 2017

Contents

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Executive summary

My overall conclusion is that revalidation has settled well and is progressing as expected.

Revalidation was introduced in December 2012. It means that doctors who wish to maintain their licence to practise medicine in the UK must demonstrate on an ongoing basis that they are up to date and fit to practise. Revalidation aims to give assurance that individual doctors are not just qualified, but safe. It also aims to help identify concerns about a doctor's practice at an earlier stage and to raise the quality of care for patients by making sure all licensed doctors engage in continuing professional development and reflective practice.

At the GMC's request, I have reviewed evidence on the impact of revalidation and met with people involved at every level of the process, across all four countries of the UK. My overall conclusion is that revalidation has settled well and is progressing as expected. For that, huge credit must go to the medical profession and those leading revalidation, both locally and nationally. Many, although not all, of those who were sceptical about the merits of revalidation at the outset now recognise it is a valuable means of assuring the public that doctors are keeping themselves up to date and safe to practise.

Revalidation has already delivered significant benefits. Firstly, it has ensured that annual whole practice appraisal is now taking place. Regular, supported reflection upon specified types of information, including feedback from patients and colleagues, is starting to drive changes in doctors' practice. Secondly, evidence shows that revalidation has strengthened clinical governance within healthcare organisations, helping them to identify poorly performing doctors and support them to improve. In time, I am confident that these developments will lead to safer and better care for patients.

I have listened to concerns raised by some doctors that revalidation is unnecessarily burdensome or that appraisal is not benefiting them. I have spoken personally to doctors in order to understand what lies behind these concerns. My conclusion is that the principles of revalidation are sound but more can be done locally to support doctors to meet requirements while maintaining a focus on personal development and improvement.

I have considered how revalidation could become more effective in assuring the public and employers that all licensed doctors are safe to practise. I am concerned that the revalidation process is sometimes less rigorous for doctors who work outside 'managed' environments or who move frequently between jobs. I would also like to see greater public awareness of revalidation and steps taken to make it easier for patients to provide feedback to doctors.

Revalidation is still a new process; it is important that we learn from the first cycle to make it more effective in the next. I do not believe major overhaul is needed. Rather, I have made recommendations to improve some aspects of revalidation, for the benefit of both doctors and patients.

Revalidation is still a new process; it is important that we learn from the first cycle to make it more effective in the next.

For revalidation to achieve its goal of increasing assurance:

- Local healthcare organisations should promote revalidation to their patients, explaining the assurance that it provides and why their feedback matters.
- Mechanisms for capturing feedback on doctors from patients and colleagues should be strengthened.
- The system needs to be more robust for doctors who work outside mainstream clinical practice and those who move around the system, such as locums.
- The GMC should work with others to identify quantifiable, long-term impact measures for revalidation.

For revalidation to secure confidence across the medical profession:

- The GMC should update its guidance on the information doctors need to collect for revalidation to make clear what is sufficient and what is (and is not) mandatory. ROs should avoid placing revalidation requirements on doctors that go beyond what is specified as necessary by the GMC.
- Local healthcare organisations should continue their work to improve and assure the quality and consistency of annual whole practice appraisal.
- The boards of healthcare organisations should offer greater challenge and support to make sure local revalidation processes are efficient, effective and fair.
- Organisations should make it easier for doctors to collect evidence for their appraisal by improving local information systems and support. But doctors also need to approach the process constructively, recognising that revalidation is a legitimate and proportionate assurance mechanism for patients and employers.

Key recommendations

For the GMC, working with others:

Update guidance on the supporting information required for appraisal for revalidation to make clear what is mandatory (and why), what is sufficient, and where flexibility exists. Ensure consistency and compatibility across different sources of guidance.

Identify ways to improve the input of patients into the revalidation process by developing a broader definition of feedback which harnesses technology and makes the process more 'real time' and accessible to patients.

Consider bringing forward the date of first revalidation for newly-licensed doctors.

Set out expectations for board-level engagement in revalidation and provide tools to support this.

Address weaknesses in information sharing in respect of doctors who move between designated bodies.

Continue work with the CQC and NHSE in England to reduce workload and duplication for GPs. Work with relevant organisations in Northern Ireland, Scotland and Wales to identify and respond to any similar issues if they emerge.

Identify a range of measures by which to track the impact of revalidation on patient care and safety over time.

Consider replacing the term 'revalidation' with 'relicensing'.

For healthcare organisations and their boards, supported by others:

Work with local patient groups to publicise and promote processes for ensuring that doctors are up to date and fit to practise.

Continue work to drive up the quality and consistency of appraisal and make sure the process is properly resourced.

Explore ways to make it easier for doctors to pull together and reflect upon supporting information for their appraisal. This might occur through better IT systems or investment in administrative support teams.

Ensure effective processes are in place for quality assurance of local appraisal and revalidation decisions, including provision for doctors to provide feedback and to challenge decisions they feel are unfair.

Avoid using revalidation as a lever to achieve local objectives above and beyond the GMC's revalidation requirements.

Boards should hear regularly about the learning coming from revalidation and how local processes are developing. They should also challenge their organisations as to how revalidation is helping to improve safety and increase assurance for patients.

For the government health departments, advised by the GMC:

Review the RO Regulations with a view to establishing a prescribed connection to a designated body for all doctors who need a licence to practise in the UK.

Review the criteria for prescribed connections for locums on short-term placements.

1 About this review

Throughout this review I have tried to see revalidation through the eyes of a patient. Is medical practice safer? Are patients' views being heard and considered by doctors?

Reasons for my review

1 When the General Medical Council (GMC) launched revalidation in December 2012, its Chief Executive, Niall Dickson, described it as: *"the most significant reform of medical regulation for over 150 years."* And so it was. We are now four years into revalidation and nearly all licensed doctors have been through the process. So this is an opportune time to take stock of progress.

2 Revalidation is a hugely ambitious programme of work. The responsibility for its delivery is shared across the GMC, the health departments in England, Northern Ireland, Scotland and Wales, the medical royal colleges, employers in both the public and private sectors, and the medical profession as a whole.

3 In March 2016 the GMC asked me to undertake a review of revalidation.* I have been the independent Chair of the *Revalidation Advisory Board* (RAB)† – a four-country group of external advisers to the GMC – since 2009. I am therefore well placed to provide an insight from a range of perspectives about how revalidation is operating for doctors, Responsible Officers (ROs) and employers and whether the public can be assured that doctors are up to date and fit to practise.

Scope and approach – revalidation through a patient lens

4 Throughout this review I have tried to see revalidation through the eyes of a patient. Is medical practice safer? Are patients' views being heard and considered by doctors? Is revalidation helping to identify the poor practitioner? And am I assured that doctors are keeping up to date and are safe to practise?

5 My approach has been to go back to the beginning of the journey and to look at the expectations set for revalidation at the start. I have tried to understand what has been achieved and to identify what should be changed in the next few years to improve systems and processes and to increase assurance.

Contributors to this review

6 I interviewed a range of doctors (including doctors working in both the NHS† and the independent sector), their professional bodies and their representative organisations, patients and patient organisations, and medical leaders in Northern Ireland, Scotland, Wales and England. I interviewed many supporters of revalidation but I also sought out doctors who were less than enthusiastic and yet to be fully convinced about the merits of revalidation.

* You can find the terms of reference for my review on the GMC's website at www.gmc-uk.org/news/27478.asp

† RAB provides external advice to the GMC about how revalidation is working on the ground. It includes representatives from health departments in the four UK countries, the royal colleges, the British Medical Association and individuals speaking on behalf of patients.

† References in this report to the NHS also cover Health and Social Care in Northern Ireland.

7 Everyone I met was generous with their time and I was struck by how keenly they wanted to engage with the review and provide their perspective. This report is their report and I hope I have done justice to their contribution. These are people and organisations involved in developing, implementing and running revalidation on a day-to-day basis as well as those experiencing it. Their commitment to high quality, safe patient care was a golden thread that ran through every interview I carried out. There is a list of all of the people, groups and organisations I spoke with at *Annex A*.

Documentary evidence informing the review

8 There has been a wealth of information published on revalidation. This report does not provide an overview of all of the literature or research. In summary, I looked at UK-wide research into revalidation and appraisal; *operational data* provided by the GMC to RAB (which is made publicly available on the GMC website[†]); reports on how appraisal and clinical governance are working in each country of the UK; UK-wide surveys completed since the introduction of revalidation; and *comments made on the GMC's website*.

9 I asked the GMC to analyse the key points of each documentary source identified for the review and to collate them for my consideration. Each document was read individually and the main points were summarised and drawn together into themes for me to review. There is a list of references at *Annex B*.

10 Both the GMC and the Department of Health in England have commissioned academic evaluations of revalidation. Interim reports from the evaluations were published in early 2016.[‡] The RAB has received presentations from both groups of researchers, and I have had the opportunity as part of this review to interview the researchers to better understand the underlying information and messages. I value their academic input and their work is reflected in this report. In particular, I have reviewed in detail the results of the profession-wide survey undertaken by the UMbRELLA consortium in 2015 which reflects the views of more than 26,000 licensed doctors.

11 All four UK countries have undertaken reviews into revalidation and publish progress reports on a regular basis. Healthcare Improvement Scotland produces an annual report for Scotland. In Wales, the Deanery's Revalidation Support Unit also issues an annual report on progress. In Northern Ireland, consideration of revalidation was part of the Regulation and Quality Improvement Authority's (RQIA) review of clinical governance arrangements supporting professional regulation, which is awaiting final publication. I have reviewed all these reports, including receiving a briefing on the RQIA report.

[†] The GMC's operational data is updated on a monthly basis.

[‡] UMbRELLA, Shaping the future of medical revalidation, January 2016; Boyd et al, Implementing medical revalidation: organisational changes and impacts, April 2016.

Revalidation – influences and objectives

It is a common misconception that revalidation was devised in response to the Shipman inquiry.

12 Revalidation was under consideration and development for over a decade before its introduction in December 2012. I do not intend to provide a detailed history of its evolution – others have done this already. However I think there is merit in highlighting the key events that contributed to the journey and influenced the current shape of revalidation. A summary timeline of these events is included at *Annex C*.

13 No one single event triggered the start of discussions around revalidation. Changing expectations of patients emerged from several high-profile public inquiries into failings in the provision of care. There were calls for more transparency in the governance of the care provided by the NHS and greater accountability – both system and personal – for that care. And it was suggested that there should be some form of regular checks on doctors.

14 It is a common misconception that revalidation was devised in response to the Shipman inquiry. In fact, revalidation had been proposed by the GMC in 1998, before Shipman was even arrested. Its rationale was not to uncover criminality but to fill a gap in the regulatory framework whereby, barring serious concerns being raised, a doctor could practise from registration to retirement without any check on their performance or competency.

Identified failings in healthcare systems

15 A number of public inquiries and medical malpractice cases between 2000 and 2005 called into question the traditional model of medical regulation.* The cumulative effect of these inquiries and cases was that, on behalf of the public, the GMC decided it needed to be proactive in checking that doctors on the register continued to be safe to practise.

16 The Bristol Inquiry was set up in 1998 to investigate the deaths of babies undergoing heart surgery at Bristol Royal Infirmary during the 1980s and 1990s. The inquiry highlighted the fact that there was no means of assessing the quality of care provided by doctors or evaluating their performance. *The final report made over 200 recommendations*, including recommendations about: strengthening leadership; promoting openness and acknowledging errors; the need for cultural change within the organisation and the wider NHS; creating effective systems within hospitals to ensure that clinical performance is monitored; and the use of appraisal, continuing professional development (CPD) and revalidation to make sure all healthcare professionals remain competent to do their job.

17 Some of the same points were reiterated by Robert Francis QC in the Mid Staffordshire NHS Foundation Trust Public Inquiry. In the *final report*, published in February 2013, he discussed the use of appraisal to reinforce cultural change, saying: *"As a part of this mandatory annual performance appraisal, each clinician and nurse should be required to demonstrate their ongoing commitment, compassion and caring shown towards patients, evidenced by feedback of the appraisee from patients and families, as well as from colleagues and co-workers. This portfolio could be made available to the GMC or the NMC, if requested as part of the revalidation process."*†

* For example, inquiries into children's heart surgery at Bristol Royal Infirmary, the retention of organs at Alder Hey Children's Hospital in Liverpool and the cases of Ledward, Ayling, Neale and Kerr/Haslam.

† Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, February 2013, Executive Summary, paragraph 1.201, page 78

Rising patient expectations

18 It is noteworthy that research carried out in 2006* found that almost half of patients when asked thought that doctors were already subject to regular assessments, with one in five believing that this happened annually. The introduction of revalidation was, therefore, in part, catching up with the public's established expectation.

19 Patient expectations have changed and they continue to change, making the interaction a patient has with a doctor very different from that of only a few years ago. Patients are better informed, increasingly acting as consumers, expecting a dialogue with a doctor, with explanation and discussion about treatment options and risks. They look increasingly to be 'consulted' when it comes to their care.

20 As patients today are informed, involved and empowered, so healthcare professionals need to adapt to hear their voice. Doctors and their leaders, educationalists and health service providers need to keep pace with the shift from the passive compliant patient to the proactive healthcare consumer; the consumer who is motivated to know more about their care and the implications of their treatment package. By way of example, I heard the case of an elderly lady who was spoken to by one of the hospital's most senior consultants during a ward round. He looked at her notes, conferred with colleagues, spoke to his patient about the treatment he planned for her and moved on. Some short time later a doctor in training attended the patients to arrange the medication that had been prescribed. In the intervening period, the patient had taken out her iPad and Googled the medication. *"Doctor,"* she asked, *"can you please explain the pharmacology of the drug I'm being prescribed and can we discuss the possible side effects?"* Informed patients will become the norm and doctors need to rapidly adapt. Appraisal and revalidation should encourage this adaptation.

21 In Professor Don Berwick's 2013 *report on patient safety in the NHS in England*, he wrote: *"The goal is not for patients and carers to be the passive recipients of increased engagement, but rather to achieve a pervasive culture that welcomes authentic patient partnership – in their own care and in the processes of designing and delivering care. This should include participation in decision-making, goal-setting, care design, quality improvement, and the measuring and monitoring of patient safety. Patients and their carers should be involved in specific actions to improve the safety of the healthcare system and help the NHS to move from asking, 'What's the matter?' to, 'What matters to you?' This will require the system to learn and practice partnering with patients, and to help patients acquire the skills to do so."*

* Department of Health (England), Good doctors, safer patients: A report by the Chief Medical Officer, July 2006.

In my interactions with patient representatives for this review, I have heard consistently that patients expect doctors to be subject to some form of ongoing review and professional development.

22 The expectation of patient-centred care has been established in all four countries of the UK. For example, in her 2014/15 annual report, *Realistic Medicine*, Scotland's Chief Medical Officer wrote: *"Shared decision-making is not a one-way transmission of information about options and risks from the professional to their patient. It is a two-way relational process of helping people to reflect on, and express, their preferences based on their unique circumstances, expectations, beliefs and values. This can be a challenging communication process and individuals will equally need reassurance that their professional has understood them."*

23 In my interactions with patient representatives for this review, I have heard consistently that patients expect doctors to be subject to some form of ongoing review and professional development. And they would like to receive an assurance that this process is taking place in their local hospitals and GP practices.

Changes in the medical profession

24 As patient expectations of healthcare have developed, so have models of care and the attitudes of doctors towards their work. Today's doctors operate in a multi-generational and multi-skilled workforce of healthcare professionals. The motivations and expectations of each generation are different. For example, the newer generation of doctors seeks greater flexibility in working hours and has different expectations of managers and leaders.

25 Anecdotally, I hear that, in comparison to earlier periods, current doctors in training are less likely to complete their training in a single concentrated period, fewer GPs wish to become full-time partners in a practice and locum work is proving increasingly attractive as a means of balancing work and family commitments. Doctors, particularly younger doctors, spoke to me about an aspiration to have a portfolio career where medicine might be only one part of that career.

26 Many doctors are employed by organisations where they are the sole qualified medical practitioner or work in settings such as public health where the main business is not the delivery of clinical care. This presents a different challenge in terms of maintaining core knowledge and professional competency.

27 I make these points because I believe we must be cautious about looking at revalidation just through the lens of today. Regulators are constantly updating their processes to reflect the context in which healthcare is delivered. For example, early in 2017, the GMC plans to begin a public consultation on the introduction of a new Medical Licensing Assessment to create a common threshold for entry on to the UK medical register for both UK and overseas-qualified doctors.

"Revalidation supports doctors in developing and improving their practice throughout their career, by making sure they have the opportunity to reflect regularly on how their practice can be developed, modified or improved. Over time, revalidation will give patients greater confidence that doctors are up to date in the areas in which they practise, and promote improved quality of care for patients by driving improvements in clinical governance."

GMC, *Guide for doctors: Revalidation and maintaining your licence*

What revalidation set out to achieve

28 The GMC and the chief medical officers of the four UK countries set out their overall objective for revalidation in a joint *Statement of Intent* published in October 2010: *"The purpose of revalidation is to assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and fit to practise."*

29 Revalidation marks a departure from the traditional method of regulation for doctors. Most professional regulators, including the GMC, regulate by controlling access to a register. Doctors are admitted to the register once they have attained the correct qualifications, training and experience.

30 However, the register only records past qualifications. It is not a contemporary account, and so it offers limited assurance that any particular doctor is as up to date now as they were when they entered the register, or that their practice across the range of their work is safe. Before revalidation, doctors would remain on the register without having to demonstrate their ongoing competence, unless a serious issue was identified about their fitness to practise and they were referred to the GMC.

31 Patients want to be assured that doctors are keeping up to date and are safe to practise. Revalidation was introduced to provide that assurance. All doctors who hold a licence are now subject to continuing evaluation of their practice in their everyday working environment.

32 This means that holding a licence to practise has extra significance – it means that anyone holding a licence should now be engaged in revalidation and working within a governance framework that regularly checks to make sure they are up to date, fit to practise and that there are no outstanding concerns.

How revalidation works

The medical register and the licence to practise

33 Registration with the GMC demonstrates a doctor has the necessary qualifications and is in good standing. However, holding a licence to practise is what allows doctors to undertake medical practice in the UK. Any doctor wishing to practise medicine in the UK must be both registered and licensed with the GMC – irrespective of whether they practise in the NHS or privately, part time or full time, or are self-employed.

34 As of 30 September 2016, 273,146 doctors held full registration with the GMC. Of those, 229,992 held a licence to practise and were therefore subject to revalidation. The remaining 43,154 were unlicensed: they may be working overseas, retired or employed in a non-clinical role.

Outline of the revalidation model

35 Revalidation is based on a doctor's whole scope of practice across all the settings in which they work. For most doctors, the evaluation of that practice takes place in the environment in which the doctor works and is part of the wider clinical governance system within an organisation.

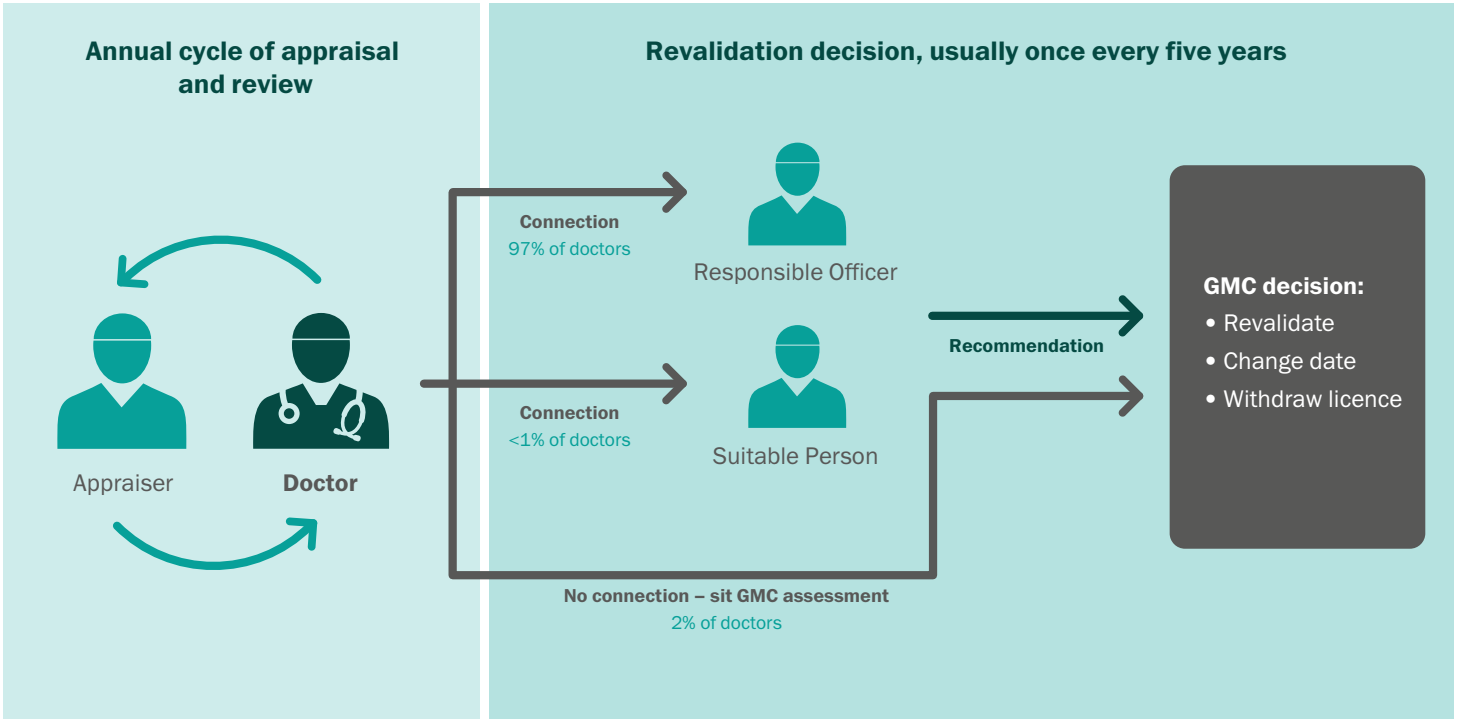
36 Revalidation is not a point-in-time assessment or merely a demonstration of training and development activities undertaken.

37 All doctors are required to have an annual appraisal that covers the whole of their practice [figure 1]. The GMC has described the *supporting information* that doctors are required to bring to their whole practice appraisals to demonstrate that they are meeting the standards in the GMC's core guidance for doctors – *Good medical practice*. Most of the supporting information is generated in the doctor's day-to-day practice or is available within their workplace. Doctors need to reflect on and identify learning from continuing professional development, feedback from colleagues and patients, any complaints or compliments made about them, any significant events they were involved in, and quality improvement activities [figure 2].

38 The vast majority of doctors have a prescribed connection to a designated body set out in the RO Regulations.* These regulations established arrangements for ROs to be appointed by each designated body (healthcare organisations and certain other bodies), with responsibilities relating to the evaluation of the fitness to practise of doctors who work in the body. When a doctor moves to work in a different body, their prescribed connection will change.

* The "RO Regulations" referred to in this report are *The Medical Profession (Responsible Officers) Regulations 2010 (as amended)* and *The Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010*. The regulations came into force in October 2010 for Northern Ireland and January 2011 for the rest of the UK.

Figure 1 - Revalidation model



Doctor	Responsible for their own revalidation, including demonstrating that they are reflecting on information from their practice, learning and making improvements.
Appraiser	Responsible for providing the doctor with a whole practice appraisal.
Responsible officer (RO)	Usually a senior doctor within a healthcare organisation – often the medical director. The role is set out in statute and includes making sure systems are in place to evaluate doctors' practice on an ongoing basis. This includes establishing appraisal processes and procedures to investigate and refer fitness to practise concerns to the GMC. The RO makes recommendations to the GMC about each doctor's revalidation. They usually sit on the executive board of the organisation.
Designated body	This is the organisation that provides a healthcare service. They range in size from large NHS trusts and private hospitals to smaller independent healthcare providers. They must appoint and resource an RO.
GMC	The professional regulator of doctors, which is responsible for setting the national framework for revalidation and for making revalidation decisions about individual doctors.
Suitable person (SP)	A licensed doctor approved by the GMC as suitable to make a recommendation to the GMC about the revalidation of a doctor who does not have an RO.

39 Generally once every five years, a doctor's RO will make a recommendation to the GMC to confirm that the doctor has been engaging in revalidation and there are no outstanding concerns about the doctor's practice. Alternatively, the RO may recommend deferring the doctor's revalidation date (for example, to give them more time to collect the necessary evidence) or inform the GMC that a doctor is not participating in revalidation by sending a non-engagement recommendation. In the latter case, if it is clear that the doctor is not sufficiently engaging with revalidation, the GMC can withdraw their licence to practise. This means that, although the doctor remains registered with the GMC, they can no longer practise in the UK.

40 If an RO has concerns about a doctor's fitness to practise (as distinct from concerns about their engagement with revalidation) which they cannot resolve locally, they may refer them into the GMC's fitness to practise processes. This occurs separately from the revalidation process. Where the GMC decides to investigate, the doctor's revalidation is placed on hold.

41 Where a doctor does not have a prescribed connection under the RO Regulations, the GMC may approve a Suitable Person (SP) to make recommendations about that doctor's revalidation. 1,002 doctors were connected to SPs approved by the GMC as at 30 September 2016.

42 There are a small number of licensed doctors (4,366 on 30 September 2016) who do not have an RO or an SP. Doctors who do not have an RO or SP are still required to revalidate. These doctors are typically working on an occasional basis, outside clinical environments or are based overseas: the majority do not require their licence to practise. The process for them involves providing evidence directly to the GMC on an annual basis, showing that they have had an annual whole practice appraisal and providing statements from organisations to which they provide medical services confirming that there are no fitness to practise concerns. They must also take part in an assessment to demonstrate their medical knowledge once in every cycle.

Figure 2 - Supporting information for revalidation

Four domains of *Good medical practice*

- Knowledge, skills and performance
- Safety and quality
- Communication, partnership and teamwork
- Maintaining trust

Concerns about fitness to practise must be raised with GMC as and when they arise

My view on the purpose of revalidation

As the regulator, the GMC has set a strong clear national framework for revalidation, but the revalidation process is owned and resourced at a local level by organisations and employers.

43 Revalidation is a safety and quality system aimed at assuring the public that doctors are up to date and fit to practise in the UK, whilst also reinforcing the professional standing of a doctor. It is underpinned by evidence and robust processes and procedures.

- **The public must have confidence that the overall system of regulation of doctors is right.** We often draw the analogy with airline pilots. As passengers, we don't ask to see the pilot's credentials, but we are confident that the airlines and regulators have passenger safety at the core of their systems of governance. Similarly, the public want to know that medical practice is safe; that their views are being heard by doctors and that doctors are keeping themselves up to date and fit to practise; we need to assure them that this is happening. It is evident that the public expect such a system to be in place, but are largely unaware that revalidation exists. It is clear from the evidence I have seen that we have not done enough to take the public with us on this journey, and I will discuss this further later in the report.
- **Revalidation is part of a wider quality assurance framework across healthcare.** As the regulator, the GMC has set a strong clear national framework for revalidation, but the revalidation process is owned and resourced at a local level by organisations and employers. Revalidation is therefore, part of a local clinical governance framework. It is also designed to strengthen that framework.
- **Doctors, as professionals, should buy in to revalidation as a demonstration of their professionalism**. Revalidation puts in place a framework where doctors can demonstrate their professional standing and, therefore, their professionalism. It requires organisations to support them in identifying learning – through an agreed personal development plan (PDP) – and making changes, where necessary, to improve their practice. Revalidation should underpin the standing of doctors in the minds of patients and provide further evidence that we have very good doctors working in the UK.
- **Revalidation will identify concerns that might lead to poor performance.** Robust whole practice appraisal, and the triangulation of information about a doctor's practice through revalidation, will help to identify areas for improvement in a doctor's practice. Identifying and dealing with these (generally minor) concerns through appraisal will make sure the concerns don't escalate and help reduce the likelihood of harm to patients.

44 I also want to be clear on what revalidation does not do.

- **Revalidation does not exist solely to identify poor performance.** Revalidation does have a vital role to play in helping to identify concerns about a doctor's practice at an early stage, before they escalate. It can and should deal with poor behaviour and performance. However, contrary to a commonly repeated myth, it was never intended to 'catch another Shipman'. Shipman was a serial killer responsible for the deaths of more than 200 people. He was also a family GP. Much has been said about whether he would have been caught earlier if revalidation had been in place. It is impossible to say for certain, but my view is that the array of governance changes put in place since Shipman, including those established as part of revalidation,

makes it much more likely that his behaviour would have been detected earlier. Alongside revalidation, these include: changes to the death certification process and coroners system; safer management of controlled drugs; closer monitoring of prescribing data, mortality rates and unexpected deaths; guidance for police officers carrying out investigations into unexpected death or serious harm of patients following medical treatment; improved approaches to investigating complaints and concerns; and inspections of GP practices. Moreover, *Good medical practice* places an obligation on doctors to report concerns about colleagues who may not be fit to practise and may be putting patients at risk.

- **Revalidation is not a complaints process.** Revalidation is not another route for patients to make complaints about a doctor. However, complaints are an important source of information for doctors to use to identify improvements to their practice. When a complaint is made, it goes into the complaints system of the organisation. It is also captured as evidence in the review of the doctor's performance in their whole practice appraisal every year. Some organisations publish all of the complaints they receive on their website and explain how they dealt with them.
- **Revalidation is not the whole system of assurance.** It is one, but only one, important part of a system of assurance in a safety critical industry. There are many processes involved in delivering safe and effective patient care, and numerous organisations responsible for setting standards, monitoring and quality assuring various aspects of healthcare provision in the UK.

How the report is set out

45 In the remainder of this report I set out my findings in three sections.

- The impact of revalidation – what I have heard and seen.
- Taking revalidation forward – what I think can be improved and my recommendations for the future.
- Closing thoughts – my key messages and what I would like to happen next.

2 The impact of revalidation to date

Revalidation means that all licensed doctors must demonstrate they are up to date and fit to practise

46 When reporting on the impact of revalidation, I am conscious that the implementation of revalidation has been a joint enterprise by the GMC, health administrations in the four UK countries, local designated bodies and others. Therefore, the successes I identify, and the areas for development I recommend, apply to a wide range of stakeholders and should not been seen as purely a matter for the GMC. I say this because the GMC may not always be best placed to make the changes required.

Doctors are meeting the requirements of revalidation

47 The population of the UK medical register changes constantly as new doctors join and others leave, either to retire or practise elsewhere. Some doctors have been practising in the UK for over 50 years; others for just a few weeks. The introduction of revalidation means every doctor who wants to maintain their licence – regardless of their field of work – must regularly demonstrate they are reflecting on how to improve their practice and taking steps to keep their knowledge and skills up to date.

48 I receive regular updates on the operational data held by the GMC about revalidation through the Revalidation Advisory Board (RAB). For this review I asked the GMC to tell me how many doctors had a revalidation decision by 30 September 2016. Up-to-date *operational data* is available on the GMC's website.

49 There have been 160,735 decisions to revalidate a doctor and 37,653 decisions to defer. Almost half of all deferrals to date have been for doctors in training, purely to align their revalidation date with the date they are expected to complete their training.* For non-trainees, the vast majority of deferral decisions were made because the RO felt the doctor needed more time to collect their evidence. I would expect to see fewer such deferrals during the second cycle of revalidation, as doctors and their organisations are more familiar with the requirements of the process. A very small percentage of deferral recommendations (4%) were made because the doctor was subject to an ongoing local human resources or disciplinary process, the outcome of which was deemed by the RO to be material to their evaluation of the doctor's fitness to practise.

50 The GMC has so far approved 499 recommendations of non-engagement made by ROs. When the GMC agrees with an RO that a doctor is not engaging sufficiently with revalidation requirements, they issue the doctor with formal notice that the GMC is minded to withdraw their licence. If the doctor does not take corrective action within a specified period, their licence is withdrawn.

* Doctors in training must participate in revalidation. Where their training lasts less than five years, trainees revalidate at the point of eligibility for their Certificate of Completion of Training (CCT). If their training lasts longer than five years, trainees will revalidate after five years, and again at the point of eligibility for their CCT. This means that trainee revalidation dates sometimes need to be adjusted or deferred.

There are several hundred privileges that are restricted by law to licensed doctors.

The licence to practise must be actively maintained

51 In 2009, in preparation for the introduction of revalidation, all doctors registered with the GMC were issued with a licence to practise, unless they told the GMC they did not want one. There are several hundred privileges that are restricted by law to licensed doctors. Notable amongst these are the ability to prescribe controlled drugs; to hold the appointment of physician, surgeon or medical officer in any public institution; to work as a GP in the NHS; to gain practising privileges in an independent hospital; to sign death certificates; to undertake duties for which approval under section 12 of the *Mental Health Act* is required; and to assess the suitability of individuals to perform certain activities (for example, to drive a heavy goods vehicle or join the police service). These are significant rights which require a level of continuing competency. Revalidation is the mechanism that testifies to that competency.

52 It was always anticipated that many of the doctors who were on the GMC register in 2009 would not require a licence for a variety of reasons; some would be wholly retired, some would be approaching retirement and some would not be living in the UK. This assumption was found to be correct. Of around 228,700 doctors who were subject to revalidation when it was introduced in December 2012, 42,904 no longer have a licence to practise in the UK. During those same years, 50,504 doctors joined the GMC register for the first time.

53 It is clear that revalidation has encouraged doctors to reflect on their need for a UK licence to practise and whether they want to go through the robust processes that are in place for keeping their licence. This has clear benefits for patient safety, as it ensures the licence to practise in the UK is proactively maintained rather than existing indefinitely upon payment of a fee. Doctors can no longer continue to treat patients and prescribe medicines in the UK just on the basis of having met the criteria for initial registration and licensing.

54 From a doctor's point of view, there is the flexibility to remain registered with the GMC – showing they are in good standing in the UK – but to give up their licence temporarily in order to take a career break or work overseas.

55 ROs have told me that revalidation has encouraged doctors to consider their current registration and licensing status. For example, I am aware of cases where doctors have decided to give up their licence, either temporarily or permanently, following a discussion with their appraiser. I have also heard that doctors are having conversations with their RO when retirement is approaching and deciding to stop clinical work or to reduce the scope of their practice, based on whether they will have sufficient supporting information for their revalidation. From a patient safety perspective, I believe this is a good thing.

The RO Regulations do not provide a prescribed connection for every doctor who is working in the UK. In my view, that is an assurance weakness that must be addressed by the UK health departments.

56 Where a doctor does not engage with revalidation and will not relinquish their licence voluntarily, the GMC can withdraw it, but it must seek representations from the doctor before doing so. It is important to note that withdrawing a licence does not mean the doctor has been found to be unfit to practise; it means they are not taking part in revalidation. Since revalidation began, the GMC has withdrawn 3,314 licences from doctors who were not engaging with the process. I am content, having looked at the process, that the GMC does not take lightly the decision to withdraw a doctor's licence to practise, but it is necessary in circumstances where the GMC – and thereby the public – cannot be assured that a doctor is up to date and fit to practise.

57 The decision to withdraw a doctor's licence can be appealed and the appeal panel is independent of the GMC. Up to the 30 September 2016, there have been 49 appeals heard by a panel. Only one such appeal has been successful. I believe this confirms that the principles underlying licence withdrawal are fair and robust.

But I hear concerns that the process is not equally robust for all doctors

58 The vast majority of doctors have a prescribed connection to a designated body under the RO Regulations. The model of prescribed connections set out in the Regulations is based, as far as possible, on the local systems of support and management that exist for doctors in the workplace. For this reason, most licensed doctors have a prescribed connection to an organisation that employs them or contracts their services.

59 But the RO Regulations do not provide a prescribed connection for every doctor who is working in the UK. In my view, that is an assurance weakness that must be addressed by the UK health departments. It is also a source of frustration for those doctors who find themselves without a connection and yet needing a licence.

60 Doctors without a connection are most likely to be working as independent practitioners, in a part-time capacity or in some form of advisory or managerial role. But many are not working in the UK at all. When a doctor informs the GMC that they have no prescribed connection, they must indicate the broad nature and location of their practice. I have asked the GMC to summarise this information and they tell me that, of 4,366 licensed doctors without a connection to an RO or SP on 30 September 2016:

- **747 say they are practising in the UK in a role involving patient contact**. This includes doctors who run their own private clinics providing advice, treatment or surgery, and doctors who do ad hoc locum work.
- **1,470 say they are based in the UK but not treating patients**. This group includes medico-legal advisers, royal college examiners, retired doctors and those currently on a career break.

- **2,149 say they are working wholly overseas**. The vast majority of these doctors do not require their UK licence because they are not practising in the UK. Some of these doctors wish to retain their licence because they, or their employer, mistakenly believe it is required as evidence of good standing in the UK. I also understand that some doctors who practise entirely overseas want to retain the ability to return to the UK to work, on a sessional basis, often at short notice.

61 I heard from some doctors without a connection that revalidation is problematic. Those based overseas can struggle to find an appraiser who meets the GMC's requirements,* and those without recent medical practice find it difficult to gather all the necessary supporting information to revalidate. This raises the question why many of these doctors feel the need to hold a UK licence to practise when their practice is not in the UK. Although the legislation and licence restoration processes have been designed so that it is straightforward for doctors to relinquish their licence to practise then restore it when they return to practise in the UK, many prefer to keep it. GPs who give up their licence will be removed from the Performers Lists† and I have heard it can be difficult to get back on a List at short notice. I believe the solution to this problem lies within the licensing and Performers List processes, not in changes to revalidation requirements.

62 I understand the problems experienced by doctors without a connection but do not believe there is a case to relax the standards of revalidation. My concern is that doctors without a connection are sometimes falling outside the most exacting standards of revalidation. They are required to have an annual appraisal in the same way as any other doctor, but there is limited assurance around the quality of those appraisals (although I understand that the GMC is currently looking at this issue). And there is no obvious mechanism for identifying and dealing with low level concerns in respect of doctors without an RO or SP. I consider it hard to explain why a doctor practising in the UK who has any role in the provision of care to patients should not have their revalidation overseen by an RO or SP. I believe the GMC and UK health departments should explore ways to bring doctors without a connection into the mainstream of revalidation.

* Amongst other requirements, appraisers carrying appraisals for doctors without a connection must themselves hold a prescribed connection to, and carry out appraisals for, a designated body or suitable person. The full criteria can be found in the GMC's revalidation guide for doctors.

† All GPs providing NHS services are required to be on the performers list for the country in which they practise.

63 In addition, I heard concerns from many sources about the rigour of appraisal and revalidation processes for doctors working as locums, especially on a short-term basis. Specifically, I heard the following.

- **It is not always clear which organisation should be responsible for the appraisal and revalidation of secondary care locums.*** I heard that the RO Regulations can be difficult to interpret in respect of prescribed connections for locum doctors on short-term contracts, especially if the locum works for multiple agencies.
- **GMC data shows that locums have their revalidation deferred more than any other doctor group apart from trainees.** For example, in 2015, locum agencies had a 36% deferral rate, compared to an average rate of 16% for other types of (non-trainee) designated bodies. It is not yet fully understood why this is the case. It may relate to difficulties experienced by locums in gathering all the necessary evidence for appraisal, administrative failings inside some locum agencies, or problems with the performance of some locum doctors. I would like the GMC to look at this in more detail.
- **Not all locum agencies are properly fulfilling their responsibilities towards doctors.** Some locum agencies are identified as designated bodies, but not all.† Many locum agencies and their ROs have introduced strong clinical governance arrangements in the wake of revalidation. But I heard that others are not supporting their doctors well to keep up to date with revalidation. This can mean that a locum doctor arrives for a temporary placement in an NHS organisation and is immediately due for appraisal or revalidation. This is mainly an issue in England at the moment but could become a problem elsewhere in the future and needs addressing.
- **Appraisers and ROs do not always have access to information and evidence covering the whole of a locum doctor's practice.** I was concerned to hear that information relevant to a locum doctor's revalidation – including details about potential performance issues – is not always transferred when they move between work locations. This appears to be partly a problem of systems. But I also heard that the healthcare bodies in which locum doctors are placed are sometimes unwilling to provide frank feedback to the supplying agency (the locum doctor's RO) on the performance of those doctors. For example, I heard that if a locum doctor's performance falls below the standard expected by the healthcare organisation, sometimes they simply say, "Please don't send this doctor again," or they argue that access to information is restricted by commercial considerations.

64 It is important to recognise that, because of revalidation, assurance processes around doctors without a connection and those working as locums are very much stronger than they used to be. However, for patients and doctors to have confidence in the revalidation process and systems, it is essential we can demonstrate that all appraisals and recommendations for revalidation have a consistency underpinned by evidence. There are areas of the assurance system that are still comparatively weak. These need to be addressed and I return to them in the next chapter.

* GP locums in England have a prescribed connection to NHS England, while those in Wales, Scotland and Northern Ireland connect to the local health board. The prescribed connection for secondary care locums depends on which agency they work for, where they are based in the UK and, if they work for more than one agency, where they did most work over the preceding 12 months. Some locums are directly employed, such as long term placements or maternity cover, and therefore have a connection with the employer.

† As of 30 September 2016, there were 86 locum agencies acting as designated bodies, with a total of 8,517 doctors connected to them. All but four of these agencies are in England. Agencies vary in size from as small as one to over 1,500 doctors.

Revalidation underpins the professional standing of doctors

One RO told me: "Once upon a time you were a doctor for life once qualified. Society now requires those in authority to continuously offer themselves to be held to account for their competence and actions."

Revalidation is a national framework but it commands ownership and confidence at the local level

65 Many of the people I spoke with believe that revalidation has enhanced doctors' accountability to their patients and underpinned their professional standing. One RO told me: *"Once upon a time you were a doctor for life once qualified. Society now requires those in authority to continuously offer themselves to be held to account for their competence and actions."*

66 A group of GP appraisers in Northern Ireland told me: *"We have moved from governance being something that you have to do to something that doctors really want to do."* A hospital consultant and appraiser I met said: *"I don't have evidence that revalidation has improved patient safety, but it has led to doctors 'on the fringes' becoming more engaged in training and development."*

67 The GMC sets the overall framework and requirements for revalidation but ROs and employers have embraced their role. Credit is due in no small part to the chief medical officers, deaneries, medical directors and senior medical and non-medical staff in organisations across the UK for the leadership they have shown. One of the strongest messages I have picked up during my conversations with medical leaders is that revalidation, whilst being a requirement of the national regulator, now feels as though it belongs to them. This is especially impressive since revalidation has been delivered against a backdrop of enormous change and demands.

68 During my review I heard many times that revalidation has benefits for doctors in reassuring them about the safety and the quality of their practice. The Chief Medical Officer for Scotland shared with me one GP's experience of revalidation: *"I've been practising in my office under the radar for 30 years; you've allowed me to realise I'm doing the right things."* Around 44% of doctors responding to a survey funded by the GMC and undertaken by the UK Medical Revalidation Evaluation coLLAboration (UMbRELLA) consortium* agreed that revalidation allows doctors to show they are up to date and fit to practise. 26% had no opinion on that statement and 29% disagreed. This demonstrates real progress but shows there is still a long way to go.

69 In summary, revalidation underpins the high standard of medical practice in the UK by providing tangible, individualised and regular evidence to this effect. This is not to say that medical practice was deficient before revalidation was introduced – on the contrary, it adds to an already well evidenced body of knowledge about the standard of medical practice in the UK.

* The UMbRELLA interim report of January 2016 sets out the findings from the survey. 156,610 doctors were invited to complete the survey and 26,171 responded, giving a response rate of 16.7%.

Doctors have told me they value the feedback they obtain from patients and colleagues as part of their revalidation and they are using it to identify potential changes to their practice.

There is evidence of more reflective practice as a result of revalidation

70 The ability to reflect regularly on one's practice and experience, and to learn from it, is a core aspect of professionalism. That is true of any profession, but is especially pertinent to doctors given the trust placed in them by patients and the critical decisions they must take on a daily basis. Reflection sits at the pinnacle of professional practice where a doctor is prepared to hear the voice of their patients and their colleagues and is willing to adjust their practice accordingly.

71 Reflection does not come naturally to all doctors. But I have heard that the introduction of whole practice annual appraisal is encouraging more doctors to reflect on their practice and to discuss this reflection with their appraiser. One consultant surgeon in independent practice told me that: *"The very fact of having to explain my practice and aspirations to my appraiser was helpful in requiring me to analyse what was going on in an objective way."* This sentiment was echoed in feedback from lead appraisers in Scotland, who told me that: *"Doctors are more reflective now. The majority of professionals are keen to do a good job and just need the support to do it. They are now getting recognition for their constant learning – they appreciate that."*

72 Some 42% of doctors responding to the UMbRELLA survey stated that they had made changes to their practice, behaviour or learning activities as a result of their most recent appraisal. Of the 58% who had not made changes, the most common reasons offered were that nothing had been identified which required that a change be made or that they were reflecting on an ongoing basis. One doctor wrote: *"My last three appraisals have been excellent and have helped me to reflect on the overall direction of my career. As a result I have made some major changes. I am grateful to have had the chance to have a one-to-one with three very different professional colleagues and have learned a lot from having these appraisals."*

73 Some organisations are actively supporting doctors to improve the frequency and quality of their reflection. The Wales Deanery has produced online support materials including templates and examples to guide doctors' reflection.* In England, NHS Employers has run workshops on reflective practice for SAS doctors, and made the more general observation that: *"Better appraisal was being blocked by poor reflective learning. There are now trusts with [improved] learning programmes and these are having an impact."* The GMC's Regional Liaison Service† and its offices in Northern Ireland, Scotland and Wales also run training sessions for doctors which focus on reflecting for revalidation.

74 Doctors have told me they value the feedback they obtain from patients and colleagues as part of their revalidation and they are using it to identify potential changes to their practice. Doctors responding to the UMbRELLA survey rated patient feedback the most useful type of supporting information. But doctors (and patients) also raise questions and challenges about the effectiveness of current feedback mechanisms: I address those later in this report.

* See the Wales Deanery's website at http://gpcpd.walesdeanery.org/index.php/reflective-practice.

† The GMC's Regional Liaison Service provides interactive sessions for doctors and medical students aimed at helping them to better understand GMC guidance around professionalism, revalidation and fitness to practise.

75 I heard that feedback from colleagues has helped doctors to realise that they can be perceived as being unapproachable or intimidating, or has identified ways they could improve their time management or communication skills (even if they are already good). Respondents to the UMbRELLA survey listed learning points such as: "*I will use written information along with verbal information when explaining a complex diagnosis"* and *"More patient involvement in medical decision making."* The overwhelming majority of feedback is positive and this in itself can be beneficial: *"Seeing positive comments from patients and colleagues can be really welcome when you're up to your eyes in work."*

76 It is probably too early to conclude that more widespread reflection has improved care for patients – although I have heard anecdotal evidence for this. But it stands to reason that reflective thought influences practice; and it is reasonable to assume that reflective thinking among doctors is becoming more embedded with the universal requirement for annual appraisal. One lead appraiser told me that, in her view: *"patient care is already safer as a result of the focus that revalidation places on professional standards, probity, personal health and doctors' duty of care."* She also quoted the personal experience of doctors who had felt empowered by revalidation to raise concerns about adverse impacts of colleagues' health or behaviour on their ability to care for patients.

But the process feels burdensome and ineffective to some doctors

77 It is clear from the UMbRELLA interim report, and from feedback received by the GMC that I have reviewed, that not all doctors have a positive view on revalidation. For example, 37% of those responding to the UMbRELLA survey do not believe that revalidation will improve the standards of doctors' practice; and 43% do not agree that it has led to an improvement in patient safety. In this review I have sought to understand the reasons that lie behind negative perceptions of revalidation and what can be done to address these.

78 The doctors I met for this review recognised that, as professionals, they should not expect to practise without demonstrating to their patients and themselves that they remain competent and safe. However, many doctors have concerns about the practicalities of the process. These centre in particular on the cost-benefit balance: the time they spend on activities related to revalidation versus the benefits they perceive for themselves and for patients.

- Some doctors feel the time they spend preparing for their annual appraisal and gathering supporting information is excessive.
- Many doctors feel that the addition of revalidation requirements to their pre-existing appraisal process has diminished the value of appraisal as a tool for personal development. Of doctors responding to the UMbRELLA survey, 30% felt that revalidation has had a negative impact on the appraisal process. Slightly more (32%) felt the impact of revalidation had been positive, while 37% said the impact was neither positive nor negative.

It is my belief that the vast majority of doctors fully accept the principles of accountability and assurance that are central to revalidation. But many do have reasonable concerns about the efficacy of the process.

- Doctors working in primary care in England have identified duplication between the information they must prepare for their appraisal and that required when their GP practice is inspected by the Care Quality Commission (CQC).
- There is sometimes disagreement or confusion between a doctor and their RO or appraiser about what is sufficient evidence for revalidation.
- Doctors without a connection to a designated body are dissatisfied with the cost and difficulty of meeting revalidation requirements without support from an employer. I am told that retired doctors and those who work overseas make up the majority of complainants to the GMC in relation to revalidation.*

79 I was concerned to hear from doctors and their representative bodies that some doctors have relinquished their licence purely because they do not want to meet the requirements of revalidation. This seems to relate in particular to doctors who are in the later stages of their careers. Several doctors have left *comments* to this effect on the GMC website. A typical example is: *"Appraisal is a waste of time. The NHS is losing huge numbers of older doctors like me who would previously have been happy to carry on working part time, but now can't be bothered to revalidate. The CPD requirements alone mean that, as part-timers, we would have to spend unrealistic amounts of time and money attending courses just to put ticks in the right boxes, without any proven benefit to our patients."*

80 In my view, some of the negative comments made by doctors about revalidation betray a lack of understanding about the purpose of the process and whom it is for. There may be some doctors who feel it is an unreasonable condition of their licence that they must show that they remain up to date and fit to practise on an ongoing basis, but I doubt that view would be shared by many patients.

81 It is my belief that the vast majority of doctors fully accept the principles of accountability and assurance that are central to revalidation. But many do have reasonable concerns about the efficacy of the process. At a time of significant workload pressures in the health service, some doctors mention revalidation as one of the reasons why they are considering early retirement.† Organisations need to be alert to the concerns of doctors who wish to continue their career but require additional support and encouragement to undertake annual appraisal and to prepare for revalidation.

82 In reviewing comments from doctors about revalidation, it is striking how many of them relate not to the whole system of revalidation but to their personal experience of appraisal. One doctor I met told me: *"When people say revalidation is a waste of time, what they mean is they have found their appraisal process has not been constructive."* This is an important distinction. I return to the question of the quality and consistency of appraisal in the next section and address with recommendations in chapter 3.

* Between December 2012 and September 2016, 924 doctors registered a complaint with the GMC about revalidation.

† See, for example, research carried out by Dale et al among GPs in the West Midlands.

83 I suspect that some negative perceptions of appraisal and revalidation have arisen, quite naturally, because the system is new. Many doctors in the UK would not have experienced a formal, whole practice appraisal prior to the introduction of revalidation. There is already anecdotal evidence that the process feels less arduous for those approaching their second revalidation, especially where doctors are properly supported to meet requirements. A lead appraiser in one NHS trust told me: *"Many who were hostile to the idea of revalidation at the start were, by the end of the process, appreciative of it with quite a lot sending thanks in writing to the Revalidation Support Team for their assistance."*

84 During my review I heard suggestions that – to reduce burdens on doctors – appraisal should take place every other year or even once every five years. But I also heard calls to make the process more demanding – for example, by replacing every fifth appraisal with a test of knowledge or by requiring additional, specialty-specific evidence. My view is that revalidation was built on the concept of annual whole practice appraisal and it is still a very young process. It would be unwise to deviate from the current approach of annual appraisal or to 'water down' the standard of assurance.

85 While there is not a case for lowering the standard of revalidation, I believe there is a case for examining the mechanisms, processes and systems for delivering it. We should look to extract greater efficiencies by reducing the time burden on doctors and ROs and the cost burden for healthcare bodies. I want to keep all the benefits of revalidation but reduce the costs for organisations and doctors. I recognise doctors' concerns about administrative burdens and, in the next chapter, I set out ways these could be reduced without compromising assurance to employers and the public.

Revalidation has embedded annual whole practice appraisal

Annual whole practice appraisal is now embedded across the UK and across all doctor groups. This is a direct result of the introduction of revalidation.

Revalidation has significantly increased appraisal rates

86 Annual whole practice appraisal is the foundation of revalidation. It is the mechanism by which licensed doctors regularly demonstrate that they have discussed and reflected on their whole practice having collected supporting information to assist their reflection. Revalidation has meant that annual appraisal is now prevalent and is underpinned by increasingly robust and structured local processes.

87 For some groups of doctors, GPs in particular, appraisal was already well developed before revalidation came along. But for others the approach was irregular and unstructured. One recently-retired trust chairman told me: *"Before revalidation, proper appraisal was rare; it was just a cup of coffee and a chat now and then. Revalidation has changed that."*

88 Throughout the course of my review I have repeatedly heard that revalidation has been the catalyst for increases in appraisal rates across all settings. 90% of respondents to the UMbRELLA survey stated that they had had a medical appraisal at some point in their career, of which 95% had done so within the previous 12 months. Despite appraisal being a contractual requirement in the NHS for many years,* annual appraisal rates in England in 2010 were just 36% for SAS† doctors, 64% for consultants and 79% for GPs. Annual whole practice appraisal is now embedded across the UK and across all doctor groups. This is a direct result of the introduction of revalidation.

89 Appraisal rates have risen steeply in all four countries of the UK since the introduction of revalidation.

- In Wales, 82% of doctors had an appraisal in 2015/16, compared with just 53% in 2012/13.
- In Scotland, 92% of doctors had an appraisal in 2015/16, compared with 87% in 2012/13.
- In England, around 88% of doctors employed by the NHS had an appraisal during 2015/16.
- For trusts in Northern Ireland, appraisal rates for 2013/14 and 2014/15 ranged from 71% to 100%.ǂ

It is generally accepted that appraisal rates can never reach 100% as, in any one year, there will be a group of licensed doctors who are new to the UK or are absent from work, for example, on sick or maternity leave.

90 I heard that the impact of revalidation on the likelihood of receiving an appraisal has been particularly marked on doctors who are not consultants or GPs. This group were often overlooked for appraisal in the past. NHS Employers told me that SAS doctors now feel more empowered to ask for – and more entitled to have – a high quality annual appraisal.

* The date on which appraisal was added to NHS contracts varies across the UK and for different roles but, for most doctors, annual appraisal has been a requirement since the early 2000s.

† Specialty, associate specialist and staff grade (SAS) doctors are those who are not employed in a training role or as consultants.

ǂ Data provided by NHS England, Wales Deanery, HIS in Scotland and RQIA in Northern Ireland.

91 The embedding of appraisal is valuable in itself. For example, the British Medical Association (BMA) told me that structured annual appraisal prevents a doctor's skills becoming so out of date that they become subject to formal competency procedures without being given the opportunity to put things right. I also heard examples from appraisers where the process had helped doctors to recognise the need, and take corrective action, to keep up to date across the whole scope of their practice, not just their main role. That said, as I noted earlier in relation to locum doctors, I have concerns that not every appraisal is yet a genuinely whole practice appraisal.

But the quality and consistency of appraisal varies

92 ROs and appraisers tell me that revalidation has driven improvements in local appraisal systems. Where no appraisal systems existed, revalidation led to their introduction, and where existing systems required improvement, revalidation has incentivised developments. In research undertaken for the Department of Health in England, but covering the whole of the UK, *Boyd et al* report that 85% of ROs responding to their survey said their organisation's appraisal systems had changed as a result of the introduction of revalidation. I commend both NHS and independent sector organisations for the effort they have put into improving local systems.

93 But I also heard concerns from doctors about the quality of their appraisal experience. The BMA told me: *"Appraisal feels like an industry or an inspection against a checklist, rather than an opportunity to reflect. Doctors are more focused on collecting reflections than the quality of the actual reflection."* One doctor responding to the UMbRELLA survey wrote: *"My appraisal was not helpful. The appraiser was stressed about her own workload issues and her energies were focused on dealing with the system rather than any content to the appraisal."*

94 It is inevitable that not everyone will have the same experience of appraisal. But it concerns me that some doctors report very negative experiences or identify revalidation as having an adverse impact on the quality of appraisal. I return to this issue in the next chapter.

95 I have also heard that, despite the *guidance issued by the GMC setting out supporting information needed for appraisal*,* there can be differences in the evidence required. One senior doctor told me: *"Variation exists. Some people are expected to bring complex data and performance comparisons and to reflect on how they've changed. Others just bring information on what they've done."* And I heard numerous concerns from doctors about being asked to complete activities above and beyond what is specified in the GMC's guidance – for example, undertaking a specific number of clinical audits or gathering patient or colleague feedback more frequently than once per cycle. I address the issue of revalidation evidence requirements in the next chapter.

* The GMC's guidance on supporting information for appraisal and revalidation was published in March 2012. It sets out six types of supporting information that doctors are expected to provide and discuss at appraisal at least once in each five year cycle: continuing professional development; quality improvement activity; significant events; feedback from colleagues; feedback from patients; and complaints and compliments. This guidance is currently under review by the GMC and a revised version is expected by the end of 2017.

96 I believe that both doctors and the public would expect to see some form of quality assurance process around appraisal and revalidation. During my review, I was pleased to see that this is beginning to emerge in many areas. For example, the Wales Deanery told me that they examine a percentage of appraisal summaries each year and have begun quality assuring revalidation processes in two pilot areas. But this type of process is not yet universal. We need to be able to demonstrate that appraisals are of high quality and capable of underpinning consistent revalidation recommendations in all cases. In its document, *A Framework of Quality Assurance for Responsible Officers and Revalidation*, NHS England states: *"ROs will want to demonstrate that their own decision-making, and also that of appraisers and case investigators, is robust and consistent, not only at the individual level and internally within the designated body, but also that they are in alignment with the decision-making of peers in other organisations, from all sectors, across the country."*

Revalidation – and the wider role of the RO – has strengthened local clinical governance

97 The RO is central to the revalidation process. Among other things, ROs are responsible for making sure appraisal systems are in place, making revalidation recommendations to the GMC and establishing procedures to investigate concerns about doctors' fitness to practise. Alongside the GMC, ROs have delivered revalidation. They are committed and have dealt with challenges and implementation problems. And now they are driving forward efforts to improve quality and consistency in revalidation processes.

Revalidation is helping to identify poor performance

98 I discussed earlier how revalidation has driven improvements in appraisal rates and helped ensure appraisal covers the whole of a doctor's practice. ROs and appraisers told me that this is beginning to have a real impact on their ability to identify doctors who may present fitness to practise concerns. *Boyd et al* asked ROs across the UK to comment on the impact of revalidation on clinical practice. Their report concluded: *"Depending on how wide a definition of clinical practice is used, then roughly between 15% and 40% of survey respondents indicated positive impacts of revalidation on clinical practice."*

99 One in ten appraisers who responded to the UMbRELLA survey said they had formally escalated a concern about at least one of their appraisees, while 23% had identified a concern that they did not need to escalate as it could be dealt with at the appraisal. The concerns most frequently cited by appraisers as requiring escalation were a lack of reflective practice (identified as a factor in 45% of escalated cases), poor relationships with colleagues (29%) and clinical knowledge and skills not being up to date (26%). It is not known whether the total number of

One RO told me: "Revalidation has forced medical directors to take an interest in the full scope of practice of their doctors and that is a benefit."

concerns being raised is higher than prior to revalidation, but it is reasonable to assume that the extension of appraisal to all doctors has increased the likelihood of difficulties being identified.

100 ROs told me that the requirement to gather and reflect upon evidence about their practice has resulted in some poorer performing doctors leaving the profession. One RO told me: *"Revalidation has forced medical directors to take an interest in the full scope of practice of their doctors and that is a benefit."* Another said: *"In short, there are fewer bolt holes for doctors with unaddressed concerns to disappear into."*

101 Anecdotal evidence from ROs about the impact of revalidation on poorer performing doctors is supported by GMC data which shows that, up to 30 September 2016, 1,413 doctors had their revalidation deferred due to an ongoing local process, of whom 94 (6.6%) subsequently relinquished their licence or had it withdrawn by the GMC.

102 Certainly, revalidation has stimulated improvements to local assurance systems for doctors. One RO described revalidation to me as: *"an extra string to the governance bow."* Boyd et al concluded that revalidation is helping to formalise the various systems that exist within organisations for managing medical performance, stating that: *"Some types of change were mentioned quite frequently in relation to many or all of the performance management systems: increased formalisation; greater doctor engagement and participation; improved record keeping and monitoring; better alignment between appraisal and other systems; greater doctor awareness of the importance of that aspect of performance; and increased robustness and quality of the system."* All in all this represents a significant and positive culture change for organisations and their relationships with their doctors.

103 For example, in relation to significant events or serious untoward incidents, the report concludes that revalidation was: *"generally felt to have brought about formalisation and made existing systems more robust and rigorous or to have forced organisations that had no systems in place to implement them."* This view was supported by the ROs that I spoke to. One said: *"I believe that patients are safer now because there is increased visibility of serious incidents and near misses."* And one representative of a royal college told me that: *"Organisations and their boards are becoming more accountable for their systems of appraisal and clinical governance."*

104 There is also evidence that revalidation is encouraging ROs to share information about doctors when they move between organisations. This is beneficial, especially where an individual may require support to address low level concerns. However, ROs tell me there is not yet a consistent approach to sharing information (taking appropriate account of data protection considerations) and difficulties can arise where a doctor joins them following a period without a connection to a designated body.

ROs are better supported to manage concerns locally

105 A key part of the RO role is in managing concerns about doctors' fitness to practise. Revalidation provides a mechanism for identifying and acting upon concerns before they reach a level that needs GMC attention. During the course of my review, I have heard that revalidation has clarified local responsibilities and given organisations the confidence to address concerns about doctors locally where appropriate. One civil servant told me: *"ROs are now inclined to be more courageous in dealing with difficult doctors. Revalidation has helped by making clear the local responsibilities rather than just referring to the GMC. It has enhanced local capability and clarified how to get things done."*

106 Almost half of designated bodies responding to the survey undertaken by *Boyd et al* reported that they had improved their systems in relation to doctors causing concern since the implementation of revalidation. One RO said: *"It is more formalised and we have a remediation policy with more support."* I have also heard that revalidation provides a vehicle to discuss lower level concerns in a supportive but challenging environment. The Welsh NHS Confederation told me that they believe organisations in Wales are developing a more open culture around raising concerns.

107 As part of its support provided to doctors and ROs, the GMC has introduced the *Employer Liaison Service* (ELS).* The ELS told me that each year their Employer Liaison Advisers (ELAs) attend more than 1,300 face to face meetings with ROs. These meetings provide an opportunity for ROs to raise any concerns they have about the fitness to practise of their doctors and to obtain advice on GMC investigation thresholds. In addition, ROs frequently contact ELAs by telephone and email for ad hoc advice and support when concerns emerge. The majority of ELA advice is to support ongoing local investigation and management of concerns, taking into account any patient safety risks. ELAs also contribute to around 40 RO network meetings across the UK each year which often include anonymised case discussions from ROs to share experiences and good practice around the management of concerns.

* The Employer Liaison Service aims to facilitate closer working between the GMC and healthcare organisations, focusing on matters related to fitness to practise and revalidation.

108 I have repeatedly heard that ROs and healthcare organisations value the advice and support provided by the ELS. For example, NHS Employers told me that the GMC ELA role has been *'a revelation'* and helps to deliver consistency in the process. *Boyd et al* also note the success of the ELS, saying that: *"Over 93% of respondents [to the survey] had contacted ELS advisers, and over 70% of these had found this very useful,"* and that: *"The attitude to the ELAs' role in this regard was overwhelmingly positive, and often ROs cited the ELAs as helping to make the process of dealing with doctors causing concern more 'robust' at a local level. One RO went so far as to suggest that it had changed their entire working relationship with the GMC."*

109 I met with a group of NHS England medical directors who told me that, in their view, the RO role has had a beneficial impact, even where appraisal is weak or the doctor does not give it their full commitment: *"The existence, and statutory duties, of the RO means that poor performers will*

There is a widely held view that boards need to become more engaged in the process – not just in monitoring compliance but looking to capture learning from the process to improve standards.

be identified sooner than they would have previously." In its report, *The early benefits and impact of medical revalidation: report on research findings in year one*, the NHS Revalidation Support Team noted: *"An important distinction is that appraisal offers the opportunity for doctors to self-identify concerns while clinical governance enables concerns to be identified by others."* One regional medical director told me that: *"We have lifted the floor of what is acceptable, and that is significant."*

But organisations are not making the most of revalidation information

110 The published research I have reviewed for this report suggests that local clinical governance systems are seen as paramount for the successful implementation of revalidation. There is anecdotal evidence to suggest that revalidation has been more successfully implemented where boards* and ROs provide strong local leadership, and where sufficient local resources are provided to support implementation. This makes sense. I have personally seen many excellent examples of organisations working to improve their appraisal and revalidation processes and to support their doctors to meet requirements.

111 However, a number of interviewees told me that revalidation is not yet having the degree of impact that it could on local clinical governance. In particular, there is a widely held view that boards need to become more engaged in the process – not just in monitoring compliance but looking to capture learning from the process to improve standards. I heard the view that: *"Some organisations have started drilling down and learning from revalidation, but not many. Most still focus on the percentages."* I believe there is considerable potential for boards to better use revalidation to drive improvement in their organisations and I explain how in the next chapter.

112 Some doctors are sceptical as to the value of the Personal Development Plan (PDP) created during appraisal. One consultant surgeon told me: *"There seems to be no connection between the agreed PDP and line managers who can make it happen."* This was an isolated view but I heard little evidence in my review that organisations are consistently taking note of the PDP requirements emerging from appraisal and ensuring the necessary resources are being deployed to make sure plans are being delivered. It seems likely that this omission would have a negative impact on doctors' attitude to the process.

And some ROs face pressures in their role

113 On average, each RO has 367 connected doctors for whom they must make a revalidation recommendation, generally once every five years. But the actual number of doctors connected to a designated body ranges from just one to over 6,000. 44% of ROs are responsible for fewer than 50 doctors; 39% are responsible for between 51 and 500 doctors; and the rest are responsible for more than 500 doctors. *Boyd et al* have questioned whether smaller designated bodies have the resources and capabilities to deliver revalidation effectively. I have also heard concerns that ROs with a very large number of connected doctors may struggle to manage their workload.

* When I refer in this report to boards, I mean the team of executive and non-executive directors who oversee the organisation.

I believe that revalidation outcomes to date confirm the high standards of practice that exist in the UK medical profession. In the rare cases where doctors' performance or behaviour does not meet accepted standards, I am satisfied there are now stronger processes in place to identify and tackle this.

114 I believe that the focus should be less on the size of the designated body and more on the conditions necessary for good governance and organisational efficiency. I am aware that the UMbRELLA consortium and the universities of Manchester, York and Plymouth are undertaking further research in this area. It would be wise to await their findings before proposing changes to structures or responsibilities. However, I would like the GMC to consider whether it needs to do more to support ROs (especially new ROs), either alongside others or on its own. The RAB could be asked to consider possible changes and to advise the GMC, particularly in respect of proportionality and balance.

115 Through my meetings with doctors, I have become aware of a perception that the revalidation process is sometimes being used to achieve goals for which it was not intended – for example, to require doctors to meet local health system objectives that are unrelated to fitness to practise – or in a way that is not fair to all doctors. Although this is a complex area, I feel such concerns need to be addressed. I return to the question of how best to ensure transparency and fairness in decision making in the next chapter.

Medical regulation is better fulfilling public expectations

The public have long expected doctors to be subject to regular checks on their fitness to practise – and now they are

116 I explained at the start of this report that patients and the public rightly assume that a system is in place to confirm that doctors continue to practise safely and to the necessary standards. They also expect doctors to be supported to learn and improve. One patient told me: *"I would expect there to be a process of continuing development for any professional."*

117 Revalidation is a now in place and forms a core element of the systems that provide assurance to patients about the safety and quality of their medical care. I have heard and seen enough to be confident that the process is operating largely as it should. I believe that revalidation outcomes to date confirm the high standards of practice that exist in the UK medical profession. In the rare cases where doctors' performance or behaviour does not meet accepted standards, I am satisfied there are now stronger processes in place to identify and tackle this.

118 The GMC and medical professionals in the UK have led the world in developing a model to assess the continuing competency of doctors. Revalidation now exists for nurses in the UK and is being developed in other professions and jurisdictions. At its 2016 conference, the International Association of Medical Regulatory Authorities (IAMRA) approved a set of principles encouraging medical regulators across the world to develop systems that are designed to improve the quality of medical practice by promoting, encouraging or requiring career-long learning for all practising doctors.*

* www.iamra.com/resources/Pictures/IAMRA Statement on Continued Competency.pdf

But we need to strengthen patient input and better measure outcomes

119 There is more work to be done to demonstrate how revalidation is improving patient care and safety. In my view, this has two elements. Firstly, we must make revalidation more visible to the public. And, secondly, we need to find simple ways to measure its impact.

120 Patients play a vital role in revalidation by providing feedback on the doctors who care for them. Doctors responding to the UMbRELLA survey said that patient feedback was the most helpful type of supporting information in terms of reflecting on their practice, but it was also the most difficult to obtain. During my review I have heard concerns about the way in which patient feedback is collected and used in revalidation – that the mechanisms are inflexible, that the sample is too small or not representative, and that patients feel unable to provide open views for fear of being identified. I will expand on these issues in the next chapter.

121 Two thirds of patient and public involvement representatives surveyed for the UMbRELLA interim report (11 out of 17) felt that patients were unaware of revalidation or did not understand its aims and purpose. My experience of talking to patient representatives for this review confirms that position.

122 There are some who argue that it is not essential for the public to know how revalidation works, merely that it exists. But I am not entirely convinced by that position. One patient representative challenged me directly by stating: "*If we are saying the system is robust, we need to be able to evidence that. We need publicly accessible information to give confidence that doctors must meet certain standards and that feedback from patients is acted upon.*" In the next chapter I set out my vision for increasing public awareness of revalidation and the assurance that it provides.

123 Finally, although I recognise the challenges involved, I believe there is more that can be done to quantify the impact of revalidation. There is emerging evidence of impact from the evaluations commissioned by the GMC and the Department of Health in England. My review has highlighted many benefits for doctors, employers and patients, but much of the evidence is anecdotal at this stage. It would be helpful – both in terms of raising public assurance and increasing support for the process across the profession – if some simple measures of impact could be agreed and monitored over time.

3 Taking revalidation forward

"Revalidation is successfully in place and we can now work to improve it. We are at the 'acceptance stage' and the next step is to strengthen ownership by the profession and engagement with the public."

Royal college representative

124 My review found widespread consensus that revalidation has been implemented successfully and it is progressing in line with expectations. But it is still a very new process. It will take time for the impact of revalidation to be recognised by patients as a means by which they can feel assured that doctors are up to date and fit to practise. The impact on the medical profession is already significant; much of this impact is positive, but there are areas of disquiet among doctors that need to be addressed by those with responsibility for revalidation locally and nationally.

125 Very few people suggested to me that revalidation should be radically overhauled. People want to see evolution rather than revolution; I think that is the right approach. As a revalidation lead at one royal college told me: *"Revalidation is successfully in place and we can now work to improve it. We are at the 'acceptance stage' and the next step is to strengthen ownership by the profession and engagement with the public."*

126 In this chapter I give a flavour of the ideas I have heard for improving revalidation. My report does not mandate what change should take place or prescribe detailed solutions. I recommend areas for development, with a view to increasing the impact of revalidation over the next five years, and I identify who should play a part in those developments.

Organisations should work with the GMC to increase public awareness of the assurance provided by revalidation

127 I have described revalidation as primarily a system for assuring the public that all doctors working in the UK are up to date and fit to practise. My review has confirmed the findings of research carried out by and for the GMC – that patients and the public are not generally aware of revalidation. In my view this is a missed opportunity as it means patients are not conscious of the increased assurance revalidation provides.

What patients and the public expect from medical regulation

128 The chief executive of one patient group commented: *"I think patients must feel that there is some means by which the GMC is checking that doctors are practising well, but I do not think there is any clarity about the types of feedback and the way that patients and the public can be involved."*

129 One medical director told me about some of the conversations he has had with relatives following a serious incident resulting in harm to a patient. His experience was that patients most want to hear that there are systems in place to prevent the same thing happening again. He told me that, when he explains to them how revalidation works and the evidence that feeds into it, they do feel reassured.

"We need to give patients the confidence that we have a governance and assurance system that works."

Royal college representative

130 I heard differing views as to how much detail the public needs in order to feel assured and sufficiently involved. Some of the people I spoke with felt that revalidation information for individual doctors should be made publicly available in their workplaces and online. Others felt that it would be sufficient for healthcare organisations to display information about the arrangements for regulating local doctors and healthcare services (of which revalidation is one part) and to confirm that their doctors participate in these arrangements.

131 I have tried to reflect the views of the profession, employers and system leaders and have attempted to synthesise the few opinions voiced by patient groups about how revalidation might be made more relevant to patients and the public. My conclusion is that the public don't need to see the 'wiring' of revalidation, but they should have confidence that the system that is in place is a robust and well-governed assurance process. And they should have access to the system so they can test that robustness for themselves. By way of example, designated bodies could, and in my view should, invite their patient groups to look at how revalidation works locally; where levels of local assurance need attention and where patient involvement could be strengthened. Patient groups could also be invited to provide an assurance statement annually.

132 Patients should understand that revalidation is one component of a wider set of processes designed to protect them and improve the quality of care. This would include – for example – knowing that any patient who is unhappy with their experience can make a complaint and, as well as receiving a response from the healthcare provider, that complaint will go into a doctor's portfolio for appraisal and revalidation. Equally, they should be able to see how compliments about a doctor's care are dealt with and should see the process that underpins the handling of serious incidents in which a doctor is involved and how this is reflected upon in appraisal and revalidation.

Increasing public confidence in revalidation processes

133 I am aware that many organisations already provide opportunities for patients and lay representatives* to contribute to local regulatory processes. For example, the Southern region of NHS England has six appointed lay representatives who are involved in the appointment of appraisers and in visits to service providers to quality assure local revalidation processes. Both Scotland and Wales include lay representatives in their revalidation review arrangements. This is to be encouraged. Such representatives provide a degree of independent scrutiny and challenge of the revalidation process.

134 I would like to see all healthcare organisations set out more clearly and publicly their local assurance arrangements, including the role played by appraisal and revalidation. I would also like to see local patient representatives invited to review periodically how those arrangements are working in practice, thereby gaining confidence on behalf of the wider public that local

* Lay representatives are drawn from the non-medical community but do not represent any specific patient group.

In my view, it would not be disproportionate to ask newly-licensed doctors to revalidate for the first time within two years of commencing their UK practice.

governance is robust. This will provide external validation of the revalidation process. Local patient representative groups will need support and guidance from both national patient organisations and local healthcare providers in order to fulfil this role effectively.

Recommendation

1. Healthcare organisations, with advice from the GMC and national partners, should work with local patient groups to publicise and promote their processes for ensuring that doctors are up to date and fit to practise, including the requirement for periodic relicensing.

135 Although I would argue for greater public access to the revalidation governance and assurance process, I am not suggesting that the public should play any direct role in the appraisal or in the revalidation recommendation. The outcome I seek is to increase public awareness and confidence in local regulatory processes that underpin and deliver the national revalidation system. I believe it should be a local decision as to how best to approach this, led by health departments in the four countries. But it would be useful for the GMC to set out some high level expectations and advice, perhaps through an update of the existing revalidation governance handbook.*

136 During my review I heard that doctors who are new to UK practice, regardless of whether they qualified in the UK or overseas, are sometimes surprised by the demands of revalidation. They may, for example, lack experience of undertaking structured reflection on their practice. Although these doctors have an annual appraisal, they currently have up to five years to cover the full requirements of revalidation, including reflecting upon patient and colleague feedback. In my view, it would not be disproportionate to ask newly-licensed doctors to revalidate for the first time within two years of commencing their UK practice. For doctors completing UK foundation training, this would form a logical and straightforward transition. For doctors joining from overseas, I believe an earlier first revalidation would be a helpful discipline and would contribute positively to public assurance.

* Effective governance to support medical revalidation: a handbook for boards and governing bodies.

Recommendation

2. The GMC should consider setting an earlier revalidation date for newly-licensed doctors so that they receive their first revalidation within two years of commencing practice in the UK.

137 At the end of the previous chapter I suggested that it would be helpful to agree some high-level quantifiable impact measures for revalidation over the next cycle. In addition to helping to reassure the public, they would be of interest both to doctors and to those who fund appraisal and revalidation. The GMC should work with local and national organisations, and in particular with patient representative bodies, to identify what measures might be appropriate and at what level data should be gathered and reported.

Recommendation

3. The GMC should work with stakeholders to identify a range of measures by which to track the impact of revalidation on patient care and safety over time.

138 A final point on terminology. In conversation with patient organisations I heard the view that the term 'medical revalidation' is simply not understood. To be clear, patients feel that the term does not convey the degree of importance attributed to the process. They felt that the patient feedback provided as part of a doctor's revalidation would be seen in a quite different light if the patient knew that this was part of a doctor being allowed to continue their practice in the UK. I asked those I met what they would prefer the process to be called and I heard that the term 'relicensing' would be more meaningful and more impactful. Irrespective of whether the name can be changed in legislation, I would like to see more accessible language used when communicating with patients and the public about revalidation.

Recommendation

4. The GMC and others should begin using the term 'relicensing' in place of 'revalidation', in order to increase understanding of the significance of the process for both patients and doctors.

We need to improve mechanisms for patient and colleague feedback

139 In the introductory chapter I spoke about patients' growing expectations of their doctors. In a report such as this it is difficult to truly represent the views of patients; when you have spoken to one patient – you have heard one view! However, I have heard enough from my interaction with patients and their representatives to be assured that there is an appetite among patients for greater involvement in the design and delivery of their care. This principle is supported by recent national initiatives such as the Shared Decision Making Collaborative: a group of organisations in England, including Healthwatch, NICE and Health Education England, who have pledged to support the wider health and care system to embed shared decision making into routine practice.

140 In looking to the next five years for revalidation, I believe that the aspiration of patients to move away from being 'passive recipients' of healthcare needs to be underpinned by a revalidation system that reflects the enhanced expectations patients have for their interactions with doctors.

141 The patient representatives I met for this review asked some pertinent questions about the role of patients in revalidation. How easy is it for patients to contribute to revalidation? How do we explain how the process works, including what happens if a doctor 'fails' revalidation? How do we reassure patients that giving feedback is a positive (and anonymous) step that will not adversely affect their future care?

142 While revalidation is not the main mechanism by which patients provide feedback on their care, it does provide a means for each individual doctor to reflect on feedback from patients about their own practice and – in combination with other information – to learn and improve as a result. Many doctors were already doing this before revalidation; but now the approach is more structured and consistent.

The challenge of obtaining high quality, representative feedback from patients

143 Most of the people I spoke with agreed that patient feedback is one of the most important elements of revalidation. A profession-wide survey by UMbRELLA found that a majority of the 26,000 responding doctors felt that patient feedback was the most useful type of supporting information to help them reflect on their practice.

144 But patients and their representatives tell me that the current mechanisms for gathering patient feedback for revalidation are not ideal. At least once in every five year revalidation cycle, each doctor must arrange for questionnaires to be distributed to their patients (or other recipients of their services) and they must demonstrate to their appraiser that they have reflected on the results. The most commonly identified problems with this approach are listed below.

- Patients are not given sufficient information about the purpose of the questionnaires, what sort of issues they should comment upon, and how their feedback will be used. For example, many are not aware that providing constructive, critical feedback about an individual doctor will be balanced with information from other sources during revalidation, and that is not the same as making a complaint.
- Patients are deterred from giving honest feedback by fears that it will not be anonymised and that critical comments may impact on the future care they receive. This is exacerbated by the 'official' appearance of the written questionnaire.
- Contributors to UMbRELLA's Patient and Public Involvement Forum were critical of the standard GMC questionnaire. They felt that some questions required them to express views beyond their expertise (for example, to indicate how good the doctor was at "assessing your medical condition") and that the questionnaire allowed insufficient space for free text comments.
- Patients, especially younger people, would like the opportunity to provide feedback online or via social media. Others, especially those who are not confident in reading or writing English, would like to be able to provide feedback verbally.

Employers and medical leaders told me: "We need to be more sophisticated around the expectation for patient feedback" and "We need a wider definition of what is meaningful feedback."

- Patient and lay representatives express concern that, due to conscious or unconscious bias, questionnaire respondents may not be truly representative of the range of patients seen by a doctor or cover the whole scope of their practice.

145 Doctors themselves have also identified shortcomings. I heard the following comments from doctors.

- The feedback is overwhelmingly positive, so there is not much chance to identify areas for learning or development (although positive feedback was still appreciated for providing reassurance and boosting confidence).
- Patients sometimes struggle to distinguish between problems with the system – for example, delays in getting access to treatment – and actions relating to the individual doctor.
- Collecting feedback once in a cycle (often covering just a single day's practice) does not provide sufficient, representative views for reflection. But it was felt by some that to collect it more often might be too costly or burdensome.
- Appraisers were felt to place too much focus on the volume of patient feedback obtained, as opposed to the quality of a doctor's reflection and learning.
- Although revalidation is about an individual doctor, much medical care is delivered in teams and it can seem artificial (and out of step with the principle of shared care) to ask patients to identify a specific doctor from within what might be a multi-disciplinary team.

146 Some doctors find it difficult to obtain feedback on their practice. Overall, 33% of respondents to the UMbRELLA survey said they found it either difficult or very difficult to collect patient feedback; a figure rising to 55% for those working in anaesthetics and intensive care, 50% for psychiatrists and 45% for doctors in emergency medicine. Doctors working in roles that do not involve patient contact also report difficulties, although GMC guidance does make clear that feedback can also be sought from other service users such as carers, students, customers or suppliers.*

Developing a more sophisticated approach to patient feedback

147 Employers and medical leaders told me: *"We need to be more sophisticated around the expectation for patient feedback"* and *"We need a wider definition of what is meaningful feedback."* I agree with these views. I would like the patient input to revalidation to be more representative of a doctor's whole practice and made easier for patients to provide.

148 While statistically valid, I am not convinced that a set of questionnaires – usually numbering around 40 or 50 and often collected on a single day in each five year cycle – provides sufficient quality and breadth of information to enable a doctor to reflect properly on their interaction with patients. I recognise that many doctors receive feedback through other means

* The GMC has published advice and case studies to help doctors in non-conventional roles to collect feedback – see www.gmc-uk.org/doctors/revalidation/colleague_patient_feedback.asp

(for example, patient participation groups in GP practices) and some will be reflecting upon such feedback on an ongoing basis. But others may not have that opportunity, either because they do not seek feedback or because it is difficult for patients to provide it.

149 I am interested in the concept of 'real time' feedback; feedback that could take place following any or all interactions a patient has with a doctor. A number of people have suggested we need to move beyond the concept of a single feedback exercise at a particular period of time and towards a continuous approach to seeking and reflecting on feedback. Patients have said that this would be more convenient and would make the process less daunting for them. One system regulator told me that real time feedback would fit well with their approach to inspection of healthcare providers.

150 But we need to explore the practicality of this approach before pursuing changes. Is a 'real time' approach feasible and manageable for revalidation purposes? How much of the responsibility for enabling patients to provide feedback should lie with individual doctors and how much with their organisations? How do we ensure feedback is open to all patients, including those whose condition may mean they require an advocate to ensure their voice is heard? Should real-time feedback replace the current questionnaires or supplement them? Does it matter if doctors use different approaches and the results cannot be directly compared?

151 I am also interested in making better use of technology to collect feedback. I have heard about organisations that have simple but effective feedback technology available for all patients in the waiting room. This might range from a touch screen in which the patient is asked a single question and can respond across a range of answers, to an iPad with multiple questions. I also heard a very creative suggestion that doctors could choose to have a Quick Response Code on their name badge which patients could scan with their mobile phone and then provide feedback via an app.

152 Although there are many ideas for alternative approaches to feedback, it is clear that they come with their own challenges and potential drawbacks. I am also aware that significant investment has been made in systems designed for the current approach. I do not want to recommend any specific changes to patient feedback mechanisms or questionnaires until they are tried and tested, and shown to be superior to existing methods without being excessively burdensome for doctors or patients.

153 I am aware that the Academy of Medical Royal Colleges is currently funding a review of patient feedback by the Royal College of Physicians. I look forward to seeing the findings of this review and hope the Academy will work with the GMC, patient groups, employers and regulators to identify changes that make it easier for patients to provide useful and productive feedback into the revalidation of doctors.

One RO told me that "the requirement to undertake colleague feedback helps deal with those doctors who drift incrementally towards the margins of good medical practice."

Recommendation

5. The GMC should work with others to identify ways to improve patient input to the revalidation process. In particular it should develop a broader definition of feedback which harnesses technology and makes the process more 'real time' and accessible to patients.

Maximising the impact of colleague feedback

154 Colleague feedback, which forms one of the required types of supporting information for appraisal, was a lively topic in many of my interviews.* Most doctors, ROs and appraisers spoke positively about colleague feedback and its importance in the revalidation process. One RO told me that: *"the requirement to undertake colleague feedback helps deal with those doctors who drift incrementally towards the margins of good medical practice."* But I also heard concerns that feedback from colleagues sometimes lacks the necessary objectivity, honesty and candour. For example, I heard from the Care Quality Commission that colleague feedback does not consistently identify doctors, whether in a hospital department or GP practice, whose behaviours are 'disruptive' and affect the cohesion of the department or practice. I was told by doctors that "we all know who these doctors are," but no one confronts the issue. It seems to me that this could translate into the quality and safety of care provided to patients.

155 Doctors have a professional obligation to 'speak up' when they have concerns about a colleague. Around 15% of appraisers who responded to the UMbRELLA survey said they have heard a doctor raise concerns about a colleague during appraisal; but we do not know whether those same doctors had also given candid feedback to the colleague concerned as part of the revalidation process. At present, some organisations allow doctors to choose which of their colleagues are approached to complete feedback questionnaires, while others have the choice made for them. I believe it would be helpful to review different approaches and determine which works best, drawing upon learning from other sectors.

156 I also heard that, when feedback does include critical comments, it is important that the appraiser is able to manage the discussion with the doctor sensitively. One royal college revalidation lead told me: *"We have found that colleague feedback works better when the appraiser approves or recommends which colleagues are sampled rather than the doctor selecting their 'friends'. Also, it is only useful if the quality of the appraiser/appraisal is good and there is appropriate reflection at appraisal and good communication with clinical leads or the medical director if appropriate."*

* The GMC requires doctors to seek feedback from colleagues and to review and act upon that feedback as appropriate. Feedback will usually be collected using standard questionnaires that comply with GMC guidance. Doctors should seek feedback from a range of colleagues, including non-medical co-workers (including other health professionals, managers and administrators) and medical colleagues (including trainees and juniors).

Boards should provide greater support and challenge

"Revalidation is an incredibly powerful tool. I don't think boards are aware of what they've got."

Medical director

157 I explained earlier how organisations have strengthened their systems of appraisal and overall clinical governance processes and become more accountable for those systems. I have also heard that revalidation has encouraged designated bodies to triangulate a range of information that didn't exist before – for example linking serious incidents involving a particular doctor or team to feedback from patients and colleagues about that doctor. These are important developments, but there is scope to get much more from the revalidation process and the information generated by it.

How organisations could benefit further from revalidation

158 It is understandable that, during the first cycle of revalidation, ROs and organisations have focused on establishing local processes to deliver revalidation and monitoring levels of compliance, such as appraisal rates. They have brought doctors into managed appraisal processes and helped make sure revalidation recommendations are made on time. 95% of organisations responding to the survey undertaken by *Boyd et al* said that they reported on appraisal to the governing body at least annually.

159 ROs in England are asked by NHS England to present an annual report on revalidation to their board or equivalent management team. I am aware that some ROs go beyond this to provide more frequent or broad-ranging information. I have also heard that some organisations involve non-executive directors in appraisal and revalidation processes, thereby giving enhanced oversight. I would like to see organisations extracting greater value from the investment they have made in local revalidation processes and challenging how governance processes could be improved.

160 System regulators tell me that high-performing healthcare organisations tend to have inquiring boards that offer both challenge and support across the span of their responsibility. I believe revalidation is a new and important tool that can provide assurance to boards (particularly non-executives) that the care provided to patients is safe and the doctors providing this care are up to date and fit to practise. The *Higgs Report* says: *"Non-executive directors need to be sound in judgement and to have an inquiring mind. They should question intelligently, debate constructively, challenge rigorously and decide dispassionately. And they should listen sensitively to the views of others, inside and outside the board."*

Suggested questions for boards and other governing bodies

161 I heard a number of suggestions for questions that boards could be asking of their organisations in relation to revalidation. I also have some suggestions of my own based on the experience of conducting this review.

- How are local appraisal and revalidation processes contributing to improving patient care and safety?
- How can we make the revalidation process less administratively burdensome for our doctors and reduce the workload of preparing for appraisal?

- What does appraisal tell us about education and training requirements for our organisation?
- Are we confident that doctors are giving honest and open feedback on their colleagues and that, where difficult issues are raised, they are being addressed? If not, how can we create an environment where this happens?
- How can we make local processes for doctors to gather feedback from patients easier and more representative? Should we be looking at using 'real-time' feedback in appraisal?
- Are we assured that, when our RO is considering the revalidation of a doctor, they have had access to all the relevant information from the doctor's work in other locations or previous posts?
- Are we confident that all revalidation recommendations are fair, based on all the relevant evidence and have been discussed with the doctors concerned?
- Are we learning from good practice in other organisations?

Recommendation

6. ROs should report regularly to their board on the learning coming from revalidation and how local processes are developing. Boards should challenge their ROs as to how they are learning from best practice and how revalidation is helping to improve safety and quality.

162 There are already networks of ROs and appraisers where good practice is shared. I would like to see all designated bodies brought into such networks so that those organisations or settings with less mature systems can learn what works and what the benefits are. Higher-level ROs (the ROs of ROs) could usefully give a lead on this. GP appraisers in Northern Ireland told me: *"The learning that you get as an appraiser you take back to your practice but we have not managed to get a process about how we capture that."*

163 The GMC and system regulators can do more to encourage and support local healthcare organisations and boards in maximising the benefits of revalidation. Organisations in the four countries jointly published a *governance handbook for revalidation* in March 2013. This document set out core elements of local governance needed to support revalidation but it does not reflect the learning we now have from the first cycle of the process and would benefit from greater ambition in places. I suggest it should now be updated and widely promoted to healthcare providers.

Recommendation

7. The GMC should work with others to update its governance handbook for revalidation and set out expectations for board-level engagement in revalidation and provide tools to support improvement.

We need to be clear what evidence is (and is not) relevant for revalidation

Some doctors raised concerns with me about the transparency and consistency of their local revalidation processes.

164 I have already welcomed the way in which government health departments and individual organisations have taken ownership of revalidation. I believe it is right that revalidation should be locally owned and managed as part of an organisation's wider governance and assurance processes, within an overarching framework set by the GMC. However, it is important that the overall purpose of revalidation as a UK-wide standard of assurance is maintained and that doctors have confidence that local decision-making is fair and consistent.

165 The doctors I met for this review told me that revalidation is a significant event in their professional life; it means they can continue to hold their licence and practise in the UK. I heard that to be revalidated feels like an achievement; that it is affirming and reinforces the professional standing of a doctor. But, if problems arise, it can also be a source of great anxiety. Some doctors raised concerns with me about the transparency and consistency of their local revalidation processes. Their concerns covered two broad issues.

- It is suggested that some appraisers or ROs are asking doctors to provide information or complete tasks, as a condition of revalidation, that are above and beyond GMC requirements.
- Doctors can sometimes perceive they have been treated unfairly when their RO makes a deferral recommendation to the GMC and there is no process by which they can challenge this.

I address each of these concerns below.

Clarifying mandatory requirements for revalidation

166 Individual doctors, their representative organisations and royal colleges have all raised concerns with me about employers adding requirements for appraisal or revalidation that go beyond those specified by the GMC. To be clear, I heard that some ROs are refusing to sign off a revalidation recommendation unless a doctor 'delivers on' a local 'priority'. I have been given examples of doctors being asked to carry out specific numbers or types of clinical audits; attend generic training courses; use specific templates or obtain fixed numbers of CPD points before they can be revalidated. These are not requirements for revalidation.

167 I have given careful thought to this issue. I want to make a clear distinction between the requirements of local appraisal processes – which are rightly a matter for individual organisations – and the strictly defined decision-making process leading to a revalidation recommendation. While revalidation is utterly dependent on good annual whole practice appraisal, the appraisal process generates benefits for the doctor and their organisation above and beyond the making of a revalidation recommendation. Organisations should, therefore, feel able to develop their approach to appraisal in a way that is efficient and effective for them.

168 It is not, of course, unreasonable for an employer to require job-related training. And some of this training will relate directly to a doctor's fitness and safety to practise – for example, I heard the example of a paediatrician who had been mandated to attend safeguarding training before the RO would make their revalidation recommendation. That makes sense. However, I

"The problem is the inappropriate implementation of requirements without flexibility to account for complexity. ROs and appraisers are taking the GMC vision and twisting it or creating myths."

Royal college representative

am less convinced that failure to undertake a clinical audit on a locally-specified topic should adversely affect a doctor's revalidation. Where doctors are being asked to carry out activities that go beyond the GMC's guidance, I would suggest that local processes other than revalidation ought to be used to secure compliance. At the very least these local requirements add an unnecessary burden; at worst they damage doctors' confidence in how revalidation contributes to increasing patient safety and demonstrating their professionalism.

169 I would like to see those who provide guidance for doctors on supporting information for revalidation – mainly the GMC and royal colleges – review that guidance in the light of experience of revalidation to date. With advice from ROs, appraisers and doctors, the GMC should look to distinguish more clearly between mandatory requirements and areas where there is scope for flexibility. And the colleges should make sure their guidance is complementary, providing specialty-specific examples but not creating new requirements. For example, the GMC requires doctors to undertake and evidence some form of quality improvement activity; but the doctor and their appraiser can decide what level and type of activity is appropriate. It would also be useful to provide more case studies and examples to help doctors and appraisers to understand the rationale for the mandatory requirements and how best to use the flexibility available.

170 I am aware that the GMC is already undertaking a review of its *supporting information guidance*, looking at how requirements can be made clearer and more accessible. This review includes wide discussion with key revalidation partners and revised guidance is expected to be available by the end of 2017.

Recommendation

8. The GMC should continue its work with partners to update guidance on the supporting information required for appraisal for revalidation to make clear what is mandatory (and why), what is sufficient, and where flexibility exists. They should also ensure consistency and compatibility across different sources of guidance.

Ensuring fair decision making

171 Most doctors are revalidated without difficulty. However, around 13% of recommendations made by ROs are to defer revalidation (excluding doctors in training from the data). This can occur because the doctor is involved in an ongoing local disciplinary process or, more commonly, because the RO decides the doctor needs more time to prepare all the necessary evidence. Deferral is described by the GMC as a 'neutral act', meaning that there is no implication that the doctor concerned is unfit to practise. Rather, they have not yet gathered all the supporting information needed for revalidation or the RO is awaiting information from other sources.

Given the significance of revalidation to a doctor's career, I believe it is important that processes are in place locally to assure the fairness of those judgements.

172 For this review, I approached a wide range of doctor representative groups to seek views on their experience of revalidation. In addition to the BMA, I invited input from groups representing black and minority ethnic (BME), women, lesbian, gay, bisexual and transgender (LGBT), and unwell doctors. In my meeting with the GMC's BME Doctors Forum I heard concerns that revalidation processes are sometimes being used to discriminate against BME doctors. Their perception, illustrated by specific examples, is that BME doctors are sometimes being recommended for deferral for reasons that are spurious or have not been applied equally to other doctors. They feel that, although deferral should be neutral, it is rarely delivered, experienced or perceived as such.

173 ROs must consider a wide array of evidence before deciding on their recommendation for a doctor's revalidation. Inevitably, there will be occasions when a doctor does not agree with their RO's judgement. Given the significance of revalidation to a doctor's career, I believe it is important that processes are in place locally to assure the fairness of those judgements. I am aware that some doctors question whether there is an inherent conflict of interest if the RO is also the medical director in an organisation.* Speaking personally, I do not believe the two roles are incompatible and I believe there is a strong argument for the RO to be a board-level position. What matters most is that organisations should have the leadership, culture and governance arrangements needed to operate fair and effective revalidation systems. However, it would be helpful if the ongoing evaluation of revalidation could explore the strengths and weaknesses of differing local approaches to the RO role.

174 As I touched on in the previous section, I would like to see boards take a more active role in overseeing the processes that support and deliver revalidation. They should be asking whether local quality assurance processes around appraisal and revalidation give sufficient consideration to questions of fairness. I have considered, but do not wish to recommend, enhanced GMC oversight of local decision making. It is for employers to make sure revalidation recommendations are made fairly. But I would be disappointed if employers did not establish robust local processes to enable doctors to challenge decisions they feel are unfair. I would also like the GMC to look in more detail at its data on deferrals and seek to understand why deferral rates vary across organisations or groups of doctors.

Recommendations

9. ROs should make sure that the revalidation process for individual doctors is not used to achieve local objectives that are not part of the requirements specified by the GMC.

10. Boards of healthcare organisations should make sure that effective processes are in place for quality assurance of local appraisal and revalidation decisions, including provision for doctors to provide feedback and to challenge decisions they feel are unfair.

* 65% of ROs who responded to the survey undertaken by Boyd et al were also the medical director of their designated body. A further 7% were an associate or deputy medical director.

Appraisal can be challenging as well as supportive

"Appraisal is the framework that allows doctors to get better."
Senior RO, NHS England

175 Annual whole practice appraisal is at the core of revalidation and is the main mechanism by which revalidation will deliver benefits for patients and doctors. Appraisal is not a construct of the GMC or of revalidation. But, as I have described earlier, one of the most significant impacts of revalidation has been to embed whole practice appraisal as an annual requirement for all doctors.

176 Many doctors are having good appraisals and reporting that the process helps them to reflect on their practice and make improvements. Most of the people I spoke with were very positive about appraisal. But I have also heard criticisms that revalidation has made appraisal a less productive experience for doctors.

Understanding negative attitudes to appraisal and revalidation

177 As I stated earlier, on closer inspection, many of the negative comments made by doctors about revalidation actually relate to their experience of appraisal. In their submission to my review, the UMbRELLA team provided information about the concerns most commonly expressed by respondents to their 2015 survey of the medical profession. I have also received direct comments from a number of doctors. The most common criticisms of the impact of revalidation on appraisal are below.

- **Revalidation has reduced the quality of my appraisal.** The UMbRELLA research suggested that the more standardised format and delivery of appraisal caused a 'loss of ownership' of the appraisal process and has focused it on judgement at the expense of learning. This comment arises especially in primary care where appraisal was more established prior to the introduction of revalidation.
- **Appraisal is just a 'tick box exercise'.** Some doctors have said that the introduction of revalidation has made their appraisal discussions too focused on compliance with evidence requirements at the expense of reflection on learning.
- **Preparing for appraisal eats into my personal time and the time I have available for patients.** The UMbRELLA survey suggested that some doctors are spending more time on appraisal and associated activities since revalidation was introduced. Many doctors question the benefits of this extra investment of time and energy.
- **My appraiser does not know me or my practice.** Some doctors question whether a doctor from outside their field of practice is in a position to help them to reflect and learn.

178 In my view some, but not all, criticisms of current approaches to appraisal are warranted. It is clear from comments I have reviewed on the GMC's website that some doctors simply don't think appraisal should apply to them. Here are three examples.

- *"We know we have to have revalidation to satisfy our paymasters. Our patients already love us."*
- *"The whole exercise was, for me, a headache. In some NHS institutions it may be beneficial but I fail to see how."*

An evidenced process of reflection and appraisal, drawing on experience and learning to identify personal development goals, is a given in almost every profession. It is the minimum the public should expect of doctors.

- *"When I got revalidated, it inspired me to retire; I informed colleagues that I'd be leaving the day after my next appraisal fell overdue. And I did, after enjoying a year free from 'reflecting' to order."*

179 I have also heard that doctors dislike filling in forms or having to document their reflection. I'm not sympathetic to those objections. An evidenced process of reflection and appraisal, drawing on experience and learning to identify personal development goals, is a given in almost every profession. It is the minimum the public should expect of doctors.

180 I do not subscribe to the view that it is impossible for an appraisal to satisfy both summative and formative goals. The positive experience of many doctors serves to dispel that myth. In other words, appraisal can provide evidence for a revalidation recommendation *and* support a doctor's learning and development. Nor have I seen evidence that appraisal cannot work if both parties do not share the same clinical background. But I do believe that success requires both a skilled appraiser and a well-prepared appraisee. Placing a regulatory framework on top of an appraisal process that was previously wholly developmental (or did not exist at all) has clearly presented challenges.

181 I would like doctors to see revalidation as a positive tool that they can use, with support from an appraiser, to make themselves better doctors. I expect some of the challenges of the first cycle to reduce as doctors and appraisers become more familiar with and confident around the new processes. But the experience of the first cycle suggests organisations need to take proactive steps to make sure the formative benefits of appraisal are retained, while also providing an assurance mechanism for patients and the public. These steps could include setting out expectations more clearly, ensuring appraisers have sufficient time for their allocated tasks, and strengthening quality monitoring.

Appraisal quality depends on both doctors and their appraisers

182 I asked some of the doctors I met to tell me, in pithy terms, what makes a good appraisal. The responses I received capture the importance of both the skill of the appraiser and the willingness of the appraisee to meaningfully reflect.

- *"Good appraisal is a formative supportive process, carried out by skilled appraisers, to enable the personal and professional development of the individual doctor."*
- *"In a good appraisal, I benefit from the facilitation of an expert peer appraiser who can help me to stop and reflect critically on my scope of work."*
- *"A good appraisal is one that doesn't place a huge additional administrative burden on a doctor and which is seen by them as their annual opportunity to review their practice and consider their plan/goals for the coming year."*
- *"In a good appraisal, by considering what has gone well, and what could have gone better, over the time since my last appraisal, and what challenges I can see ahead, I can plan for how to make changes that make a real difference to improve the care that I can provide."*

183 The GMC has set expectations for what doctors need to do for their appraisal and appraisers need to check that these requirements are met. In some sense, that could be construed as 'box ticking'. But doctors have a responsibility here too. One senior doctor told me: *"If you take a tick-box mentality, it will become a tick-box exercise."*

184 It concerns me if some doctors are having appraisal meetings consisting entirely of checking compliance with the rules. If the doctor has prepared properly and submitted their portfolio of evidence ahead of time, there should be plenty of time available for a flexible and informative discussion about the doctor's practice. By the same token, appraisers need to have the confidence to challenge appraisees. Having focused, challenging conversations can be difficult, but it is these conversations that really have impact and can be where the 'reflection' really begins.

185 I heard from, and read about, doctors who have been negative about appraisal and revalidation, but after having an appraisal with a good appraiser, have found it a valuable and affirming experience. One doctor wrote: *"I might have had negative comments to make about appraisal and revalidation two or three years ago. But I've changed my mind, or maybe my mind has been changed by the process! We've got to do it; it's a bit of a hassle but it's not that difficult if you put your mind to it. My last appraisal was a completely positive experience, has given me direction and has pointed me in the right direction for another revalidation when I'm even more elderly."*

186 The RCGP has published helpful *guidance for GPs*, emphasising the need for a proportionate approach.* It states: *"All doctors should have to meet the same standards to revalidate, no matter what their scope of work, and revalidation should not detract from patient care. You must not allow the effort involved in producing your documentation to become disproportionate by attempting to document every example of your reflective practice. Appraisal is a valuable opportunity for facilitated reflection and learning, sharing and celebrating successes and examples of good practice, and planning for the future. It is important that you and your appraiser keep a supportive and developmental focus on quality maintenance and improvement through your personal and professional development without a major increase in workload."*

* The RCGP has also produced a 'Mythbuster' document, to address common misunderstandings about appraisal and revalidation.

Improving the skills and confidence of appraisers

187 Appraisers need the experience and confidence to allow the necessary level of flexibility in their appraisals. They should be able to exercise their judgement about whether the doctor has met the requirements, but not limit the appraisal discussion to checking off requirements. They need to talk about reflection and improvement, and provide a 'proportionate' challenge to the doctor.

I have been very impressed by the leadership shown by appraisers locally. They have created networks to share good practice and improve consistency.

188 Many organisations have invested heavily in training and development for their appraisers and I applaud this level of commitment. As we enter the second cycle, this commitment needs to continue and to reflect the learning from the process so far. My review of the published literature tells me that, despite some ongoing challenges around resourcing and training for appraisers, revalidation has positively impacted on appraisers and their role by increasing the importance and visibility of appraisers and appraisal.

189 I have heard suggestions of specific areas for appraiser development. The BMA told me: *"Appraisers need better training on how to use and interpret data. GP appraisers are better at this than hospital ones. You need to focus on the important stuff and make sure it is not just an exercise in collecting diplomas or training courses. We need to make that clear to appraisers to prevent it becoming a tick box exercise and make sure there is a robust and respected link between the information held about our work and our appraisal. Otherwise appraisal occurs in a vacuum and feels like going through the motions. Fixing this would make the process more real for practitioners and also raise public confidence."*

190 Organisations also need to value their appraisers more, providing sufficient protected time for them to prepare. I would like to see greater acknowledgement (particularly from boards) about the crucial work appraisers do in the revalidation process. Appraisers and appraisal should be seen as one of the mechanisms through which the board gains assurance. I am also persuaded by the argument that, in order to maintain and develop their skills, appraisers need to do a minimum number of appraisals each year.

Developing and sharing good practice

191 I have been very impressed by the leadership shown by appraisers locally. They have created networks to share good practice and improve consistency. The Wales Deanery examines a percentage of appraisal summaries each year. In Scotland, lead appraisers do performance reviews of appraisal. Appraisers in Northern Ireland undertake a similar exercise. NHS England has published *quality assurance guidance for appraisal* and I understand that an appraisal network is well established at national and regional levels, with some designated bodies also running their own meetings.

192 There is ongoing debate around the selection of appraisers. Should a doctor choose their appraiser or have one allocated? Does the appraiser's background matter? The Medical Appraisal and Revalidation System (MARS) online appraisal system used in Wales prevents a doctor choosing the same appraiser more than twice in five years. In Scotland, on the other hand, doctors cannot select their own appraiser. There is emerging opinion that a mixed approach to matching appraisers with appraisees could be beneficial, and I share this view. Following a quality assurance exercise, the Wales Deanery recommended that secondary care doctors have at least one appraisal by an appraiser who is outside their field of practice/specialty.

193 It is probably still too soon to understand fully the anatomy of successful appraisal. I am conscious of the fact that the long-term evaluation of revalidation being carried out by the UMbRELLA consortium has a work stream focused on appraisal. Alongside other research, this work should help us to gain a better understanding of what works. In the meantime, I believe the priority for healthcare organisations should be to raise the quality of appraisal locally, so that it has increasing value in the eyes of doctors and contributes reliably to assurance for patients.

Recommendation

11. Healthcare organisations should continue work to drive up the quality and consistency of appraisal, learning from feedback and acknowledged good practice. They should also make sure the time set aside for appraisal adequately reflects its importance to revalidation outcomes.

We can reduce burdens for doctors

194 Revalidation attests the fitness to practise of individual doctors. It is therefore right that each doctor is responsible for drawing together and presenting the required evidence. But I believe healthcare organisations also have a responsibility to make the process as efficient and effective for doctors as possible.

195 One senior doctor told me: *"Doctors perceive the need for revalidation: no-one says get rid of it. But doctors complain about burden of paperwork; not just the quantity of paperwork but whether it is the right paperwork. Will it flush out the people who are not practising as the GMC would like? Will it reduce harm?"* I have argued earlier that revalidation is not just about early identification of poor performers. But clearly it is problematic if doctors feel that the burdens of the process outweigh the benefits.

196 Doctors told me about the frustrations they experience in preparing for appraisal and revalidation.

- **Difficulty accessing personalised information on activity and outcomes.** Other than consultants, most hospital doctors do not have their work recorded under their name, so they struggle to identify evidence through their employer's treatment and patient care records systems. This also affects locums and SAS doctors. The *BMA's Charters for Staff and Associate Specialty Doctors for each of the four UK countries* emphasise that, where appropriate or applicable, patients and work activity should be coded under an SAS doctor's name.

I believe all the supporting information that the GMC specifies for appraisal has a valuable purpose. It is the ease of collecting this information that needs attention.

- **Time wasted in extracting information from a variety of different work-based systems.** I heard that it can take considerable time for some doctors to identify and extract the information required for their appraisal portfolio from multiple IT systems covering quality outcomes, complaints, serious events, patient feedback etc. As one appraiser told me: *"We're asking doctors to work in three or four different systems to extract the data they need for appraisal."*
- **Insufficient allowance in contracted hours for reflection and development.** For most doctors, preparation for appraisal and revalidation is undertaken in their own time. One royal college representative told me: *"Everyone has the best of intentions but doctors also have the day job."*
- **The amount of time needed to prepare for the appraisal discussion.** Respondents to the UMbRELLA survey indicated that, on average, they spent 14.5 hours in direct preparation for their most recent appraisal, including collating and completing paperwork and attendance at the appraisal meeting itself. Some spent much longer. This time is on top of ongoing learning and development activity.

197 When considering whether the demands of revalidation are proportionate, I want to make a clear distinction between personal and organisational development activity (which was, or should have been, occurring at a similar level prior to revalidation) and the extra administration involved in collating the specific supporting information required by the GMC for revalidation.

198 I believe all the supporting information that the GMC specifies for appraisal has a valuable purpose. It is the ease of collecting this information that needs attention. I recognise that there will always be an element of local variation and personal choice in the amount of time a person spends putting together a portfolio of evidence. One doctor told me: *"It depends on your personality and your appraiser. Some people collect reams of information, whereas I just do what I need to do."* I also think it likely that doctors will find the process progressively easier and quicker as they experience it for a second and third time.

199 But there remains scope for organisations to better support their doctors by providing, or enhancing, the systems or advice available to support appraisal and revalidation. The GMC has itself made assumptions about the quality of local information systems: *"Revalidation is concerned with how doctors perform in practice. Therefore workplace systems of clinical governance and appraisal need to be sufficiently mature to enable doctors to collect the information they need for their revalidation and for that data to be properly evaluated in the workplace."*[*]

* GMC, *Revalidation impact report*, submitted to RAB June 2015.

Better use of technology

200 Technology is part of the solution. I would like to see doctors being easily able to access all relevant clinical governance data from across the organisation. They should be able to download into their portfolios any relevant complaints and compliments, colleague and patient feedback and patient care and treatment data. I believe doctors should be able to record reflections in real time straight into their portfolios. I want organisations to consider the value of smart data transfer technology inside their organisations and the inter-operability of appraisal and revalidation systems within and between the four country systems; supporting doctors to assure patients (and themselves).

201 I have heard some good examples of how organisations have set up systems to make information sharing throughout the organisation easier. One doctor told me how she helped set up a bespoke system that allowed doctors to access information from different parts of the healthcare provider and drop them into their e-portfolio. It also allowed doctors to request information such as complaints and compliments directly from the complaints department.

202 At the UK level, the four countries have taken different approaches to information systems for appraisal and revalidation. Scotland and Wales developed whole-country systems prior to the introduction of revalidation and a single system for collecting multi-source feedback. These systems were seen as critical to the smooth rollout of revalidation in those countries by the system leaders and doctors alike. In England, a range of different commercial and in-house systems are in use, although I am aware that NHS England is now rolling out a national system that is similar to those used in Scotland and Wales.

203 I do not believe that technology can solve all the challenges presented by the first cycle of revalidation and am wary of recommending major investment to change existing systems or develop new ones. But it does appear that frustration with information systems is a major source of grievance in relation to appraisal and revalidation. I would suggest that future developments should address two broad objectives.

- **Ensuring revalidation considers the whole of a doctor's scope of practice.** Systems should help appraisers and ROs to access easily all the information needed to make a revalidation recommendation about a doctor. In particular, there is scope to increase the inter-operability of systems within and between UK countries to make sure revalidation decisions for doctors who work in multiple locations (including locums) are robust and based on evidence covering the doctor's whole scope of practice.
- **Reducing burdens for doctors and appraisers.** Where possible, systems supporting appraisal should be designed to increase the ease and speed with which doctors can collate their evidence. The e-portfolio systems used by postgraduate doctors in training seem to have the support of these doctors and might be a model to build upon.

I would like to think that in five to ten years' time there will be an online lifelong learning system that doctors across the UK can access throughout their career.

204 The GMC has developed a CPD app. It allows doctors to make a record of their learning or reflections 'on the go' on a mobile phone or tablet. It recognises that there are opportunities for learning every day and that doctors don't always have time to note them down. I would like the GMC to consider whether any value would be added by extending their CPD app to cover some of the other supporting information categories. This might help doctors who do not work in standard employment settings.

205 I would like to think that in five to ten years' time there will be an online lifelong learning system that doctors across the UK can access throughout their career. This is already starting to happen in Scotland. It would reflect their learning from medical school through to retirement and would help to develop doctors more effectively. It would talk to other systems, facilitate the sharing of information between employers, and help to bring locum and other more isolated doctors into a shared environment. This is my ambition.

Administrative support and advice

206 Technology is not the only way to support doctors. And it may not always be the most effective way of solving the problems identified. One senior RO told me: *"I would rather put the resource into the quality of the appraisal than a new IT system."*

207 I have seen organisations that have dedicated teams who help doctors to collate their supporting information in advance of appraisal. Some also provide (optional) templates and tools to support reflection. This is something that doctors value. I heard that one designated body in the independent sector collates a data pack of all complaints, incidents, outcomes, prescribing information, audit results and other governance information for their doctors each year and sends it to them in advance of their appraisals. The majority of their doctors have their prescribed connection to another larger designated body, but they are supporting the doctors to discuss their work in the independent sector at their appraisal.

208 I recognise the varying size and complexity of healthcare settings and would not wish to be prescriptive. But I recommend that organisations consider whether a local support function for revalidation would be a worthwhile investment in terms of the time freed up for doctors to concentrate on their clinical duties. The ELS tell me that a number of ROs have drawn attention to a lack of local HR support and resources and the challenge this can present to delivering their role effectively.

Recommendation

12. Healthcare organisations should explore ways to make it easier for their doctors to pull together and reflect upon supporting information for their appraisal. This might occur through better IT systems or investment in administrative support teams.

The addition of revalidation to existing processes of medical regulation places an obligation on those involved in assurance to share intelligence with others.

Reducing duplication in the regulatory system

209 I heard from the English GPs I met during my review that some of the information they need to gather for appraisal and revalidation duplicates what is requested by the CQC inspection process. I understand this particularly affects GPs in small practices. In England, the GMC, CQC and NHS England have recently published a *joint statement of intent around reducing regulatory burdens on general practice*. This is a promising development, for which I commend those involved. But I heard there is more work to be done to reduce burdens in practice.

210 The addition of revalidation to existing processes of medical regulation places an obligation on those involved in assurance to share intelligence with others. For example, I would expect system regulators to use information coming out of revalidation to inform their judgements around the quality and impact of clinical governance in the organisations they inspect. One doctor told me: *"CQC do not look at the quality of revalidation processes generally, which is a missed opportunity. Also, their questionnaire only asks about audit rather than the broader spectrum of quality improvement activity."*

211 In addition, the CQC told me that they would expect to see greater coherence between their inspection scores for hospital and GP services and the revalidation status of the doctors who work in those services. This is a complex issue because the scope of inspection differs significantly from that of revalidation. However, I believe there would be merit in the GMC, CQC and NHS England exploring whether further changes are needed to better join up regulatory systems. This work might also uncover issues that would be of relevance to systems in Scotland, Wales and Northern Ireland.

Recommendation

13. The GMC should continue its work with the CQC and NHSE in England to reduce workload and duplication for GPs, and work with relevant organisations in Northern Ireland, Scotland and Wales to identify and respond to any similar issues if they emerge.

Revalidation processes must be equally robust for all doctors

212 I believe that, for the vast majority of doctors, revalidation processes are rigorous and effective; they provide good assurance that doctors are up to date and fit to practise. But it has become apparent to me that there are some weaker points in the system. To put it simply, I do not have the confidence, at this point, to say to patients that every doctor is subject to the same high standard of whole practice appraisal or that ROs always have sight of all relevant information about a doctor's fitness to practise. I should, however, qualify this by saying that patients should draw considerable confidence from the fact that all doctors are now in a managed system of governance with whole practice appraisal taking place annually and revalidation leading to a doctor being relicensed every five years.

We need to strengthen assurance around locum doctors

213 It is increasingly common for doctors to work as locums, for lifestyle or other reasons. That is not a problem in itself – most of these doctors are good doctors, and many healthcare providers rely on them and speak highly of the contribution they make. However, I am hearing that the increasing mobility of the healthcare workforce is putting strain on assurance systems, including revalidation. One lead appraiser told me: *"Locum doctors are generally perceived to be a greater risk for a variety of reasons, many of which are systemic rather than related to the individual practitioner. A 'perfect storm' of risk occurs where a short-term locum doctor from a poorly organised agency is given an urgent short-term placement in an organisation with poor governance procedures."*

214 In England, when the NHS or other public sector healthcare providers need temporary or fixed term cover they can secure medical services through a locum agency which appears on the *Crown Commercial Service (CCS) Framework Agreement list*. An agency on the Framework list is able to supply locum doctors from its own pool or can rely on doctors sourced from pre-approved sub-contracting locum agencies. Under the RO Regulations, an agency that supplies medical locums under the Framework Agreement to NHS bodies and the wider public sector is deemed to be the designated body for doctors contracting with it.

215 I have some concerns about the current position for revalidation of locums.

- There is some confusion as to where prescribed connections lie for secondary care locums in England, especially where the doctor is employed by a sub-contracted agency. This situation appears to be caused by a lack of clarity in both the RO Regulations and the CCS Framework Agreement.
- I heard that not all locum agencies are properly fulfilling their responsibilities as designated bodies in terms of ensuring that locum doctors are up to date with appraisal and supporting them to collect and reflect upon the evidence required.
- Deferral rates for locum doctors are higher than for any other group. It has been suggested to me that one reason for this is the difficulty experienced by ROs in accessing all the information they need to make revalidation recommendations for locum doctors.

The public has the right to expect that governance arrangements are of the same high standard, regardless of the size or type of organisation that is responsible for a locum doctor's revalidation.

216 I regard the lack of clarity around revalidation arrangements for locums as unacceptable. The public has the right to expect that governance arrangements are of the same high standard, regardless of the size or type of organisation that is responsible for a locum doctor's revalidation; public protection and the rules of good governance are paramount. Recognising these overriding priorities, there needs to be certainty about the identity of the organisations that exercise the statutory responsibilities of being a designated body – particularly bearing in mind that it falls to the Secretary of State for Health (following consultation with the Scottish or Welsh Ministers or Monitor, as appropriate) to nominate an RO for any designated body that fails to appoint an RO themselves. And those bodies that are designated bodies by virtue of the RO Regulations need to be clear about their responsibilities.

217 I would like the Departments of Health in England (in consultation with Scotland and Wales) and Northern Ireland to look again at the provisions in the RO Regulations for connecting locum doctors to a designated body to make sure that locum doctors have a clear connection to an organisation that is accountable and has robust clinical governance systems. I also want to see the responsibilities that locum agencies are required to undertake under the RO Regulations (and the consequences of failing to do meet them) being made clearer – preferably through terms within the Framework Agreement/Contract.

218 I am also concerned about the potential for information about a locum's revalidation and appraisal history to be lost when a doctor moves between provider organisations and roles. My starting point – and one that I am sure the public would share and expect – is that, when a doctor moves between designated bodies, and between postings, information pertaining to their revalidation should move with them. So there needs to be a clear obligation to share information on an appropriate basis where this is relevant to a doctor's revalidation.

219 As I mentioned when discussing fairness in decision making, I would like the GMC to undertake further analysis to identify the reasons behind higher deferral rates for some designated bodies and to share that information. Boards and healthcare providers can use the data to improve the efficiency and effectiveness of the delivery of high quality healthcare in their organisation.

Improving information sharing across designated bodies

220 Earlier in the report, I explained my concerns that locum doctors (and their ROs) are not always receiving proper feedback on their performance, including details of any concerns. This is not acceptable from a patient safety perspective and does not afford the doctor the opportunity to understand how to strengthen and improve his or her practice, to reflect and make the necessary changes. Locum agencies need to work with hospital trusts and other receiving organisations to share information relating to the revalidation of these doctors. And ROs should be cognisant of their own duty, applying to all doctors, to raise any concerns about colleagues at an appropriate level (in the case of locums, this would be their employing or contracting authority).

"Are there ways the system could better support doctors without a designated body? They are getting a raw deal and are probably the doctors who need revalidation most."

Faculty revalidation lead

221 I have heard that ROs of locum agencies and membership organisations (who do not directly employ the doctors who are connected to them) are not always able to obtain information about concerns and any subsequent investigations involving their doctors. These ROs are often reliant on the employer/contractor to notify them when there has been a concern and to undertake the investigation. The GMC's ELS tells me that ROs have noted several examples where this has not happened and they have only become aware of the concern because the doctor has told them. This represents a significant weakness in a system that is intended to provide assurance to patients and it must be addressed.

222 ROs making revalidation recommendations need to be confident that they are seeing all of the doctor's practice. This requires organisations, including agencies, to share information. The issues around locum doctors and doctors working away from their designated body present a strong case for my earlier suggestion to improve the inter-operability of systems around appraisal and revalidation.

Recommendation

14. The GMC should work with health departments and ROs to address weaknesses in information sharing in respect of doctors who move between designated bodies.

All doctors working in the UK should have an RO

223 Throughout the development of revalidation, it was known that there would be doctors who did not have an obvious designated body to oversee and support their revalidation. However, when the RO Regulations were drawn up, it was not anticipated quite how many doctors would lack a prescribed connection and yet want to keep their licence. I understand from the GMC that, while the number of licensed doctors without a connection is falling, there are still around 4,360 doctors in this position, of whom 750 are currently engaged in clinical work with patients in the UK. As I have already said, from a patient safety perspective, that cannot be right.

224 I have heard a range of opinions about doctors who have no connection, from the need to offer more support and flexibility to these doctors to the heightened risk presented by doctors working in environments without established clinical governance. One faculty revalidation lead asked me: *"Are there ways the system could better support doctors without a designated body? They are getting a raw deal and are probably the doctors who need revalidation most."*

225 The GMC explored a range of mechanisms that it could use to revalidate doctors without connections. These options were limited in critical ways by the legislation. For example, the GMC has no power to require a doctor to give up their licence if they are no longer practising in the UK. And it has no power to enforce a connection to an SP, even if the doctor meets the criteria for connecting to that SP. Finally, there is no provision for any authority to force a particular organisation to accept its obligation to be a designated body under the RO Regulations and to appoint an RO.

226 The SP route has allowed over 1,000 doctors to connect to an SP to support their revalidation. There may be disappointment in some quarters that more individuals and organisations have not stepped forward to become an SP, but I would not support calls for the GMC to lower its standards. It must be right that potential SPs are required to demonstrate that they can deliver the high standards of clinical governance expected.

227 The current revalidation process for doctors without an RO or SP who wish to retain their licence has two aspects: they must provide a return to the GMC each year with appraisal details and statements that there are no known fitness to practise concerns from organisations to which they provide medical services; and, where the GMC decides that it is reasonable, they must sit a written test of knowledge once every five years. I do not consider those to be unreasonable requirements. But I do recognise that they may not reflect the doctor's exact scope of current practice to the same degree as the RO/SP model for revalidation.

228 I want to recognise the progress that the GMC has made in developing assurance arrangements in respect of doctors without a prescribed connection. However, I am not confident that current revalidation arrangements for unconnected doctors provide the same level of assurance to patients as those for a doctor subject to clinical governance via an RO. I believe there should be an expectation that more robust measures will be put in place during the next cycle of revalidation.

229 In thinking about how to tackle this issue, I am conscious that the cohort of doctors without a connection is very diverse and also that it is constantly changing. It includes the following groups:

- Doctors who definitely require a licence to practise in the UK for their current work, but who are unable or unwilling to connect to a designated body or SP.
- Doctors who do not require their licence at the present time but expect to need it in the near future. This includes those who are temporarily overseas (including some working for charities), on a career break, or suffering from ill health. I have heard that some UK employers give preference to doctors holding a current licence when shortlisting for posts. If true, this is of dubious legality.
- Doctors who are unsure whether a licence is needed for their current work. This includes those undertaking medico-legal work that does not involve direct patient contact and some doctors working in managerial or civil service roles.
- Doctors who are working permanently and wholly overseas and therefore do not require their UK licence to practise (but, by law, are entitled to keep it).
- Doctors who are not undertaking any formal medical practice but wish to keep their licence, perhaps because they advise or prescribe on an occasional basis.

230 The diversity of doctors without connections makes it very challenging to arrive at an approach to revalidation that appears fair and proportionate to those doctors whilst also delivering the level of assurance that the public has a right to expect. Certainly, no-one I met was able to suggest an immediate solution that would meet my expectations – on behalf of the public – that every doctor holding a licence and, therefore, capable of practising in the UK is subject to the same high standards of appraisal and revalidation.

231 I believe the solution lies partly in legislative change and partly in the provision of better advice to doctors and employers. Firstly, I would like the Departments of Health in England (in consultation with Scottish and Welsh Ministers) and Northern Ireland, in discussion with the GMC, to review the RO Regulations with a view to establishing a prescribed connection to a designated body for all doctors who need a licence to practise. The current situation – whereby a doctor may be required by statute to hold a licence (for example, those acting as crematoria referees or approved under section 12 of the *Mental Health Act*) and yet not have a prescribed connection under the RO Regulations – is not sustainable.

232 Secondly, I would like organisations that use the services of doctors in the UK to accept that they should be making sure that those doctors are subject to robust clinical governance, including annual whole practice appraisal, and are properly supported with their revalidation. This could be achieved either by appointing an RO or ensuring that the doctor makes a connection elsewhere. At the very least, bodies that commission medical services should reflect upon whether they require the doctor to hold a licence to practise (as opposed to registration alone) for that role and be clear about the reasons why. The GMC could assist by providing clearer guidance on the roles that do and do not require a licence and indicating where explicit legal advice might be needed.

Recommendation

15. The Departments of Health, in consultation with the GMC, should review the RO Regulations with a view to establishing a prescribed connection to a designated body for all doctors who need a licence to practise in the UK. They should also review the criteria for prescribed connections for locums on short-term placements.

Closing thoughts

4

My key messages for those involved in revalidation

Revalidation, alongside and underpinning other clinical governance and regulatory systems in the four countries of the UK, places the safety of patients as central to its purpose.

For patients and the public

233 Most patients who have an interaction with a doctor in the UK do so through the NHS. The opening paragraph of the *NHS Constitution for England* reminds us that: *"The NHS belongs to the people."* It goes on to say: *"It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most."*

234 Most, if not all, doctors will have given witness to the *Hippocratic Oath*, possibly the most famous text in western medicine. A line from that text reads: *"And I will use treatments for the benefit of the ill in accordance with my ability and my judgment..."* I am assured that, since the introduction of medical revalidation, licensed doctors can now evidence that they continue to be up to date and fit to practise as a doctor in the UK. I am further assured that all doctors holding a licence to practise in the UK are now in a managed system of governance that requires them to undertake an annual whole practice appraisal and to be revalidated (relicensed) once every five years. Revalidation, alongside and underpinning other clinical governance and regulatory systems in the four countries of the UK, places the safety of patients as central to its purpose. Patients and the public should be assured that many of the recommendations I have set out in this review seek to further strengthen patient safety. But I want you, as patients, to be assured too. I make recommendations that patients through patient representative bodies should be able to validate this most important of all reassurance systems. I also want your experiences of the interaction you have with doctors to play a bigger role in their reflection and learning and I recommend ways that this can be achieved.

235 I want to make it easier for you to give feedback on your doctor. Currently, a doctor may obtain and reflect on patient views only once in each revalidation cycle. While this feedback will be valuable, I would like to shift the balance towards making it easier for you, as patients, to feedback on any interaction you have with a doctor. Real-time feedback should over time become commonplace. Bodies that represent the views of patients and the boards of healthcare organisations should consider how you, as patients, can inform the discussions about how this might best be achieved.

For doctors

236 I started this review believing that revalidation existed primarily to assure patients that doctors were current in their practice and fit to practise. I still believe that, but have developed a greater appreciation of the benefits of the process to healthcare organisations and to doctors themselves. I believe that revalidation underpins and evidences the professional standing of a doctor. Richard Horton, editor of the Lancet and prime author of a *report on medical professionalism from a working party of the Royal College of Physicians*, wrote: *"Professionalism is medicine's most precious commodity."**

* Horton, Medicine: the prosperity of virtue, *The Lancet*, Vol. 366, No. 9502, p1985–1987, 10 December 2005.

237 I hear and share doctors' concerns about the cost and administrative demands of the appraisal and revalidation process. I am asking healthcare organisations, the GMC and system regulators to look at practical ways they can reduce the time and effort needed to prepare for appraisal. I am also asking organisations to continue work to improve the quality of appraisal and to make sure they have processes in place to assure the fairness of local revalidation processes. However, I do not want to recommend lowering the evidence requirements or the standard of assurance that revalidation provides to patients.

238 For doctors without a connection, I recognise the difficulties and anxieties you have faced in meeting revalidation requirements. In my view, the system needs to change; recognising that, provided you need a licence, you should be better supported. But I will not sanction a lesser standard of revalidation for licensed doctors who work only occasionally or have a very limited scope of practice. That wouldn't be right for patients. I believe it would be best if every doctor who needs a UK licence to practise had a connection to an RO. While I understand this will require legislative change, I still believe this should be seen as a realisable ambition.

For ROs and boards of healthcare organisations

239 This report recognises that you have played a critically important role in the successful delivery of revalidation. I also believe that ROs and their organisations are in a good position to know how processes can be improved and, indeed, have already begun to do this.

240 I would like to see continued progress in increasing the quality of appraisal, so that every doctor can benefit from a supportive yet challenging appraisal. I would also like you to look at ways you can reduce the administrative demands on doctors. I believe this will help doctors to buy in to the process. In addition, you should seek to raise public awareness of revalidation. I would like you to invite patient representative bodies to look at this important system of governance and offer advice about how, locally, patients could be further reassured about their doctors' fitness to practise. This could be achieved by working with local patient bodies, for example the Scottish Health Council, the Community Health Councils in Wales, Healthwatch in England and the Patient and Client Council for Northern Ireland.

241 This report contains a number of messages for boards. The fact that every doctor in your healthcare organisation is supported, by you, to be appraised annually, and to reflect on colleague and patient feedback is a strong message to patients and the public that you take this aspect of your clinical governance responsibility seriously. Demonstrating that these same doctors are evidencing that they are also up to date and fit to practise through the revalidation and relicensing process is reassuring and confidence building for patients. Discussing appraisal rates and the outcomes and learning from revalidation at board meetings underpins that commitment. Giving every patient the supported opportunity to feedback on their interaction with your doctors supports the new approach to revalidation that I recommend in this review.

I would like to see the GMC supporting local healthcare organisations in promoting awareness of revalidation and strengthening their governance arrangements; and working with system regulators to reduce duplication.

For the GMC

242 I want to acknowledge the significant role that the GMC has played in the successful implementation of revalidation. From my perspective as Chairman of RAB, the GMC has provided clear and professional leadership to the planning and introduction of revalidation. It has led on the principles and key requirements, while being willing to step back and allow local processes to take shape.

243 Annual whole practice appraisal and revalidation are now embedded throughout the four countries and increasingly seen by doctors as part of the norm of being a doctor. To have achieved this degree of operationalisation and broad acceptance of revalidation in barely four years is remarkable and worthy of recognition in this review. The GMC will continue to be seen to lead revalidation into and through the second cycle. I urge the GMC Council to carefully review the recommendations in this report and to seize the opportunities they provide to increase assurance to patients that doctors are up to date and fit to practise.

244 The GMC will also need to hear the voice of those doctors that find revalidation to be more difficult, more time consuming and perhaps more arduous than it should be. They should work with royal colleges and others to clarify guidance on appraisal. And they should use the data gathered on revalidation to investigate concerns around deferral rates and to consider some high-level impact measures.

245 I would like to see the GMC supporting local healthcare organisations in promoting awareness of revalidation and strengthening their governance arrangements; and working with system regulators to reduce duplication. I have also raised in this review that patients and the public struggle with the term 'revalidation' but instantly connect with 'licensing' and the concept of 'relicensing'. Now may be the time for the GMC to revisit this terminology. And I have suggested that consideration be given to an earlier revalidation date for doctors completing UK foundation training and those from overseas who are new to UK practice.

246 Finally, I have encouraged the GMC and national governments to take another look at the RO Regulations with a view to strengthening oversight of locums and doctors who work outside managed environments. Legislation is not the only possible avenue for increasing assurance in relation to these doctors, but I believe the overall revalidation system would be considerably strengthened if all doctors who practise in the UK were to be given a prescribed connection to a designated body.

4

What I would like to happen next

247 This report was commissioned by the GMC and delivered to their Council. However, by no means all my recommendations are addressed to the GMC. This reflects the fact revalidation is, to a large degree, owned and operated by designated bodies and ROs. GMC leadership and support is vital, but many of the actions I suggest will need to be taken at a local level.

248 When responding to my report, I have asked the GMC to consider how it will co-ordinate and monitor the activity needed to implement my recommendations. I have further suggested that this should include a review of the role, membership and functions of the current Revalidation Advisory Board, which I chair.

249 I believe my recommendations are pragmatic and can be largely delivered within the next five years. In particular, I would expect to see early action to strengthen revalidation processes for locum doctors, remove unnecessary burdens for doctors and increase public understanding of the purpose and impact of revalidation.

Annex A – List of people I met

Organisation	Representatives
Academy of Medical Royal Colleges, England	Professor Dame Sue Bailey, Chairman Mr Alastair Henderson, Chief Executive Professor Graham Layer, Academy's CPD Lead Dr Andrew Long, Academy's Remediation Lead Dr Ian Starke, Chair of the Academy Revalidation and Professional Development Committee and Chair of the Patient Feedback Group
Association of Independent Healthcare Operators	Lene Gurney, Practice and Policy Advisor Dr David Mitchell, Responsible Officer for the Hospital of St John and St Elizabeth
BME Doctors Forum, GMC	Professor Iqbal Singh, Chair of Forum Dr Babatunde Gbolade, President, Medical Association of Nigerians Across Great Britian (MANSAG) Dr Alam Khan, Pakistani Medical Association Dr Ramesh Mehta, President, British Association of Physicians of Indian Origin (BAPIO) Professor Iqbal Memon Dr Murthy Motupali Dr Anthea Mowat, Chair of the BMA representative body, and the BMA's equality, diversity and inclusion advisory group Dr Umesh Prabhu Dr Gurpreet Singh
British Medical Association	Dr Peter Bennie, BMA Chairman, Scotland Dr Sara Hunt, Deputy Chairman, BMA Welsh Consultants Committee Dr Mark Porter, BMA Chair, England Mark Hope, Senior Policy Advisor
Care Quality Commission	Professor Ted Baker, Deputy Chief Inspector of Hospitals David Behan, Chief Executive Professor Steve Field, Chief Inspector of General Practice Peter Wyman, Chairman
Department of Health, England	Dr Nick Clarke, Deputy Director, Professional Standards Branch and Workforce Division Professor Dame Sally Davies, Chief Medical Officer
Faculty of Public Health	Dr John Woodhouse, Responsible Officer

Faculty of Pharmaceutical Medicine	Sam Hutchinson, Revalidation Manager
Faculty of Sport and Exercise Medicine	Yvonne Gilbert, Executive Manager
Health and Social Care in Northern Ireland	Bob Magill, Business Partner Medical & Dental Workforce, South Eastern Trust Dr Charlie Martyn, Medical Director, South Eastern Trust Dr Moya McAleavy, Medical Adviser, Health and Social Care Board Helen Rogers, Revalidation Manager
Health Education England	Dr Julia Whiteman, Postgraduate Dean
Health Foundation	Gavin Larner, Policy Associate
Healthcare Improvement Scotland	Leslie Marr, Senior Programme Manager Steven Wilson, Programme Manager
Healthcare Inspectorate Wales	Kate Chamberlain, Chief Executive Alison Kedward, Clinical Director
Independent Doctors Federation	Mr Ian Mackay
Individual doctors speaking in a personal capacity	Dr Dean Marshall Dr Anthea Mowat Dr Daniel Redfern Baroness Finlay of Llandaff
Alliance Manchester Business School	Professor Kieran Walshe, Professor of Health Policy and Management
NHS Education for Scotland	Niall Cameron, National Appraiser Advisor
NHS Employers	Bill McMillan, Assistant Director, Medical Pay and Workforce Sarah Parsons, Medical Workforce Manager

NHS England	Dr Maurice Conlon, National Appraisal Lead Professor Sir Bruce Keogh, National Medical Director Dr Andy Mitchell, Regional Medical Director (London) Dr Mike Prentice, Regional Medical Director (North) Dr Nigel Acheson, Regional Medical Director (South) Attended meeting of senior medical directors
NHS Lothian	Dr Rosie Dixon, Appraisal lead for primary care Dr Eddie Doyle, Appraisal lead for secondary care
NHS Wales	Dr Paul Buss, Medical Director, Aneurin Bevan University Health Board
Northern Ireland Government	Dr Paddy Woods, Deputy Chief Medical Officer
Northern Ireland Medical and Dental Training Agency	Professor Keith Gardiner, Chief Executive & Postgraduate Dean GP Appraisers: Dr John Adams, Dr Fiona Allen, Dr Ivor Cairns, Dr Tracey Cruickshanks, Dr Richard Ferguson, Dr Claire Loughrey
Regulation and Quality Improvement Authority, Northern Ireland	Dr David Stewart, Chairman Dr Gareth Lewis, Clinical Leadership Fellow Dr Lyndsey Thompson, Clinical Fellow
Royal College of Anaesthetists	Chris Kennedy, CPD and Revalidation Co-ordinator
Royal College of General Practitioners	Dr Susi Caesar, Medical Director for Revalidation
Royal College of Paediatrics and Child Health	Dr Carol Roberts, Officer for Continuing Professional Development & Revalidation
Royal College of Pathologists	Professor Peter Furness, Director of Professional Standards
Royal College of Psychiatrists	Dr Wendy Burn, College Dean Julian Ryder, Revalidation and Workforce Manager

Royal College of Physicians, London	James Hill-Wheatley, Head of Revalidation and CPD Dr Gerrard Philips, Vice-President for Education and Training Dr Myra Stern, Federation Medical Director, Revalidation and CPD
Royal College of Physicians, Edinburgh	Professor Derek Bell, President Sushee Dunn, Programme Manager
Royal College of Physicians, Ireland	Professor Hilary Hoey, Director of Professional Competence, Senior Fellow and Censor
Royal College of Surgeons, London	Professor Clare Marx, President
Royal College of Surgeons, Edinburgh	Duncan McArthur, Director of Professional Activities
Scottish Association of Medical Directors	Professor Andrew Russell, Medical Director, NHS Tayside
Scottish Government	Dr Catherine Calderwood, Chief Medical Officer Professor Ian Finlay, Senior Medical Director Shirley Rogers, Workforce Director
University of Plymouth	Dr Julian Archer, Director of the Collaboration for the Advancement of Medical Education Research & Assessment (CAMERA) Dr Samantha Regan De Bere, Deputy Director of the Collaboration for the Advancement of Medical Education Research and Assessment (CAMERA)
Wales Deanery	Dr Chris Price, Deputy Director of General Practice, Revalidation Support Unit Katie Laugharne, (former) Organisational Lead of Revalidation Support Unit Katie Leighton, Deputy Organisational Lead Revalidation Support Unit
Welsh Government	Professor Chris Jones, Deputy Chief Medical Officer Geraldine Buckley, Revalidation Policy Manager
Welsh NHS Confederation	Vanessa Young, Director Andrew Davies, Policy and Development Manager

Representing patient views	James Austin, Macmillan Cancer Support Sir Donald Irvine Clare Jenkins, Community Health Councils in Wales Christine Johnstone, Scottish Health Council Eddie Lynch and John Mackell, Office of the Commissioner for Older People for Northern Ireland Sol Mead, Independent lay representative Andrew McCulloch and Bridget Hopwood, Picker Group Neil Walbran, Healthwatch Manchester Patricia Wilkie, National Association for Patient Participation Dr Rose McCullough, Robin McHugh, Karen Mooney and Jill Brennan (members of the RCGP PiP group)

Annex B – Bibliography of documentary sources

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Annex C – Revalidation timeline

1976

Merrison Report

The Royal Commission on the National Health Service, chaired by Sir Alec Merrison, was established in 1976 to consider the best use and management of the financial and human resources in the NHS. The report raised the idea of relicensure or periodic testing for doctors.

1995

Publication of *Good medical practice*

The GMC published the first version of *Good medical practice* – the core guidance for doctors setting out what is expected of them.

1998

A first class service: quality in the new NHS

Report set out the UK government's strategy for re-organisation of the NHS and a modernisation programme to deliver higher quality care, including promotion of lifelong learning and CPD.

1999

Supporting doctors, protecting patients

A consultation paper on preventing, recognising and dealing with poor clinical performance of doctors in the NHS in England, including the idea of compulsory appraisal as part of revalidation.

2000

GMC principles of revalidation

The GMC undertakes its first consultation on a revalidation model.

2001

Bristol inquiry report published

The inquiry into children's heart surgery at the Bristol Royal Infirmary made over 200 recommendations, including the creation of effective systems within hospitals to ensure clinical performance is monitored; and appraisal, continuing professional development and revalidation to make sure all healthcare professionals remain competent to do their job.

2001

Appraisal first introduced into the NHS

2002

The Medical Act 1983 (Amendment) Order 2002

Introduced the concept of revalidation into legislation.

2004

Fifth Shipman Report

Dame Janet Smith DBE chaired the Shipman Inquiry into serial killer and GP Harold Shipman. Six reports were published between 2002 and 2005. *The fifth report Safeguarding patients: lessons from the past – lessons for the future* considered the GMC's proposals for revalidation. Progress on revalidation was paused, and the Chief Medical Officer for England (Sir Liam Donaldson) undertook a major review of medical regulation.

2006

Good doctors, safer patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients

Recommendations are made by Sir Liam Donaldson following his review of medical regulation, including recommendations about appraisal and revalidation (Department of Health, 2006).

2007

Trust assurance and safety: the regulation of health professionals in the 21st century

Building on the Chief Medical Officer's report of 2006, the Government set out a programme of reform to UK healthcare regulation, including the introduction of ROs and proposals to ensure all statutorily regulated healthcare professions have a revalidation process in place (Department of Health, 2007).

2008

Medical revalidation – principles and next steps: the Report of the Chief Medical Officer for England's Working Group

Report by an expert working group chaired by Sir Liam Donaldson setting out the principles and next steps for implementing revalidation (Department of Health, 2008).

2008

Health and Social Care Act 2008

Introduced the statutory role of Responsible Officer into legislation. This included creating designated bodies, giving specific responsibilities to ROs and prescribing the connections between designated bodies and individual doctors.

2008

Appraisal for SAS doctors

2009

UK revalidation Programme Board set up

To provide strategic oversight and leadership of the delivery of revalidation in the four countries of the UK, consistent with the core UK revalidation model.

2010

GMC consultation revalidation – the way ahead

Extensive GMC consultation on the current revalidation model.

2010

Responsible Officer Regulations in place across the UK

2010

Joint statement

About the implementation of revalidation was agreed by the GMC, the Chief Medical Officers for England, Northern Ireland and Wales, the Deputy Chief Medical Officer for Scotland and the Medical Director of the NHS in England. Subject to an assessment of readiness, all parties committed to the introduction of revalidation in late 2012.

2011

GMC's Employer Liaison Service begins

2012

Revalidation formally begins on 3 December 2012

NES **NES/18/24**
Item 11a **(Enclosure)**
March 2018

NHS Education for Scotland

Board Paper Summary: Partnership Forum Minutes

1. Title of Paper

Minutes of the Partnership Forum meeting held on 18 January 2018: copy attached.

2. Author(s) of Paper

Jennifer Sheen, Administrator WIBS
Jenn Allison, Admin Officer

3. Purpose of Paper

To receive the unconfirmed minutes of the Partnership Forum meeting 18 January 2018.

4. Items for Noting

Item 6 – Preventing and Responding to Sexual Harassment in the Workplace

Kristi Long introduced the paper to invite the Partnership Forum to review and discuss a draft response to an information request from the EHRC and recommendations for actions.

The Partnership Forum approved the survey response to be submitted to the EHRC on 19th January. They agreed that the papers should also be submitted to the Staff Governance Committee, Senior Leadership and Management Team and the Senior Operational Leadership Group.

Item 7 – Collection of Staff Data- exiting the EU/Staff Communication

Dorothy Wright presented the letter from the Scottish Government to update the Partnership Forum and to discuss views on engagement with staff on Brexit negotiations in relation to EU citizens living in the UK and regarding the collection of data.

The Partnership Forum noted the letter from the Scottish Government.

Item 8 – Staff Governance Monitoring Letter

Christine McCole presented the letter to advise the Partnership Forum of the requirement for NES to complete the Scottish Government National Annual Monitoring Return for 2017-18.

The Partnership Forum noted the return for information and were pleased that the paper covered the implementation of Turas.

Item 9 - Review of Partnership Working in NHSScotland

The Partnership Forum agreed to participate in the Review of Partnership Working in NHSScotland.

Item 10 – Policy Approval

The Partnership Forum noted that no further amendments are required to the Fixed Term Contract Policy and Employee Conduct Policy, following a scheduled 3-year review and were satisfied with the minor recommended actions following the Equality Impact Assessment (EQIA).

5. Recommendations

None.

NES
January 2018
JA

(Draft) **NES/PF/18/08**

NHS Education for Scotland

PARTNERSHIP FORUM

Minutes of the Seventy-ninth meeting of the Partnership Forum held on Thursday 18 Jan 2018 at DDEC, Dundee

Present: Liz Ford, Employee Director (Joint Chair)
Dorothy Wright, Director of Workforce
Donald Cameron, Director of Planning and Corporate Governance

In attendance: Jenn Allison, Admin Officer
Jennifer Sheen, Administrator
Kristi Long, Equality & Diversity Adviser (VC)
Christine McCole, Head of Service - Human Resources (phone)

1. Welcomes and Introductions

Liz Ford welcomed everyone to the meeting, particularly Donald Cameron who was deputising for Caroline Lamb, Kristi Long who was attending via VC to present to item 06, Christine McCole who was attending via phone to present to items 08 and 10 and Jennifer Sheen, who was attending her first Partnership Forum and who will be providing admin support to the Partnership Forum throughout 2018.

The members agreed to take items 08 and 10 at the start of the meeting.

2. Apologies for Absence

Apologies were received from Caroline Lamb, Chief Executive (Joint Chair), David Felix, Postgraduate Dental Dean/Management Representative, David Cunningham, BMA Representative, Jackie Mitchell, RCM Representative Ros Shaw, RCN Representative, and Linda Walker GMB Representative.

3. Partnership Forum Minutes 19 Oct 2017 (NES/PF/17/31)

The minutes of this Partnership Forum meeting were approved as a correct record.
Action: JA

4. Partnership Forum Actions 19 Oct 2017 (NES/PF/17/32)

Dorothy Wright noted that the Dignity at Work survey was completed in November with results due in February. The Partnership Forum noted that there had been some technical issues which resulted in a lower response rate than expected. It was understood that the response rate to iMatter had increased from previous years. A paper on both iMatter and Dignity at Work will be brought to the Partnership Forum once national reports are available. **Action: DW**

It was noted that all the action points from the previous meeting had been completed or were in hand.

5. Matters Arising from the Minutes

Dorothy Wright updated the Partnership Forum on the following:

- Lead Employer – The number of GP trainees employed by NES will increase with the February intake. It is yet to be decided which board will become the employer of GP trainees working in the West and it is anticipated this will be identified soon. An update on progress will be submitted to the next Partnership Forum. **Action: DW**/McME

- Recruitment Shared Services – Dorothy Wright W advised that she had written to the programme lead for Recruitment Shared Services to ask when national boards might receive a letter asking for notification of the regional hub our recruitment activity will be placed. To date no response had been received.
- An email will be sent to all staff regarding the move from eKSF to Turas appraisal.

There were no matters arising from the previous minutes.

6. Preventing and Responding to Sexual Harassment in the Workplace

(NES/PF/18/02)

Kristi Long introduced the paper which updated the Partnership Forum on NES's current arrangements for preventing and responding to potential sexual harassment, benchmarked against the Equality and Human Rights Commission's (EHRC) guidance on policy and implementation. The Partnership Forum were invited to review and discuss a draft response to an information request from the EHRC and recommendations for actions. The following was noted/discussed:

- In response to recent events that have highlighted the significant impact of sexual harassment, the EHRC are currently gathering evidence from a range of employers and has written to public bodies requesting that they respond to a survey on current policy and process to prevent and manage risk of harassment.

- NES has a strong policy basis in the Dignity at Work and Equality, Diversity and Human Rights in Employment policies which situates sexual harassment within the context of discrimination and harassment more broadly.

- The Partnership Forum noted that through employment and training quality management processes NES currently monitor experience, including bullying and harassment.

- Kristi Long and Liz Ford will liaise with David Cunningham, BMA Representative to discuss the implications of the GP contracts into NES.

The Partnership Forum agreed that this was an excellent paper produced by Kristi Long and they approved the survey response to be submitted to the EHRC on 19th January. They also agreed that further consideration should be given to how sexual harassment is positioned in NES policies and the Partnership Forum would return to this topic at the next meeting. It was also agreed that a discussion at Staff Governance Committee would be helpful as well as the Senior Leadership and Management Team and the Senior Operational Leadership Group. **Action: KL/DW**

7. Collection of Staff Data- exiting the EU/Staff Communication

(NES/PF/18/03)

Dorothy Wright presented the letter from the Scottish Government to update the Partnership Forum and to discuss views on engagement with staff on Brexit negotiations in relation to EU citizens living in the UK and regarding the collection of data. The following was noted/discussed:

- A letter was issued by Scottish Government on the 22nd December 2017 to update NHSS boards on the ongoing Brexit negotiations in relation to EU citizens living in the UK. The letter advises of the Withdrawal Agreement which will provide reciprocal protection for EU citizens living in the UK and UK citizens living in the EU. The Cabinet Secretary requested that the information is forwarded on to EU citizens working in NHSS, to inform them of developments.

- The Partnership Forum discussed the challenges in relation to gathering of data in NHSS on non-UK EU Citizenship.

- The Partnership Forum discussed how to communicate the messages in the letter recognising this was a sensitive issue. It was also agreed that in respect of trainees Morag McElhinney would discuss with Heads of Medical Staffing.

- Kristi Long will liaise with John MacEachen to develop appropriate staff communication in conjunction with Morag McElhinney- see above

Action: KL/MMcE

The Partnership Forum noted the letter from the Scottish Government and noted the it had been submitted to the Staff Governance Committee. It will be placed on the Staff Governance Committee agenda. **Action: DW**

8. Staff Governance Monitoring Letter (NES/PF/18/04)

Christine McCole presented the letter to advise the Partnership Forum of the requirement for NES to complete the Scottish Government National Annual Monitoring Return for 2017-18. The following was noted/discussed:

- The Annual Monitoring Return for 2017-18 is required to be signed off and submitted to the Scottish Government by Thursday 31st May 2018.

Action: CMcC

The Partnership Forum were pleased that the paper covered the implementation of Turas and will advise Caroline Lamb of this. **Action: DW**

The Partnership Forum noted the return for information.

9. Review of Partnership Working in NHSScotland (NES/PF/18/05)

Dorothy Wright presented the Research Advisory Group's terms of reference, to seek endorsement to volunteering to contribute to the research phase of the review of Partnership Working in NHSScotland.

The Partnership Forum agreed to participate in the Review of Partnership Working in NHSScotland. **Action: DW**

10. Policies

a) Fixed Term Contract Policy (NES/PF/18/06)

Christine McCole presented the policy to advise the Partnership Forum that following a scheduled 3-year review of the Fixed Term Policy, an Equality Impact Assessment (EQIA) was completed. The following was noted:

- Following the review, it was recommended that no further amendments are required, however new recommendations have been identified following the EQIA, to improve the collection of data pertaining to the use of fixed term contracts (FTC) in NES.

The Partnership Forum noted and were satisfied that no amendments are required to the policy and welcome the recommendations from the EQIA. **Action: CMcC**

b) Employee Conduct Policy: Disciplinary Policy and Procedures (NES/PF/18/07)

Christine McCole presented the policy to advise the Partnership Forum that following a scheduled 3-year review of the Fixed Term Policy, an Equality Impact Assessment (EQIA) was completed. The following was noted:

- Following the review and EQIA, it was recommended that no further amendments are required to the policy. The only change to the policy is linking to 'Our Way' (NES ways of working) which will be Equality Impact Assessed separately.

The Partnership Forum noted and were satisfied that no amendments are required to the policy and welcome the recommendation that 'Our Way' is attached as an appendix to the current policy. **Action: CMcC**

11. Healthy Working Lives Gold Award

Healthy Working lives – the Executive Team were satisfied with results.
An email will be sent out to all staff for ideas for future campaigns and information regarding previous campaigns. **Action: DW**

12. Policy Tracker

The Partnership Forum noted the Policy Tracker. The hospitality policy is in process of being complete. Tracey Gill from Data Protection will submit a paper for this at the next Partnership Forum meeting on 22 March. **Action: DW**

13. Metrics

There were no metrics due for submission. Dorothy Wright updated the Partnership Forum that Ameet Bellad is currently working on a new format for a high-level dashboard, which will be presented to the next Partnership Forum in March.

14. Health, Safety, Welfare Committee Minutes 31st Oct

The Partnership Forum noted these minutes.

15. Change Management Programme Board Minutes 11th Dec

The Partnership Forum noted these minutes.

16. Any Other Business

There was no other business to be discussed.

17. Date and time of next meeting

The next Partnership Forum meeting will take place on Thursday 22nd March in Westport, Edinburgh at 11:00 with an all staff meeting taking place at 10:00.

NES
Jan 2018
JA/dw

NHS Education for Scotland

Board Paper Summary

1. Title of Paper

Training and Development Opportunities for Board Members

2. Author(s) of Paper

David Ferguson, Board Services Manager

3. Purpose of Paper

To provide details of any upcoming training and development opportunities for Board members

4. Key Issues

- Papers detailing any upcoming training, conferences and seminars that may be of interest to Board members have become standing items for noting on Board agendas.

- We also continue to draw training and development opportunities to Board members' attention as they arise.

- The items below have been notified to Board members previously by e-mail:

(i) 'On Board Scotland' training

15th March 2018 – Glasgow
19th June 2018 – Stirling
11th September 2018 – Edinburgh
10th December 2018 – Stirling

(ii) Non-Executive Directors Networking Session

16th March 2018 - Dumfries

(iii) Non-Executive Directors National Event

14th May 2018 – To be confirmed (central Scotland)

(iv) Public Body Board Members' Finance Event

23rd April 2018 – Glasgow

- A list of confirmed and pending national conferences for the coming year and beyond (provided by the NES Conference Team) is attached to this paper.
- Members may also find it helpful to have this link to the details on the NES website of forthcoming events organised by the NES Conference Team: http://events.nes.scot.nhs.uk/

5. Educational Implications

None.

6. Financial Implications

The events at (i) above cost £295.00 plus VAT per place.

There is no charge for the events at (ii), (iii) and (iv).

7. Recommendation(s) for Decision

None. This paper is for information only.

NES
February 2018
DJF

National Conference Dates 2018

Month	Date	Meeting/Workshop	Location	NES Contact	Conference Team Confirmed
March	TBC	Infection Prevention & Control: Showcasing Care Home Trainers Programme	TBC	Lesley Armstrong	Y
April	26 & 27	Medical / Appraisers / Practice Managers Pharmacy GPN Conference Also, proposals to include NMAHP	EICC	Rowan Parks / Niall Cameron / Tracey Crickett / Anne Watson / Ruth Aird	
Nov / Dec	TBC	Health Protection Symposium	TBC	Lesley Armstrong	Y

NES
Item 10b(i)
March 2018

NES/18/21(a)
(To Follow)

Annual Operational Plan 2018/19

1. Introduction from our Chair and Chief Executive

NHS Education for Scotland (NES) is the national board with responsibility for education, training and workforce development. We are committed to working collaboratively with the national boards, territorial boards, regions and our partners in social care to deliver the actions set out in the *National Board Plan for 2018-23*.

We have a contribution to make across all the key areas set out in the *National Board Plan*; and, as the national board responsible for workforce development and with our contribution to digital transformation we are particularly well placed to support the activities described under the headings 'Developing a Sustainable Workforce' and 'Digitally Enabled Service Redesign'. The outcomes set out in this section extend our established areas of focus into workforce planning, attraction, and recruitment; as well as into retaining the workforce by enhancing the employment experience.

Our 2018-19 Annual Operational Plan (the annual plan) brings together the priority areas identified within national board and regional plans, Scottish Government and other stakeholder priorities as well as the established business we deliver year on year to ensure that the right numbers of trained staff are in the right place at the right time. These activities are key to supporting the triple aim of better care, better health and better value set out in the Scottish Government's *Health and Social Care Delivery Plan.* This summary annual plan is supported by a more detailed operational plan which includes the full range of our activities, their desired outcomes and delivery targets, for 2018-19.

Lindsay Burley	Caroline Lamb
Chair	Chief Executive

2. Our Vision, Mission and Role

Our vision: ***Quality Education for a Healthier Scotland***

Our mission: ***Education that enables excellence in health and care for the people of Scotland***

2018-19 represents the final year of our five-year strategic framework *Quality Education for a Healthier Scotland* which is being delivered through five strategic themes supported by nine outcomes. As well as the *Health and Social Care Delivery Plan*, these themes and outcomes help to deliver key national policy drivers including the *National Clinical Strategy*, the *Everyone Matters: 2020 Workforce Vision*, health and social care integration, reducing health inequalities and wider public-sector reform. Our five strategic themes are

- ***an excellent workforce***
- ***improved quality***
- ***new models of care***
- ***enhanced educational infrastructure***
- ***an improved organisation***

2.1 What is our role?

As a national board, we have a crucial role in the education, training and development of Scotland's health and care staff. At the undergraduate level, we play a key role in the performance management of nursing and midwifery programmes at Scottish universities; and we support placements in clinical settings for trainee doctors, dentists, nurses, midwives and allied health professionals (AHPs). We are responsible for recruiting to post-graduate training posts for key groups of staff including doctors, dentists, pharmacists, clinical psychologists and healthcare scientists. We manage the progression through structured training programmes of more than 6,500 trainees, who are delivering services to patients and their families.

We support continuous professional development and commissioning programmes and evidence-based educational resources in a range of formats. These resources are designed to support the workforce across both health and social care and to ensure that patients and their families get the best care possible from a well-trained and educated workforce. We have the networks and educational materials that are relevant to staff from every group within health, and to staff working in social care.

2.2 Why is this important?

The people who work in health and social care are its most important asset. Having the right numbers of trained staff, in the right place, at the right time is key to delivering better health and better care. At the same time, expectations are changing, as people look for more control over their working lives, better career development and more flexible working.

Through our structured training programmes and our high-quality educational resources, we have a unique opportunity to engage with staff across all of health and social care. We know that there are challenges in both recruiting and retaining staff, so more than ever, we need to be able to support people to have rewarding and fulfilling careers. We also support the workforce to gain the new skills and embrace the new ways of working that are needed, as more healthcare is delivered in the community rather than in hospital, and as healthcare technologies advance.

2.3 How do we do this?

The workforce whose training programmes we manage, and who access our educational resources is based across the whole of Scotland. These clinicians, support workers, administrative staff, and many others, are employed by multiple employers, including territorial boards, local authorities, voluntary organisations and the private sector. We work in partnership with Scottish Government, employers and many other organisations to try to ensure that staff experience a quality learning environment in their place of work, and to ensure seamless access to our resources. We do this by using our infrastructure which includes many people working in educator roles across Scotland; facilities and equipment for

training; and our digital infrastructure which enables materials and support to be accessed anywhere, and from any device.

2.4 What more can we do?

The publication of the *Health and Social Care Delivery Plan* in December 2016 signalled a change in the way that we work with a requirement for us to work more collaboratively and to focus on how we best use our collective resources and expertise to support better health, better care and better value, at a local, regional and national level.

This annual plan describes at a high level, the key areas where we will work through national board planning arrangements, or through our own structures, to support the people who work in NHSScotland and across the care sector.

3. Developing a Sustainable Workforce

This annual plan highlights the role we will play in delivering the *National Board Plan* which sets out where we will work together to support the *Health and Social Care Delivery Plan* and help drive transformational change to address the key pressures, challenges and opportunities outlined in regional plans and from our own collective analysis.

3.1 A Digitally Enabled Workforce

Digital technology offers real benefits in delivering more efficient and safe person-centred services. The development of the *Digital Health and Care Strategy* will ensure that future digital systems support integrated services, user centred approaches and national delivery. Digital leadership and a digitally enabled workforce will be key to its success and to improving health and wellbeing.

We will provide training and support to enable the workforce across health and care to be confident with digitally enabled services. This will focus on developing a network of digital champions to lead transformation and best practice. We will also

develop learning resources and identify the best way for them to be delivered along with digital standards for employers and employees.

3.2 Workforce Planning

The *Health and Social Care Workforce Plan* is clear that better workforce data and planning is key to developing sustainable services. This will require more joined up, accurate and up to date data at a national, regional and local level enabling self-service, and supporting scenario planning. We are leading the development of a cloud-based data platform bringing together existing workforce data sources which will enable scenario planning for future workforce demand and supply. We will also work to develop training in how to apply new workforce planning guidance.

3.3 Health and Care Careers

Digital resources are key to addressing the recruitment and engagement challenges outlined in the *Health and Social Care Workforce Plan.* We will work with others to develop a stronger employer brand supported by social marketing.

To improve recruitment and retention, we will develop our use of social media, build a new *Careers Portal* and develop an employee engagement tool to support *iMatter*. This will enable interactive and collaborative employee engagement and seamless job application or register of interest in work opportunities.

3.4 Youth Employment

The Scottish Government has set out the vision of a prosperous and fair society where everyone can contribute and share success. A key element of achieving this is how we support young people into employment and this will require a fundamental change in how we equip young people for jobs in health and care so that, whatever their life experience, they have better access to opportunities.

We will work with the further and higher education sectors and Young Scot to connect with employers and provide a national work experience scheme informed by young people's experiences. This will be supported by national principles and

guidelines to enable a consistent approach to recruitment, employment and development which supports more flexible movement across employers.

3.5 Educational Commissioning

The *National Health and Social Care Workforce Plan* highlighted opportunities to develop a more consistent national approach to education, training and workforce development to help develop a more sustainable 'pipeline' of skilled staff for health and care. Working with the Scottish Credit and Qualifications Framework Partnership (SCQFP), territorial boards and the higher and further education sectors, we will develop national commissioning and *Recognition of Prior Learning* (RPL). This will involve national guiding principles and an overarching process.

3.6 Online Learning and Knowledge Services

Underpinning improvement and transformation programmes is a requirement for modern and easily available learning and knowledge services. We will ensure that health and care staff have consistent access to learning and decision support resources from any device, anywhere at any time. We will do this by developing the *Learn* application on our *TURAS* digital platform to enable sharing of learning across health and social care, particularly in areas such as equality and diversity (the Equalities Duty), statutory and mandatory training and induction.

3.7 Leadership and Talent Management

Developing a workforce that is open to change and focused on improvement is central to the *Health and Social Care Delivery Plan*. We will support key strands of work under the Scottish Government's *Project Lift* aimed at transforming our approach to leadership development, talent management, performance appraisal and values-based recruitment.

We will also develop further applications on our *TURAS* platform to track skills, roles and competencies and assemble high-potential employees, resulting in a pool of talented people to be drawn upon. This will be supported by a single national system of organisational, leadership and workforce development to work with local systems on evaluation, improvement, transformational change and leadership.

4. Education and Training

While developing our contribution to *the National Board Plan* we will continue to deliver our core business preparing professionals for practice in medicine, dentistry, psychology, pharmacy, optometry and healthcare science and providing education for the nursing, midwifery and allied health professions, healthcare chaplains, support workers and managers. We will deliver education for improving quality, patient safety, role development, leadership and management, mental health, dementia, older people and children and young people and we will include the actions to meet our *corporate parenting* duties under the Children and Young People (Scotland) Act 2014 within our planning and performance.

4.1 An Excellent Workforce

We will continue to recruit to, and manage the post-graduate training programmes for doctors, dentists, pharmacists, clinical psychologists, and health care scientists; providing a 'pipeline' of trained professionals for the health service. We will also work with Scottish Government, territorial boards and others to support policy initiatives to increase the number of GPs in Scotland over the next decade, develop pharmacists with advanced clinical skills, provide additional training for GP nurses and support more training places for nurses and midwives.

We will also deliver support for people at the undergraduate and pre-registration stages of their careers and provide a high-quality workplace learning environment through educational governance, quality management, supervision and practice education. Finally, we will provide *Return to Practice* and *Return to Work* initiatives for a broad range of healthcare professionals.

4.2 Improved Quality

We will provide education for improving quality to enhance patient safety and people's experience of services. The will involve embedding person-centred care in all our activities, placing people at the heart of services and providing education for safe and effective care. We will also provide quality improvement (QI) education

and curricula supported by a national network of leads and practitioners to build QI capacity and leadership and management development to support the five *Everyone Matters: 2020 Workforce Vision* leadership and management priorities.

4.3 New Models of Care

New models of community based care supported by multi-professional teams will be key to meeting the challenges of technological, demographic and societal change. In primary care we will deliver postgraduate training and continuing professional development for practitioners and teams in general medical and dental practice, community pharmacy and optometry. We will also support workforce planning through data analysis, information and modelling covering workforce, training, labour markets and trends in access to health and social care.

Developing existing, new and extended roles and the people in those roles is an important enabler of new models of care and to help address recruitment and retention issues. As well as developing pharmacists and optometrists with advanced clinical skills we will support Scottish Government policy initiatives to help train more health visitors and advanced nurse practitioners, playing an active role in the development of education pathways from registration through to advanced practice. We will also continue to improve access to learning, qualifications and education for healthcare support workers. Finally, we will deliver a range of workforce development to support integration, improve health and reduce health inequalities, with a focus on people who have complex needs, or who need extra support and protection.

4.4 Enhanced Educational Infrastructure

We will provide educational infrastructure to support postgraduate training and practice education as well as for national clinical priorities such as mental health where we play a key workforce development role in evidenced based therapies. This will involve providing trained networks of healthcare professionals and educational support in the clinical learning environment.

We will also provide digital resources designed to manage training and employment and improve access to knowledge, information and learning through our *TURAS* digital platform. Finally, we will provide educational infrastructure and research support to quality assure our services and gather feedback.

4.5 An Improved Organisation

We will continue to improve our systems, processes and structures, sharing best practice and resources to deliver our services in a more streamlined way while progressing our workforce, organisational development, digital and property strategies. This will involve maintaining efficient and effective business support while delivering organisational improvement programmes and releasing resources to invest in new areas.

5. Our Workforce

This section of the annual plan focuses on our workforce and what we are going to do to support the *Everyone Matters: 2020 Workforce Vision Implementation Plan*. Our *People and OD Strategy* is designed to enable a capable, sustainable and flexible workforce that has the skills to adapt to a changing world.

5.1 Healthy Organisational Culture

We will embed *iMatter* through the second year of organisation wide implementation during 2018, supporting teams to implement their action plans and embed our leadership behaviours, values and ways of working. We will continue to drive four core areas of organisational performance improvement where our services can be better integrated and delivered more efficiently.

5.2 Sustainable Workforce

We will continue to promote the health, wellbeing and resilience of our workforce. The establishment of *Our Way*, co-produced with our staff, promotes positive organisational culture and behaviour aligned to our organisational values. We will continue the development and provision of *I want to know more…* sessions on key issues such as dignity at work, organisational values and well-being. We will

maintain our *Health Working Lives Gold Award* and promote positive mental health, healthy eating and physical activities while preparing our workforce for further organisational change.

5.3 Capable Workforce

We will build digital capability and use technology to encourage participation in learning through our *TURAS Learn* system. We will continue to invest in learning and development and increase participation in personal development planning and essential learning. We will continue to improve employee engagement and drive forward our programmes of digital transformation and organisational performance improvement to develop a flexible workforce with the ability to work across traditional boundaries.

5.4 Workforce to Deliver Integrated Services

Through our established health and social care integration group we will support cross sector and multi-professional working, sharing evidence based practice in learning and development. We will also develop collaborative working principles and practice to support the *National Board Plan* and our ambition to work in different ways across traditional boundaries.

5.5 Effective Leadership and Management

We will continue to develop *TURAS Appraisal* to support executive and senior manager performance management arrangements. We will develop leadership and management capacity and capability through our *Managers Passport* and *Coaching Skills for Managers* programmes. We will also extend the use of Workforce Scotland developments such as *Leadership Exchanges* and the *Scottish Coaching Collaborative*.

6. Our Annual Operational Plan for 2018/19

This annual plan is focused on our support for the new national and regional plans, the *Health and Social Care Delivery Plan* and key national policy, particularly the *Everyone Matters: 2020 Workforce Vision*. The annual plan also includes

information on how will develop our workforce and address the workforce priority areas identified by our stakeholders which are

- ***youth employment and careers***
- ***recruitment and retention***
- ***role development***
- ***digital transformation***
- ***mental health***
- ***statutory and mandatory training***
- ***workforce planning***
- ***leadership and management development***

This annual plan is supported by a detailed operational plan aligned to our strategic framework which includes the full range of our activities and their desired outcomes and delivery targets for 2018-19. Both this delivery plan and our strategic framework can be found at: www.nes.scot.nhs.uk/about-us/corporate-plans-and-annual-reports.aspx

The more detailed information contained in our 2018/19 operational plan can be obtained by e-mail from nes.planning@nes.scot.nhs.uk