Tri-Faculty Revalidation Pilot - Summary of key findings
October, 2012

Over the last two years in particular, the Faculty has been working closely with the General Medical Council (GMC), Academy of Medical Royal Colleges (AoMRC), Society of Occupational Medicine and other stakeholders to pilot and put in place systems for revalidation.

In 2010, the three Faculties of Occupational Medicine, Public Health and Pharmaceutical Medicine received funding from the AoMRC to pilot how the revalidation process would work for doctors employed outside of the NHS. The pilot methodology mirrored the same methodology used in the Pathfinder pilots for the NHS. The pilot was led by Dr Rob Thornton, Faculty of Occupational Medicine, who worked closely with his counterparts in the other two Faculties.

This article outlines the main aims of the pilot, its methodology and a summary of the key findings for our Faculty.

Aims of the Revalidation Pilot

- Test the strengthened form of medical appraisal;
- Assess the effectiveness of appraisals;
- Test the role of the Responsible Officer (RO);
- Test the role of multi-source feedback (MSF);
- Assess the organisational impact on the faculties;
- Examine how an e-portfolio works in practice;
- Identify communication flows required between appraisee, appraiser, RO and the GMC.

Methodology

- In 2010, a total of 48 volunteers, who were Faculty members, were recruited to take part in the main pilot. They were matched to appraisers through the Society of Occupational Medicine's Quality Approved Appraisal Scheme (QAAS). A total of 25 volunteer appraisers were selected on a regional basis from the QAAS pool and given additional training on strengthened appraisal and the revalidation IT management system.

- Appraisees used the revalidation IT management system to load their supporting information for appraisal, allowing the appraiser to view it in advance of the appraisal meeting. Appraisals took place between April and November 2011. Appraisees were encouraged to obtain colleague multi-source feedback (MSF) using a questionnaire developed by the Faculty of Public Health (FPH) and the Faculty of Pharmaceutical Medicine (FPM) and administered on line by 360 Clinical.

- In addition to the core pilot, we also conducted a series of nested pilots. This involved three organisations participating in the pilot process. The difference was that each organisation appointed their own RO and trained their own appraisers.

- Feedback was sought from all participants using questionnaires designed by Frontline Consultants, at various stages of the process.
Once appraisals had been completed by core pilot participants, the Faculty RO for the pilot accessed the IT management system and checked the quality of the supporting information provided and made an appropriate entry to state whether to recommend revalidation or not. As the normal revalidation cycle will be five years and some items of supporting information are not required annually, a degree of extrapolation was required. For example, patient feedback is only required once in a revalidation cycle. Its absence in this appraisal, providing other key elements of supporting information were available, did not prevent a positive recommendation.

In a separate initiative to support work being done by the GMC to develop an appropriate form of words for RO recommendations, an anonymised return was provided to the GMC (appraisees were offered the opportunity to opt out of this element of the pilot). Individual appraisees were provided with specific feedback on the strength of their portfolio. Feedback was also provided to appraisers and the pilot ROs within each organisation, which took part.

Quality assurance of core pilot revalidation recommendations was provided by the other two faculty ROs selecting and reviewing at a sample of 15 FOM portfolios. For the nested pilots, the FOM RO provided quality assurance on all portfolios.

**Summary of key findings of the Revalidation Pilot**

- In line with the NHS Pathfinder pilots, appraisees were asked to link each piece of supporting information to the GMC’s Good Medical Practice four domains and twelve attributes. Appraisees found that the domains and attributes did not fit well with occupational medicine roles and struggled to match evidence to the attributes. This requirement has now been removed from the process.

- It was felt that simpler, more specific guidance on the type and amount of supporting information to submit for appraisal was required.

- Revalidation will be a process which is based mainly on electronic communication and storage. A prototype electronic revalidation management system was used during the pilot. Some users encountered certain difficulties using it. Some also cited that they would have liked assistance with scanning and uploading their evidence (28% recorded that they did have some assistance with this). It should be noted however that pilot participants had to upload their evidence in a short space of time, on the run-up to their appraisal date. Normally, the revalidation portfolio should be completed gradually, throughout the year.

- In preparing for strengthened medical appraisal, it is essential that appraisees provide full details of the scope of their whole practice, with a clear statement of their specific responsibilities, in their pre-appraisal submission. The aim of this is to ensure that their appraiser and their RO are clear against which responsibilities appraisees should be evaluated. Some pilot participants found that their revalidation recommendation was 'deferred', because this information was either missing or incomplete. It is important that appraisers ensure that this information is fully presented as part of the pre-appraisal submission, prior to the appraisal meeting.

- Aside from the scope of practice, some other mandatory elements of appraisal were not completed. These included the health and probity forms. Some also felt that the questions asked in these forms were too intrusive. These will be refined.

- Some pilot participants did not complete a Personal Development Plan (PDP); this is another essential component for revalidation. PDP is one of the factors on which CPD for the following year will be judged. It will be important for appraisees to monitor their
PDP throughout the year and if requirements change, they should be able to justify them to their appraiser.

- The quantity of supporting information varied. The message to come out of the pilot process is that it is the quality, rather than the quantity of information which counts. The number of items should be between ten and twenty good pieces of evidence, which helps to highlight to the appraiser and RO that the appraisee is competent for his/her role.

- Appraisees cited that their average time preparing for appraisal increased from 8 hours 11 minutes to 17 hours 18 minutes.

- The colleague feedback tool came under criticism from appraisees, over the difficulty in identifying the number of respondents (15) and the format and complexity of the report. Further consideration is being given to this.

- On a more positive note, appraisees’ views of the appraisal process improved as a result of the pilot. Measured from the onset of the pilot to its conclusion, appraisees recorded significant increases in levels of agreement to the following statements:
  a) "I intend improving the way I undertake my medical practice as a result of my strengthened appraisal”
  b) "My appraiser performed the appraisal well”
  c) "Appraisals are a good way of improving an individual’s practice”

- No concerns were raised by appraisers about their appraisees. A total of 71% of appraisers felt that they had submitted sufficient information for the RO to make an objective recommendation. However, some appraisers did not ensure that all mandatory forms were complete and that all supporting information was uploaded on to the revalidation IT management system. Difficulties identified in using the revalidation IT management system undoubtedly accounted for some of these issues. These should be addressed with improvements which are being made to the tool and also appraiser training.

**Discussion**

- It should be remembered that the emphasis on appraisal moving forward will be on ensuring that in the context of a doctor’s medical practice, that they are up to date and fit to practise. One of the biggest learning points to take away from the revalidation pilot was the importance of the appraisee and appraiser comments. For revalidation, the appraiser will need to justify his/her reasons for the appraisal outcome. Therefore, the commentary from the appraiser in the appraisal summary will be of paramount importance. The appraisal summary will need to give the RO confidence to make a recommendation to the GMC. The RO is likely to review the portfolios in depth, only when the appraisal summary does not give confidence to make a positive recommendation or through a quality assurance process.

- In the revalidation pilot, there were a number of deferrals. This was because the key elements of supporting information (such as scope of practice, health and probity statements) were incomplete. It is anticipated that with improvements to the revalidation IT management system, more guidance and also appraiser training, this is not likely to happen when revalidation is formally introduced at the end of 2012.

**Pilot Participants**

- We wish to thank all of the appraisees, appraisers and organisations who took part in the pilot. All had to commit a significant amount of time and effort. We hope that all participants gained from the experience. The pilot was instrumental in helping the Faculty to shape how it plans to roll-out the revalidation process.