Revalidation and appraisal for SAS doctors

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Medical Director Cornwall Partnership FT
Outline

- What is revalidation?
- How is it going?
- What are the “SAS issues”?
- What is the College’s role?
- Can it help to drive up quality?
- Where next?
What is revalidation?

• “the system of regular checks on doctors’ performance, which aims to provide greater assurance that each doctor is competent, up to date and able to deliver safe and effective care.”
Revalidation is unavoidable...
Facts and figures

• Total 230,000 doctors registered with GMC and subject to revalidation
• Estimated cost £100 million per year
The expected benefits of revalidation include improved:

– governance of professional development and standards
– patient safety
– quality of care
– effectiveness and efficiency of systems and working practices, leading to...

• improved public trust and confidence in the medical profession.
Revalidation, how’s it going?...

• ... too early to say?
Progress so far – July 2016

• 214,442 doctors are connected to a designated body or suitable person in the UK.
• 192,158 approved recommendations. Of those:
  – 155,654 were to revalidate
  – 36,023 total deferred
  – 481 were recommendations of non-engagement
• Deferral rate 19% - main reason is insufficient evidence
• Deferral rates higher for doctors not in training, nor on GP or specialist register
• Higher deferral rates for younger <30 and older >65 doctors
Appraisal rates are rising

Figure 15b: The percentage of completed appraisals by doctor type, comparison year on year

<table>
<thead>
<tr>
<th></th>
<th>Consultant</th>
<th>Staff Grade, Associate Specialist, Speciality Doctor</th>
<th>GP/Performers List</th>
<th>Practising Privileges</th>
<th>Temporary or Short-Term Contract Holder</th>
<th>Other</th>
<th>Total Doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-11</td>
<td>64.1%</td>
<td>35.6%</td>
<td>79.0%</td>
<td>13.6%</td>
<td>0.0%</td>
<td>27.1%</td>
<td>63.3%</td>
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<tr>
<td>Mar-12</td>
<td>73.9%</td>
<td>53.5%</td>
<td>90.1%</td>
<td>69.0%</td>
<td>23.8%</td>
<td>33.4%</td>
<td>72.7%</td>
</tr>
<tr>
<td>Mar-13</td>
<td>75.1%</td>
<td>63.9%</td>
<td>90.3%</td>
<td>99.2%</td>
<td>41.8%</td>
<td>52.3%</td>
<td>76.1%</td>
</tr>
<tr>
<td>Mar-14</td>
<td>86.3%</td>
<td>78.6%</td>
<td>91.6%</td>
<td>74.2%</td>
<td>53.9%</td>
<td>67.0%</td>
<td>83.8%</td>
</tr>
<tr>
<td>Mar-15</td>
<td>87.3%</td>
<td>83.9%</td>
<td>93.2%</td>
<td>84.7%</td>
<td>65.7%</td>
<td>76.0%</td>
<td>86.2%</td>
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</tbody>
</table>

Revalidation Support Team 2014
SAS appraisal rates

![Bar chart showing SAS appraisal rates for 2011 and 2015]

- 2011: 35.60%
- 2015: 83.90%
Medical appraisal is a recognised mechanism that enables doctors to:

• discuss their practice and performance with an appraiser
• demonstrate that they continue to meet the principles and values set out in the GMC’s Good Medical Practice Framework for Appraisal and Revalidation
• plan their professional development around their own needs
• contribute to appraisal outputs used to inform the responsible officer’s revalidation recommendation to the GMC.
Is appraisal helping?

- 80% of doctors agreed or strongly agreed that their appraisal was conducted in a supportive way.
- 64% of doctors agreed or strongly agreed that their last appraisal was a good use of their time.
- 24% of doctors reported that they changed aspects of their clinical practice or behaviour as a result of their last appraisal.
Revalidation evaluation: UMbRELLA

• 90% of surveyed doctors have had an appraisal in their career, 94% in the previous 12 months
• a third of doctors said revalidation has improved the appraisal process
• More than 40% of doctors believe appraisals are effective in helping doctors to improve their clinical practice – and less than a third disagreed
• Doctors in some specialties (such as anaesthetics, psychiatry and emergency medicine) struggle to collect patient feedback.
• Doctors who obtained patient feedback found it is the most helpful information to support reflection on their practice.
Figure 7 – Impact on standard of practice of requirement to consider patient feedback

ROs agree more strongly that feedback is valuable.
Department of Health report:

• 85% of Responsible Officers said that their organisation’s appraisal systems had changed as a result of the implementation of revalidation – mostly for the better

• 77% of Responsible Officers reported that doctors’ participation in appraisal has had a positive impact on their clinical practice with 58% saying it has made it a ‘little better’ and 19% saying a ‘lot better’.
How much time taken?

Figure 10 – Time spent by doctors preparing for and completing their last appraisal

- **Time spent collecting supporting information**:Total responses: 1122
  - 6% for 0 - 1 Hours
  - 18% for >1 - 2 Hours
  - 27% for >2 - 4 Hours
  - 48% for >4 - 8 Hours

- **Time spent completing pre-appraisal forms**:Total responses: 671
  - 16% for 0 - 1 Hours
  - 29% for >1 - 2 Hours
  - 27% for >2 - 4 Hours
  - 26% for >4 - 8 Hours

- **Time spent attending the appraisal meeting**:Total responses: 1037
  - 10% for 0 - 1 Hours
  - 45% for >1 - 2 Hours
  - 40% for >2 - 4 Hours
  - 4% for >4 - 8 Hours

- **Time spent completing post-appraisal forms**:Total responses: 1159
  - 50% for 0 - 1 Hours
  - 35% for >1 - 2 Hours
  - 11% for >2 - 4 Hours
  - 3% for >4 - 8 Hours

More than 8 hours preparation

Revalidation Support Team 2014
Figure 2: Differing messages about the purpose of revalidation

**Improving patient care**

- **Royal colleges**: Intended to strengthen continuing professional development and reinforce systems that identify doctors who encounter difficulties and require support.
- **GMC**: Provide assurance for patients and the public, employers and other health care professionals that licensed doctors are up to date and fit to practise.
- **HR, complaints and operations directors**: A framework to evaluate performance and ensure compliance.
- **ROs**: Quality improvement, reflective practice and doctor development.
- **Boards**: Demonstrating we are implementing revalidation processes to target.
- **Doctors**: Facilitate improved practice for all members and fellows.
- **Equity**: Is it to catch bad doctors? Or make good doctors better?
Positives

• More appraisals and reflection
• More uptake of CPD – structure for learning
• More ownership of data and interest in quality
• Reference to GMC guidelines
• More accountability
• Transparency about errors and concerns
• Integrating marginalised groups, level playing field
• Improved morale
• More patient input
Negatives

• Time and emotional cost
• Tick box compliance
• Risk aversion
• Devalued appraisal
• Exacerbate divides of marginalised groups
SAS issues?

Improving SAS appraisal: a guide for employers

June 2013
What are the SAS issues?

• SAS doctors are not always known to organisation, particularly new starters.
• Variation in the terminology used to indicate the grade of the doctor.
• Lack of communication from trusts to SAS doctors and vice versa.
• SAS doctors can be part-time doctors
More SAS issues

• Consultant-led appraisal may be seen as an exercise in control.
• History of poor quality appraisals has led to a lack of confidence in the appraisal process.
• There is a lack of Supporting Professional Activity (SPA) time, or SPAs are lost at short notice in order to provide Direct Clinical Care (DCC).
• Study leave is not used.
Even more SAS issues

• Hierarchical culture - SAS doctors are seen as a 'non-training' grade.
• Lack of recognition that SAS doctors require training and development opportunities.
• SAS doctor appraisals are not prioritised
• SAS doctors fail to engage in the appraisal process.
The list goes on...

- SAS doctors may not be able to attend team meetings, mortality and morbidity meetings, etc.
- A lack of time and resources, including study leave and SPA time. SAS doctors may not be in the management structure and may not receive clinical governance information relevant to their practice.
- SAS doctors may not have access to systems for collating portfolios.
- Not all doctors may be accustomed to reflecting on their practice.
Top 10 SAS Doctor Solutions

1. Embrace a positive appraisal culture
2. Make/take opportunities to integrate locally
3. Provide constructive feedback on the appraisal experience
4. Prepare for appraisal in a professional and timely way
5. Understand professional and regulatory obligations
6. Engage actively - knowing the appraiser's expectations in advance
7. Take responsibility and initiative for own appraisal
8. Undertake and record personal reflections, especially related to team-based activities
9. Pursue learning /development opportunities through peer contact activities
10. Participate in, and record, activities such as CPD, QI and audit.
   Encourage reflection.
Top 10 SAS employer solutions

1. Accurate database of all doctors, using agreed and limited designations
2. Communicate appraisal expectations, process and requirements
3. Appoint and train SAS appraisers; ensure they have sufficient SPA time
4. Protect SPA time
5. Conduct annual job plan reviews (or more frequently if role changes)
6. Encourage reflection - work with the local deanery to provide workshops
7. Monitor SAS doctor appraisal quality and rates. Respond positively if quality is in doubt, and actively engage with those who do not participate
8. Appoint a SAS tutor / SAS appraisal lead
9. Encourage SAS doctors' participation in governance meetings
10. Ensure SAS doctors receive feedback from relevant clinical governance issues which demonstrates their own individual performance
Where is the bar?

• Below average?
• Statistical outlier?
• Unsafe?
Requirement with a minimum non-negotiable cut off

Good medical practice
<table>
<thead>
<tr>
<th>Domain</th>
<th>Attributes</th>
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</thead>
<tbody>
<tr>
<td>1. Knowledge, skills and performance</td>
<td>1.1 Maintain your professional performance</td>
</tr>
<tr>
<td></td>
<td>1.2 Apply knowledge and experience to practice</td>
</tr>
<tr>
<td></td>
<td>1.3 Ensure that all documentation (including clinical records) formally recording your work is clear, accurate and legible</td>
</tr>
<tr>
<td>2. Safety and quality</td>
<td>2.1 Contribute to and comply with systems to protect patients</td>
</tr>
<tr>
<td></td>
<td>2.2 Respond to risks to safety</td>
</tr>
<tr>
<td></td>
<td>2.3 Protect patients and colleagues from any risk posed by your health</td>
</tr>
<tr>
<td>3. Communication, partnership and teamwork</td>
<td>3.1 Communicate effectively</td>
</tr>
<tr>
<td></td>
<td>3.2 Work constructively with colleagues and delegate effectively</td>
</tr>
<tr>
<td></td>
<td>3.3 Establish and Maintain partnerships with patients</td>
</tr>
<tr>
<td>4. Maintaining trust</td>
<td>4.1 Show respect for patients</td>
</tr>
<tr>
<td></td>
<td>4.2 Treat patients and colleagues fairly and without discrimination</td>
</tr>
<tr>
<td></td>
<td>4.3 Act with honesty and integrity</td>
</tr>
</tbody>
</table>
College Guidance

CR194

Supporting information for appraisal and revalidation: guidance for psychiatrists

Based on the Academy of Medical Royal Colleges’ core guidance for all doctors

COLLEGE REPORT
College principles of revalidation:

• Command confidence of patients, public and profession
• Facilitate improved practice for all psychiatrists
• Allow those working to acceptable standards to achieve without undue stress
• Identify and address those whose standards fall below acceptable practice
What are the doctor challenges?

• Declaration on health
• Declaration on probity
• Scope of practice / contextual issues
• Annual appraisal:
  – Whole practice
  – Trained appraiser
  – Good Medical Practice at its heart
  – Includes reflection on supporting information
• Portfolio of supporting information
What supporting information?

• 1. Continuing professional development
• 2. Quality improvement activity
• 3. Significant events
• 4. Feedback from colleagues
• 5. Feedback from patients
• 6. Review of complaints and compliments
Principles for CPD

• GMC Guidance
New College Guidance on CPD

• Active peer group member (minimum 4/year)
• 250 credits over 5 years
  – Clinical 30 hours/year
  – Academic 10 hours/year
  – Professional 10 hours/year
• Reflection essential
• Peer group to formulate and monitor PDP
• E-learning maximum 25 credits per year
Peer groups

• Share understanding of process
• Endorse planned CPD and help identify suitable options
• Case Based Discussion
• Support in reflection on all supporting information
• Engage avoiders
• Identify data requirements
Quality Improvement

- Clinical audit (1 per 5 year cycle)
- Review of clinical outcomes (no specific number)
- Case based discussion (2 per year)
How can I ensure continuous improvement?

• How do I measure the quality of what I do?
• What am I trying to achieve?
• Who can help me to measure improvement?
How can I ensure continuous improvement?

• How do I measure the quality of what I do?
• What am I trying to achieve?
• Who can help me to measure improvement?
• Ask four questions:
  – How good are you?
  – Where do you stand relative to the best?
  – Where does variation exist?
  – What is the rate of improvement over time?
• Do I achieve what I think I do?
• Does my practice match my peers?
What might help with quality improvement?

• College sets quality standards
• Clinical audit – measure against standards (POMH, NAS, NAPT etc.)
• Clinical outcome measures – generic or specific
• Case-based discussion – role for peer group
National Audit of Schizophrenia

Figure 23: Monitoring of cardiometabolic health parameters, including family history and weight, once in the past 12 months

- Green bars: All cardiometabolic health parameters monitored
- Red bars: Some/none of the cardiometabolic health parameters monitored
Significant events

• Importance is not their absence, but learning and reflection
• Include anonymised reports
• Peer discussion and review
• Appraisal discussion
• Incident reporting: yellow card, safety concerns
Significant events

- Importance is not their absence, but learning and reflection
- Include anonymised reports
- Peer discussion and review
- Appraisal discussion
- Incident reporting: yellow card, safety concerns
- RO needs to be aware of / provide data
- Better reporting culture could improve safety
Feedback from colleagues

• Not just a formal process
• Keep evidence
• Give feedback to others
• Reflection and learning essential – may require incorporation into PDP
Feedback from colleagues

• Not just a formal process
• Keep evidence
• Give feedback to others
• Reflection and learning essential – may require incorporation into PDP

• Earlier action where there are interpersonal issues, especially undermining behaviour?
STRICTLY CONFIDENTIAL

ACP 360 Feedback Report for:

Date: 14 December 2012

The information contained in this report is confidential. It should only be read with the agreement of the person to whom it refers.

How your colleagues rated your core attributes and professional relationships

[Diagram showing ratings for communication, availability, emotional intelligence, decision making, and other areas with patients, peers, relatives, partners, and external agencies.]

The ACP 360 assessors are copyright of Curves for Health Leadership, Wales, University of Wales, Swansea. The scale is based on NPS 360.
Feedback from patients

• Needs careful planning and preparation, especially for special patient or doctor groups

• Appraisal and/or buddy discussion, may lead to development plan
Feedback from patients

- Needs careful planning and preparation, especially for special patient or doctor groups
- Appraisal and/or buddy discussion, may lead to development plan

- Utilise data such as “friends and family” test
- Consider routinely asking patients about their experience

GMC guidance 2013
Review of compliments and complaints

• Need reliable data from employer or trust governance, customer experience, patient advice and liaison service

• Emphasis on learning and reflection – inclusion into PDP
Review of compliments and complaints

- Need reliable data from employer or trust governance, customer experience, patient advice and liaison service
- Emphasis on learning and reflection – inclusion into PDP

- RO needs to be aware of / provide data
Portfolio?

• Cohort of Royal Colleges have purchased a portfolio system from Equiniti, free to College members

• Optional – potential benefit for members outside an organisation (unlikely to be needed in Scotland, Wales, N.Ireland)

• Some organisations have purchased commercially available system

• Medical Appraisal Form (based on Medical Appraisal Guide) available free from NHS England website
Looking forward

• Bureaucratic burden

OR

• Opportunity for improvement in quality of care to patients
Can revalidation help me?

• Formalise reflection on supporting information
• Focus peer group activity
• More constructive challenge through appraisal process (not a “cosy chat”)
• Inform and challenge Personal Development Plan
• Give confidence that standard achieved
Can revalidation help organisations?

• Better tracking of who they “own”
• Reliable capture of appraisals, including groups frequently lost, e.g. SAS doctors, locums
• Overview of supporting information
• Peer support for Responsible Officers
• More structure to remediation if required
How can we use revalidation to our benefit?

• Back to the inevitability
• We might as well find a way to use the process to improve patient:
  – Safety
  – Effectiveness
  – Experience
• Integrate it into routine practice
• Use it to ensure our own development is supported
Conclusion

• Revalidation is here to stay
• Some groups of psychiatrists have additional challenges to overcome
• A positive approach to these challenges is recommended
• Help is available from the GMC, the College, PIPSIG, NHS England
Thank you

QUESTIONS?