NHS

Revalidation Support Team

September 2009

Assuring the Quality of Medical Appraisers for supporting Revalidation

Appraiser Training: Where are we now?

Many NHS Trusts are now planning and developing appraiser update training and naturally are linking these updates to the requirements revalidation will place on appraisers. However exactly what these requirements will be is not yet entirely clear. RST presents this paper to assist organisations in preparing usefully for the changes that appear likely to emerge.

Work is in progress developing the strengthened appraisal framework and a consultation document will be published in Autumn 09; pilot projects in primary care, secondary care and the independent sector are testing the proposed GMC Good Medical Practice framework for appraisal and assessment and will report in January 2010; a project is underway to explore the current readiness of NHS Trusts across England to support revalidation (AQMAR); and an expert group is exploring the roles, responsibilities, skills and knowledge appraisers will need in the future.

The NHS Revalidation Support Team recognises the need to ensure that individuals performing the roles of appraiser are consistently educated and developed to a common agreed set of competencies. Appraisers will be naturally hesitant about the impact of the introduction of revalidation upon their role. It is important to emphasise that the appraiser's important core skills remain unchanged:

- Emphasis on positives and on developmental actions
- Praise the good, use open questions and appropriate challenge, encourage reflection and self-understanding
- Clinical governance, performance and other presented information should be relevant and include reflection on how the doctor might learn from these or maintain good performance
- Develop an appropriate PDP for the forthcoming year
- Recognition of issues that require delay in the appraisal process or which might halt the appraisal

These are well-recognised existing appraiser skills, as is managing the difficult appraisal discussion. Appraisers will certainly need further support and training in order to become familiar with the additional needs that a strengthened appraisal process to underpin continuously improving quality in healthcare provision, and one fit to support an individual doctor's revalidation at the same time, will require.

There is also a need to ensure that the future Responsible Officers (ROs) are able to demonstrate their competence (and therefore legitimacy to make a decision and

recommendation for revalidation for each doctor) against a single, shared set of standards which should be linked to - indeed should overlap with - the standards underpinning the competencies for appraisers.

RST is therefore leading a project with the British Association of Medical Managers (BAMM) and the National Association of Primary Care Educators (NAPCE) to be followed by collaboration with Royal Colleges and other stakeholders to design an effective and rigorous, practical training framework to ensure that:

- Appraisers are properly equipped for their roles by developing a clear, standardised set of competencies, by definition of their roles and responsibilities, and by setting out training objectives for providers of such training in designing the content and delivery of appropriate programmes

- The impact of this training and the consistency and rigour of the appraiser's performance are appropriately assessed after training, and subsequently, so that standards are maintained over time

The output of this work will comprise of the following:

- A Competency Framework for Appraisers – a document outlining the competencies and behaviours required by appraisers along with examples of evidence which might be used to demonstrate competence

- Training objectives for new and existing appraisers.

- Methodology for initial and ongoing assessment of appraiser competencies.

- Recommendations for recruitment, performance review, development and support of appraisers

- An option appraisal paper on the potential benefits and impact of a system of formal accreditation of appraisers

The outcomes of this work will, it is anticipated, be ready for consultation at the end of 2009 and published in Spring 2010 alongside the plans for strengthened medical appraisal. Both these concepts will then be tested through the next stage revalidation pathfinder pilots 2010-2011.

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Advice on training and updates during 2009 - 2010

Until the framework and competencies for appraisers and the results of AQMAR and pilot work are known, and new national guidance is in place, the RST suggests that organisations should consider working on the following areas:

- Develop a clear understanding of the link between Good Medical Practice, Appraisal and Revalidation using key information available in documents including “GMP Framework for assessment and appraisal”, “AQMAR” and the proposals in “Strengthened Medical Appraisal” to be published shortly
- Overall development needs following the AQMAR project (with SHA help)
- Existing appraisal documentation in place in the organisation can still be used. Appraisers (and appraisees) should begin to consider how evidence produced for the appraisal might relate to different attributes within the domains of GMP. Thus familiarity with the new 4 Domain structure within GMP will improve over time
- Remain up to date with information available from publications and web sites of GMC, Royal Colleges, Speciality Societies and Faculties etc on their proposals on evidence, standards etc and support appraisers in developing an understanding of how their abilities to manage this might improve
- Consider how information the organisation already receives or collects for other purposes might usefully be disseminated as supporting evidence for appraisals. Ideally work done towards embedding a revalidation system would build on work already ongoing to improve safety, quality and patient experience. All these have been shown to improve clinical outcomes
- Involve clinical governance and data collection teams from an early stage in your discussions. They may well be able to help in introducing any changes you are considering

Hints and tips for appraisers and trainers

In this transition phase, the following general principles are worthy of consideration at appraiser updates and will be effort well spent when the new agreed structures are known:

Evidence: What to look for and what to think about

In this context, the term "evidence" is used to describe the supporting information available to inform the appraisal discussion. NB: In any one year, it is not expected that evidence will be available to cover every attribute of all 4 domains. The portfolio will build over time such that the totality of evidence over 5 years covers all attributes in all 4 domains in sufficient quality and breadth.

Pre- appraisal: Is the required evidence presented against the necessary requirements for this appraisal? If not should the appraisal go ahead?

Do not focus solely on revalidation. Fundamentally appraisal remains a formative process, reviewing progress to date and producing a summary together with a new relevant and appropriate PDP for the forthcoming year.

Begin to think about which type of evidence supports which GMC *Good Medical Practice* Domain. This is being covered in the pilots, but is worth having at the back of one's mind as an appraiser at least. Can you identify the best fit/correct one?

Sufficient evidence for personal re-licensure will need to be present during the revalidation cycle. Is the evidence applicable to the doctor individually, the team or the service delivery as a whole? Is the evidence relevant to the doctor's current specific areas of work?

Does the evidence demonstrate an organisation or service delivery issue that needs to be highlighted to the organisation? How might the appraisee achieve this? It remains the appraiser's job to ensure the summary and PDP reflect the breadth of the discussion.

For doctors with additional roles: Has the doctor brought evidence and reflection on performance in all roles which they hold including work for other Trusts, for the wider NHS, in the private and other sectors, and the development items pertaining to them from any performance review in the other setting? This might include their role in research work, medical management, as a trainer or appraiser themselves, etc. The peer medical appraiser at an annual appraisal cannot cover all these items in sufficient depth, and therefore the result of "appraisal" or performance review in a doctor's other roles should be submitted by the appraisee as part of their portfolio of evidence. PDP items identified from the other roles should be added to the annual appraisal PDP.

Developing processes and skills to support a doctor toward their revalidation

Appraisal leads within the Trust should continue to identify themes arising from the appraisal and promote greater Board-level engagement if necessary as described in the AQMAR standards.

Every organisation has reluctant engagers. Raise awareness and work to improve their understanding of the changes ahead.

Appraisers should try to identify issues that may affect their appraisee's progress toward satisfactory periodic relicensure/recertification (eg: no audits done for some years). The appraiser can then ensure that possible gaps are covered in the PDP.

As now, from review of the presented evidence and the appraisal discussion itself, does an issue need to be referred to the RO (for now, the MD) or elsewhere?

The appraiser might wish to highlight to the appraisal lead a way to improve the process generally. Appraiser support structures should be developed, perhaps using a team structure of monitoring appraiser skills and for support

Evidence itself is not as powerful as *reflection* on that evidence

Reflection on evidence produced remains key. Is there evidence of written reflection presented in the appraisal submission? Is/was there presented an intention to change practice as a result? (NB: sometimes none seems needed and practice is clearly demonstrated to be of a very high standard)

If reflection occurs during the appraisal discussion itself make sure to document the detail of this in the appropriate section of the output form

When reviewing reflective documents or discussion points, consider these underpinning principles and then document how the PDP will address this:

- an appropriate change was identified and has already happened. What strengths can be built on?

- a need was identified, but no changes have yet been made

- the doctor has not yet identified any appropriate learning or has not recognised an obvious development need

The PDP should (as now) document what is agreed in relation to these

The appraisal discussion

As now: must be supportive but be as objective as possible based on validated information, and include reasonable and appropriate challenge. In the course of discussion did the doctor sufficiently do the following:

- describe and discuss the outcomes from last year's PDP?

- identify areas for personal development which are appropriate to their needs at this time? The new PDP should reflect the development needs of the doctor to fulfil their roles, and also show some relevance to their service aims. (NB: the PDP is not the same as the service objectives, but does define how the doctor can contribute effectively to improving these as well as advancing their own personal development)

In addition, did the doctor:

- show firm commitment to achieving these in an appropriate timeframe?

- demonstrate any serious inappropriate behaviours when challenged? If so, did you agree an action to address these?

- demonstrate distress (or illness) of concern? If so, did you agree an action to address these?

Are any issues and appropriate actions to address them covered in the documented appraisal summary form and/or the PDP?

Conclusion which the appraiser should be able to make after the appraisal

Potential risk (as exists now):

Are there genuine immediate concerns about this doctors practice? If yes: You must report these to the appropriate person, and document:

- are measures in place to protect patients, colleagues, the doctor and the public?
- does the doctor appear to have appropriate support to deal with these issues?

Short term: Areas for development:

Are there areas where the doctor's performance has not been clearly demonstrated to be of a satisfactory standard with regard to the guidance expressed in GMP? Does the PDP cover all areas that the doctor needs to address, with timeframes?

Have you agreed and recorded any issues to follow up at the next appraisal?

Are the PDP items 'SMART' and are they assigned priorities?

Long Term: Progress toward Relicensure/Recertification/Revalidation:

Some of this will require further guidance to be developed but appraisers can begin to consider:

Are there areas where the doctor's progress towards satisfactory relicensure may be in doubt? If so, these should be identified and understood, with an appropriate plan in place including adequate recording for the next appraisal/appraiser.

Avoid collusion! If sequential appraisals over time demonstrate continued deficiencies in areas of required evidence, this should be addressed so that the doctor may collect and present the required evidence *in* good time, and *over* time. No action taken until the end of the 5 year cycle is inappropriate.