Summary of the am workshops and pm sector discussions for the All England Appraisal Network Lead Appraiser's Conference held on the 23/2/16 and the 1/3/16

Morning Workshops

Workshop A Medical Appraisal team peer review

Challenges shared and solutions explored

Few challenges identified, delegates were looking to implement peer review and were there to obtain information about the process.

- Time to undertake peer review was one challenge identified by a small independent – advice given was to look at different models, sharing documents; looking at particular problem areas rather than the whole process, look at linking with peers in a different way, at networks, etc. Another option would be to organise call with regional team to explore issues and obtain advice.

Topical or outstanding issues

- Primary care networking – M&E (whole primary care network event to be used as method to identify suitable buddy(s).
- Internal audit, not as valuable as peer review/regional visits because the audit teams don't understand the revalidation process.
- Lack of understanding about the two way nature of peer review – why can't you just add the questions identified in the peer review process to the AOA – no learning; feedback or sharing of best practice.

Next steps

- Organisations wishing to peer review to identify themselves to regions if they are unable to identify suitable peers.
- Organisations wishing to obtain policy documents not available online to contact region to see if the region have access to any identified during the independent verification process.
- Share the peer review document electronically (enclosed).
- Begin a list of DBs who have carried out peer review to date, include detail such as organisation type, number of doctors, learning from the peer review – then share this document twice a year at networks and include in regional newsletter.
- Consider sharing list of DBs who have had a regional IV visit (with their consent) so others can contact them for advice/support/sharing.
- Get organisation that have peer reviewed to present at an RO/LAN Network.

Workshop B Impact on patient and colleague feedback

Challenges shared and solutions explored

- How to get more useful patient feedback
  Most patient feedback is very positive most of the time for most organisations and this is an important affirmation that the Dr and the organisation are delivering a good quality service. Some specialities e.g. anaesthetics, have developed cards to give to patients to record their feedback on line, as they may be too drowsy to remember much post GA.
- Other specialities such as pathology struggling to know how to obtain feedback.
- Colleague feedback – follow up request with an exploratory email on what you are looking for specifically – educate colleagues.
- Is once (or twice) every 5 years enough? Probably not – use lots of examples, use annual examples
- This topic is always a good topic to start the appraisal discussion with.
- A good benchmark to say you put yourself down too much, or you are too confident in yourself.
- Doctors not engaged enough in patient feedback process - not directly involved.
- Positive feedback is a pat on the back – good self esteem
- Colleagues do tend to be honest, and choosing friends won't stop them shafting you, i.e. being honest and constructive.
- Cases of selective feedback of patients who are likely to given positive feedback only.
- Variation in the quality of questionnaires – some go in-depth, some very high level. In-depth versions often expensive but work the expense for the quality and benefits.
- Each doctor should be measured against the DB norm/average rating.
- Peer review does not always reflect a typical 360 reflection of colleagues across the spectrum at all levels/grades.
- Mortuary staff only meet/deal with a handful of colleagues and no patients.
- Self-assessment and colleague feedback important.
- Negative ratings without comments are not helpful – have to be qualified.
- Generic questionnaire not helpful – need speciality/themed questionnaires that are consistent across a DB.
- Peer review systems very widely, some clearly defined e.g. how many 3 doctors, 2 nurses etc. Others do not stipulate who/how much at all.
- More focus on positive feedback – celebrate it!
- 360 feedback still seen as pass/fail test by too many people, which is wrong culture – it is development and reflection.

Topical or outstanding issues

- GMC website new – 6 case studies and a leaflet for patients.
- Primary care – more terrified of colleague feedback
- Secondary care – more terrified of patient feedback

- Sequential, random and confidential selection.
- 3rd Party should be requesting and collecting feedback, not the doctor themselves.
- Consistency, negative colleague feedback can be devastating but needs to be discussed and addressed. Try and triangulate with other forms of feedback.
- Patient feedback usually of no real value in looking at a doctor's behaviour, usually v positive or doesn't go in to any detail.

Next steps

- GMC website this week – new patient feedback leaflet – 6 case studies where doctors struggle for feedback.
- Some DBs doing feedback exercises every two years (ensures two are captured in every 5-year cycle)
- Internal NHSE Policy required on this area for consistency!

Workshop C Engagement of appraisers

Challenges shared and solutions explored

- It is an evolving process!
- There is also a good deal of variation in what DBs do
- Support already provided to appraisers by some DBs (not all):
  - annual update to their appraisers
  - run 'support groups'/network type meetings for their appraisers – frequency varies from ~quarterly to annual; content varies but largely includes looking at difficult appraisals, feedback on what a good PDP looks like, QA, look at sign-off of forms not received within 28 days (some also have systems that alert appraiser to return the docs within 28 days), etc.
  - provide feedback to appraisers
  - meeting appraisers individually
  - share info from appraisal meetings to appraisers
  - put info on intranet and monitor access
  - feedback form to doctors (and therefore assume appraisers too) after their own appraisal to ask if they have any development needs as a result of their appraisal

Topical or outstanding issues

- Choice of appraisers: Debate about some DBs where there is little choice in appraisers – but another organisations may have a waiting list for appraisers and a WL for appraiser training
- Number of appraisals each appraiser is asked to carry out – varies between sectors, and DBs individually
- Motivation of appraisers:
  - Some roles in some DBs (e.g. CD) have to appraise as part of their job role
  - Emphasise that it is a professional role
  - Promote as a developmental role/stepping stone to other roles
  - Who appraises who:
  - More than half the DBs in the room allow cross-specialty appraisal
- Supervision of appraisers, specifically new appraisers
  - Mixed views – Morecambe Bay observe new appraisers – first group no one else did, second group there were others that did

Next steps

To progress the above issues

in context that it is an evolving process

Workshop D Scope of work and supporting information

Challenges shared and solutions explored

- How do you ensure whole of scope covered in appraisal?
- Fundamental difference between organisations which push information and those requiring it to be pulled.
- Failure of a doctor to provide info could be a probity issue particularly in the latter group
- There is a need to prompt doctors to include all information
- Ensure doctors know what is required
- Could be a probity issue but must ensure guidance is given

Topical or outstanding issues

- What type of info do you require?
- There is considerable amount of variation amongst organisations represented in to the amount of data supplied to the doctor automatically.
- Some organisations provide a didactic list of information required either to doctor or place of work. Felt that more guidance on this would be helpful.
- Use standard template for other places of work - this in place by some
- Only dawning on some doctors re need to cover whole scope in appraisal and what this includes
- Great reliance on doctor's honesty (probity) in providing information which could be a problem in those with most need
- Lack of confidence around information sharing and what is actually done/provided by different organisations
- Stress to appraisers the need to be robust in checking with doctor that whole scope is covered before signing off appraisal statement
- What to do if doctor brings information from other organisations but nothing comes from the organisation to verify. Suggest conversation with other MD or appropriate other person and/or discussion with ELA.

Next steps

- Need to drive expected standards and requirements for what is expected in portfolio.
- Minimum data set requirements would be useful.
- Need to improve access to information from different organisations.
- Define national standards for information and how to share, what is expected from other organisations.

Workshop E How to achieve consistency and quality in Medical Appraisal

Challenges shared and solutions explored

- Providing development opportunities for appraiser
  - Need competency-based training
  - Could RO/AMD sit in on appraisals? Need to use a QA tool to inform training needs
    - Use external input e.g. courses or online
  - Feedback to the appraiser from Doctors & appraisal lead
  - Expose appraisers to other roles related to revalidation e.g. Case investigator
  - Need to ensure appraisers cover the full scope of work
  - Need to encourage appraisers to write a good appraisal
  - Need to ensure appraisers provide challenge in the appraisal
  - Need to ensure appraisers write SMART PDPs that are reviewed via a meeting to review their work
- Obtaining feedback from doctors being appraised
  - Compulsory or Voluntary …debate but no conclusion
  - Anonymised (at least 3) and shared with appraiser
  - Themes should be identified and brought together for general appraiser training
- Reviewing appraisal outputs (summary and PDP)and inputs where necessary
  - Appraisal team should audit and provided calibration
  - Feedback to appraisers via network meeting
  - Need local toolkit to improve the inputs in to the 4 domains
  - There are various QA systems , is there consistency?
  - Needs to be seen as a positive developmental process, with so few appraisers if not done well may lose appraisers if punitive
  - Focus on training and development of appraisers for improvement
  - Resources should be standardised (NHSE to support this position)
  - Organise inputs to align with Trust objectives
  - Intelligent use of current data e.g. Datix and complaints
  - QA of output summary is needed
  - Need a system to feedback to appraiser with admin support

- Reviewing appraisers' performance individually (self/peer/appraisal lead/responsible officer/ appraisal and revalidation administration teams)
  - Key is appraiser engagement
  - Appraisers should reflect on their practice as an appraiser (informed by QA information of their output summaries)

- Performance review process depends on size of organisation and may only be for consistently problematic performance
- Appraisers should be provided with individual anonymised feedback, QA ratings of their summaries, and attendance at in house cpd
- Resources are an issue to provide 1 -2-1 feedback
- There is inconsistency across the whole process between organisations, “where is the yardstick?”

Topical or outstanding issues

- Concern over a lack of resource to manage QA properly
- Concern that QA could put off appraisers, and they are in short supply
- Concern that there is variation and little standardisation, within and between Trusts

Next steps

- Future sessions to include sharing by organisations on how they are tackling these issues would be beneficial

Workshop F Prompting participation of short-term contract doctors in a quality medical appraisal programme

Challenges shared and solutions explored

- What are the responsibilities and opportunities of the doctor and the MA programme?
- Provision of useful data to create useful SI
- Logistics essential STC doctors are engaged in the MA and supporting governance system from the day of their appointment
- Provision of a useful appraisal to a doctor new to medical appraisal; what are appropriate action plans?

Topical or outstanding issues

- Work in progress
- Re prompting participation in medical appraisal from appointment
- Provision of SI to enable reflection across sow
- Guidance re how to enable a quality medical appraisal
- Issues different for new to NHS and where doctor familiar with medical appraisal
- Litmus test of engagement by doctors in medical appraisal and quality of medical appraisal programmes

Attached paper captures reflections within NHS England North

Next steps

The solution is everyone's challenge and opportunity!- if we all look to participate the objective will be achieved

Summary of the am workshops and pm sector discussions for the All England Appraisal Network Lead Appraiser's Conference held on the 23/2/16 and the 1/3/16

Afternoon Seminars

Acute sector

Challenges shared and solutions explored

- What does success look like for good appraisal systems?
  - Support from effective and efficient administrators
  - Sufficient allocated time in job plans for appraisers
  - Clear and robust appraisal processes: For example clear and easy to follow appraisal policy; policies for escalation of concerns.
  - A single team managing appraisal and medical personnel (or effective close working) to identify new starters and those who leave a Trust.
  - Good appraisal IT platforms
  - Formal appointment of appraisers with job descriptions and interviews (recognising the concern where there may not be sufficient appraisers to make this work).
  - Getting the correct balance between high uptake of appraisal (i.e. the percentage of doctors who have been apprised each year) with the quality of the actual appraisal discussion.
  - Essential that doctors see appraisal to be personally useful to them rather than an imposed process.

Topical or outstanding issues

- Last minute appraises addressed by ownership by doctors and good logistics
- Lack of engagement by appraisers/doctors
- Doctors on short term contracts or locums require >> focus to ensure they can participate usefully. Within this essential prompted in a timely manner to participate and provision of supporting information is facilitated. They are everyone's problem but also opportunity to progress.
- Lack of collaboration or sharing information both within organisations and interaction with other institutions for doctors moving post.
- Establishing sufficient number of appraisers, recognition that a formal process for appointment may drive away potential appraisers.
- Insufficient time/incentive or reward for appraisers: how do we provide incentive/reward to engage with appraisal by both appraisers and doctors? This is perhaps particularly relevant at a time of increasing operational pressure
- In order to provide sufficient time for appraisers, we discussed the potential merit in establishing a 'sub-specialty' or greater professional role for appraisers. These consultants would have a significantly increased role within the appraisal process, perform more appraisals and relieve some of

the pressures of time/incentive. It would mean there would be fewer appraisers but they could be better performance managed and provide a mechanism to develop those who will become Lead Appraisers/Deputy ROs.

- Difficulties recognised for performance managing appraisers.
- Discussion around separating performance management (which should not sit within appraisal) from the formative part of appraisal.

Next steps

- Recognition that NHS England as part of future development for appraisal recognise that the bar set for revalidation by the GMC could be considered to be low. Consideration could be given to the level of the bar to allow revalidation.
  Role of the Medical Colleges in supporting this objective should be explored further.
- Further discussion on the fitness for purpose versus fitness to practice argument where many felt that they would wish to see the former whereas the GMC bar is at the later level.
- The patient feedback tool was felt to be too simplistic and with time a better mechanism of obtaining effective feedback should be developed.
- Some additional resource may be required and the sharing of good practice to support appraisal office skill mix and resilience, Q/A and appraiser engagement

Mental Health sector

Challenges shared and solutions explored

- To allocate appraisers or not mixed; economy currently opportunities to share to enable best solution
- Some programmes rely on significant appraiser good will; therefore to ensure appraiser engagement is sustainable dedicated support to appraisers may be required.

Topical or outstanding issues

- Striving for quality and consistency – using QA tools, feedback to appraisers and encouraging appraisers to reflect on the role at their own appraisal.
- The benefits of having appraisal, Revalidation, Medical Staffing and Medical Education resources under one roof and in one team – to support Revalidation and managing doctors in difficulty.
- The challenge of improving the skill of reflection to improve quality – through appraiser skills and insistence on recorded reflection before the appraisal begins.
- The unique role of the PDP Group in psychiatry – as ours is the only College to recommend peer groups as the mechanism for delivering CPD and signing off "Good Standing" for CPD.
- Opportunities of purpose 4 remain work in progress for most designated bodies. However opportunities are now recognised and in part are being taken forwards

Next steps

- To continue the journey focused on a quality programme to enable added value of medical appraisal within medical revalidation.
- Collaboration between Mental Health designated bodies to complement discussions and actions from the regional networks have been helpful and will continue to be so.

Independent sector

Challenges shared and solutions explored

- Failures (frustrations)
  - No major failures but recognition that this sector is perhaps the most broad reflecting the variety of services, number of prescribed connections and characteristics of the designated bodies. Therefore perhaps have the greatest challenges and as a group longest journey to achieve their objectives. Review of the AOA for 14/15 shows the number of prescribed connections ranges from 1 to 300 doctors with the vast majority having < 30. The independent sector is therefore a broad church, building on the analogy, including both Westminster Abbey and village churches but with far more (as is the reality) of the latter.
  - Appraiser engagement and their consistency reflects work in progress, as does a quality assurance programme to demonstrate outcomes and inform further development of the programme.

- Successes
  - Significant progress reflected by Medical Appraisal Uptake in light of the introduction of Medical Revalidation
  - Introduction of the Regional programme of blueprint networks for clinical and managerial medical appraisal leads, emerging network programme within designated bodies.

Topical or outstanding issues

- Addressing the whole scope of work within medical appraisal. Examples of good practice but not comprehensive, the information flows and inputs to medical appraisal guidance will be helpful.
- The consistent leadership and practical input of external ROs, to ensure appropriate governance and medical revalidation programmes in such circumstances requires further consideration. This will benefit from the sharing of good practice.

Next steps

- Opportunities for collaboration between independent sectors designated bodies. Clear benefits to support peer review and support for leaders as well as the infrastructure and resilience of the medical appraisal programme. How may this be achieved requires consideration of the commercial sensitivities and rivalries requires further exploration.
- Progression of a sound governance to support doctors with a prescribed connection and those working within the organisation (often the majority) within all independent sector designated bodies. Governance to ensure all doctors appropriately appointed to their role, supported to maintain their core competencies and therefore demonstrate they are safe and provided with the opportunities to develop as appropriate.

Locum Agencies

Challenges shared and solutions explored

There was significant discussion around the concerns NHS Bodies may have regarding the quality of locum appraisals and the confidence they needed to ensure appraisals were in place and of an appropriate quality.

The following challenges were raised –

- Locums being appointed who had no Designated Body (DB),
- How an NHS Body could get reassurance that an appraisal had taken place
- How can an NHS Body be reassured the locums appraisal has been quality assured
- How can everyone be comfortable all relevant information about a locum is being included in an appraisal?
- We considered the use of the procurement process as a solution to some of these issues as demonstrated by Pennine Acute.
  Although the various framework contracts which are in place for the provision of Medical Locums address these issues, it was felt that a specific and more detailed Service Level Agreement (SLA) was extremely useful as this would be agreed with the preferred suppliers to the NHS Body. The SLA could have far more detailed criteria around appraisal policies of the agency's DB and their quality assurance methods. The SLA may also address the options for the NHS Body to provide support and possibly appraisals to the locums if they met certain criteria and lay out the charges associated with that.
    - The SLA could lay out how an efficient transfer of information between the NHS Body and the agency DB could be established.
    - Dr Khan has his own QA tool for appraisals which is straightforward to use and he is happy to share this.
    - Whilst this was considered a very positive step, it was pointed out that all agencies will be providing doctors who have a prescribed connection to a different organisation and so this could be difficult to manage. They may of course have a prescribed connection to another NHS Body or Deanery which in itself would give reassurance.
    - From the agency perspective, it would be a welcome step if the day to day procurement processes considered the agency's processes for revalidation and so this in turn would reward those agencies who invested in quality.
- There was a brief discussion about how an NHS Body would know if a doctor was under investigation. It was confirmed that an agency should always inform the NHS Body if there are any concerns about a doctor although this should not automatically assume they will not be suitable for work. However, investigations which are not yet disclosed on the GMC website may not be communicated as that relies on the doctor informing the agency.
- At the London seminar, there was a particular focus on the difficulties locums may have in obtaining suitable CPD, Audit, Patient Feedback etc. and it was again felt that providing a more supportive environment for locums had significant benefits for everyone. One member of a Trust in the South confirmed they had good support systems for locums and as such they very rarely had new locums coming to the Trust, as they all returned on a regular basis which was a significant benefit to them.

Topical or outstanding issues

- It was agreed that locums are a valuable part of the NHS workforce and they are likely to grow as a proportion.
    - Many locums find the process difficult as they are not part of a team where support may be available, if, for example they receive poor patient or colleague feedback. Although this is discussed during the appraisal they feel they have no redress. There is very little remediation available for locums, although one London agency DB does offer remediation and this is managed by the Responsible Officer (RO) personally.
    - It was acknowledged that good supportive practices for locums including induction, leads to a much more satisfactory relationship and will in many cases result in a locum wishing to return on a regular basis giving continuity to the NHS Body.
    - The system by which a locum doctor must determine his DB was discussed but there were different views. It was acknowledged that the principle of looking retrospectively at the past 12 months to determine who the main employer was is widely accepted and understood. However, it was also suggested that the regulations allow for some flexibility around this depending on the contractual relationship of the doctor and the agency. There was also a discussion about whether, due to the nature of locum work, regularly swopping Designated Bodies was effective in providing a quality process.
    - In London, one of the agency Designated Bodies has an arrangement whereby they will allow a doctor to connect with them if they haven't previously worked for the organisation, provided they sign a contract to say they will not work through any other agency. Some doctors do sign the contract but then do not keep to the terms agreed.
- The main topic of discussion was the difficulty presented to agencies, NHS Bodies and locum doctors in obtaining feedback information about their performance. The current system results in multiple requests being sent to people for the same doctor and from several agencies. It was also acknowledged that it is very difficult to assess someone who has worked for a short shift or a night shift with limited contact with the Consultant. It was agreed that a better system could be created which improved the flow of information and reduced inefficiencies.
- We discussed whether the system could be redesigned, perhaps on the basis of the information following the locums RO, rather than every agency with which the locum has worked requesting the same information. This would require an RO to RO portal which ensured performance information could be accessed appropriately. The possibility of a central credentialing service for locums or a system similar to the Performer's List for GPs may be suitable.
- One agency at the London seminar had an IT system which continued to prompt individuals to complete feedback and had a dashboard approach which allowed NHS employees to log in and see what tasks were outstanding. This had significantly improved their return rate.

Next steps

- The risks associated with being a locum doctor are not the fault of the individual so how do we create a more supportive environment.
- Should HR (rather than Medical Staffing) vet locum doctors as well as the locum agency? There were a variety of views about this although it was agreed that with a good SLA in place and a strong relationship with the chosen agencies, NHS Bodies should be able to trust their suppliers who are audited on a very regular basis.

- It was felt it would be useful to clarify what checks are undertaken by locum agencies, which are mandatory and which are desirable, as well as the different requirements for contract and off contract agencies and how agencies can be on contract under one framework and off contract under another.
- A more strategic approach should be adopted between NHS Bodies and locum agencies rather than always fighting the “Friday night” problems. Revalidation offers an opportunity for a different kind of engagement between locums and the NHS which ensures benefits for all.
- A tightening of the reference process which currently allows locums to select referees. One suggestion is that all references come from the RO but that would be a considerable increase in workload and may be difficult to facilitate.

NHS England

Challenges shared and solutions explored

- Should be more emphasis on the benefits of appraisal, i.e. providing support for doctors, enhancement of professional development etc.

Successes

- Engagement: good compliance, gradually increasing commitment
- Appraiser development
- Appraisal quality: pre-, peri- and post
- RMS and IT systems
- Nationally agreed processes

Challenges

- QA tools – using them and time efficiency
- Merging groups of appraisers e.g. hospitals coming together
- Evidence for appraisal – is there any?
- Improving patient safety
- Resource for QA – limited

Topical or outstanding issues

- Clarification centrally from NHS England of minimum sessions and on supporting information required for revalidation.

Next steps

- Development/identification of resources to provide support for doctors in difficulty.

End