

Appraisal and revalidation – where are we now?

Christiane Shrimpton

BACKGROUND

Revalidation is the process used by doctors to demonstrate that they are up to date and fit to practise and is based on annual appraisals. It was finally introduced in December 2012 and is now a requirement for holding a licence to practise as a doctor in the UK. By April 2016 the majority of doctors had been revalidated by the General Medical Council. This makes it an appropriate time to review how the process is working and what it has meant for appraisals.

ROLE OF APPRAISALS

Revalidation has introduced a clearer and more robust summative element into appraisal for medical staff as it is used to demonstrate that doctors remain up to date and fit to practise. Unlike appraisal for other professional groups in the NHS it is not a performance review and has a significant and very important formative element. It guides the professional and personal development of doctors and is a vehicle for discussing the quality improvements made to patient care doctors have been involved in. There is an element of tension between the burden to prepare and make time for appraisals and effectively using it as a tool to help doctors review their current practice and future aspirations.

THE NATIONAL PICTURE

National appraisal rates have increased from 63% in March 2011 to 86% in 2015.¹ The GMC has commissioned a study into the regulatory impacts of revalidation including a survey completed by 26,171 doctors. The recently published interim report² showed that 90.3% of respondents have had an appraisal at some point in their career. Of these 95% had an appraisal in the preceding 12 months. There was a mixed picture of the impact revalidation has had on appraisals with 32.3% considering it positive and 30.3% considering it negative. Only 42.4% of respondents reported that they made a change to their clinical practice, professional behaviour or learning activities as a result of their most recent appraisal. Overall 36.5% of doctors think revalidation will not improve standards of practice.

Of the respondents who had conducted appraisals (4,116) 38.3% had identified concerns. This included 10.4% that required escalation. The most common categories were lack of reflective practice and poor relationship with colleagues.

THE MORECAMBE BAY PICTURE

Appraisal rates at the University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB) were 94% in 2014/15 and 97% in 2015/16. This compares favourably with regional and national appraisal rates. In the 2015 staff survey³ 75% of responding medical staff felt appraisals had helped them improve how they did their jobs. We currently do not collate any information about the frequency of appraisers having concerns. Appraisers regularly seek advice from the clinical appraisal lead or responsible officer if they have any concerns and we also discuss how to deal

with issues that may arise in the quarterly appraiser support sessions.

Quality assurance review of appraisal summaries showed the two areas that could be improved most in 2014/15 were the evidence of quality improvements submitted and personal development plans challenging the doctor to make quality improvements.

APPRAISAL AND REVALIDATION TEAM FOCUS IN 2015/16

Having achieved excellent engagement from doctors we decided to focus on improving the quality of appraisals. Feedback from appraisers tells us that lack of reflective practice is prevalent in some of our appraisals. In addition we know that quality improvement evidence could be strengthened. Medical staff want to provide excellent patient care. They may find appraisal a more useful process if the focus is on the discussion of improvements and personal development. For some it feels like revalidation has shifted the priority to compliance with mandatory requirements. This makes it feel more like a tick box exercise and will not help achieve the improvements in patient care we all strive for. We set out to investigate the barriers doctors and appraisers see to good quality appraisals. These are the themes that came up:

- Appraisees and appraisers need to understand what is required of them for their appraisals
- Time for appraisals needs to be supported
- There needs to be clarity on how job planning feeds into appraisals
- All staff need to understand what quality improvement is
- Quality of care needs to be reviewed by teams on a regular basis
- Ongoing review of quality of care needs to be supported
- Organisational culture needs to support evaluation of changes made
- All staff need to be clear about the corporate, divisional and departmental objectives
- We need a more robust audit process

There are various underlying themes that come up regularly.

Access to relevant information

Many doctors find it difficult to get access to robust information about the quality of care they provide. Reports produced via hospital episode statistics mainly give workload information and are often based on consultant teams rather than individual doctors. Not all areas have systems set up to collect patient outcome data. In addition more patients are discharged into the community earlier after hospital interventions and a system wide data collection would be required to enable a review of the care provided. As a health community this requires the development of new processes to review patient outcomes and look at the contribution individual doctors have made to that as part of a team.

Job planning and appraisal

How should job planning and appraisal be linked? The discussions of personal development plans (PDPs) and career aspiration should feed into job planning discussions. Any changes in the scope of work that are discussed in the job planning process could give rise to further personal development requirements. Aspirations need to be realistic and fit in with the departmental and Trust strategy and objectives in order to be supported. It would be useful for clinical leads to have an overview of the departmental development needs in order to support staff to achieve their PDPs. It would be useful for the Trust to know about the generic PDP elements of their staff in order to arrange local access to training and development opportunities to make best use of the SPA time doctors have in their job plans. Appraisals are confidential discussions and most areas do not have any way of collating and collecting this information in an anonymised way. This is an area that has given rise to many local discussions and we are still considering what the local processes should be.

Quality Improvement Culture

In the context of appraisals there was a feeling that either medical staff did not understand what was required as part of the quality improvement supporting information for appraisals or had a perception that only a large project would be acceptable. There often were comments that “we do not have time to do this”. Many teams did not appear to have regular multi-disciplinary meetings to discuss the quality of care they provide. Audits do not always lead to improvements in the quality of care provided.

WHAT WE HAVE DONE LOCALLY

We focussed on the quality improvement and personal development plans in our quarterly appraiser peer support sessions. We also introduced sessions open to all permanent medical staff about the preparation for appraisals. This clarified the expectations we have and gave doctors several examples of the kind of things they could do or include. The feedback for these sessions was very positive.

We also set up meetings with the information department to discuss the information doctors are expected to present for their appraisal and the difficulties they experience in access to information about the quality of care provided. As a result of these discussions suggestions have been made for specialty clinical leads to provide information about the kind of reports required to assess quality of care in their area. The information department can then work with the different departments to see how this could be enabled in the future.

The appraisal and revalidation team has regular meetings with the governance team to discuss the input of compliments, incidents and complaints and audits into appraisals. These are an important element of quality improvement discussions and this is allowing us to improve the local process and discuss any issues that have arisen.

Clinical audit

One of our current projects is taking a different approach to audits. In the past the initial presentations have usually included recommendations already and these were

developed by the auditing doctors with little if any input from the wider team. These have often been in the format of “People are not doing X so we tell them to do it and then re-audit”. We know from the re-audits that frequently this has not led to any improvement. We are currently piloting a human factors approach to looking at audit results. The results are presented and the whole team is using a human factors based model and checklist to explore the underlying reasons why standards are currently not being met. Based on these reasons actions can then be developed and prioritised and a quality improvement approach used to implement and evaluate changes.

ACHIEVEMENTS SO FAR

The Quality Assurance tool we use is the EXCELLENCE tool and our two lowest areas were **L** and **C**:

Look at supporting information, lessons learned and changes made? *does the summary drive quality improvements by reflecting what has been learned and what needs to be changed as a result?*

Contain SMART PDP Objectives? *Are they Specific, Measurable, Achievable, Relevant and Timely? Do they challenge the doctor to make quality improvements?*

We scored “Yes, well done” in 23.5% of appraisals for L and 17.6% of appraisals for C in 2014/5. This has improved to 73.5% for L and 61.8% for C in 2015/16.

DISCUSSION

It is a fine balance between meeting the regulatory requirements revalidation has put on appraisals and ensuring the formative developmental aspect of appraisals does not get lost. The process needs to assure the responsible officer that the doctors he/she is responsible for are fulfilling their GMC obligations. This can feel like a cumbersome burden and we need to remember that expectations should be reasonable and proportionate. Doctors find appraisal most useful if it gives them protected time to think about their current work and career aspirations. Many appreciate the time to explore with a colleague what has gone well and what has not gone quite so well and why. In order to make the time doctors spend on their preparation and appraisal meeting valuable to them we have to ensure this aspect remains at the heart of appraisal discussions.

REFERENCES

1. Senior Responsible Owner’s Report to Ministers on the implementation of the Responsible Officer Regulations and Medical Revalidation. 2014/15.
2. UMBRELLA shaping the future of medical revalidation, Interim Report January 2016 [Available from: http://www.gmc-uk.org/UMBRELLA_interim_report_FINAL.pdf_65723741.pdf]
3. UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS TRUST Locality report: Medical and Dental, Final Report. Picker Institute; January 2016.

Correspondence to:

Re-validation lead for Morecambe Bay NHS Trust, RLI