Faculty of Medical Leadership and Management

Understanding the drivers of appraisal rates within acute trusts

Dr Tom Foley
Clinical Fellow, FMLM
Dr Robin Cordell
Deputy Medical Director, FMLM

October 2014

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Summary

Appraisal is the process by which licensed doctors are able to demonstrate that they are meeting the professional standards set out in Good Medical Practice[i], essentially that they remain up to date and fit to practice, as well as having a key role in development and therefore promoting excellence in medical practice.

The annual appraisal, along with clinical governance data, is a vital part of the evidence on which the Responsible Officer (RO) will make a recommendation to the General Medical Council (GMC) in respect to a doctor's suitability to retain their licence to practice (revalidation). Despite appraisal being compulsory in the NHS for over 12 years, and 18 months having passed since the requirement for revalidation was introduced, published data showed that appraisal rates remain variable, and this is a significant concern.

In order to ensure safe and high quality care for the patients in their charge, as well as meeting the legal requirements relating to the revalidation of doctors, healthcare organisations are required to support the appraisal process. This study was commissioned by NHS England (London) and NHS England (South of England) and undertaken by the Faculty of Medical Leadership and Management (FMLM) in June and July 2014. Based on interviews with key staff at four NHS trusts in the South of England and in London, the factors contributing to lower and improving appraisal rates, and their implications, were identified. Having considered these factors, ten recommendations for improving appraisal rates have been made.

In essence, the key to success in achieving high appraisal rates was:

- To have the right people in the key posts of RO, the dedicated post of revalidation and appraisal administrator and an appraisal lead (usually a deputy medical director, ideally working exclusively in support of revalidation and appraisal).

- To ensure the Board was kept informed and thus was well placed to offer the appropriate level of support and resources to sustain appraisal.

- To strike the right balance between support and training for doctors, and reminding doctors of their responsibilities as licensed medical practitioners and where necessary cajoling them to engage fully in appraisal. Certain groups of doctors will benefit from additional support and all should be encouraged to seek advice through an "open door policy"; failure to engage must be seen to have consequences however.

- To maintain a group of trained and motivated appraisers, each undertaking a minimum number of quality assured appraisals each year.

- To have in place the right people, and processes that are simple, straightforward and work, before investing in information systems.

Background

Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise[ii]. The core requirement is that doctors meet the standards set out in the GMC's Good Medical Practice (GMP) guidelines[iii]. The GMC requires that licensed doctors take part in annual appraisal; a recent Department of Health (DH) White Paper 'Trust Assurance and Safety'[iv] positioned medical appraisal as the cornerstone of revalidation. A further DH paper[v] argues that appraisal provides the most appropriate and cost-effective means of delivering this assurance and that the benefits of the policy outweigh the costs.

From the FMLM perspective, we would state that appraisal should principally be formative, notwithstanding the necessarily summative element, and that the value derives from supporting professional development and continued improvement in professional practice across a doctor's scope of work. Quality is therefore key.

Annual appraisal has been compulsory in the NHS since 2002. However, despite the centrality of appraisal to medical revalidation, at a point over 12 months into the process, published data showed that appraisal rates remain variable, and this is a significant concern.

In September 2014, NHS England published the results of their annual organisational audit (AOA)[vi]. This is the successor to the organisational readiness self-assessment (ORSA) exercise[vii] previously conducted by the NHS revalidation support team. This showed that the percentage of

completed appraisals was, on average 80.2% (up from 67% in 2013) among acute hospitals. This increase was welcome after last year's worrying slow-down in the progress that had been made to increase appraisal rates from 56% to 63% between 2011 and 2012. The appraisal rate among non-NHS organisations was only 69.4%, but this also represented an increase on the 2003 figure of 61.4%. Mental health trusts and primary care organisations achieved appraisal rates of 86.8% (82.4% in 2003) and 91.5% (90.3% in 2003) respectively. Averaged figures disguise large variation in appraisal rates between organisations. staff grade, associate specialty doctors, and those on short-term contracts had particularly low appraisal rates.

In 2003, the vast majority of designated bodies had an appraisal policy in place, but only 71% performed an audit to understand the reasons for missed or incomplete appraisals. This figure actually decreased from 80% the previous year, suggesting that many organisations may be failing to learn important lessons from current performance. Figures for 2014 were not available at the time of publication.

It is important to note that organisational readiness self-assessment tool (ORSA) and annual organisational audit (AOA) figures are self-reported and there is a risk that trusts have had differing interpretations of some of the questions.

Responsible officers (ROs) are responsible for ensuring that their doctors have a quality assured appraisal each year. As these appraisals are the basis for making a revalidation recommendation, low appraisal rates could be both a risk to the revalidation system and a potential risk to the ability of individual doctors to practise. This was acknowledged at a national level, by Professor Sir Bruce Keogh, in a letter[viii] to medical directors and chief executives following publication of the 2013 ORSA report:

"These appraisal rates are worrying and I am keen to understand the underlying factors behind these rates. I am also sure that boards of provider organisations would wish to understand the reasons behind such low rates and what actions are being taken to improve the situation."

Methodology

FMLM has worked with NHS England (London), NHS England (South), and four NHS trusts, to understand the factors that drive appraisal rates and the initiatives that have been attempted to improve them. Our findings are outlined in this report. We have assessed the extent to which local and national factors have contributed and the reasons why the initiatives attempted have been successful or otherwise. Specifically, our methodology included:

1. Identifying four acute NHS trusts with a range of appraisal rates. Two in London and two in the South.

2. Deskwork: We conducted a review of available performance data and relevant published literature to help understand the strategic context within which the trusts were working. We also analysed the data and documentation available on the appraisal performance of the four trusts.

3. We conducted interviews with the chair, chief executive, RO, appraisal lead, and revalidation administrator at each trust (20 individuals in total).

4. We conducted a thematic analysis of findings from the literature review and interviews.

5. FMLM's revalidation expert group met as a focus group to discuss the thematic analysis findings. This group drew out the key lessons to be learnt and ensured the generalisability of findings to other organisations.

The small number of trusts in our sample means that drawing statistically significant quantitative conclusions is not possible. The aim of this project was therefore through a qualitative analysis to identify important themes that may require further investigation. The selection of trusts by NHS England (South) and NHS England (London) was aimed at reducing the risk that our sample is unrepresentative.

This methodology did not include questionnaires or interviews with the doctors who have been subject to appraisal in these trusts. This would have been beyond the resources of this project and is currently being undertaken as part of a broader revalidation impact analysis.

This report outlines the limited literature available on appraisal rates and then focuses on the results of interviews with key personnel at four acute trusts, outlining the initiatives that they have attempted, to improve appraisal rates, and gives an indication of how successful they have been.

Literature review

There has been a significant amount of research into the costs, benefits, and efficacy of revalidation, and into the quality of appraisal. There is however, very limited research touching on the question posed by Professor Sir Bruce Keogh (above) – What are the reasons behind low and variable rates and what actions are being taken to improve the situation?

Keyword searches of the academic bibliographic database Medline revealed no peer-reviewed papers that were relevant to medical appraisal rates in the UK. Searches of the grey literature (such as think tank and government publications) were more successful and the findings are outlined below.

The research that does exist includes five broad themes that are important determinants of appraisal rates:

- Board engagement
- Professional regulation
- Clinician engagement
- Investment
- Existing systems and processes

These themes are also reflected in the indicators contained within the 2009 NHS (England) revalidation support team (RST) document, Assuring the quality of medical appraisal for Revalidation[ix]. This illustrates the inter-relatedness of appraisal quality and appraisal rates. The limited literature on each of these themes is outlined below.

Board engagement

In a study by the King's Fund[x], ROs highlighted the support of boards as a key factor in the successful set up of revalidation and in engaging more doctors in higher quality appraisal processes.

Another study from the King's Fund[xi] found that revalidation was being discussed at board level, primarily in the form of a report from the RO on process-outcomes, that is, numbers appraised, numbers revalidated, numbers deferred and so on.

The most engaged board members were those who had identified the power of revalidation to support wider initiatives in their organisation such as:

- Clinical excellence
- A safety net for cost improvement programmes
- Clinical leadership
- Patient focus

The King's Fund found variation in boards' approaches to revalidation. For example, at one board, the chair had already initiated conversations about the potential benefits of revalidation to the organisation. At another organisation almost all strategy around revalidation (beyond process metrics) was happening at the RO level. This was partly because fiscal challenges had placed revalidation as a lower priority at board level than it might otherwise have been.

The King's Fund concluded that when an initiative is discussed and acted on at board level, it sets the tone for how it is viewed by other leaders. The behaviour and attitudes of Board members towards improving clinical quality is critical to creating a culture in which quality and patient safety are prioritised[xii].

Professional regulation

ROs now have a statutory duty to ensure that appraisal and clinical governance systems are robust and, once every five years, to use outputs from appraisals and clinical governance information to make a revalidation recommendation to the GMC for each doctor. Medical appraisal was introduced as a requirement in the NHS for consultants from 2001 and for general practitioners (GPs) in 2002.

Alongside regulatory requirements placed on ROs, the GMC has stepped up its electronic communication with individual doctors around their responsibilities in relation to revalidation and appraisal[xiii]. A small number of doctors have actually been removed from the register for non-engagement.

While the introduction of revalidation has coincided with an increase in appraisal rates, there

is anxiety that appraisal may become more process orientated and less developmental[xiv].

Clinician engagement

The RST outline the potential benefits of appraisal, to the individual doctor as:

- Serving as a guide to performance
- Supporting trust between the employee and organisation
- Setting goals
- Looking at opportunities for improving performance
- Determining training needs

Clinical engagement is difficult to disentangle from regulation. The King's Fund found that the impact of revalidation on culture and behaviour was still unclear, but it was agreed that revalidation was driving compliance with appraisal. This is reflected in the ORSA and its replacement, the annual organisational audit (AOA) return[xv]. Appraisal rates have increased, especially in those sites where appraisal had not been undertaken universally, and among those doctors who had not previously engaged in appraisal.

Investment

The King's Fund report, "Medical Revalidation: From compliance to commitment" found that investment in personnel, processes and IT, was important to the successful implementation of appraisal and revalidation.

This investment included identification, recruitment and development of the RO role and training programmes for both ROs and appraisers. It was felt to be important that a clinician (the RO) was driving the changes from within the organisation. This had the potential to change cultures.

Another report from the King's Fund, "The early experiences and views of responsible officers from London", highlighted the importance of investment in IT systems. It reported that having to use 'out of date and clunky' paper based processes was having a negative impact on the experience of being an RO as it added extra time to what they saw as an already 'lengthy' process. We as the authors do however comment on this finding further in light of our research.

It is a requirement for doctors to provide their RO with complete information on their performance across the whole scope of their practice. This may be collated through their annual medical appraisal or by other means that the RO or the designated body (DB) prescribes. While the King's Fund study[xi] reported some issues with the accuracy and completeness of data provided to doctors on their performance within their DB, ie their principal place of work for the purposes of revalidation, the infrastructure for providing data was usually in place.

In the same study, doctors reported that increased investment and time were taken in their organisations to ensure that all doctors were undertaking appraisal. However, doctors in some organisations felt there had still been insufficient investment in appraisal processes.

Existing systems and processes

The implementation of revalidation does not take place independently of existing organisational structures. A recent report from the King's Fund[x] found that, where robust systems of appraisal and clinical governance were already in place, they supported the process of revalidation and made it more straightforward to implement.

Interviews at four acute trusts

Four trusts were chosen, by NHS England (London) and NHS England (South), in order to represent the range of acute hospital trusts across their regions. These range in size from a semi-rural trust with around 400 beds on one site, to an urban academic centre with around 1000 beds across multiple sites. The trusts also had a wide range of appraisal rates in the last ORSA, from mid-fifties (percentages) to over ninety percent. However, the AOA that was submitted during the life of this project showed that all but one of the trust's appraisal rates had increased to at least 80% (with the other following the next month). It is believed that while some of this apparent increase may be due to differences over the timing of appraisals last year, IT errors and incorrect GMC Connect registrations, the introduction of revalidation has undoubtedly focused attention on increasing the appraisal rate. This trend has been reflected across the sector.

People

The factor that each trust cited as being most important to their success or failure in increasing appraisal rates was having the right people in the key positions:

- Responsible officer (usually the medical director)
- Revalidation and appraisal administrative support staff
- Appraisal lead or deputy medical director for revalidation and appraisal
- A group of well trained and motivated appraisers
- Well briefed and supported doctors undergoing appraisal
- Reporting to and support from the Board and chief executive

The interviews identified key issues for each of these roles.

The responsible officer

The RO in each of the trusts was the Medical Director. The role of the RO in relation to revalidation and appraisal was well understood by all the ROs, and the others interviewed, as being responsible for:

- Making every effort to ensure that doctors take part in appraisal
- Ensuring that there is a robust system in place to support revalidation and appraisal
- Monitoring the fitness to practice of individual doctors
- Making one of the three choices of recommendation to the GMC on revalidation of individual doctors, including non-engagement
- Keeping the Board informed

It was also recognised that the medical director has many competing priorities and so requires significant support to manage the large volume of revalidation traffic to, from and about doctors and to fulfil the full range of their responsibilities under the RO Regulations. This support usually came in the form of an appraisal lead and a revalidation administrator.

The revalidation and appraisal administrator

Support for the RO role is now a statutory requirement and provision is monitored in the AOA. The revalidation and appraisal administrator was seen as essential by all of the appraisal leads and ROs interviewed. This person was always a non-clinical individual who in some trusts worked within the HR department and in others was a dedicated role. Their job generally involved:

- Engaging doctors
- Acting as a first point of contact to the revalidation system
- Keeping track of GMC Connect
- Managing the IT system and tracking the progress of doctors
- "Chasing" doctors who had missed deadlines and escalating cases where appraisal dates had been missed with the RO as appropriate

Again resources for this role varied between trusts. One trust had two full time revalidation/appraisal administrators while another had one person who performed the role in addition to other duties. The seniority of the person holding this role also varied from Band 3 to Band 8 (this person undertook many of the roles usually left to the appraisal lead).

Revalidation administrators based in London reported benefiting from an informal network that has been set up to share best practice. This group meets every two months. It was originally started by NHS England (London), but it has now become self-sustaining. Administrators outside London reported that they would appreciate such a network.

The appraisal lead

The appraisal lead was usually a senior clinician, often a deputy or associate medical director. They were seen as the person who engaged most with doctors and often set up the revalidation system under the supervision of the RO. All of the ROs viewed their appraisal leads as being essential to the success of the system. As illustration of the importance of the appraisal lead, at one trust, the appraisal rate dropped from 90% to 60% in the year that the appraisal lead took a sabbatical, returning to over 90% on their return.

It was felt that there were three keys to success as an appraisal lead:

- Organisation
- High visibility within the trust
- Being a doctor essential to reaching peers who were difficult to engage

Despite the importance of appraisal leads, their resources varied significantly between trusts. One appraisal lead worked three days per week, entirely on that role. Another appraisal lead had to do the work in their spare time as they had not been allocated any time in their job plan.

The doctor undergoing appraisal

Designated bodies (DBs) and their ROs have a statutory duty to put in place appraisal and clinical governance systems[11]. Individual doctors who hold a licence to practice are similarly required to engage in annual appraisal every year, and to meet all other GMC requirements if they are to retain their licence and to be revalidated (usually every five years).

Doctors in training revalidate through their Local Education and Training Board (LETB), so although trusts must support doctors in accessing relevant data, it is not their responsibility to organise appraisals for trainees. The four trusts reported varying levels of engagement from their non-training doctors. Individual trusts reported difficulties engaging certain groups of doctor.

One trust had experienced great difficulty engaging its academic doctors. The associated university had been providing conflicting instructions and there were problems sharing information between the two organisations. This was only resolved when a joint working group was established to agree and coordinate on the provision of appraisal and associated information.

Specialty doctors, and those serving under the terms of the earlier "SAS" doctor grades including associate specialists, staff grades and a number of other career grades[xvi], appeared to be a difficult group to engage. This has already been recognised by NHS England (London), who have appointed a SAS doctor, on a one-year contract, to work with this subset of doctors. One trust had only a small number of SAS doctors, the other three had experienced difficulty engaging this group. There was a feeling that they had missed out on opportunities to familiarise themselves with the revalidation process and traditionally had lower appraisal rates. All three trusts have made targeted efforts to engage these doctors. One trust has had notable success after targeting specific training for this group; appraisal rates for SAS doctors at the other trusts was 10% lower than for consultants, but comparable to consultants in this latter trust.

Doctors who held a range of atypical contracts, including honorary consultants who may have retired, doctors from overseas who practice in the UK for only a couple of weeks per year, and short term staff, were reported to be difficult to engage. It was felt that many of these doctors might reconsider whether they should continue holding a licence to practice in the UK.

One trust initially allowed doctors on short-term contracts to use the MAG form, but eventually they insisted on everyone using the same IT system to reduce the logistical challenge. Another trust still allows certain groups to use the MAG form, but then uploads it onto the IT system.

There were anecdotal reports that some of the most difficult doctors to engage were those who had been in post for many years and had not previously been offered or accepted appraisals. There was a feeling that new consultants, who had been through the training programme recently, were already used to the format. There were anecdotal reports of doctors retiring early to avoid the need to engage with appraisal and revalidation. None of the trusts had undertaken detailed research to explore the impact of this phenomenon. This represented only a small proportion of their doctors, and so although important, will not have significantly impacted on the overall appraisal rate for the trust.

The Board

All of the board chairs interviewed acknowledged that it was necessary for their boards to be assured of the quality of their staff and of the systems in place to support revalidation and appraisal. They all felt comfortable that they were achieving this by:

- Providing the necessary resources to support revalidation
- Holding their executive to account
- Investing in training
- Listening to complaints from doctors
- Monitoring the appeals processes

In all cases, boards received regular dashboard type updates containing information on the number and percentage of doctors, of each type,

who had been appraised. They also received ad hoc updates relating to systems and procedures, either from the RO or directly from the appraisal lead. These usually occurred at times of system change or when further resources were required. This is in keeping with the findings of the King's Fund report[xi].

All of the chairs were clear that their role was strategic rather than operational divide and so they did not need and nor should they have large amounts of data presented to them. They liked the current dashboard approach and most sought further information only when exceptions were raised. ROs generally agreed that the information flowing to their boards was sufficient, but views were mixed on whether their boards had a good understanding of revalidation. Indeed, interviews with chairs revealed varying levels of awareness of the system, of their trust's performance on appraisal rates, and of how that compared with other similar organisations. One RO felt that their board was not in a position to ask the right questions or to hold their team to account. This was rationalised by chairs and other interviewees as being a reflection of the multiple priorities faced by trusts in today's NHS. This was congruent with the findings from our literature review.

Boards were seen as being responsible for ensuring that resources were in place to support revalidation and most chairs reported that they had achieved this. However, resources allocated to revalidation varied significantly between trusts, in terms of personnel involved and IT systems provided. The differing size of trusts did not entirely account for these differences.

All of the chairs saw great value in appraisal and reported that their trust would probably continue with annual appraisal, even if it were not required by the legislation. Two noted that they might seek to vary the appraisal process had it not been a regulatory requirement. One noted that other staff appraisals had better alignment with the organisation's objectives. The professional appraisal is mandatory in order to meet GMC requirements, but NHS England is also making efforts to encourage greater alignment between the contents of a medical appraisal and the organisation's objectives. This requires the PDP to be focused on the doctor's development in order to meet organisational priorities as well as their own personal objectives.

Initiatives to increase appraisal rates

We asked each interviewee about the initiatives that had been successful and unsuccessful at increasing appraisal rates in their trust. We heard a variety of answers and there was significant agreement between trusts. Trusts were less able to identify initiatives that had failed, because the last two years have seen a deluge of initiatives aimed at increasing rates. Rates have duly increased, but it is now very difficult to establish causality between the different initiatives.

One of the chairs shared the model of change management that they had applied to this challenge and we have used it here to organise the initiatives. The chair told us that successfully increasing appraisal rates required four actions, to:

- Set clear expectations
- Monitor progress at the right level
- Provide the right tools and support
- Ensure that there are consequences for both good and poor performance

Initiatives to increase appraisal rates can be categorised under these four headings. Some occur at a national level, some at a regional level and some at trust level.

Set clear expectations

ROs mentioned that revalidation has been talked about for most of the past decade. There was a sense that trusts were reluctant to improve their appraisal systems in the five years before revalidation was implemented, in case they were rendered inappropriate by the legislation once it was actually enacted. Although unlikely, it is therefore possible that the introduction of revalidation actually held back some aspects of progress on appraisal and that some of the increase in appraisal rates now being seen may have otherwise occurred earlier.

A more common view was that the publicity from the GMC and other organisations in the past year has successfully raised awareness of revalidation among trusts and doctors. There is now broad expectation that all doctors will engage with appraisal, as the GMC requires them to[xvii]. This was felt to be one of the key drivers behind the increased uptake of appraisal. Letters, emails, and text messages to doctors, from the GMC, were cited as being particularly effective.

All of the trusts reported that before revalidation, even though obligatory with the NHS since 2001 for hospital medical staff, many doctors saw appraisal as being an optional activity. Along with the initiatives from the GMC, trusts have also been setting clear expectations for their doctors, through regular emails, newsletters and intranet sites. There were reports, particularly from medical directors, of doctors with serious conduct and performance issues who had not had an appraisal for over 10 years. Setting new expectations for these doctors has been a challenge and for a small number, their employment within the trusts we visited has ended.

It was also reported that trusts now had much clearer expectations of their appraisers, in terms of what training they should undertake, how many appraisees they should have, how appraisers should be allocated, what appraisals should include, and how quality should be monitored. Some trusts have introduced job specifications for their appraisers. One RO specifically commented on the value of having a smaller number of committed and experienced appraisers undertaking at least six appraisals a year, in contrast to a larger number of doctors undertaking just one or two appraisals a year.

Monitor at the right level

There was concern among some trusts that the monitoring returns that they were required to submit to national and regional bodies, such as the ORSA/AOA were too burdensome and there was an indication that such documents were sometimes filled in hurriedly. This may have implications for the accuracy of the findings. There was also a suggestion that the cut-off date caused some trusts to report artificially low appraisal rates, notwithstanding guidance on this being included in the NHS England appraisal policy[xviii].

There was a clear view that boards should hold their executives to account, but that they should be careful not to move from a strategic to an operational role. They all felt that the dashboards currently in use contained a sufficient level of detail. Two felt that the AOA was too detailed to be useful at board level.

All trusts noted that their monitoring systems have improved significantly as a result of revalidation. Previously, many trusts did not know what their appraisal rates were. Many doctors were receiving appraisals of different types within their own departments and often HR held no central record. Three of the trusts felt that new IT systems had given them the ability to monitor progress with much more granularity. The fourth trust felt that they achieved an adequate level of monitoring without a commercial IT system.

Provide the right tools and support

There was a clear view that the implementation of revalidation has required a significant investment from all four trusts. As has been mentioned already, the level of investment has varied between trusts. Within trusts that have recently merged with or acquired other sites, there has often been a disparity in levels of investment between different parts of the same organisation. This had been recognised as a significant issue and generally, the parts of the organisations with lower levels of funding have achieved lower appraisal rates and have reported having less reliable systems in place.

These funding variations are most notable in the differing job plan allocations for appraisal leads and revalidation/appraisal administrators that have been discussed in the sections above.

Some interviewees expressed concern that this year's increase in appraisal rates had been achieved through the goodwill of unpaid appraisers and may not be sustainable in the longer term. This dilemma was not lost on leaders within the trusts. One chief executive expressed frustration that their organisation was being asked to do more and more with fewer resources. Another complained that they had to satisfy 26 different regulators and while they supported revalidation, they felt that the general regulatory burden was too high.

Training for appraisers was cited as an important factor in developing the capacity to cope with an increased number and increased quality of appraisals. All four trusts have commissioned external appraiser training and are actively expanding their group of appraisers. One trust made the point that this expansion was not always positive. Their appraisal quality audit found that appraisals undertaken by appraisers who had undertaken ten appraisals in the previous year, were, on average, of higher quality than those completed by appraisers who had undertaken five or less appraisals. They also felt that if they concentrated appraisals on a smaller number of appraisers, they could free resources to spend on

additional training and those people would also become more expert in the use of the IT system (three of the four trusts using a commercial system, the other using the MAG Form).

All four trusts also provided training and information to doctors on what they needed to do in preparation for appraisal. This took the form of emails, online learning, classroom sessions, road shows, and intranet sites with examples, contact details and external links.

Three of the trusts had a commercial IT solution that provided portfolios, 360-degree feedback systems to doctors and allowed administrators to track progress through dashboards and reports. Their view was that it would not have been possible to manage a robust appraisal system and to track the progress of their doctors without an electronic system. They all identified weaknesses with their chosen systems, mostly around responsiveness and usability, but felt that these were outweighed by the advantages. Each had previously been using the MAG form and had been tracking progress with spread sheets. They felt that this was becoming increasingly difficult to manage as new data was added each year. They also valued the ability to track what percentage of the process each doctor had completed, so that they could spot non-engagement early. However, the fourth trust, with a high appraisal rate, had decided to invest first in the personnel needed to manage appraisal and revalidation. Their view was to put the people in first, get the system right, and then introduce an IT system that met their needs. They were content at present with the MAG Form and the information management system they had set up in the trust. In regard to managing those doctors who had not had an appraisal, while they were unable to track their progress as precisely, they had a strong information provision and escalation procedure to ensure that support was offered early, and if they did not engage, the DMD for appraisal and then the RO became involved

The trusts using a commercial IT provider noted that initially, a proportion of doctors found it difficult to use the IT systems and there was some clinical resistance. To overcome this, training sessions were run and staff were made available to “hold their hand”. One trust reported that the IT provider was responsive to their feedback and changed the system to better meet their requirements. Another trust increased medical buy-in by allowing the doctor body to choose the provider, after hearing presentations from each bidder.

ROs, appraisal leads, and revalidation administrators derived some value from regional and other informal networks of peers. They found these to be useful forums to seek advice on difficult situations.

Ensure that there are consequences for good and poor performance

It has been the consequences of completing or not completing appraisal that appears to have had most impact on appraisal rates at the four trusts in our sample.

Before the implementation of revalidation, all four trusts required that consultants engaged with appraisal before their application for a clinical excellence award was considered. The trusts noted a surge in appraisals at that time of year.

More recently, trusts have been "selling" appraisal as a developmental opportunity. They have used informational emails, intranet sites, workshops, etc to help doctors see what they could get from appraisal. Trusts feel that this has had some success, but most felt that it has been the consequences for non-engagement that have been the more powerful motivators.

Thanks to the GMC information campaign, most doctors now understand that their licence to practice depends on successful revalidation. This has produced powerful motivation to engage. Despite this, trusts have found that many doctors will delay their engagement for as long as possible; there seems to have been widespread ignorance of the requirement to have had an appraisal every year since the 2012/13 appraisal year (1 Apr 2012 to 31 Mar 2013) and a view that engagement was only necessary as their revalidation date approached. Each of the trusts has developed their own systems to chase up these doctors. The most effective systems work as follows:

- Informational emails are sent regularly to keep doctors informed of what is expected and where they can get help.
- An automatic email is generated by the IT system, informing the doctor what they must do and when.
- Regular reports produced by the IT system identify doctors who are not meeting deadlines for their annual appraisal.
- The revalidation administrator emails these doctors to remind them and to offer support.

- Doctors who ignore these emails are referred to the appraisal lead and to their own appraiser, who emails or phones them again.
- Local management structures are informed by the appraisal lead and contact is made by their clinical director, service line lead, or operations manager, as appropriate.
- If the doctor does not engage and does not accept assistance, they are referred to the RO, who arranges a meeting to discuss the issues.
- If this is not successful, and following adequate warning of the consequences, the RO considers informing the GMC of non-engagement.

Trusts report that this escalation procedure has been effective. They do note that it often reveals personal or mental health issues that have not previously been detected and the process must be applied sensitively; where concerns over health are identified, the RO will follow the Trust acting on concerns policy.

Quality

Quality of appraisal is technically outside of the scope of this report, but it is impossible to consider appraisal rates without considering the impact on quality. Interviewees from all trusts appreciated that high quality appraisal was critical to making valid revalidation recommendations and to realising the potential benefits.

There were two broad approaches to quality. The more common approach was to recognise the urgent need to increase appraisal rates and to devote most effort to achieving that goal. These trusts aimed to improve quality in the years to come. The other approach was to improve the quality first having taken the view that this would drive demand for appraisal and would make it easier to increase appraisal rates in a sustainable way. All the trusts achieved increased appraisal rates and as this study did not investigate the quality of appraisals it was not possible to determine the relative success of the two approaches.

This raises the question whether the quality of appraisals has deteriorated in the drive to improve rates, as had been feared by an earlier report from the RST[xiv]. There was no evidence of this from the interviewees. The ROs and appraisal leads acknowledged that quality could always be improved, but they described more robust appraisals and a move away from "cosy chats" in previous years. Although all of the trusts have trained more appraisers and most have introduced quality audits, only one has so far removed appraisers for poor performance as an appraiser.

The issue of appraisal quality will be a continuous concern in the years ahead and should be addressed by any on-going revalidation evaluation work.

Findings and recommendations

This section links the report's findings to recommendations that might sustain and further the improvements in appraisal rates that have been observed:

Recommendation 1. It is important to have the **right people** in the right jobs with **the right support**. The trusts told us the following people were essential:

- RO
- Revalidation and appraisal administrator
- Appraisal lead

These roles should be given the **status, time and resources**. The precise time and resources needed will depend on the individual organisation, but trusts may find it helpful to benchmark against others.

Recommendation 2. A supportive and informed board is important **to ensure that appraisal receives the resources and priority that it requires** within the organisation. Dashboards reporting quantitative metrics around appraisal rates are helpful, but not sufficient to keep boards informed about their trust's performance on appraisal and revalidation. Feedback from doctors, benchmarking against other trusts, peer reviews, and qualitative updates from the RO may also be helpful in providing a full picture.

Recommendation 3. Trusts have used a combination of **information, support, progress monitoring and escalation** to successfully drive up appraisal rates. These systems could be collated in a **toolbox** to help trusts who continue to struggle with appraisal rates.

Recommendation 4. Some groups of doctors appear to be **harder to engage** in appraisal than others. Trusts can increase appraisal rates in these groups by analysing the barriers to their

engagement and providing **tailored training and support**.

Recommendation 5. There must be consequences good and bad in relation to appraisal; those who engage fully, and who produce high quality professional development plans (PDPs) focused on improved health outcomes (directly or indirectly) should be rewarded through resourcing of their PDPs. Conversely, inadequate engagement must have consequences, ultimately including dismissal. At the very least, no doctor should be considered for a clinical excellence award if they have not had an appraisal in the past year.

Recommendation 6. For doctors with significant **academic commitments**, it has sometimes been difficult for the trust to coordinate appraisals and deliver consistent information. Following review of the process of appraisal and revalidation, those who have both academic and clinical roles, who under the current Follett rules[xix] are required to have two appraisals, should instead have just one professional appraisal. This should cover the full scope of their practice, as is the case for all other doctors. This is not to say that employers in trusts and LETBs should not require their employees to undertake performance appraisal, but **doctors should in principle have only one professional appraisal**[xx].

Recommendation 7. Some trusts allowed doctors to continue using the e-portfolio they are familiar with, when the majority of others had been migrated to another system. This has created some logistical difficulties. Whereas the authors have no concern over this, provided all supporting information is accessible by the RO, and the outputs of appraisal are shown to be satisfactory, trusts may find it easier to **maintain a common system** for their doctors.

Recommendation 8. High quality appraisers are crucial to increasing appraisal rates and appraisal quality. Each trust should maintain a sufficient pool of well-trained appraisers. The pool should not be that large, as a smaller group will have a greater degree of expertise borne out of experience, and hence quality. A formal job description is helpful to ensure appraisers are clear about what is expected, and all appraisers must be subject to quality assurance. Those who perform poorly should be retrained or no longer permitted to perform appraisal.

Recommendation 9. Appraisal monitoring systems have improved as a result of revalidation. Three of the trusts found specialised IT systems helpful in improving monitoring, while the fourth trust achieved a similar outcome using a standard spread sheet programme. The choice of Information management system will be determined by the needs of that trust.

Recommendation 10. The **GMC communication campaign** has raised awareness of revalidation and the need for doctors to engage with appraisal. This has made it easier for trusts to increase appraisal rates. The focus should now shift to assuring the **quality** of appraisal.

Conclusion

This report has examined the limited literature available on the drivers of appraisal rates. It has confirmed most of the findings and has built on them.

People, rather than for example IT systems, are considered to be the most important factor in determining appraisal rates. It is clearly important that trusts put the right people in the right positions. The Board must be supportive, the RO must show leadership, the appraisal lead must be visible and must engage with their peers, the revalidation/appraisal administrator must be organised and must reduce the burden on the other team members. The doctors themselves are not a homogeneous group. Some are more easily engaged than others and their reasons for non-engagement are varied. Some need to have their expectations reset while others need to be supported through difficult personal or professional periods.

Many initiatives have been employed to increase appraisal rates, some have clearly been successful, a few have failed, but given the crowded implementation space, it is difficult to establish the individual effectiveness of each. It is clear that since the implementation of revalidation across the four trusts, expectations have become clearer, monitoring has improved, appraisal has benefited from more resources, and the trusts and the individual doctors employed by the trusts have begun to feel the consequences of not engaging with appraisal.

Appraisal rates have increased in recent years. There remain questions about whether this can be sustained without further investment, but in the years to come, the focus seems likely to shift onto quality of appraisal and further work will be required in that area.

Acknowledgements

We are grateful to NHS England London and NHS England South, who commissioned this work and ensured access to the most up-to-date data on appraisal rates. The report would not have been possible without the extensive input of the editorial team:

- Mrs Ros Crowder, NHS England (South)
- Mr Ray Field, NHS England (London)
- Mr Peter Lees, Faculty of Medical Leadership and Management

We are also grateful to Kate Rogers at NHS England, who supplied the latest annual organisational audit data.

Interviews were conducted by:

- Dr Robin Cordell, Faculty of Medical Leadership and Management
- Dr Tom Foley, Faculty of Medical Leadership and Management

Findings were kindly reviewed by the Faculty of Medical Leadership and Management's expert revalidation group.

The most important contributors have been the 20 members of staff at the four acute trusts who agreed to be interviewed as part of this work. They cannot be acknowledged by name because the team wanted to ensure their anonymity.

Appendix A – Interview questions

1. Tell us the story of how your trust implemented revalidation.
    a) Focus on appraisal
    b) What was your (your predecessor's) role?
    c) Impact on quality of appraisal?

2. Describe your baseline appraisal infrastructure before revalidation.
    a) What was your appraisal rate in 2010 and 2014?
    b) How important was infrastructure investment (IT, etc)?

3. How important was investment in appraisal support staff?

4. What steps have you taken to increase appraisal rates?
    a) Which have been successful? Why?
    b) Which have been unsuccessful? Why?

5. How engaged was the Board?
    a) Was that an important factor?

6. How engaged were the clinicians?
    a) Was that an important factor?
    b) Were there differences between groups (eg specialties, grades)?
    c) What training / support is available for doctors?

7. What challenges remain in increasing your appraisal rates?
    a) How do you plan to meet them?

8. What quality assurance mechanisms do you have around appraisal?
    a) Ever stop using an appraiser because of quality?
    b) How do you ensure appropriate information is included in appraisal (complaint/SUIs/etc)

9. Do you think that the benefits of increased appraisal rates have outweighed the investment required to achieve them?
    a) Impact on patient care?

10. What advice would you give to other trusts who are trying to improve their appraisal rates?

11. Is there anything else that you think is important, that I haven't asked you about?

References

[i] GMC. GMP Framework for appraisal and revalidation, 2013.

[ii] GMC. An introduction to revalidation. Secondary An introduction to revalidation 2014. http://www.gmc-uk.org/doctors/revalidation/9627.asp.

[iii] GMC. Good Medical Practice: GMC, 2013.

[iv] DH. Trust, assurance and safety: the regulation of health professionals in the 21st century. In: DH, ed., 2007.

[v] DH. Medical Revalidation - Costs and Benefits: Analysis of the costs and benefits of medical revalidation in England. In: DH, ed., 2012

[vi] England N. Annual Organisational Audit 2014 - Prepublication correspondence Awaited, 2014

[vii] RST. Organisational Readiness Self-Assessment (ORSA) Report 2012-13: Revalidation Support Team, 2013

[viii] Keogh. Organisational Readiness Self-Assessment (ORSA) 2012/13

[ix] Shelly, Judkins. Assuring the Quality of Medical Appraisal for Revalidation: Revalidation Support Team, 2009.

[x] Nath. Revalidation: The early experiences and view of responsible officers from London: The King's Fund, 2013.

[xi] Nath, Seale, Kaur. Medical Revalidation: From compliance to commitment: The King's Fund, 2014.

[xii] Nath, Steward, Machell, et al. Putting quality first in the boardroom: Improving the business of caring: The King's Fund, 2010.

[xiii] GMC. Revalidation. Secondary Revalidation 2014. www.gmc-uk.org/doctors/revalidation.asp.

[xiv] RST. The Early Benefits and Impact of Medical Revalidation: Report on research findings in year one: Revalidation Support Team, 2014.

[xv] England N. Annual Organisational Audit 2013-2014, 2014.

[xvi] Employers N. Specialty and Associate Specialty Doctors. Secondary Specialty and Associate Specialty Doctors 2014. http://www.nhsemployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/specialty-and-associate-specialist-doctors.

[xvii] GMC. Supporting information for appraisal and revalidation, 2012.

[xviii] England N. NHS England Appraisal Policy, 2013.

[xix] Follett. Annual appraisal for clinical academic consultants: The Follett Review. In: Health Do, ed., 2003.

[xx] GMC. My Appraisal. Secondary My Appraisal 2014. www.gmc-uk.org/doctors/revalidation/12386.asp.