ACADEMY OF MEDICAL ROYAL COLLEGES

Assessment Tools Workshop Report
30 June, Royal College of Paediatrics and Child Health, London

Introducing Assessment: Plenary session - chaired by Dr Andrew Long
Andrew Long introduced the first session with a presentation on the current state of the use of formative and summative assessments within medicine. - full slides are available from kate.tansley@aomrc.org.uk and/or yvonne.livesey@aomrc.org.uk

Andrew discussed the varied terms for assessment – although he stressed that the workshop should be discussing mainly formative rather than a summative assessment as recommended in the previous report (qv). Since regular workplace-based assessments were first introduced, the summative nature of assessment (ARCP, revalidation) has meant that the role of formative assessment has been underplayed - which may discourage doctors from striving towards more than 'just good enough'. There is a need to change the culture so that all doctors welcome formative assessment throughout their career as has successfully been accepted in many aspects of WPBA within training programmes. It was agreed that for supportive assessment to be of maximum benefit it needs to be carried out at an early stage with doctors experiencing difficulty. NCAS reported that many doctors are referred late when their problems had been identified much earlier and early intervention would have been likely to have had more chance of a more successful outcome.

Methods of identifying doctors in difficulty at an early stage needed to be found. Peer review was suggested as one means of doing this. It was also mentioned by NCAS that 12-16% of their referrals are trainees - and some had had issues identified much earlier in their career, even at medical school. There is a problem with transfer of information during training which mean that some trainee doctors with considerable problems may slip through unidentified.

Issues noted with the use of assessment tools included:

- need to ensure that assessors are well trained and supported in using them
- assessors may often need support and training in giving feedback to those who need to improve - often assessors find it hard to give negative feedback.
- assessors need sufficient time to carry out their role

Dr Alison Budd, NCAS - principles of assessment
Alison Budd introduced herself and Mr Sanjay Sekhri from NCAS and gave an overview of the work of NCAS in supporting the diagnosis and resolution of doctors in difficulty - full slides available from kate.tansley@aomrc.org.uk and/or yvonne.livesey@aomrc.org.uk

NCAS has always offered very comprehensive assessments of doctors in difficulty. They are now offering more of a menu service as not all assessments are needed for every doctor. If there is no evidence of an individual doctor having a serious clinical problem, they can also consider team review. There may sometimes be an issue with individuals working within

teams which may require mediation. NCAS is also now encouraging people to think through information they have and move into a remediation plan of action earlier with some assessment already in place, rather than awaiting a full assessment.

Focus Group 1 – Assessment tools currently used and their validity
The workshop discussed in groups the results of participants' pre-filled questionnaire on assessment tools already used by Colleges and other information gathered in advance.

Key comments made by different groups included:

How do we recognise the warning signs of a doctor in difficulty and what to do to respond to them? Time frames should be built into any response. Doctors may develop mastery in a particular small area of medicine but lose general competencies over time. There are other doctors who become generalists but lose specialist skills. How far revalidation helps with a process of quality improvement is something which was questioned, given that it is frequently seen as a summative process.

Patient and colleague feedback is now required for all doctors as part of revalidation - in some trusts it is carried out more often than the once in five years required by the GMC. Although this is one of the tools which can help in assessing the quality of a doctor's work questions still remain about the effectiveness of the tools and the frequency of use. There is still a great deal of variability according to the tool provider – particularly in the number and range of responders required by different tools which led participants to question their validity. Rater selection is also an issue. In practice many colleagues (and patients) find it hard to write negative feedback about doctors and offering challenging, yet constructive feedback is even harder. Finally, in small teams, it can be very hard to disguise who has made individual comments which inhibits open and constructive feedback.

Key points for development of tools for assessment of doctors include the ability to assess following areas of practise:

- whether doctors know the limits of their competency and stick to these
- doctors' judgement
- doctors' leadership skills
- doctors' non-technical skills

Regular peer review was suggested as a key area which could offer better identification of doctors in difficulty and could also assist in identifying problems at an earlier stage if used more comprehensively. It was felt that if this was carried out more frequently and seen as a normal part of medical life it would encourage more doctors to adopt self-improvement. The Royal College of Psychiatrists has developed peer review, mentorship and case based discussion and there may well be learning for other Colleges in this work. In addition, morbidity and mortality meetings could be used as another method of identifying individuals who need further help.

Medical schools should also have systems in place to identify potential failing doctors at an early stage. It might also be helpful if NCAS could have access to data on trainees' previous assessment records. It is true that increasing robustness of assessment tools has screened out some doctors who were not performing well. However, in surgical specialties, it was

noted that this might not be identified as jobs are not necessarily tailored to their training. It was also queried as to what happens to those doctors who are asked to leave training programmes but not encouraged to seek alternative career paths outside medicine. Further guidance is needed.

Focus Group 2 –Identifying areas for further research

Areas for further research were discussed in groups. Comments included:

- There is a need develop a resource for information systems that could identify issues and offer detection of doctors in difficulty.

- There is also a need for time for doctors and peer reviewers to work together.

- The purpose of any tool needs to be clearly defined, as do ensuring that tools are sensitive to the particular situation of the doctor being assessed. Research could help with this.

- Doctors often have difficulty acknowledging their own health problems and need Occupational Health to ask good questions to identify these. More research is needed on this.

- Shape of training – the timeframes for recognising/acting on issues is likely to be shortened. Picking up trainees with issues and addressing them is key to successful training outcomes. Research on how this could best be done would be helpful.

- Autistic tendencies/Aspergers syndrome – some doctors with these conditions have been diagnosed late (or not at all) – earlier recognition would potentially make a big difference.

- Recruitment – more refined tools should be developed for use to assess the skill set including interpersonal skills and teamworking capability.

- How far would self-assessment tools be useful?

- A continuing dialogue with NCAS on issues that require research and future work together would be useful.

- Any research into the use of tools for assessment need to consider how far tools need to be piloted prior to being used in practice.

- The use of generic versus specialty specific tools also needs consideration, in addition to whether core versus ‘enhanced’ standards could be better described.

- It was also commented that a discussion about/research into how to demonstrate improvement would be helpful.

- There is a value of testing assessment tools on trainees, in an environment where assessment is an accepted part of normal working life.

- Further discussions led into the recommendations for future work, recorded below.

Final plenary and recommendations for future work:

- As early intervention is universally agreed to be essential, time needs to be put into considering how doctors in difficulty can best be identified at an early stage (as well as what mechanisms should then be used to support them). Case based discussion and peer review were both suggested as methods to support this, as well as tools designed to assess leadership and teamworking skills.

- A doctor's ability to have insight into their own difficulties is often agreed to be critical to their success - time also needs to be put into considering whether insight can be developed in some doctors (recognising that it may not be possible in all cases). No single tool currently exists to develop this, however some possibilities which might be considered include: self ratings when considering patient and colleague feedback, NCAS behavioural assessments, reflective practice and behavioural coaching.

- Support when doctors first become consultants is key and Colleges should consider developing further work in this area.

- Scenario based assessments could be used as part of recruiting doctors to new posts. In this area there could be a focus on behavioural elements and non-technical skills.

- Peer review and case based discussions are key areas which have great potential to help identify doctors in difficulty earlier and support them to make improvements. The Academy and Colleges need to work with other agencies in order to develop and extend the use of peer review. It was felt that there was an enhanced value of the newer case based discussion (SLE) approach. There is a need to normalise the use of peer review so that doctors expect to be part of it. This could help avoid later problems.

- Any work to develop tools should include advice on which situations/at which times in a doctor’s career the tools could best be used. If tools are implemented at the right time this could enhance their success.

- The role of tools in helping to set goals/supportive actions needs to be considered – for example once a theme or issue has been identified, the next step for the tools should be to decide how they can aid improvement of practise.

- Current patient and colleague feedback systems need considerable improvement and greater standardisation so that they offer better support for formative assessment of doctors. The Academy should consider recommending that trusts and those promoting patient feedback tools seek the views of their local patient groups on the tools being used. In addition Responsible Officers have access to further information from patient satisfaction surveys and the Friends and Families Test and this could be used to provide more information about a doctors practise. It is essential to have proper facilitated feedback before appraisal takes place.

- When guidance and tools become available they need to be well promoted, and their purpose explained, so that people are aware of them and how they can be used with maximum benefit for doctors and patients.

Appendix

Attendance list:

Andrew Long, Academy of Medical Royal Colleges
Kate Tansley, Academy of Medical Royal Colleges
Alison Budd, National Clinical Assessment Service
Ian Starke, Academy of Medical Royal Colleges
Sanjay Sekhri, National Clinical Assessment Service
Mat Lawson, Royal College of General Practitioners
Huw Rees, Royal College of Physicians of London
Larry Benjamin, Royal College of Ophthalmologists
Ahmed Afthab, Royal College of Ophthalmologists
Elaine Tait, Royal College of Physicians of Edinburgh
Chris Kennedy, Royal College of Anaesthetists
Sarah Griffin, Royal College of Radiologists
John Woodhouse, Faculty of Public Health
Jocelyn Hewitt, London Professional Support Unit
Fauzan Palekar, Royal College of Psychiatrists
Ros Crowder, NHS England
Derek Burke, College of Emergency Medicine
Louise Massey, Faculty of Sexual and Reproductive Health
David James, Royal College of Paediatrics and Child Health
Winnie Wade, Royal College of Physicians of London
Maria Bussey, Royal College of Surgeons of England
Julie Froggatt, Royal College of Paediatrics and Child Health
Jo Anthony, Royal College of Obstetricians and Gynaecologists
Sol Mead, Patient and Lay Group, Academy of Medical Royal Colleges