SPECIALTY GUIDANCE GROUP

PHASE 3 PROJECT REPORT

MAY 2014
CONTENTS

Executive summary 2
Recommendations 4
1 Background 6
2 Aims and Objectives 7
3 Methodology 9
4 Results 12
5 Survey Findings 14
5.1 Doctor (as appraisee) Survey 14
5.2 Appraiser Survey 22
5.3 Responsible Officer Survey 29
6 Focus Group 31
7 Helpdesk Enquiry Data 32
8 Discussion, Key Themes and Questions 33
9 Next steps: 37
Acknowledgements: 38

Appendices
1 College and Faculty Helpdesk Enquiries 39
2 Doctor (as appraisee) survey report 42
3 Appraiser survey report 63
4 Responsible officer survey report 77
5 Focus group report 81
6 Core framework analysis 84
7 Helpdesk enquiry template 89
EXECUTIVE SUMMARY

The overall objective of Phase 3 of the Specialty Guidance Group project has been to evaluate the effectiveness of the group’s outputs from previous phases of the project and give consideration to the wider question of how colleges and faculties can support doctors, appraisers and responsible officers through appraisal and revalidation most effectively.

The group’s outputs from Phase 1 and 2 of the project were:
- The Core Framework
- Specialty Guidance
- A recommended model of advice provision for colleges and faculties
- A description of the Specialty Adviser role
- A document outlining the scope and content of Specialty Adviser training.

This report is primarily concerned with objectives 1, 2, 4 and 5 as included in the project application. These were:
- To gather feedback from responsible officers, specialty advisers, appraisers, doctors, revalidation helpdesks and other key stakeholders
- To establish common themes raised with helpdesks and advisers
- To establish, the requirements for the on-going support of advisers and whether there is a need for “top-up” training
- To review the core and specialty supporting information frameworks in light of the findings from objectives 1 and 2, and to identify whether any changes are required.

The report findings are based on three sources of data:
- Survey data from doctors (appraisees)\(^1\), appraisers and responsible officers who had been involved in an appraisal for revalidation
- A focus group for doctors and appraisers
- A helpdesk enquiry data collection exercise.

The group received 790 and 171 responses to the doctor and appraiser surveys respectively, and 16 responses to the responsible officer survey. The data should be treated with caution due to specialty and (possible) geographical bias.

There was a strong strand of feedback from doctors who found the appraisal process supportive, well-managed and helpful in their personal development. However, there were also concerns relating to bureaucracy, the time required for appraisal, cumbersome IT systems and the ability of current appraisal systems to identify poorly performing doctors.

Fifty-five percent of doctors had accessed information from colleges and faculties to support them in their appraisal. Seventy-eight percent of those who had accessed college and faculty resources found them helpful.

Forty-eight percent of doctors had used one or more of the Specialty Guidance documents for their most recent appraisal. These were generally considered to be useful and contain the right level of detail, although some areas required further clarification.

\(^1\) Referred to as the ‘doctor survey’ subsequently in this document
Doctors identified that the three most challenging areas relating to the development of a portfolio of supporting information were:

- Patient feedback
- Quality improvement activity
- Significant events (e.g. critical incidents).

The majority of respondents to the appraiser survey were positive about the appraisal training they had received and the support they were able to access within their trust or employing organisation.

Fifty-seven percent of appraisers had sought college or faculty resources to support them to provide an appraisal, the most common form of support being (general) guidance documents. Forty-eight percent of all appraiser respondents had indicated that they had accessed one or more of the Specialty Guidance documents.

Appraiser feedback on the clarity, accessibility and level of detail in the Specialty Guidance was largely positive, although feedback on the usefulness of the Specialty Guidance was slightly less positive.

The number of appraisal and revalidation enquiries received by colleges and faculties was lower than might have been expected. The proportion of enquiries referred to specialty advisers has been relatively low.

Analysis of the survey, focus group and helpdesk enquiry data identified a number of themes, including:

- A degree of confusion of the number of guidance documents available and their purpose
- A perception that colleges and faculties are ‘raising the bar’
- Uncertainty over quality and quantity thresholds for supporting information
- A need for further guidance in the areas of quality improvement and patient feedback
- Benefits and challenges associated with ‘cross specialty’ appraisal (i.e. a doctor and their appraiser being in separate specialties)
- A need to balance the summative and formative elements of appraisal.

The draft recommendations of this report were discussed at the Academy Revalidation Group (ARG) on the 28th January 2014 and endorsed by the Academy Council on the 30th April 2014.
RECOMMENDATIONS

1. To review the Core Framework to ensure it is completely aligned with the GMC’s Supporting Information for Appraisal and Revalidation document.

2. To clarify the purpose of the Core Framework and its positioning with generic guidance, including that of the GMC.

3. To review the Core Framework with a communications specialist to ensure maximum accessibility whilst retaining necessary detail and remaining appropriate to the audience.

4. To provide guidance to colleges and faculties on the modification of their specialty frameworks to a consistent pattern between specialties, with a focus on the following areas:
   - Provision of guidance on the quantity and quality of supporting information
   - Clarification of guidance on quality improvement and patient and colleague feedback
   - Development of worked examples of supporting information
   - Guidance on reflective practice (including the provision of practical examples)
   - The above to be included in Specialty Guidance or signposted from it, as appropriate.

5. To work with the Academy and other relevant stakeholders to resolve issues and share learning relevant to:
   - Patient feedback, particularly for specialties where this may be difficult to obtain
   - Quality improvement activity for locum doctors
   - Appropriate use of use of team/service/organisation-level data in supporting information.

6. To continue developing appraisal guidance (and/or a learning resource), with a particular emphasis on:
   - The formative aspects of appraisal in a revalidation context
   - Cross-specialty appraisal (or appraising a doctor with a highly specialised area of practice)
   - Preparation for appraisal (as a continuous, reflective process)
   - The balance between the generic or specialty specific aspects of appraisal.

7. To give fresh consideration to the role of colleges and faculties in supporting the appraisal and revalidation process, and engage with relevant stakeholders to consider:
   - Where there are gaps in provision to doctors, appraisers and responsible officers
   - Where there is duplication of activity
   - Where advice between different organisations is incongruous (or is perceived to be) and can be better aligned
   - How these issues can be addressed, and where the opportunities are for specialty input
   - Whether there is opportunity to develop the role of the Specialty Adviser, with a view to achieving greater integration with non-specialty sources of advice
   - Whether there are opportunities for joint communications
• Where closer working is required between the four countries of the UK.

8. To contribute to:
   • The evaluation of revalidation through consideration of the impact of the process on patient care and experience.
   • The evaluation of the effectiveness of appraisal in supporting revalidation and in maintaining a formative and developmental approach.
1 BACKGROUND

The Academy of Medical Royal Colleges (the Academy) Specialty Guidance Group (SGG) was established in 2009 with an initial brief to develop a training programme for appraisers in the specialty-specific aspects of appraisal. When the training of appraisers became the remit of NHS organisations in the UK, the group’s focus broadened to encompass specialty-specific aspects of appraisal and revalidation in general. In essence, the group’s overarching interest is in the design of consistent, robust and effective mechanisms of advice provision, and in the development of guidance that addresses the specialty-specific aspects of appraisal and revalidation whilst sharing a common format across the specialties. The group has produced a series of documents and recommendations, which can be accessed on the Academy’s Specialty Advice page.2

One of the group’s key outputs has been the Core Framework, which takes the principles of the GMC’s guidance and offers practical examples of the information that doctors can present to demonstrate that they are keeping up to date and fit to practise. The Core Framework has been designed in such a way that colleges and faculties can add information that is specific to their specialty. These documents are referred to as Specialty Guidance (sometimes referred to as ‘Specialty Frameworks’) and doctors are advised to read these in conjunction with GMC guidance. It is important that the Core Framework and GMC guidance, particularly the GMC’s Supporting Information for Appraisal and Revalidation, are aligned.

The composition of the group is designed to reflect, as much as is reasonably possible, the broad range of specialties represented by the Academy, all of whom are consulted regularly in the development of the group’s work. The project is delivered by the Royal College of Physicians London (RCPL), the Royal College of General Practitioners (RCGP) and, until September 2013, the Royal College of Anaesthetists (RCoA), followed by the Royal College of Psychiatrists (RCPsych), with significant input from the Royal College of Physicians and Surgeons of Glasgow (RCPSG) and the Royal College of Physicians of Edinburgh (RCPE).

2 www.aomrc.org.uk/revalidation/item/specialty-advice.html
2  AIMS AND OBJECTIVES

Phase 3 has sought to evaluate the effectiveness of the group’s outputs from previous phases of the project and give consideration to the wider question of how colleges and faculties can support doctors, appraisers and responsible officers through appraisal and revalidation most effectively.

The individual objectives of this phase of the project as stated in the project application were:

1. To gather feedback from responsible officers, specialty advisers, appraisers, doctors, revalidation helpdesks and other key stakeholders. This will subdivide into three areas of enquiry:
   a. To establish how the specialty frameworks are being used and to identify whether they have been helpful in the different stages of the revalidation process, or whether there are any gaps, inconsistencies or lack of clarity within them
   b. To obtain feedback from specialty advisers regarding their role, exploring any challenges that they may have experienced
   c. To gather expert opinion from college revalidation leads and other stakeholders, e.g. GMC, RST as to the role of colleges in the provision of specialty advice after revalidation has been launched. The group will also seek input from patient and lay representatives associated with the colleges and faculties of the AoMRC in pursuit of this objective

2. To establish (from objective 1) common themes raised with helpdesks and advisers. This area of work will feed into the development of core content FAQs to be hosted by the Academy and the updating of core guidance

3. To develop a framework for the quality assurance of colleges and faculties’ specialty advice provision, based on the principles of advice giving developed by the group in Phase 2

4. To establish (from objectives 1 and 2) the requirements for the on-going support of advisers and whether there is a need for ‘top-up’ training. If a need for the latter is identified, the group will design the content of this training

5. To review the core and specialty supporting information frameworks in light of the findings from objectives 1 and 2, and to identify whether any changes are required. Any changes to the Core Framework will be agreed with colleges and faculties via the Academy Revalidation Steering Group. As with Phase 1, the group will check the consistency of the any modifications to the specialty frameworks

6. To develop a document setting out guidance for appraisers in what to look for when considering the specialty supporting information brought to appraisal by doctors. This will act as a resource for appraisers in considering doctors outside their own specialty, and a resource for doctors to help them to understand in more detail what specialty information is expected from them and what their appraisers will be looking for.
This report is concerned predominantly with objectives 1, 2, 4 and 5. The quality assurance framework, as specified in objective 3, was developed by the group and agreed by colleges and faculties in March 2013. The guidance for appraisal (objective 6) will be finalised following input from all colleges and faculties, including their lay representatives. With regards to objectives 1b and 1c, the group decided to postpone these activities until it had analysed the various sources of data generated through the project. The group did not feel there would be benefit in obtaining feedback from specialty advisers about their role unless they had been sufficiently active in the way originally envisaged, which may be the case in some colleges and faculties but certainly not all.
3 METHODOLOGY

This section is primarily concerned with the research exercise undertaken to achieve objectives 1, 2, 4 and 5.

Helpdesk enquiry data
The RCGP, RCoA and RCPL initially analysed the appraisal and revalidation enquiries received by their college helpdesks. Through this analysis, a series of enquiry categories and sub-categories were identified and colleges and faculties were asked to comment on the relevance of these to their specialty. Once the framework was agreed, colleges and faculties were asked to record enquiries in accordance with this framework between 1st January 2013 and 30th September 2013. Colleges and faculties were asked to indicate the number of enquiries they had received in each category, the number of ‘generic’ and ‘specialty specific’ enquiries received, the number of enquiries that had been referred to a specialty adviser, and to provide general comment and highlight any challenging issues. Data analysis identified the most common areas of enquiry, the balance between generic and specialty specific information needs and the extent to which specialty advisers were required to support the process. The helpdesk enquiry data report template is included as Appendix 1.

Surveys
The group identified three target groups: doctors, appraisers and responsible officers and developed a survey for each. The surveys were designed to generate quantitative and qualitative data, using a mixture of Likert scale-based questions and free text boxes. The surveys were shared with colleges and faculties for comment when in draft form and then piloted on a small sample group of GPs, physicians and anaesthetists (i.e. the specialties represented by the three main colleges on the project group the time of the initial development of the surveys). Feedback from the devolved nations was sought to ensure the questions included were relevant to all four countries of the UK.

Information was sought in the areas outlined in Table 1 below.
Table 1. Information sought in surveys from each target group

<table>
<thead>
<tr>
<th>Doctor (as appraisee)</th>
<th>Appraiser</th>
<th>Responsible Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background details</td>
<td>Background details</td>
<td>Background details</td>
</tr>
<tr>
<td>Details about the respondent's professional role(s) and responsibilities in considering the context of your answers in this survey</td>
<td>Details about respondent’s professional background</td>
<td>Details about respondent’s professional background</td>
</tr>
<tr>
<td>Experience of recent appraisal</td>
<td>Workload issues</td>
<td>Sources of information and guidance</td>
</tr>
<tr>
<td>Whether appraisal was constructive and helpful for professional development and facilitated progress towards revalidation</td>
<td>Time available to undertake appraisal and workload issues for appraisers</td>
<td>Advice and guidance used to inform the respondent on their role as a responsible officer or lead clinician for revalidation or appraisal</td>
</tr>
<tr>
<td>Sources of help on appraisal and revalidation</td>
<td>Training and professional development</td>
<td>Specialty guidance on supporting information for appraisal</td>
</tr>
<tr>
<td>Identifying the sources of help the respondent turned to in supporting your appraisal and revalidation.</td>
<td>Participation in appraiser training and professional development for the role</td>
<td>Usage of college and faculty Specialty Guidance on Supporting Information for Revalidation documents in understanding the specialty context of a doctor’s revalidation</td>
</tr>
<tr>
<td>Specialty guidance on supporting information</td>
<td>Sources of advice and guidance</td>
<td></td>
</tr>
<tr>
<td>If the respondent used the Specialty Guidance on Supporting Information for Revalidation documents developed by the colleges and faculties and, if so, whether they were useful.</td>
<td>Advice and guidance made available to appraisers</td>
<td></td>
</tr>
<tr>
<td>Difficulties in collecting and developing a portfolio of supporting information</td>
<td>Specialty guidance on supporting information</td>
<td></td>
</tr>
<tr>
<td>If the respondent had difficulties and concerns in collecting the supporting information required for appraisal and revalidation</td>
<td>Usage of college and faculty Specialty Guidance on Supporting Information for Revalidation documents in understanding the specialty context of a doctor's work and portfolio</td>
<td></td>
</tr>
<tr>
<td>Effective appraisals</td>
<td></td>
<td>Issues that could facilitate or hinder the ability to carry out an effective appraisal</td>
</tr>
</tbody>
</table>
The surveys were live from the 1st October 2013 to the 15th November 2013 and were hosted on Adobe Forms Central software. Prior to the launch of the surveys, colleges and faculties invited their members and fellows to respond to the surveys, using a standard communication prepared by the Academy. Members and fellows were encouraged to respond to all surveys that were applicable to them.

The group analysed the quantitative data and then sought to identify themes in the free text commentary, giving particular consideration to free text provided by specialty ‘outliers’, as identified in the quantitative data.

The doctor, appraiser and responsible officer survey reports are in Appendices 2, 3 and 4 respectively.

**Focus groups**
Survey respondents were asked to indicate their availability to attend a focus group in a question included in the surveys. A focus group for ‘doctor’ survey respondents was held at the Royal College of Physicians and facilitated by senior members of the RCP Education Department on 3rd December 2013. The participants were volunteers and drawn from primary and secondary care, although general practitioners were in the majority. The criteria for participation in the focus group was to have received an appraisal structured around Good Medical Practice (i.e. a ‘revalidation ready’ appraisal). Participants were asked a series of questions, formulated through consideration of the survey data, and their answers are summarised in Appendix 5.

There was not a sufficient number of volunteers available on the 3rd December to run appraiser and responsible officer focus groups, although a much smaller group of doctors who were also appraisers (four in total), were invited to discuss any particular issues they had encountered with the specialty guidance after the main focus group. This discussion is also summarised in Appendix 5.
4 RESULTS

Surveys
The group received 790 and 171 responses to the doctor and appraiser surveys respectively, and 16 responses to the responsible officer survey.

Respondents were asked to select their main area of specialist practice and the tables below show the specialty breakdown of the respondents to the doctor and appraiser surveys. Responsible officers were not asked to indicate a particular specialty, so there is no such table for that survey.

Figure 1. Breakdown of specialty responses to the doctor survey
Focus groups
The doctor focus group was attended by 15 participants. The specialties represented were: Transfusion Medicine (1), Obstetrics and Gynaecology (3), Anaesthetics (1), General Practice (4), Ophthalmology (1), Paediatrics (2), Pathology (2) and Full Time Leadership and Management (1).

The specialties represented on the appraiser group were General Practice (2), Physicianly Specialties (1) and Obstetrics and Gynaecology (1).

Helpdesk data
Helpdesk enquiry data was received from all medical royal colleges and faculties. See Appendix 1.
5 SURVEY FINDINGS

5.1 Doctors (as appraisee) Survey

Experience of appraisal
Ninety-one percent of doctors (720) had undergone an appraisal in the previous year. Of these, 94% agreed or strongly agreed that their appraisal had covered the full scope of their clinical practice, 77% agreed or strongly agreed that it was constructive in reviewing their CPD, identifying learning needs and formulating a personal development plan, but only 70% agreed or strongly agreed that it was helpful in reviewing the quality of their professional work.

Figure 3. Whether appraisal was helpful in reviewing the quality of professional work (by specialty)

While 88% agreed or strongly agreed that there was an adequate system of managed appraisal in their organisation, 25% disagreed or strongly disagreed that enough time was made available to prepare for, and participate in, appraisal. There was little difference here between those working within or outside the NHS.

There was variability in whether the appraiser was from the same specialty as the doctor – this was the case for 98% of general practitioners, but for only 50% of pathologists. The average duration of appraisal meetings also varied between specialties, the greatest proportion of those lasting over two hours being in general practice, and the greatest proportion of those lasting less than one hour being in Ophthalmology.

3 For comparative purposes throughout this report, we have used the eight most prevalent specialties (anaesthetics, general practice, obstetrics and gynaecology, ophthalmology, paediatrics, pathology, physician specialties and psychiatry).
There were 346 free text comments related to doctors’ experience of appraisal. The main areas of feedback were:

- Positive feedback from doctors who had found the appraisal process supportive, well-managed and helpful in their personal development
- Where consistent, proven appraisal management and IT systems has been established and in place for a number of years, the response was much more positive.
- There was concern that current appraisal arrangements would do nothing to identify poorly performing doctors, and indeed that it was not the function of the appraisal system to do this
- Many doctors reported issues with appraisers – lack of training in individual appraisers, the process not being taken seriously by appraisers, and a lack of appropriately trained appraisers in some parts of the country
- There was positive feedback where doctors had undertaken an appraisal with someone from a different specialty. While there were issues about lack of specialty knowledge, many doctors welcomed the challenge and fresh perspective a cross-specialty appraiser brought to the process
- There was strong feedback that the appraisal process in many organisations was seen as a ‘box ticking’ exercise which tested doctors’ ability to compile a folder of supporting information, rather than their ability and competence as a doctor
- Many doctors reported a lack of time provided by their organisations in which to properly prepare for appraisal, resulting in this being done at weekends or elsewhere in their own time.

**Sources of help for appraisal and revalidation:**
Seventy percent of doctors had referred to sources of help or guidance on appraisal and / or revalidation when developing their portfolio of supporting information. Of these 66% had referred to college or faculty resources, and 65% had referred to GMC resources.
Of those who had accessed colleges and faculties resources, 78% said they were useful, 15% said they were not useful and 7% were neutral / non committed. The most commonly used college and faculty resource was guidance documents, which had been referred to by 68% of those who had accessed information from the colleges and faculties. Relatively few doctors had used college and faculty revalidation helpdesks (6%).

Sixty percent of doctors who had sought help or guidance had referred to one or more of the following GMC resources:

- Good Medical Practice Framework for Appraisal and Revalidation
- Supporting Information for Appraisal and Revalidation guidance
- Revalidation section of the GMC website.

Respondents were asked if they found the GMC resources useful. Seventy-three percent said yes, 19% said no, and 8% were neutral / non-committed.

The main areas of feedback relating to sources of help for appraisal and revalidation were:

- Typical positive comments noted that the GMC resources were well set out, and helpful in conjunction with college guidance, straightforward and easy to follow, and essential for structuring an appraisal.
• Less positive comments noted that GMC guidance was too generic and did not relate to a particular area of practice
• Typical positive comments noted that the college and faculty resources were clear and comprehensive, and helpful in gathering information related to specialty needs
• Less positive comments noted that college and faculty resources added little to what was available from the GMC, and provided little help in getting patient feedback.

Speciality guidance on supporting information
Seventy percent of respondents who had referred to a source of help on appraisal and revalidation answered the question ‘For your last appraisal, did you use one or more of the specialty guidance documents developed by the colleges and faculties?’ Of these, 48% responded positively, and 52% said no. Of those who had used one or more of the Specialty Guidance documents, 89% agreed or strongly agreed that they enhanced what they already knew about appraisal and revalidation from other information resources. Eighty-nine percent also agreed or strongly agreed that they had found them useful when developing a portfolio of supporting information based on their professional and specialty practice.

Figure 7. Doctors were asked whether the Specialty Guidance helped to make the appraisal process more meaningful in relation to their area of professional work
Figure 8. Doctors were asked to respond to a series of statements relating to the Specialty Guidance

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Total Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Enhances what I already know about appraisal and revalidation from other information sources</td>
<td>12% (33)</td>
<td></td>
<td>59% (184)</td>
<td>34% (266)</td>
<td></td>
</tr>
<tr>
<td>(b) Is useful when developing a portfolio of supporting information based on my professional and specialty practice</td>
<td>20% (62)</td>
<td></td>
<td>69% (184)</td>
<td>34% (266)</td>
<td></td>
</tr>
<tr>
<td>(c) Includes sufficient examples (processes and tools) to help in producing my supporting information</td>
<td>22% (58)</td>
<td></td>
<td>69% (173)</td>
<td>34% (266)</td>
<td></td>
</tr>
<tr>
<td>(d) Provides adequate information on professional and specialty standards to help me demonstrate the quality of my work</td>
<td>17% (46)</td>
<td></td>
<td>70% (187)</td>
<td>34% (266)</td>
<td></td>
</tr>
<tr>
<td>(e) Did help make the appraisal process more meaningful in relation to what I do in my areas of professional work</td>
<td>20% (54)</td>
<td></td>
<td>65% (172)</td>
<td>34% (266)</td>
<td></td>
</tr>
</tbody>
</table>

Ninety-one percent agreed or strongly agreed that the Specialty Guidance contained enough detail in the Keeping Up-To-Date section, 83% agreed or strongly agreed enough detail was contained in the Review of Practice section and 79% agreed or strongly agreed that enough detail was contained in the Feedback on Practice section.

Figure 9. Doctors were asked to comment on the level of detail in each section of the Specialty Guidance

<table>
<thead>
<tr>
<th>Section</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Total Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) General information – providing context about what you do in all aspects of your professional work</td>
<td>73% (195)</td>
<td></td>
<td>16% (43)</td>
<td>34% (266)</td>
<td></td>
</tr>
<tr>
<td>(b) Keeping up-to-date – maintaining and enhancing the quality of your professional work</td>
<td>73% (195)</td>
<td></td>
<td>16% (47)</td>
<td>34% (266)</td>
<td></td>
</tr>
<tr>
<td>(c) Review of your practice – evaluating and improving the quality of your professional work</td>
<td>15% (40)</td>
<td></td>
<td>62% (185)</td>
<td>34% (266)</td>
<td></td>
</tr>
<tr>
<td>(d) Feedback on your practice – how others perceive the quality of your professional work</td>
<td>17% (46)</td>
<td></td>
<td>67% (178)</td>
<td>34% (266)</td>
<td></td>
</tr>
</tbody>
</table>

The main areas of feedback relating to the clarity and accessibility, usefulness and level of detail of the Specialty Guidance documents were:

- The Specialty Guidance was generally considered to be clear and comprehensive
- Some doctors appreciated the specificity of the guidance, and also the fact that the guidance followed the format of the GMC documents
There was a ‘confusion’ between what was perceived to be the ‘minimum standards’ prescribed by the GMC and the ‘gold standard’ set out by colleges and faculties, and the need for a clearer distinction between the two.

A consistent theme was that of multi-source feedback; anaesthetists in particular felt the guidance could be clearer and more specific, but this feedback was by no means limited to Anaesthetics.

There was also feedback that the guidance on Significant Untoward Incidents (SUIs) could be more specific – in ‘definition’ of a SUI and how doctors should reflect on any SUIs received.

Anaesthetists were outliers in relation to colleague and patient feedback, with comments about the ineffectiveness of ‘generic’ trust 360 feedback systems (i.e. not developed for the specialty).

Lack of guidance on quality measures were mentioned by two specialities (Pathology and Ophthalmology).

Figure 10. Doctors were asked whether the Specialty Guidance provided adequate information on professional and specialty standards to help them demonstrate the quality of their work.

Difficulties related to developing a portfolio of supporting information
Thirty-six percent of respondents indicated that they had experienced difficulties or concerns when collecting and developing a portfolio of supporting information for appraisal and revalidation (with 64% stating that they had no such concerns). The results were generally very consistent across specialties, with the exception of Psychiatry, where 64% of respondents indicated some level of concern.

In section 5.2, doctors were asked about the difficulties they had experienced when collecting specific types of information. The three most challenging areas were patient feedback, quality improvement activity and significant events (e.g. critical incidents).
Concerns regarding patient feedback were most prevalent amongst anaesthetists, although the feedback provided little information other than it was difficult in anaesthesia to gather feedback, there was inadequate time to do this and patient response rates tended to be low. Pathologists were slightly more expansive on patient feedback, with lack of ‘infrastructure’ (administrative support) being cited, although one doctor also noted that college guidance (Pathology) was helpful in relation to getting feedback.

GPs scored low for quality improvement activity, with the most consistent theme being the difficulty of collecting and managing quality improvement data for locum or freelance GPs, particularly getting access to organisational data.

Physicians were a clear outlier in relation to significant incidents (over 60% had experienced ‘some difficulty’), but no qualitative data was provided.

There were 175 free text comments relating to difficulties or concerns doctors have in collecting supporting information for appraisal and revalidation. The main areas of concern were:

- **Patient feedback:**
  - Difficulties in collecting (especially Anaesthesia, Community Sexual Health, Pathology, Psychiatry)
  - Language barriers
  - Tensions between local or individual solutions that work and are proven, and ‘validated’ feedback systems that might be imposed on doctors
  - Difficulties for locum doctors (mobility)
  - Perception of either lack of frequency of patient feedback and therefore out of date, or the perception that patient feedback is required every year for appraisal and is too time-consuming.

- **Time constraints** – lack of time in the job plan for collecting and organising supporting information – consistent feedback that this is being done outside of working hours in doctors’ own time.

- **Clinical data systems** – trust systems are out of date, restrictive, not sophisticated enough for the job, unreliable and doctors are frequently keeping their own data for audit purposes. There was also feedback about the lack of reliable benchmarked data (paediatrics).
- **Quality improvement / audit work** – locums were finding it very difficult to complete the audit / re-audit cycle. Locums are expected to share the workload, not contribute to service improvement or re-design. Current guidance on revalidation is not explicit enough for locums and temporary practitioners.

**General (appraisee) comments on appraisal and revalidation**

Doctors were asked for any final comments regarding appraisal and revalidation. There were 264 free text comments received (equating to one third of all respondents).

The main areas of concern were:

- **Appraisal process:**
  - There were many doctors – albeit a minority – who saw appraisal and revalidation as a positive development that supports reflection and learning, while acknowledging that you will only get out of a system what you put in
  - Appraisal was seen by many as a ‘box-ticking’ process with little value. Some respondents considered that appraisal had changed in nature in recent years from a formative process focussed on personal development to a mechanism purely designed to support revalidation
  - There was some feedback that appraisals were too frequent (a burden on the majority of competent / high-performing doctors).

- **Revalidation:**
  - There was strong feedback that the whole revalidation was too bureaucratic, time-consuming and costly, with little real value for doctors in their everyday practice
  - There was a perception that revalidation would have little benefit for patient safety and would do nothing to identify the next ‘Shipman’
  - The expense of revalidation was seen by some respondents as overly burdensome on an already stretched system and the process generally would need to be ‘pruned’
  - The system was also seen by some doctors as individually expensive, with independent appraisals and revalidation costing too much and potentially pushing some doctors out of practice
  - Other doctors applauded the introduction of revalidation, and found the process less painful than they had anticipated
  - The process in Wales in particular was seen as ‘joined up’ and the Medical Appraisal and Revalidation System (MARS) was generally (though not universally) regarded as easy and straightforward to use.

- **College speciality guidance:**
  - There was mixed feedback on the college and faculty Specialty Guidance (detailed in section 5) but the positive comments slightly outweighed the negative
  - Two doctors indicate that they were not aware of college specialty guidance.

- **IT systems:**
  - Doctors were having a mixed experience when it comes to IT systems to help them manage their appraisal and revalidation. The multiplicity of systems doctors have to use (appraisal, 360 feedback, CPD) is a source of frustration, coupled with the duplication of entering information on to more than system
Doctors who commented on the NHS Revalidation Support Team (RST) Medical Appraisal Guide (MAG) Model Appraisal Form were generally positive.

- **Multi-source feedback:**
  - There was feedback primarily from anaesthetists and pathologists that patient feedback was difficult to obtain, and that this should have been more fully explored before the launch of revalidation.

- **General comments:**
  - A few doctors regarded revalidation as an entirely political process imposed on the NHS by the GMC. Others saw revalidation as a ‘necessary evil’ which was about as good as it could be given the breadth of medical practice and the need to have one system for the whole UK.

### 5.2 Appraiser Survey

**Information on appraisals – general**

Nearly half (48%) of appraisers had conducted between 1 - 5 appraisals in the past 12 months, with 31% conducting 6-10 appraisals, 13% conducting between 11-15 and 8% conducting 16 or more appraisals in the past year. There was some variation in the length of appraisal meetings across specialties (looking at the six most common specialties of respondents in the survey: Psychiatry, Pathology, Paediatrics, Obstetrics and Gynaecology, General Practice and Anaesthetics).

In common with doctors and responsible officers, there was a general concern that not enough time was provided to conduct appraisals and that much of this work inevitably took place outside of normal working hours. The notion of appraisal workload being conducted outside of core hours was particularly pronounced in Paediatrics, Obstetrics & Gynaecology and General Practice, but less so in Psychiatry and Anaesthetics.

One hundred and one free text comments were received on appraisal workload. The majority reported carrying out appraisal-related activity (if not the actual appraisal) outside of working hours, with the preparation and follow-up / writing taking at least as long as the appraisal meeting. Where appraisers did have Supporting Professional Activities (SPA) provision in their job plans for appraisal time, this time was almost universally reported as being insufficient, with the task being completed outside of core hours. It should be noted that contractual arrangements relating to the provision of time for professional development activity are likely to vary between the four countries of the UK.

**Appraisal training**

For appraisal training, 90% of respondents across all specialties had undertaken revalidation-focussed appraiser training or professional development in the past 12 months. Variations in this figure included Psychiatry (100%), Obstetrics & Gynaecology (97%) and General Practice (96%) to Pathology, Paediatrics and Anaesthetics (83-86%).

There was a wide range of providers for the appraisal training, but 50% was provided by the employer / trust. The medical royal colleges were the second smallest provider (6%). Of the 90% of appraiser respondents who had undertaken revalidation-focussed appraiser training or professional development in the last 12 months, 24% disagreed that their training had sufficiently covered specialty awareness and 4% strongly disagreed.
Of the 171 respondents, 78% had continued their development as an appraiser through a range of activities, the most popular being appraiser / peer support groups in their own organisation and further ‘top-up’ training.

Fifty-eight free text comments were received on the subject of appraisal training, the majority positive about the appraisal training they had received and the support they were able to access within their trust or employing organisation. There was little substantive comment, but clearly a degree of ‘nervousness’ around appraising doctors from different specialities.

Figure 12. Appraiser feedback on appraisal training

<table>
<thead>
<tr>
<th>Area</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Total Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Knowledge and understanding - the role and purpose of the appraiser in undertaking effective appraisals</td>
<td>52% (96)</td>
<td>35% (64)</td>
<td></td>
<td></td>
<td>90% (154)</td>
</tr>
<tr>
<td>(b) Communication skills - facilitate an effective discussion and document the outputs of appraisal</td>
<td>57% (103)</td>
<td>29% (44)</td>
<td></td>
<td></td>
<td>90% (154)</td>
</tr>
<tr>
<td>(c) Specialty awareness - appraise a doctor’s performance in their area of specialty practice</td>
<td>24% (37)</td>
<td>36% (55)</td>
<td></td>
<td>17% (26)</td>
<td>90% (154)</td>
</tr>
<tr>
<td>(d) Professional development skills - consider a doctor’s quality improvement activities, CPD and personal development plan</td>
<td>67% (103)</td>
<td>27% (42)</td>
<td></td>
<td></td>
<td>90% (154)</td>
</tr>
<tr>
<td>(e) Evaluation and judgement - analysis information presented at appraisal and judge a doctor’s performance against expectations</td>
<td>70% (108)</td>
<td>23% (35)</td>
<td></td>
<td></td>
<td>90% (154)</td>
</tr>
<tr>
<td>(f) Handling various concerns - knowledge of actions to take if serious concerns arise including stopping/suspending on appraisal</td>
<td>69% (109)</td>
<td>21% (32)</td>
<td></td>
<td></td>
<td>90% (154)</td>
</tr>
</tbody>
</table>

Seeking guidance for a revalidation-focussed appraisal:
Seventy-five percent of appraisers had referred to guidance from a range of sources in order to conduct appraisals (ranging from Paediatrics (100%) to Obstetrics and Gynaecology (64%)).

Figure 13. Sources of advice and guidance used by appraisers to support them in appraisal

* 128 total responses, 75% of submission
Fifty-seven percent of appraisers across all specialties had sought out college and faculty resources, with guidance the most common type being used (57%).

There were 64 free text comments received in relation to resources provided by the colleges or faculties. The main areas of feedback were:

- That the resources were generally considered to be helpful
- Negative comments tended to focus on the perception that colleges were setting a ‘gold standard’ which was higher than the bar set by the GMC (and therefore confusing)
- There were a few comments suggesting lack of awareness (in relation to more than one college) of the guidance, helpdesk and general resource available.

A large majority of appraisers had consulted various GMC resources on appraisal and revalidation, the most popular being the GMC supporting information guidance (91%).

There were 84 free text comments in relation to the resources provided by the GMC. One theme that was repeated was the generality of GMC guidance; two appraisers suggesting making appraisal generic (i.e. not specialty-specific). Two specific suggestions that arose were:

- ‘More guidance on going abroad and returning from abroad and the requirements’
- ‘More specific with respect to examples of what do and don’t meet requirements for revalidation’.

Use of college and faculty Specialty Guidance

Forty-eight percent of respondents who had referred to any sources of advice or guidance to support them to provide an appraisal indicated that they had accessed Specialty Guidance from the colleges or faculties. Awareness of the Speciality Guidance primarily came from the college or faculty itself (50%) or someone else in their organisation (32%).

Seventeen comments were received on the clarity and accessibility of the Specialty Guidance documents:

- Comments were largely positive
- There were one or two comments (across specialties) that the documents did not add much to the GMC generic guidance
- The one specific observation that did recur (albeit a small number of times given the limited data set) is lack of guidance given on minimum case requirements or the ‘threshold’ for revalidation.
The feedback on the detail provided in the specialty guidance was equally positive, though it was difficult to extract any meaningful specialty-specific trends or information from the responses.

The feedback on the usefulness of the specialty guidance to appraisers was slightly less positive. Written comments included:

- ‘Guidance on content/numbers of reflections would be helpful as currently rather subjective’
- ‘Written guidance does little to address the interpersonal skills needed to tackle difficult issues or challenging appraisals with significant issues to discuss—especially as these are mostly about conduct rather than medical practice and involve relationships within departments.’
Organisational support for appraisers

Respondents highlighted concerns over clinical governance systems and the type of support and useful information they provide to appraisers. The next most significant issue is the level of administrative support available.

Seventy free text comments were received in relation to the provision of organisational support to appraisers.

- One positive theme to emerge was the process in Wales, described as supportive (though under-funded) and with separate systems for appraisal and clinical governance
- The lack of administrative support was a constant theme, with several appraisers reporting that this had been down-graded or removed in recent times.
- Non-engagement of the appraisal process was a consistent theme, with most appraisers reporting that their appraisal / clinical governance system was not able to address this
- IT systems also seen as problematic in many cases – either non-existent or difficult to use
- Several appraisers stated that they wished for feedback on their performance as an appraiser but this was not possible within their trusts’ systems
- Positive responses were often prompted by the leadership and enthusiasm of one or two individuals (e.g. medical director) rather than the embedded systems and structures within a trust.
Forty free text comments were received in relation to conducting the appraisals of doctors from other specialties. There were mixed views on the desirability of appraising doctors from different specialties to your own – some felt appraisal should be a generic skill and someone from a different specialty would bring fresh challenge and perspective, while others expressed nervousness around lack of knowledge of clinical data and expectations, and the degree of trust they placed in the appraisee and the data they provided. Some reported that their trusts had in place a policy that all doctors would be appraised ‘within specialty’. There also seemed to be a particular issue with GPs appraising GPwSI for similar reasons as above.
Final (appraiser) comments:
Thirty-four free text comments were received in relation to revalidation generally. Themes included:

- The proliferation of advice (GMC, colleges, trusts, RST) – a confusing picture of support
- A perceived discrepancy in standards required of appraisers between primary and secondary care
- A predictable range of views on revalidation and the pros and cons of it
- College guidance was highlighted (by one respondent) as needing to explain how feedback, especially from patients, could more easily be gathered.
5.3 Responsible Officer Survey

Feedback on generic advice and guidance
Respondents highlighted the following views:

- The GMC website is particularly clear, and useful as a primary source of guidance; the RST website was reported to be harder to navigate (1 respondent)
- The combination of background knowledge and discussion with peers was reported as being very useful, particularly in the independent sector
- One respondent reported that the guidance ‘would be better if it had been clear and directive from the outset. Instead we have had a system where different organisations have sent conflicting advice and the NHS England website has not been updated efficiently or accurately’
- Guidance in Wales was felt to be particularly clear as it is agreed between the deanery, GMC, NHS Wales and the BMA
- Royal colleges ‘pretty helpful’.

Figure 19. Sources of advice and guidance used by responsible officers

<table>
<thead>
<tr>
<th>Source of Advice and Guidance</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Medical Association</td>
<td>13% (2)</td>
</tr>
<tr>
<td>Department of Health</td>
<td>19% (3)</td>
</tr>
<tr>
<td>General Medical Council</td>
<td></td>
</tr>
<tr>
<td>Medical royal college or faculty</td>
<td>63% (10)</td>
</tr>
<tr>
<td>National Clinical Assessment Service (NCAS)</td>
<td>50% (8)</td>
</tr>
<tr>
<td>NHS Employers</td>
<td>19% (3)</td>
</tr>
<tr>
<td>NHS England/NHS Scotland/NHS Wales/HSC Northern Ireland</td>
<td>31% (5)</td>
</tr>
<tr>
<td>NHS Revalidation Support Team</td>
<td>38% (6)</td>
</tr>
<tr>
<td>Postgraduate deanery</td>
<td></td>
</tr>
<tr>
<td>Regional responsible officers’ network</td>
<td>81% (13)</td>
</tr>
</tbody>
</table>

1 additional choice not shown
* 16 total respondents, 100% of submissions

Feedback on college / faculty guidance
Of the 16 respondents, 13 had used college and faculty resources.

- Guidance was the most commonly used resource
- College / faculty revalidation help desks had not been used at all
- The majority of respondents found the revalidation guidance offered by their college useful
- One respondent described them as useful ‘now they are in line with GMC guidance’
- Three respondents (of 16) described the college guidance as not useful, in one case ‘less useful than generic materials’
- One respondent described the college suggestions as ‘excessive’ in terms of CPD and documentation where doctors have a limited field of practice but are members of a college CPD scheme.

Feedback on Specialty Guidance
Of the 16 respondents, 10 had used one or more of the Specialty Guidance documents when reviewing a doctor’s portfolio. Of these ten, all respondents reported the Specialty
Guidance they used as being well structured, with the wording clear and unambiguous, and the guidance enhanced their knowledge about appraisal and revalidation and clarified the supporting information requirements expected.

There was wide agreement that there was enough detail in the specialty guidance around, but one ‘dissenting opinion’ (Psychiatry) around Keeping Up-To-Date. One respondent also noted that it was ‘difficult to know how to use some of the guidance around numbers of cases etc.’

On the usefulness of the Specialty Guidance to responsible officers/appraisal leads
- The one positive comment noted that the template (included by a particular college/faculty) for reflection is very helpful
- Other feedback noted that ‘clinical governance within the organisation for which I am responsible officer will require multi-faceted systems and one guide is not enough….as a locum agency, these systems are not yet fully thought through’.

Figure 20. Responsible officer feedback on the usefulness of the Specialty Guidance

Final (responsible officer) comments
Positive comments noted that the guidance in general was useful, although levels of awareness amongst college members could be higher. Other comments noted:

- The importance of a clear responsible officer checklist
- The need for advice to be consistent across multiple sources
- Given the early, evolutionary stage of revalidation, advice needs to be practical rather than too prescriptive
- Locum agencies are ‘largely out in the wilderness as far as robust clinical governance goes’
- The need for some useful and practical guidance around how GPs with Special Interests should be accredited and appraised
- ‘There needs to be clear guidance on what patient feedback or its equivalent is required for pathologists and anaesthetists given their particular contact/no contact with patients’.
6 FOCUS GROUP FINDINGS

The focus group (and appraiser discussion) provided an opportunity to explore some of the themes identified through the survey data in greater detail. Several of the issues highlighted by participants are reflected in the wider findings of the project. A full summary of the focus group is provided as Appendix 5, but the main themes of discussion were as follows:

Doctor group

- The majority of participants had used the Specialty Guidance and thought that it had been easy to access and broadly useful
- Overall the participants found the Specialty Guidance relatively straightforward for standard clinical roles, but more challenging for other roles such as medical education or leadership. It was noted by a number of participants that guidance was not available for subspecialties such as Transfusion Medicine
- Most members of the group felt that the Specialty Guidance did not give sufficient emphasis to quality of the supporting information required, although two participants felt it was fine. Some participants also asked for more examples to be included, for example a reflection
- There was also considerable discussion around CPD with issues being raised relating to the quality of the CPD
- A number of participants felt that the quality improvement activity was not clear and needed greater clarification
- Terminology also caused some confusion between specialties, with secondary care and general practice interpreting the meaning of a SUI very differently. GPs who attended the appraiser group also highlighted the issue of interpreting a SUI and felt these was a need for more guidance
- Some participants also noted that the guidance was not clear in relation to reviewing compliments and complaints
- Most participants did not think there was a difference between the GMC revalidation threshold with the Specialty Guidance provided by colleges and faculties. However a minority perceived that the GMC had ‘set the bar lower’.

Appraiser group

- The main focus of the appraiser’s concerns related to assessing the quality of the supporting information and how helpful the Specialty Guidance had been in making the assessment
- There was also concern with the lack of guidance regarding the quantity of supporting information required, with one participant stating ‘Some people put everything in - I don’t think there is any guidance from the college about quantity’
- Many found the process ‘time consuming but not difficult’ and ‘doable’
- Some participants found quality improvement challenging
- The small number of participants who had been appraised by an appraiser from outside their specialty all seemed satisfied that they had been familiar with the guidance.
7 HELPDESK ENQUIRY DATA

See Appendix 1. In total, the colleges and faculties had received 1,676 enquiries between the 1st January and the 1st September 2013. The number is, arguably, lower than would be expected and reflects the low use of college and faculty helpdesk identified through the survey reports. In general, the number of enquiries was commensurate with the size of the college’s or faculty’s membership. Overall, the proportion of enquiries being referred to specialty advisers was low (approximately 10% of enquiries received), suggesting that the majority of enquiries were of a non clinical nature or low level of complexity. However, one or two colleges / faculties had a policy of referring all enquiries to specialty advisers.

The most common category of enquiry was “professional circumstances”, which encompasses issues such as detached doctors, working abroad, trainees and retirement. These are not specialty specific issues, but the enquiries may have had a specialty context.
8 DISCUSSION, KEY THEMES AND QUESTIONS

8.1 Limitations of the study

Specialty bias
The dominant specialties in the doctor and appraiser surveys are General Practice, Obstetrics and Gynaecology and Pathology, which together amounted to 70% of responses in both surveys. Some specialties are not represented at all (Clinical Radiology in the doctor survey and Clinical Oncology, Clinical Radiology, Emergency Medicine, Intensive Care Medicine, Occupational Medicine and Surgical Specialties in the appraiser survey). The group does not consider that the overall findings of the study are without relevance to the under-represented specialties, but would caution against making ‘statements’ about particular specialties on the basis of the study data.

Geographical bias
With 68% of doctor respondents, 86% of appraiser respondents and 81% of responsible officer respondents being England-based, any conclusions we draw from the surveys may be biased towards English circumstances. It is important that the report’s recommendations are considered from the viewpoint of each of the devolved administrations and implemented in such a way that is appropriate for each national context.

Sample approach
For practical reasons, it was not practical for the group to use a controlled sample approach. Instead colleges and faculties were invited to promote the surveys to their members and fellows using established communication channels. The over/under-representation of some specialties may be, in part, due to the timing of college and faculty communication activities or the ability of colleges and faculties to promote the surveys above other news and initiatives. Nevertheless, the support of colleges and faculties was vital to achieve the dissemination of the survey links.

A non controlled sample approach presents the risk of respondents being ‘self selecting’, for example those already familiar with appraisal and revalidation processes and college and faculty outputs in this area. It is not possible to verify whether this was the case, but it may be seen from the free text comments that a full spectrum of views was expressed.

Relative numbers of appraisers, doctors and responsible officers
It would appear that appraisers and, particularly, responsible officers are under-represented in the study. Whilst the group would have welcomed further responses from these groups, the relative sizes of the respondent groups were broadly reflective of the situation ‘on the ground’ (our respondents represented 4.62 doctors per appraiser and 49 doctors per RO). The responsible officer respondents included three non NHS responsible officers (1 x locum agency and 2 x independent healthcare provider), which the group considers beneficial to the study.
Helpdesk data
College and faculties have not received the number of enquiries originally anticipated. Consequently the amount of helpdesk data for the group to consider is limited, but arguably of sufficient volume to identify emerging themes and trends.

8.2 Key themes

Reasons for lack of specialty – specific activity through the helpdesks
Doctors, appraisers and responsible officers appear to use a variety of college and faculty resources – including the Specialty Guidance documents – but it would appear that overall awareness of college and faculty resources is low and heavily reliant on college and faculty communication channels. It is not clear whether the lower than expected use of college and faculty helpdesks is a consequence of limited need, perhaps due to the availability of resources elsewhere, or limited awareness – or a mixture of both.

Time for appraisal preparation
Where consistent, proven appraisal management and IT systems has been established and in place for a number of years, the response was much more positive. Doctors were used to what was expected and the time required to collect supporting information was less burdensome. This is reflected in the findings of a recent King’s Fund survey, which identified that:

‘Where boards or executive leaders prioritise revalidation through investment in the systems (including IT systems), resources and development of individuals, the process runs smoothly and is seen as valuable’.4

Additionally, the NHS Revalidation Support Team’s (RST) Early Benefits and Impacts of Medical Revalidation report identifies ‘early issues with the time commitment for doctors and appraisers to collect and provide information and prepare for appraisals and, for responsible officers, required to manage and quality assure the process.’5

Multiplicity of guidance
Confusion exists over the various sources of guidance (college / faculty, GMC and NHS). The intended purpose of each type of guidance may not be clear and / or there is perceived to be duplication between sources of guidance.

Perceptions of a discrepancy between GMC and college / faculty guidance
A common perception is that colleges and faculties are attempting to ‘raise the bar’ by setting an expectation for more supporting information than stipulated by the GMC. It is the role of colleges and faculties to describe the types of supporting information that doctors, within a specific specialty context, should collect to demonstrate that they are meeting GMC standards, but this is not necessarily widely understood.

4 Revalidation: The early experiences and views of responsible officers from London (The King’s Fund, 2013)
5 The Early Benefits and Impact of Medical Revalidation: Report on research findings in year one (NHS Revalidation Support Team, 2014)
Quality / quantity
There is uncertainty over quality and quantity thresholds for supporting information. Should quality be emphasised above quantity? Where would it be appropriate to provide guidance about quality and quantity? The more procedural specialties (e.g. surgery and anaesthetics) may have a view on the number of cases for inclusion etc, whereas for other specialties stating the quantity of a specific type of supporting information may be less of a priority. In every case the emphasis should be on the quality of the information provided to the appraiser, rather than quantity alone.

Amount of detail
There is a tension throughout the responses between those wanting more detail and those wanting brevity. The challenge is to produce a version of guidance which finds a suitable balance.

Quality improvement
The requirements for quality improvement are not always clear, including the meaning of the term “Significant Event” in a general practice context. Difficulties for locums in terms of accessing data and being able to achieve system change have been highlighted.

Patient feedback
Clarity and assistance has been sought regarding patient feedback, and how it should be reflected on for appraisal. The patient feedback process is not always clear. There are reported difficulties for the Anaesthesia and Pathology specialties in particular.

Cross-specialty appraisal
The evidence would suggest that appraisals take can place across specialties without any particular difficulty. Indeed, the generic nature of appraisal is highlighted in the survey response as is the potential for cross-specialty appraisal to bring a fresh perspective. However, there is also a degree of ‘nervousness’ associated with appraising doctors in other specialties, the most challenging areas being:

- Assessing the robustness and validity of data for quality improvement (e.g. outcome data)
- Making a judgement on the appropriate level of activity (e.g. minimum number of clinical sessions to maintain competence in a particular specialty).

Difficulties associated with appraising GPs with Specialty Interests (GPwSI), due to specialist areas of practice, are highlighted.

Responsible officers
The responsible officer role is, perhaps, more orientated more towards establishing systems of quality assurance than consideration of specialty detail. However, responsible officers do appear to be accessing college and faculty resources, including guidance. It is still early in the revalidation process and responsible officers may be likely to take a pragmatic approach at this stage rather than focus on specialty detail.

Appraisal
The difficulties of balancing the summative and formative elements of appraisal have been highlighted, including the perception amongst some who contributed to the data that
appraisal has become a ‘box ticking’ exercise. Of relevance, the RST’s Early Benefits and Impacts of Medical Revalidation report recommends that appraisal should be promoted “as a developmental activity within a governed system” and that it should be “designed to motivate doctors to aspire to the highest standards of practice, rather than to meet minimum requirements.”

The SGG study provides some evidence of frustration that, while the appraisal process as such is appreciated from a personal reflection point of view, it does not lead to any quality improvement in the system. There is also evidence for concern that at an employer level, the clinical governance information required for successful appraisal is not available and IT systems do not sufficiently support availability of such data on an individual’s level. There are serious concerns around the sustainability of appraisal when insufficient or no time is allowed for it in job plans.

Additionally there is a question of how much time is required for an effective appraisal. Most respondents’ appraisal meetings lasted between one and two hours. However, 11% of appraisers respondents stated that the appraisals meeting they conducted lasted less than 30 or up to 60 minutes. Thirty-seven percent of doctor respondents stated that their appraisals lasted either less than 30 minutes or up to 60 minutes.

Organisational processes
There is a clear need for joined up processes, particularly when several organisations are involved in the appraisal and revalidation process. Wales was cited as an example of a country where there is an effective, joined-up agency approach. Such an approach may be easier to achieve on a smaller scale, but this is a matter for discussion.

IT systems
The experience of doctors, appraisers and responsible officers in appraisal and revalidation is clearly more positive when there are established and robust IT systems.
9 NEXT STEPS

The Specialty Guidance Group will work with relevant stakeholders to implement the recommendations of the report.
ACKNOWLEDGEMENTS

The Specialty Guidance Group would like to thank the following for their support for the project:

- The Academy of Medical Royal Colleges
- Medical Royal Colleges and Faculties
- College and Faculty helpdesks
- Survey respondents and focus group participants
- Stakeholders represented on the Academy Revalidation Development Group, particularly the GMC, RST(England), NHS England and the Health Departments of the devolved countries who have commented on the development of the group’s deliverables.
APPENDIX 1
COLLEGE AND FACULTY HELPDESK ENQUIRIES

In October 2013, all colleges and faculties in the Academy of Medical Royal Colleges submitted information about the number and nature of enquiries received by their revalidation helpdesk between 1 January and 1 September 2013. In total, the colleges and faculties had received 1676 enquiries during that period. In general, the number of enquiries was commensurate with the size of the college’s or faculty’s membership. However, two faculties, which act as designated bodies had received large number of enquiries compared to their size of membership. The Royal Colleges of Surgeons (50) and Royal College of Anaesthetists (65) received fewer enquiries than might be expected for the size of membership and may suggest that the information they provide through other media has been successful. The Scottish colleges have received very few enquiries.

Colleges and faculties reported that 159 specialty-specific enquiries had been answered by their specialty advisers, roughly 10% of all the enquiries received. The Speciality Guidance Group will encourage all colleges and faculties to review their specialty-specific enquiries in line with the review of supporting information guidance in early 2014.

Helpdesk data was submitted in different categories and those categories are considered below in order of how many enquiries were received in each.

Professional circumstances (453)
- The category with the most number of enquiries on issues such as detached doctors, working abroad, trainees and retirement and suggests that in some cases the GMC needs to be clearer about their policy
- The GMC did not start writing to detached doctors until October 2013. The guidance on suitable persons has been unclear until this point. Doctors in this category may correspond more with the GMC than the colleges and faculties from this point
- The GMC has been clear that retired doctors or those working overseas do not need to retain their licence to practise and should look to relinquish their licence. Some doctors do not consider this a satisfactory option and have contacted colleges and faculties to explore other routes to revalidation in their circumstances. This is likely to continue unless further assurances can be provided by the GMC about relinquishing and reinstating the licence
- There was a recurring theme of retired doctors carrying out some work after retiring from the NHS that related to their medical training. Queries appear to relate to how those doctors find a designated body and how they keep up to date. The advice from the GMC to ask the employer (e.g. sports club, law firm) whether the doctor requires a licence to practise has not been perceived as helpful
- RCP and RCGP had fielded a number of enquiries about returning to practice.

Revalidation requirements (246)
- The second highest number of enquiries and received in the largest numbers by the designated body faculties
Some colleges reported enquiries about SPAs and job planning. These enquiries were often received from those working part-time or SAS doctors.

The Academy should monitor enquiries about ongoing pressure on non-clinical SPAs and pressure to include additional clinical sessions when job planning.

The minimum number of sessions required to revalidate appears to be a recurring theme.

Feedback on practice (261)
- RCPath (15) and the CEM (10) received more enquiries about patient feedback than on any other issue. RCoA and acute medicine physicians also flagged enquiries about the logistical difficulties with collecting patient feedback.
- There is question about validated tools that meet GMC criteria. If trusts do not support a colleague and patient feedback system, doctors need clearer guidelines on how to carry out this exercise and what resources they can use.
- Professionals finding it difficult to collect patient feedback about their own practice have started to consider the information they can get at a service/team/organisational level and how to reflect on that data from their own perspective.

Appraisal (202)
- Enquiries regarding appraisal were received mostly by the faculties with designated body status and regarded finding an appraiser and including the right information at appraisal.
- FPM had some very specific queries about commercial confidentiality between the appraiser and the appraisee and questions about whether joint-appraisal is required.
- Appraisal was also a hot topic for GP enquiries.
- Appraisal for locum doctors was a recurring theme amongst the colleges.

Keeping up to date (192)
- A broad range of enquiries were received about CPD and keeping up to date and most colleges and faculties supplied different examples.
- A recurring theme was how those practising across different specialties weighted their CPD to reflect their diverse scope of practice.
- Other recurring themes have been noted above: CPD for SAS doctors and retired clinicians.
- There may be some confusion between the collection of sufficient credits for revalidation and the importance of reflection.

Content of practice (107)
- Content of practice enquiries regarded doctors changing specialty, working in independent practice, GPwSIs, etc.
- Some thought that guidance could be improved for those in non-clinical roles.

Review of practice (63)
• Given the concerns raised about the lack of clarity in the review of practice section of the supporting information guidance, a surprisingly low number of enquiries have been received about reviewing practice
• Case-based discussion was a hot topic for the RCPsych
• Access to data may be a growing concern and should be monitored
• There was a recurring theme that outcome data reflected team rather than individual performance (in some specialties)

Performance (26)
• A very small number of enquiries were received in relation to health, probity, performance concerns and remediation, and colleges and faculties did not comment on these enquiries.

141 enquiries fell into the category of ‘other’ and cannot be readily analysed.

Recommendations of the SGG
• Meet with the GMC to discuss recurring policy themes:
  - Retired doctors
  - Doctors overseas
  - Detached doctors
• Revisit college and faculty guidance on return to practice.
• RCP, RCGP and RCPsych to review guidance on revalidation requirements
• For the Academy to consider a review of its 2010 guidance on SPAs for revalidation
• To include information on the minimum number of sessions required for revalidation in the supporting information guidance
• To consider guidance or signposting on the validated tools for colleague and patient feedback
• To explore (with the GMC and other stakeholders) the use of team or organisational-level patient feedback data for the purposes of individual appraisal and revalidation
• For the Academy to publish an update on locums and revalidation
• To revisit guidance for managers, academics, and educationalists and work with relevant organisations to update guidance where required
• To consult colleges and faculties on whether helpdesks are being used as the main portal for doctors to raise concerns about professional practice.

Analysis by Sarah Campbell
November 2013
APPENDIX 2
DOCTOR (AS APPRAISEE) SURVEY REPORT

Appraisees survey feedback: summary

| Date range of survey responses: | 9 September – 15 November (this includes pilot feedback) |
| Total number of responses:     | 790 |
| Role of appraisees:            | Consultant (68%); General Practitioner (27%); SASG doctor (3%); Other (2%) |
| Location:                     | England (68%); Scotland (9%); Wales (20%); Northern Ireland (3%) |

Section 1 – General information on doctors / appraises

The breakdown of the specialties of respondent appraisers was as follows. For comparative purposes throughout this report, we have used the eight most prevalent specialties (anaesthetics, general practice, obstetrics and gynaecology, ophthalmology, paediatrics, pathology, physician specialties and psychiatry).

![Specialties Graph]

Sixty percent of respondents stated that they had significant non-clinical roles:
Professional roles were broken down as follows:

Employment status was as follows:
Section 2: Information on appraisals – general

91% of respondents had undertaken an appraisal in the past year. The feedback on the appraisal process was as follows:

The feedback on the appraisal helping in reviewing the quality of professional work was as follows:
The feedback on organisational issues relating to appraisals was as follows. There was little variation depending on work setting (i.e. NHS / non-NHS):

Doctors were asked whether their appraiser was from the same medical specialty as themselves:
Feedback on the length of appraisal meetings per specialty:

<table>
<thead>
<tr>
<th>2.5 Variations by specialty in length of appraisal meetings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiology</td>
</tr>
<tr>
<td>General practice</td>
</tr>
<tr>
<td>Obstetrics and gynecology</td>
</tr>
<tr>
<td>Ophthalmology</td>
</tr>
<tr>
<td>Paediatrics</td>
</tr>
<tr>
<td>Pathology specialties</td>
</tr>
<tr>
<td>Physician specialties</td>
</tr>
<tr>
<td>Psychiatry</td>
</tr>
<tr>
<td>All specialties</td>
</tr>
</tbody>
</table>

- **Less than 30 minutes**
- **30 - 60 minutes**
- **60 - 120 minutes**
- **Over 2 hours**

There were 346 free text comments related to doctors’ experience of appraisal. The main areas of feedback were:

- **Bureaucracy and time required**
  - There was strong feedback that the appraisal process in many trusts was seen as a ‘box ticking’ exercise which tested doctors’ ability to compile a folder of supporting information, rather than their ability and competence as a doctor
  - Appraisals were seen by many doctors as overly time consuming and eroding precious patient hours in a system in which patient contact was already at a premium
  - Many doctors reported a lack of time provided by their trusts in which to properly prepare for appraisal, resulting in this being done at weekends or elsewhere in their own time
  - Overall, many doctors saw the appraisal process as being bureaucratic and expensive, both on the system of healthcare as a whole, and for individual doctors outside of managed governance systems (i.e. where they had to pay for appraisal / revalidation).

- **Appraiser issues**
  - Many doctors reported issues with appraisers – lack of training in individual appraisers, the process not being taken seriously by appraisers, and a lack of appropriately trained appraisers in some parts of the country. Much as doctors often reported struggles to find time to prepare for an appraisal, there was a perception that appraisers were also having the same issues in their role as appraisers
  - There was positive feedback where doctors had undertaken an appraisal with someone from a different specialty. While there were issues about lack of specialty knowledge, many doctors welcomed the challenge and fresh perspective a cross-specialty appraiser brought to the process.

- **Identifying poorly performing doctors**
  - There was concern that current appraisal arrangements would do nothing to identify poor performing doctors, and indeed that it was not the function of the appraisal system to do this – this should be a GMC role.
• **Appraisal systems**
  - Where consistent, proven appraisal management and IT systems has been established and in place for a number of years, the response was much more positive. Doctors were used to what was expected and the time required to collect supporting information was less burdensome
  - New IT systems were frequently regarded as cumbersome and not capable of reflecting a doctor’s whole scope of practice.

• **Positive feedback**
  - There was also a strong strand of feedback from doctors who found the appraisal process supportive, well-managed and helpful in their personal development. As with the feedback in other parts of the survey, there was a feeling that if the appraisal was treated as a ‘box-ticking’ exercise, then there would be little value to the process. Where, however, trusts were supportive of robust appraisal, had appropriate and well-managed systems in place, then the experience was viewed much more positively (although time management was still seen as an issue).
Section 3: Sources of help for appraisal and revalidation

Seventy percent of doctors asked had referred to sources of help or guidance on appraisal and/or revalidation when developing their portfolio of supporting information. The breakdown was as follows:

Sixty percent of respondents had sought guidance from one of the following GMC resources:

Respondents were asked if they found the GMC resources useful; 73% said yes, 19% said no, and 8% were neutral/non-committed.

Typical positive comments noted that the GMC resources were well set out, and helpful in conjunction with college guidance, straightforward and easy to follow, essential for structuring an appraisal and to remind oneself about 'missing' information and a 'bit wordy and vague, but at least you know that is the official line'

Less positive comments noted that the guidelines were too generic and do not relate to a particular area of practice, overly long and time-consuming to read, and do not provide enough practical pointer about how to revalidate.
Fifty five percent of all respondents had accessed information from the colleges and faculties:

![Graph showing usage of various resources](image)

Respondents were asked if they found the college and faculty resources useful; 78% said yes, 15% said no, and 7% were neutral / non-committed.

Typical positive comments noted that the college resources were clear and comprehensive, and helpful in gathering information related to speciality needs. Comments about online CPD systems were generally positive and the RCGP resources were identified for particular praise.

Less positive comments noted that the resources available added little to what was available from the GMC, were ‘bland’ and ‘wordy’ and provided little help in getting patient feedback.
Section 4: Speciality guidance on supporting information

Seventy percent of respondents answered the question ‘For your last appraisal, did you use one or more of the specialty guidance documents developed by the colleges and faculties?’ Of these, 48% responded positively, and 52% said no. The specialty breakdown is as follows:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthesia, Intensive Care and Pain Medicine</td>
<td>6% (16)</td>
</tr>
<tr>
<td>Pathologists</td>
<td>27% (73)</td>
</tr>
<tr>
<td>General Practitioners</td>
<td>6% (19)</td>
</tr>
<tr>
<td>Physicians</td>
<td>3% (8)</td>
</tr>
<tr>
<td>Obstetrics and Gynaecology and/or Sexual and Reproductive Health</td>
<td>24% (65)</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>4% (12)</td>
</tr>
<tr>
<td>Public Health</td>
<td>3% (9)</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>5% (12)</td>
</tr>
<tr>
<td>Surgeons</td>
<td>2% (4)</td>
</tr>
<tr>
<td>Paediatrics and Child Health</td>
<td>6% (16)</td>
</tr>
</tbody>
</table>

Awareness of the specialty guidance came from the following sources across the specialties:
Respondents were asked two questions about the clarity and accessibility of the speciality guidance. Response are broken down by specialty:

There were 67 free text comments received in relation to the clarity and accessibility of the speciality guidance resources provided by the colleges or faculties. Comments were generally positive, with the guidance being seen as clear and comprehensive. Some doctors appreciated the specificity of the guidance, and also the fact that the guidance followed the format of the GMC documents. Less positive comments noted the perception of ‘confusion’ between the ‘minimum standards’ prescribed by the GMC and the ‘gold standard’ set out by the college, and the need for a clearer distinction between the two. The need for more sub-specialty information was also noted (Ophthalmology and Paediatrics).

‘OUTLIER SPECIALTIES’ (updated)
Free text comments from specialists in psychiatry and ophthalmology (the two most ‘negative’ specialties) mentioned vagueness and poorly developed sub-speciality guidance (ophthalmology) and complexity and weight of evidence / data required (psychiatry).
Respondents were asked about the usefulness of the specialty guidance provided by the colleges and faculties. The chart below shows the responses for all doctor / appraisees surveyed:

The three most mixed responses were questions 4.6(c), (d) and (e). The specialty breakdown for these questions was as follows:
The chart below includes the ranking for **SAS grade doctors**, where concern over specialty standards was more pronounced than amongst consultants:

There were 52 free text comments regarding the usefulness of the specialty guidance from the colleges. Feedback was generally positive, with some respondents noting that the college guidance went beyond that provided by the GMC / RST etc. As far as any themes emerged, again there was a perception in a limited number of responses of the colleges and faculties setting ‘super-human’ standards which were not realistic in the busy life of a real doctor, and that medicine could learn from other industries (aviation / nuclear) in setting the bar at an attainable threshold. The only other specific feedback was from doctors in Pathology specialties noting that more guidance was required around patient / service-user feedback for the purposes of revalidation.

**‘OUTLIER SPECIALTIES’ (updated)**
Free text comments from those specialties at the negative end of the spectrum were limited. Lack of guidance on quality measures were mentioned by two specialities (pathology and ophthalmology). Further feedback from pathologists stated that the guidance added little to that provided by the GMC, while the psychiatrists mentioned (again) that the guidance was complex and too detailed.
Respondents were then asked for their views on the level of detail provided in the college specialty guidance in relation to the four categories of supporting information:

Breakdown by specialty for questions 4.8(c) and (d):

- **4.8(c) Detail in supporting information categories - review of your practice - evaluating and improving the quality of your professional work**
  - Anaesthetics
  - General practice
  - Obstetrics and gynaecology
  - Ophthalmology
  - Paediatrics
  - Pathology specialties
  - Physician specialties
  - Psychiatry
  - All specialties

- **4.8(d) Detail in supporting information categories - feedback on your practice - how others perceive the quality of your professional work**
  - Anaesthetics
  - General practice
  - Obstetrics and gynaecology
  - Ophthalmology
  - Paediatrics
  - Pathology specialties
  - Physician specialties
  - Psychiatry
  - All specialties
Respondents were then asked about three specific areas of the specialty guidance – responses are presented here broken down by specialty:
There were 51 free text comments in relation to the level of detail in the specialty guidance documents. The most consistent theme was that of multi-source feedback; anaesthetists in particular felt the guidance could be clearer and more specific, but this feedback was by no means limited to anaesthetics. There was also feedback that the guidance on SUI could be more specific – in ‘definition’ of a SUI and how doctors should reflect on any SUIs received.

**‘OUTLIER SPECIALTIES’ (updated)**
Psychiatrists gave a mixed response, but provided very little additional information other than one comment on how difficult it can be to define and audit untoward incidents. Anaesthetists were (predictably) outliers in relation to colleague and patient feedback, with comments about the ineffectiveness of ‘generic’ trust 360 feedback systems (i.e. not developed for the specialty) and, again, the lack of guidance on what constitutes a significant or untoward incident.
Section 5: Difficulties and concerns in collecting and developing a portfolio of supporting information

Some 36% of respondents indicated that they had difficulties or concerns collecting and developing a portfolio of supporting information for appraisal and revalidation (with 64% stating that they had no such concerns). The results were generally very consistent across specialties, with the exception of psychiatry, where 64% of respondents indicated some level of concern. Unsurprisingly, the key areas of concern (across all specialties) were feedback from patients and quality improvement (audit) activity:

![Image of a chart showing the level of difficulty or concern across specialties in collecting supporting information.](chart)

Of the three most problematic areas (d), (e) and (f), the speciality breakdown was as follows – patient feedback:

![Image of a chart showing the level of difficulty or concern in collecting feedback from patients across specialties.](chart)
Quality improvement activity:

In section 5.2, doctors were asked about the difficulties they had in collecting specific types of information, the three most challenging areas being patient feedback, quality improvement activity and significant incidents. Concerns regarding patient feedback were most prevalent amongst anaesthetists, though the feedback provided little information other than it was difficult in either anaesthesia to gather feedback, there was inadequate time to do this and patient response rates tended to be low. Pathologists were slightly more expansive on patient feedback, with lack of ‘infrastructure’ (admin support) being cited, though one doctor also noted that the college guidance (pathologists) was helpful in relation to getting feedback. There was also feedback regarding the lack of clarity around the use of the RCGP e-portfolio and how patient feedback fed into this.

GPs scored low for quality improvement activity, with the most consistent theme being the difficulty of collecting and managing QI data for locum or freelance GPs, particularly getting access to trust data.

Physicians were a clear outlier in relation to significant incidents, but no qualitative data was provided.
Respondents were then asked whether the cause of any difficulty or concern related to one or more of the following organisational considerations. The results shown below are for all respondents:

![Organisational Issues Graph]

Respondents were then asked whether the cause of any difficulty or concern related to professional practice or specialty-specific considerations. The results shown below are for all respondents:

![Professional Practice or Specialty Issues Graph]

When asked to provide free text comments on any difficulties or concerns doctors have in collecting supporting information for appraisal and revalidation, there were 175 responses. The main areas of concern were:

- **Patient feedback** – several strands:
  - Difficulties in collecting (especially anaesthesia, community sexual health, pathology, psychiatry), language barriers
  - Tensions between local or individual solutions that work and are proven, and ‘validated’ feedback systems that might be imposed on doctors
  - Difficulties for locum doctors (mobility)
  - Perception of either lack of frequency of patient feedback and therefore out of date, or the perception that MSF is required every year for appraisal and is too time-consuming.
• **Time constraints** – lack of time in job plan for collecting and organising supporting information – consistent feedback that this is being done outside of working hours in own time.

• **Clinical data systems** – trust systems are out of date, restrictive, not sophisticated enough for the job, unreliable and doctors are frequently keeping their own data for audit purposes. There was also feedback about the lack of reliable benchmarked data (paediatrics).

• **Quality improvement / audit work** – locums finding it very difficult to complete the audit / re-audit cycle. Locums are expected to share the workload, not contribute to service improvement or re-design. Current guidance on revalidation is not explicit enough for locums and temporary practitioners.
Section 6: Final comments on appraisal and revalidation

Doctors were asked for any final comments regarding appraisal and revalidation. There were 264 free text comments received (equating to one third of all respondents). The main areas of concern were:

- **Appraisal process** - various issues:
  - There were many doctors – albeit a minority – who saw appraisal and revalidation as a positive development that supports reflection and learning, while acknowledging that you will only get out of a system what you put in
  - Appraisal was seen by many as a ‘box-ticking’ process with little value. Doctors, as intelligent people, should be easily capable of satisfying the requirements whether or not they are good doctors. The appraisal system is heavy handed when imposed on all doctors; there should be more focus on struggling doctors. Appraisal has changed in nature in recent years from a formative process focussed on personal development to a mechanism purely designed to support revalidation
  - There was some feedback that appraisals were too frequent (a burden on the majority of competent / high-performing doctors – see above) – different suggestions to deal with this ranged from annual online exams with a five-yearly face-to-face appraisal to bi-annual appraisals.

- **Revalidation**:
  - There was strong feedback that the whole revalidation was too bureaucratic and time-consuming, with little real value for doctors in their everyday practice. There was a perception that revalidation would have little benefit for patient safety and would do nothing to identify the next Shipman (15 mentions!). The expense of revalidation was seen by some respondents as overly burdensome on an already stretched system and the process generally would need to be ‘pruned’. The system was also seen by some doctors as individually expensive, with independent appraisals and revalidation costing too much and potentially pushing some doctors out of practice
  - Other doctors applauded the introduction of revalidation, and found the process less painful than they had anticipated. The process in Wales in particular was seen as ‘joined up’ and the MARS system was generally (though not universally) regarded as easy and straightforward to use.

- **College specialty guidance**:
  - There was mixed feedback on the college specialty guidance (detailed in section 5) but the positive comments slightly outweighed the negative
  - Two doctors indicate that they were not aware of college specialty guidance.

- **IT systems**:
  - Doctors are clearly having a mixed experience when it comes to IT systems to help them manage their appraisal and revalidation. The multiplicity of systems doctors have to use (appraisal, 360 feedback, CPD) is a source of frustration, coupled with the duplication of entering information on to more than system
  - Doctors who commented on the MAG form were generally positive.

- **Multi-source feedback**:
  - There was feedback primarily from anaesthetists and pathologists that patient feedback was difficult to obtain, and that this should have been more fully explored before the launch of revalidation.

- **General comments**:
  - A few doctors regarded revalidation as an entirely political process imposed on the NHS by the GMC. Others saw revalidation as a ‘necessary evil’ which was about as good as it could be given the breadth of medical practice and the need to have one system for the whole UK.
Potential issues to be raised in the focus group (3 December)

- Are there ways in which guidance from different agencies (GMC, NHS, colleges etc) could be better aligned and integrated? (cf Wales)
- Are there inconsistencies between generic guidance and guidance from the specialties? Should the speciality guidance go further than it does (e.g. provide ‘template’ supporting information for additional guidance)?
- What more could colleges do to promote and support effective multi-source feedback (especially in perceived ‘difficult’ specialties such as anaesthesia, pathology and psychiatry)?
- The college documents are frequently seen as promoting a ‘gold standard’ which is unrealistic for many doctors to attain. Is the bar for revalidation being set too high (or too low)? Is there a need for the college guidance to be more in tune with the ‘minimum standards’ set out by the GMC?
- Does the college guidance need to be more specific about the emphasis on the quality of supporting information, rather than the quantity (feedback from doctors ‘expected’ to have SUIs to reflect upon)
- What more could trusts be doing to support an effective appraisal process?
- How accessible is college / faculty support? Are there ways in which it might be disseminated more effectively to highlight the support available to members?
- There is little feedback in the survey on either the helpdesk or the role of the specialty adviser. Are doctors aware of these? Do they need greater promotion / development?
- What more might colleges do to help reduce the administrative burden of revalidation on doctors?
- There is general frustration with the complexity and multiplicity of the IT systems that support and facilitate appraisal / revalidation? What would be helpful to doctors to overcome this issue?
- Are doctors clear (if not in agreement with) on the level of documentation and supporting information required for appraisal and revalidation?
APPENDIX 3
APPRAISER SURVEY REPORT

Date range of survey responses: 9 September – 15 November (this includes pilot feedback)
Total number of responses: 171
Role of respondent: Consultant (68%); General Practitioner (27%); SASG doctor (3%); Other (2%)
Location: England (86%); Scotland (6%); Wales (6%); N. Ireland (2%)

Section 1: Appraisers by specialism

The breakdown of the specialties of respondent appraisers was as follows. For comparative purposes throughout this report, we have used the six most prevalent specialties (anaesthetics, general practice, obstetrics and gynaecology, paediatrics, pathology and psychiatry).

NHS appraisers classified themselves as following:
Non-NHS appraisers classified themselves as following:

- **Academic or research organisation**: 48% (13)
- **Government body/executive agency**: 26% (7)
- **Hospice and charity/voluntary organisation**: 0% (0)
- **Independent healthcare provider**: 26% (7)
- **Locum agency**: 0% (0)
- **Non-healthcare commercial organisation**: 0% (0)
- **Professional medical body**: 7% (2)
- **Other non-NHS body**: 0% (0)

* (7) total responses, 10% of submissions
Section 2: Information on appraisals – general

Nearly half (48%) of appraisers had conducted between 1-5 appraisals in the past 12 months, with 31% conducting 6-10 appraisals, 13% conducting between 11-15 and 8% conducting 16 or more appraisals in the past year.

There was some variation in the length of appraisal meetings across specialties (looking at the six most common specialties of respondents in the survey):
In common with doctors (appraisees) and responsible officers, there was a general concern that not enough time was provided to conduct appraisals and that much of this work inevitably took place outside of normal working hours:

2.4 Please indicate how strongly you disagree or agree with the following statements about workload issues relating to your role as an appraiser

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Total Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) My job plan fully takes into account the role and responsibilities of an appraiser</td>
<td>18% (31)</td>
<td>38% (58)</td>
<td>38% (61)</td>
<td></td>
<td>98% (168)</td>
</tr>
<tr>
<td>(b) The work involved in being an appraiser (including preparing for and writing up appraisals) can be done during my normal working hours</td>
<td>30% (51)</td>
<td>45% (75)</td>
<td>21% (35)</td>
<td></td>
<td>98% (168)</td>
</tr>
<tr>
<td>(c) Given the time available, I am able to carry out appraisals to a level of quality that I would like</td>
<td>20% (34)</td>
<td>68% (103)</td>
<td>12% (20)</td>
<td></td>
<td>98% (168)</td>
</tr>
</tbody>
</table>

The notion of appraisal workload being conducted outside of core hours (Q2.4(b)) was particularly pronounced in paediatrics, obstetrics & gynaecology and general practice, less so in psychiatry and anaesthetics.

Regarding free text comments on appraisal workload, 101 were received. The majority reported carrying out appraisal-related activity (if not the actual appraisal) outside of working hours, with the preparation and follow-up / writing taking at least as long as the appraisal meeting. Where appraisers did have SPAs in their job plans for appraisal time, this time was almost universally reported as being insufficient, with the task being completed outside of core hours.
Section 3: Appraisal training

For appraisal training, 90% of respondents across all specialties had undertaken revalidation-focussed appraiser training or professional development in the past 12 months. Variations in this figure included psychiatry (100%), obstetrics & gynaecology (97%) and general practitioners (96%) to pathology, paediatrics and anaesthetics (83-86%).

There was a wide range of providers for the appraisal training, but 50% was provided by the employer / trust. The medical royal colleges were the second smallest provider of the choices (6%).

Feedback on training coverage:

![Training Feedback Chart]

3.3 Please indicate how strongly you disagree or agree that your training sufficiently covered the following key appraiser competencies.

- Knowledge and understanding of the role and purpose of the appraiser in undertaking effective appraisals
- Communication skills to facilitate an effective discussion and document the outputs of appraisal
- Specialty awareness - appraise a doctor's performance in their area of specialty practice
- Professional development skills - consider a doctor's quality improvement activities, CPD and personal development plans
- Evaluation and judgement - analyse information presented at appraisal and judge a doctor's response towards recommendations
- Knowledge of actions to take if serious concerns arise including stopping/suspending an appraisal
In question 3.3(c), appraisers were asked whether their appraiser training covered specialty awareness:

Of the 171 respondents, 78% had continued their development as an appraiser through a range of activities, the most popular being appraiser / peer support groups in their own organisation and further ‘top-up’ training.

Free text comments: 58 comments were received, the majority positive about the appraisal training they had received and the support they were able to access within their trust or employing organisation. There was little substantive comment, but clearly a degree of ‘nervousness’ around appraising doctors from different specialities:

• ‘Sometimes, I do find it difficult to grasp the full nature of the workload and specialty-specific issues that come up during the appraisal meeting. The discussion may become rather frustrating if both appraisee and appraiser do not get the sense that there is sufficient understanding of the challenges faced.’

At the other end of the spectrum, there were isolated comments on the general value of appraisal:

• ‘appraisal is an unproven process that will make no lasting difference to the health service / any doctor’
Section 4: Seeking guidance for a revalidation-focussed appraisal

75% of appraisers had referred to guidance from a range of sources in order to conduct appraisals (ranging from paediatrics (100%) to obstetrics and gynaecology (64%)):

A large majority of appraisers had consulted various GMC resources on appraisal and revalidation, the most popular being the GMC supporting information guidance (91%).

There were 84 free text comments in relation to the resources provided by the GMC. One theme that was repeated was the generality of GMC guidance; a couple of appraisers suggesting making appraisal generic (i.e. not specialty-specific). Two specific suggestions that arose were:

- ‘more guidance on going abroad and returning from abroad and the requirements’; and
- ‘more specific with respect to examples of what do and don’t meet requirements for revalidation’

For college revalidation guidance, 57% of appraisers across all specialties had sought out college resources:
There was some variation across specialties in use of college guidance:

There were 64 free text comments received in relation to the ‘generic’ revalidation guidance resources provided by the colleges or faculties. The resources were generally perceived to be helpful, with the RCGP guidance receiving particularly positive feedback (obstetrics & gynaecology and pathology were less positive). Negative comments tended to focus on the perception that colleges were setting a ‘gold standard’ which was higher than the bar set by the GMC (and therefore confusing). There were a few comments suggesting lack of awareness (in relation to more than one college) of the guidance, helpdesk and general resource available.

‘OUTLIER SPECIALTIES’ (updated)
The data set for appraisers was small (171 in total so identifying outliers within that data is problematic. However, as the graph below shows, there were some differences in responses across the specialties in response to the question: as an appraiser, did you find the (‘generic’) college and faculty guidance documents useful?
Section 5: Use of college and faculty specialty guidance

Across all specialties, 48% of respondents for this question indicated that they had accessed specialty-specific guidance from the colleges or faculties. Awareness of the specialty guidance primarily came from the college or faculty itself (50%) or someone else in their organisation (32%). It should be noted that the number of returns on this section was low so the quantitative data should be treated with caution.

The feedback on the clarity and accessibility of the specialty guidance available from the colleges / faculties was largely positive:

Free text comments: 17 comments were received on clarity and accessibility: The RCGP document was praised, but there were one or comments (across specialties) that the documents did not add much to the GMC generic guidance. The one specific observation that did recur (albeit small number of times give the limited data set) is lack of guidance given on minimum case requirements or the ‘threshold’ for revalidation – so possibly some work required clarifying that there is no minimum case / hours requirements (emphasis on quality rather than quantity).
The feedback on the detail provided in the specialty guidance was equally positive, though it was difficult to extract any meaningful specialty-specific trends or information from the responses:

| 5.6 Please indicate how strongly you disagree or agree that enough detail is provided in the specialty guidance in helping you review the following categories of supporting information in a doctor |
|--------------------------------------------------|-----------------|-----------------|-----------------|-----------------|
| (a) General information – providing context about what a doctor does in all aspects of his or her professional work | Strongly Disagree | Disagree | Agree | Strongly Agree |
| 74% (46) | 23% (14) | 36% (62) |
| (b) Keeping up-to-date – maintaining and enhancing the quality of professional and specialty work | Strongly Disagree | Disagree | Agree | Strongly Agree |
| 74% (46) | 24% (15) | 36% (62) |
| (c) Review of practice – evaluating and improving the quality of professional and specialty work | Strongly Disagree | Disagree | Agree | Strongly Agree |
| 16% (9) | 68% (42) | 18% (11) | 36% (62) |
| (d) Feedback on your practice – how others perceive the quality of a doctor’s professional work | Strongly Disagree | Disagree | Agree | Strongly Agree |
| 13% (8) | 73% (45) | 18% (9) | 36% (62) |

The feedback on the usefulness of the specialty guidance to appraisers was slightly less positive:

| 5.7 Please indicate how strongly you disagree or agree that the specialty guidance is useful to you as an appraiser in undertaking the following: |
|--------------------------------------------------|-----------------|-----------------|-----------------|-----------------|
| (a) Conducting a challenging and constructive appraisal relevant to a doctor’s specialty practice | Strongly Disagree | Disagree | Agree | Strongly Agree |
| 26% (10) | 33% (35) | 18% (11) | 36% (62) |
| (b) Helping a doctor produce quality supporting information related to his or her specialty practice | Strongly Disagree | Disagree | Agree | Strongly Agree |
| 16% (10) | 60% (37) | 23% (14) | 36% (62) |
| (c) Helping to resolve issues affecting the ability of the doctor in providing items of required supporting information | Strongly Disagree | Disagree | Agree | Strongly Agree |
| 23% (14) | 53% (35) | 13% (8) | 36% (62) |
| (d) Evaluating a doctor’s personal reflection and demonstration of learning in his or her supporting information | Strongly Disagree | Disagree | Agree | Strongly Agree |
| 32% (20) | 52% (32) | 16% (9) | 36% (62) |
| (e) Helping a doctor formulate a personal development plan covering his or her scope of practice | Strongly Disagree | Disagree | Agree | Strongly Agree |
| 21% (13) | 51% (30) | 16% (10) | 36% (62) |
| (f) Discussion of reported complaints and/or critical or significant untoward incidents involving the doctor being appraised | Strongly Disagree | Disagree | Agree | Strongly Agree |
| 24% (10) | 50% (30) | 18% (11) | 36% (62) |
| (g) Evaluating that a doctor is up-to-date and fit to practice in his or her area of specialty practice | Strongly Disagree | Disagree | Agree | Strongly Agree |
| 16% (10) | 58% (43) | 13% (8) | 36% (62) |
Seventeen free text comments were received in relation to the usefulness and relevance of the revalidation specialty guidance. Comments included:

- ‘RCGP should develop their e-Portfolio to include sections/mechanisms to collect/sort CPD relevant to special interests e.g. dermatology, GP training, CCG work or other GPSI roles.’
- ‘Guidance on content/numbers of reflections would be helpful as currently rather subjective.’
- ‘Written guidance does little to address the interpersonal skills needed to tackle difficult issues or challenging appraisals with significant issues to discuss- especially as these are mostly about conduct rather than medical practice and involve relationships within departments.’
- ‘General guidance from RCPPath is useful but it needs to produce more a more comprehensive list of issues that repeatedly need discussion during the appraisal meeting, including specialty-specific information.’
- The colleges need to communicate to their members that for CPD if the College has a e-portfolio or equivalent then the expectation is that must be used when preparing for appraisal/revalidation.’

### OUTLIER SPECIALTIES (updated)

The only ‘outlier’ specialty with sufficient data to consider was pathology, with over half of respondents disagreeing with questions 5.7(c), (d) and (f) and nearly half disagreeing with questions 5.7(a) and (e). There were two free text comments received from pathology specialists, suggesting that the RCPPath guidance was ‘useful but it needs to produce more a more comprehensive list of issues that repeatedly need discussion during the appraisal meeting, including specialty-specific information.’ The other comment related to the need for better marketing of college e-portfolios and CPD systems.
Section 6: Organisational Support for Appraisers

Appraisers were asked about the support they received from their employing organisations:

There are clearly ongoing concerns over clinical governance systems and the type of support and useful information they provide to appraisers – the project team will need to think about how to report or feed this back. The next most significant issue is the level of administrative support available – this probably relates to the workload issues highlighted in Q2.4.

Seventy free text comments were received in relation to the provision of organisational support to appraisers.

- One positive theme to emerge was the process in Wales, described as supportive (though under-funded) and with separate systems for appraisal and clinical governance
- The lack of administrative support was a constant theme, with several appraisers reporting that this had been down-graded or removed in recent time.
- Non-engagement of the appraisal process was a consistent theme, with most appraisers reporting that their appraisal / clinical governance system was not able to address this
- IT systems also seen as problematic in many cases – either non-existent or difficult to use
- Several appraisers stated that they wished for feedback on their performance as an appraiser but this was not possible within their trusts’ systems
- Positive responses were often prompted by the leadership and enthusiasm of one or two individuals (e.g. medical director) rather than the embedded systems and structures within a trust.
Appraisers were asked whether their appraisees were all from the same specialist area as themselves:

![Bar chart showing percentage of doctors whose appraisees are from same specialty across different specialties.](chart.png)

The appraisers who do appraise doctors from other specialties were asked for further detail:

![Table showing difficulty in making an informed judgement about various aspects of appraisal.](table.png)

Forty free text comments were received in relation to conducting the appraisals of doctors from other specialties. There were mixed views on the desirability of appraising doctors from different specialties to your own – some felt appraisal should be a generic skill and someone from a different specialty would bring fresh challenge and perspective, while others expressed nervousness around lack of knowledge of clinical data and expectations, and the degree of trust they placed in the appraisee and the data they provided. Some reported that their trusts had in place a policy that all doctors would be appraised ‘within specialty’. There also seemed to be a particular issue with GPs appraising GPwSI for similar reasons as above.
Section 7: Final comments

Thirty four free text comments were received in relation to revalidation generally. Themes included:

- The proliferation of advice (GMC, colleges, trusts, RST) – a confusing picture of support
- ‘Discrepancy in standards required of appraisers…between primary and secondary care… I can see no reason why doctors in secondary care should have to provide fewer colleagues for an MSF or fewer patients for a patient survey than a GP locum for example.’
- A predictable range of views on revalidation and the pros and cons of the this; some felt it had had the benefit of promoting the use of robust appraisal, though admittedly it could be years before the benefits of this could be seen. Others were less positive(!) about revalidation, citing the cost in finances, resources and time for marginal benefits. There were also appraisers who thought that revalidation had changed appraisal from a formative, supportive process to a tick-box exercise
- College guidance was highlighted (by one respondent) as needing to explain how MSF, especially from patients, could more easily be gathered.

Issue raised for appraisers in the focus group (3 December)

- Do appraisers feel there are inconsistencies between generic guidance and guidance from the specialties?
- What more could be done by the colleges and others to support appraisal of doctors from different specialties as their appraiser?
- The college documents are frequently seen as promoting a ‘gold standard’ which is unrealistic for many doctors to attain. Is the bar for revalidation being set too high (or too low)? Is there a need for the college guidance to be more in tune with the ‘minimum standards’ set out by the GMC?
- There was consistent feedback about the difficulties in obtaining robust clinical data within trusts. Is there anything the colleges could do to support appraisers and doctors in this area?
- How accessible is college / faculty support? Are there ways in which it might be disseminated more effectively to highlight the support available to members?
- There is little feedback in the survey on either the helpdesk or the role of the specialty adviser. Are doctors aware of these? Do they need greater promotion / development?
- There is general frustration with the complexity and multiplicity of the IT systems that support and facilitate appraisal / revalidation? What would be helpful to doctors to overcome this issue?
APPENDIX 4
RESPONSIBLE OFFICER SURVEY REPORT

Date range of survey responses: 9 September – 15 November (this includes pilot feedback)
Total number of responses: 16
Role of respondent: Responsible Officers (13); Lead clinician for revalidation or equivalent (3)
Number of doctors responsible for: Less than 10 (4); 10 – 50 (0); 51 – 100 (1); 100+ (11)
Location: England (13); Scotland (1); Wales (2)

Feedback on Generic Advice and Guidance
All respondents had referred to generic guidance (from colleges, GMC, RST etc) on their role as responsible officer or appraisal lead;

The main sources of guidance used are set out below:

The general view was that the GMC website is particularly clear, and useful as a primary source of guidance; the RST website was reported to be harder to navigate (1 respondent).

The combination of background knowledge and discussion with peers was reported as being very useful, particularly in the independent sector.

One respondent reported that the guidance ‘would be better if it had been clear and directive from the outset. Instead we have had a system where different organisations have sent conflicting advice and the NHS England website has not been updated efficiently or accurately.’

Guidance in Wales felt to be particularly clear as it is agreed between the deanery, GMC, NHS Wales and the BMA.

Royal colleges ‘pretty helpful’ (especially the RCP).
Feedback on College/Faculty Guidance

Of the 16 respondents, 13 had used College / Faculty resources:

The majority of respondents found the revalidation guidance offered by their college useful.

One respondent described them as useful ‘now they are in line with GMC guidance’.

Three respondents (of 16) described the college guidance as not useful: specifics included the RCGP website and ‘less useful than generic materials. When I turn to particular college or faculty for issue affecting their members in particular way, I don’t find much of use’.

One respondent described the college suggestions as ‘excessive’ in terms of CPD and documentation where doctors have a limited field of practice but are members of a college CPD scheme.

Feedback on Specialty Guidance

Of the 16 respondents, 10 had used one or more of the specialty guidance documents when reviewing a doctor’s portfolio.

Of these ten, all respondents reported the specialty guidance they used as being well structured, with the wording clear and unambiguous, and the guidance enhanced their knowledge about appraisal and revalidation and clarified the supporting information requirements expected.

When asked to agree or disagree, there was wide agreement that there was enough detail in the specialty guidance around:

- Providing context about what a doctor does in all aspects of his or her professional work
- Maintaining and enhancing the quality of professional and specialty work
- Evaluating and improving the quality of professional and specialty work
- Feeding back on a doctor’s practice.

There was one ‘dissenting opinion’ (psychiatry) around ‘Keeping up-to-date - maintaining and enhancing the quality of professional and specialty work’. One respondent also noted that it was ‘difficult to know how to use some of the guidance around numbers of cases etc.’

Usefulness of specialty guidance to ROs/appraisal leads:

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**Table: College or Faculty Resources Utilization**

<table>
<thead>
<tr>
<th>Resource Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conference seminars and workshops</td>
<td>0% (1)</td>
</tr>
<tr>
<td>Guidance documents on CPD, audit, etc</td>
<td>8% (1)</td>
</tr>
<tr>
<td>Newsletters and journals</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Online educational materials</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Revalidation helpdesk</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Website</td>
<td>46% (6)</td>
</tr>
</tbody>
</table>

*13 total responses, 81% of submissions*
The one positive comment noted that the template for reflection is very helpful.

Other feedback noted that ‘clinical governance within the organisation for which I am RO will require multi-faceted systems and one guide is not enough....as a locum agency, these systems are not yet fully thought through’.

Final comments
Positive comments noted that the guidance in general was useful, though levels of awareness amongst college members could be higher.

Other comments noted:
- The importance of a clear RO checklist
- The need for advice to be consistent across multiple sources;
- Given the early, evolutionary stage of revalidation, advice needs to be practical rather than too prescriptive;
- Locum agencies are ‘largely out in the wilderness as far as robust clinical governance goes’
- The need for some useful and practical guidance around how GPs with Special Interests should be accredited and appraised. ‘So far people seem to e putting that in the ‘too difficult, must be a CCG responsibility’ pile’
- ‘There needs to be clear guidance on what patient feedback or its equivalent is required for pathologists and anaesthetists given their particular contact/no contact with patients’.

Potential issues to be raised in focus group (3 December)
Limited data due to low number of responses, but some important issues were raised:
- Could there be specific elements of guidance that would be useful to responsible officers (e.g. checklists etc)?
- Are there ways in which guidance from different agencies (GMC, NHS, colleges etc) could be better aligned and integrated? (cf Wales)
- Are there perceived gaps/inconsistencies between generic guidance and guidance from the specialties? What is ROs’ understanding of the positioning between the two?
- Relative importance/value of guidance vs peer support
- Relative importance/value of generic guidance vs specialty guidance and support coming from Colleges and Faculties
• How accessible is C/F support? Are there ways in which it might be disseminated more effectively to highlight the support available to members?
• How can the role of the specialty adviser be developed – is there a need for such a role at present? How could the role be developed to meet needs?
• Are ROs following a pragmatic approach at present and adopting local solutions?
• One respondent described the college suggestions for CPD as ‘excessive’ where a doctor had a limited scope of practice / worked less than full time. Do you agree?
• Have ROs received feedback from doctors expressing concern about the quantity of supporting information required (e.g. number of case-based discussions)? Could the college guidance be more specific or place greater emphasis on the nature of the SI rather than the amount?
APPENDIX 5
FOCUS GROUP REPORT

Introduction

The focus groups were conducted at the Royal College of Physicians by senior members of the Education Department on 3rd December 2013. The focus group participants were all volunteers and drawn from both primary and secondary care, although General Practitioners were in the majority. There were fifteen attendees. The focus groups were convened to ascertain the views of appraisees and appraisers on the effectiveness of the specialty guidance (SG) from the Colleges and Faculties in supporting the appraisal and revalidation process. The specialties represented in the focus groups were; Haematology/Transfusion medicine, Obstetrics and gynaecology, Anaesthetics, Medical Microbiology, General Practice, Ophthalmology, Paediatric Cardiology and Paediatric Palliative Medicine.

The appraisee focus group participants were asked a range of questions and their answers are summarised below:

Did you use any specialty guidance documents developed by the Colleges and Faculties to support you with your appraisal? If so, what were they and how useful were they?
The majority of participants stated that they had used the specialty guidance and that it had been broadly useful. However it was noted by a number of participants that some guidance was not available for subspecialties such as transfusion medicine. Comments that reflected the tone of the group noted that the SG was ‘useful in preparing for an appraisal’ and that it ‘provided a broad view of the required documentation’. However some participants also noted that the guidance was ‘not as helpful to someone in a non-standard specialty’.

Please comment on the accessibility of the specialty guidance that you used.
The group were unanimous that the specialty guidance was easy to access and readily available.

Please comment on the clarity of the SG and that you used. Was the quality and quantity of the supporting information clear to you?
The response was more mixed, with some criticism around the complexity of the information and the revisions of the documents had caused some confusion. Terminology also caused some confusion between specialties, with secondary care and general practice interpreting the meaning of a SUI very differently.

Is the specialty guidance sufficiently clear in emphasising the quality of the supporting information required as opposed to the quantity?
Most members of the group felt that the SG did not give sufficient emphasis to quality of the supporting information required, although two participants felt it was fine. Some participants also asked for more examples to be included, for example a reflection.
To what extent did the specialty guidance support you in identifying each of the 6 types of supporting information required by the GMC?

Much discussion around what exactly a SUI is, which again reflected possible differences in interpretation between primary and secondary care. A number of participants felt that the quality improvement activity was not clear and needed greater clarification. Comments included ‘Quality improvement activity not clear’, ‘QI activity not sufficient detail’ and QI confusing’.

Also much discussion around CPD with issues being raised relating to the quality of the CPD although generally the participants were clear on the quantity required. Some participants also noted that the guidance was not clear and ambiguous on reviewing compliments and complaints – “what is learnt from reviewing compliments?” Compliments and complaints seen as difficult to gather by pathologists.

How easy was it to meet the requirements of the specialty guidance under each of the headings?

Overall the participants found it relatively straightforward for standard clinical roles, but more challenging under other roles such as medical education or leadership. Many found the process ‘time consuming but not difficult’ and ‘doable’. Some participants found QI challenging.

Was the GMC revalidation threshold with respect to supporting information different to that established by the specialty guidance from Colleges and Faculties?

Most participants didn’t think there was a difference. However, a few individual comments noted the following:

- “The bar for GMC revalidation was set lower”
- “I believe the feedback amounts are out of synch”
- “More detail given by College guidance”

Was your appraiser from within or without your specialty? In either case how familiar were they with the specialty guidance that applied to you?

The overwhelming number of participants had an appraisal by someone from the same specialty and felt confident that they were familiar with the specialty guidance. Comments included ‘Fully aware, within my specialty. All seemed well informed’, and ‘Good, well aware’.

The small number who had an appraiser from outside their specialty all seemed satisfied that they were familiar with the guidance, with comments such as ‘although there were subtle differences the idea was the same’ and ‘without, this was a far better appraisal’.

Focus group discussion for appraisers

A much smaller group of appraisers, four in total, were asked to discuss any particular issues that the had encountered with the specialty guidance. There were two GPs, a physician and O&G surgeon. The main focus of their concerns was around assessing the quality of the supporting information and how helpful the specialty guidance had been in making the assessment.
The group were unanimous that this was a challenging area. Comments which reflected this concern were:

- “Absolutely useless. I’m flying by the seat of my pants!” (GP)
- “There is one sentence that says your appraiser would rather see quality rather quantity, but it is hidden in the middle of a large College document and it needs to be clearer.” (GP)
- “I think the bottom line is actually that they have engaged with the process” (GP)
- There was also concern with the lack of guidance regarding the quantity of supporting information required, with an O&G surgeon stating “Some people put everything in - I don’t think there is any guidance from the college about quantity.”
- The GPs present also mentioned the issue of interpreting a SUI and felt this was a need for more guidance.
- “There is a difference in practice in terms of what we call a significant incident and what the GMC term a SUI”
- “We need more guidance on what it (SUI) means.”
APPENDIX 6
CORE FRAMEWORK ANALYSIS

The Academy of Medical Royal Colleges published core guidance on the supporting information for revalidation in June 2012. Each college and faculty appended their specialty-specific guidance to the core framework and published at the same time.

In 2013, the Academy Specialty Guidance Group completed work to assess the usefulness of the specialty guidance on supporting information for revalidation. The group used the following methods:

- Surveys of doctors, appraisers and ROs
- A review of helpdesk enquiries across colleges and faculties
- Focus groups of doctors and appraisers.

In the main, respondents to the survey were positive about the supporting information guidance but their comments suggest changes that could be made to improve the guidance.

This document details the issues raised about the guidance, which might be resolved through changes to the core guidance. It does not compile feedback relevant to individual specialties; the raw data will be supplied for colleges and faculties to lead their own review. It includes the response of the Specialty Guidance Group and the resulting action to be taken. The document is for discussion with the ARSG on 28 January 2014. Following this meeting, changes will be made to the core guidance and the document returned to the ARSG for consultation.

Section: Introduction and about this document (includes general feedback not relating to one of the 6 areas of supporting information)

<table>
<thead>
<tr>
<th>Issue</th>
<th>Source</th>
<th>SGG response</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPAs and job planning for revalidation – how many SPAs should be stipulated for revalidation and preparation for revalidation?</td>
<td>Helpdesks Appraisee survey</td>
<td>AoMRC guidance from 2010 estimated: “the minimum number of SPAs allowed for this purpose should be 1.5 per week, not including annual study leave… If a consultant is employed with 2 or fewer SPAs, any problems with revalidation should lead to an urgent review of the SPA allocation”.</td>
<td>Reference in core guidance if still agreed upon</td>
</tr>
<tr>
<td>Is the quality of the information supplied more important than the quantity of information supplied?</td>
<td>Focus group RO survey</td>
<td>In general, the answer to this from the RST and colleges and faculties has been ‘yes’. However, we need to be careful in any changes to the wording of the guidance. 10% of doctors have been deferred due to a</td>
<td>Change to be discussed</td>
</tr>
</tbody>
</table>

84
Doctors do not know how much information to present.  

| The guidance is ‘bland’ and ‘wordy’ | Appraiser survey  
| The college and faculty guidance does not provide sufficient detail. | Appraiser survey  
| As revalidation continues to evolve, the guidance should avoid being too prescriptive. | RO survey  

| The college and faculty guidance sets the bar higher than the requirements of the GMC. Meeting college and faculty requirements takes up extra time. | Appraiser survey  
| It is unclear how the college and faculty guidance relates to the GMC guidance. | Appraiser survey  
| The college and faculty guidance does not provide sufficient detail. | RO survey  
| The college and faculty guidance does not add anything to other guidance available. |  

| The guidance does not provide practical examples. Examples of reflection would be useful. | Focus group  
|  

| lack of supporting information. The appraiser and RO will judge whether they believe that there is sufficient information. |  
| There is a tension throughout the survey responses between those wanting more detail and those wanting brevity. We will edit the core guidance where possible. |  
| There is disagreement amongst the responses on how the college and faculty guidance should be approached. For some, the college and faculty guidance sets a ‘gold standard’ above what the GMC requires for revalidation. For others, college and faculty requirements should set a higher bar and be more detailed. |  
| We need to make a clearer distinction in the guidance between the ‘should dos’ that stem from the duty of the colleges and faculties to promote clinical excellence, and the requirements of revalidation as stipulated by the GMC. We may wish to state that revalidation is a minimum threshold. |  
| We could provide examples of reflective practice within the guidance. Practical examples are likely to be more effective when provided by each specialty. One RO commented that there is a useful reflective template in one of the guidance documents. Colleges and faculties can share best practice. |  

| Edit core guidance  
| Changes to the core guidance – to be discussed  
| Additions to the core guidance – to be discussed  
| Colleges and faculties to consider practical examples. |
The length of time it has taken to collect the necessary supporting information. Complaints about the bureaucracy of the exercise.

Appraisee survey

Whilst we believe that the process will become less burdensome in time, we should encourage doctors to prepare for appraisal and revalidation throughout the year rather than in the final days leading up to the appraisal date. Time spent on preparation and reflection benefits the appraisal discussion and avoids the often complained about ‘tick-box exercise’

Changes to the core guidance – to be discussed

There is insufficient guidance for non-clinical roles, particularly medical education and leadership.

Focus Group Helpdesks

We should revisit the guidance for managers and leaders, academics, and medical educators and work with the relevant organisation to update guidance where required.

No changes to core guidance. To work with organisations supporting non-clinical doctors.

The guidance is insufficient for sub-specialties.

Focus Group Appraisee survey

Changes cannot be made to the core guidance to meet all specialty requirements. Colleges and faculties have worked collaboratively on supporting information guidance in order to ensure that the bar for one specialty is not deemed to be higher than another. Sub-specialties within colleges and faculties have raised this issue previously. The RCP published ‘resource guides’ for its physician specialties in 2013. These were written by representatives of the physician-specialties but within a tight framework supplied by the RCP. The RCP reviewed all guides to ensure that specialties were not setting a higher bar for revalidation.

No change to the core guidance. Colleges and faculties to consider needs within their own sub-specialties.

Checklists are very helpful

RO survey

We will ensure that the checklist in the guidance is up to date and well publicised.

Potential update

The guidance does not aid those working outside of the NHS.

Appraisee survey

Unclear as to how to approach this as revalidation requirements are consistent regardless of employer.

No change – to be discussed.

Section: General information

<table>
<thead>
<tr>
<th>Issue</th>
<th>Source</th>
<th>SGG response</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>The minimum number of sessions, cases or procedures required to revalidate.</td>
<td>Helpdesks Appraiser survey</td>
<td>Most specialties will not set a minimum number of sessions required to revalidate. Revalidation for part-time doctors is the same for full-time doctors. However, some specialties may require their professionals to</td>
<td>No change to core guidance –</td>
</tr>
</tbody>
</table>
### Section: Keeping up to date

<table>
<thead>
<tr>
<th>Issue</th>
<th>Source</th>
<th>SGG response</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors are collecting sufficient credits for revalidation but not focussing on reflection.</td>
<td>Helpdesks</td>
<td>We can promote reflection throughout the guidance.</td>
<td>Changes to the core guidance – to be discussed.</td>
</tr>
<tr>
<td>The guidance is not clear about the quality of CPD.</td>
<td>Focus Group</td>
<td>This may be a specialty by specialty issue.</td>
<td>Any changes to be discussed.</td>
</tr>
</tbody>
</table>

### Section: Review of practice

<table>
<thead>
<tr>
<th>Issue</th>
<th>Source</th>
<th>SGG response</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater clarity is needed around quality improvement activity, particularly outcomes and case reviews.</td>
<td>Focus Group Appraisee survey</td>
<td>This issue has been raised before with the Guidance Group. As the core guidance cannot go much further than the GMC guidance on quality improvement activity, this may be a specialty by specialty issue.</td>
<td>To be discussed.</td>
</tr>
<tr>
<td>There is still confusion of the definition of Significant Untoward Incidents.</td>
<td>Focus Group</td>
<td>The core guidance should align with the GMC guidance. However, colleges and faculties can refine their guidance to ensure the terminology meets their requirements.</td>
<td>No changes to core guidance. Specialty guidance to be reviewed by each college and faculty.</td>
</tr>
<tr>
<td>Outcome data for most specialties reflects team rather than individual performance.</td>
<td>Helpdesk</td>
<td>An issue for specialty guidance.</td>
<td>No changes to core guidance.</td>
</tr>
</tbody>
</table>
### Section: Feedback on professional practice

<table>
<thead>
<tr>
<th>Issue</th>
<th>Source</th>
<th>SGG response</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is insufficient guidance on patient feedback and it continues</td>
<td>Helpdesks</td>
<td>We believe that this is a specialty by specialty issue but that the Academy</td>
<td>No changes to core guidance. Specialty guidance to be reviewed by each</td>
</tr>
<tr>
<td>to be an area of concern in certain specialties. This issue</td>
<td>Appraisee survey</td>
<td>should look at patient feedback processes as a larger issue.</td>
<td>college and faculty.</td>
</tr>
<tr>
<td>generated a large number of free text responses in the appraisee</td>
<td>RO survey</td>
<td></td>
<td></td>
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<tr>
<td>survey.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is insufficient guidance on which tools for colleague and</td>
<td>Helpdesks</td>
<td>Is this information available? It would be too lengthy to include in the</td>
<td>To discuss</td>
</tr>
<tr>
<td>patient feedback have been validated for the purposes of revalidation.</td>
<td></td>
<td>guidance but we could reference a source.</td>
<td></td>
</tr>
<tr>
<td>Using team or organisational-level patient feedback data for an</td>
<td>Helpdesks</td>
<td>We should raise this with the GMC before making changes to the core framework.</td>
<td>No change at present.</td>
</tr>
<tr>
<td>individual appraisal.</td>
<td></td>
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</tbody>
</table>

### Section: Complaints and Compliments

<table>
<thead>
<tr>
<th>Issue</th>
<th>Source</th>
<th>SGG response</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>The purpose of reviewing complaints and compliments is unclear. What</td>
<td>Focus Group</td>
<td>We can highlight the need for reflection on all pieces of supporting</td>
<td>Change to core guidance – to be discussed.</td>
</tr>
<tr>
<td>is learnt through this process (particularly compliments)??</td>
<td></td>
<td>information. Reviewing compliments allows the doctor to consider what</td>
<td></td>
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<td></td>
<td></td>
<td>has gone particularly well during the year, which is as important and</td>
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<td></td>
<td></td>
<td>learning from mistakes.</td>
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</tbody>
</table>
APPENDIX 7
HELPDESK ENQUIRY TEMPLATE

Contents

• Instructions for use
• Section 1: College/Faculty details
• Section 2: Information on all (generic and specialty related) enquiries received
• Section 3: Further information for the working group

Instructions for use

All colleges and faculties are requested to provide the following information to the Academy working group:

• The number of enquiries received in each of the main framework categories from 1st January 2013 to 30th September 2013.

• A brief descriptive summary of those enquiries received and responses provided (if not an FAQ) in each of the categories.

• Any comments you would like to make where you feel that there is a lack of information/guidance in answering an enquiry or relate to issues that are proving a particular challenge within your specialty.

The types of enquiries defining each main category are found in Appendix A at the end of this document. An example of a completed form is attached with this document.

This form is to be completed and submitted to Helen Brownridge (RCP Revalidation Coordinator) at Helen.Brownridge@rcplondon.ac.uk. If you require any assistance please email or call 020 3075 1611. Please return your form between 1st and 15th October 2013.
SECTION 1: College/Faculty details

1.1 Name of College or Faculty (please indicate)


1.2 Main contact information

Name:
Email address:
Telephone number:

1.3 Does your college provide a revalidation helpdesk function on behalf of another organisation (e.g. faculty)? Please tick.

No:
Yes, if so please state which organisation(s):

SECTION 2: Information on all (generic and specialty related) enquiries received between 1st January 2013 and 30th September 2013

<table>
<thead>
<tr>
<th>Main categories</th>
<th>Information requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Content of practice</td>
<td>Number of enquiries received:</td>
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<tr>
<td></td>
<td>Summary:</td>
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<td></td>
<td>Comments/Challenging Issues:</td>
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<tr>
<td>2.2 Professional circumstances</td>
<td>Number of enquiries received:</td>
</tr>
<tr>
<td></td>
<td>Summary:</td>
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<tr>
<td></td>
<td>Comments/Challenging Issues:</td>
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<tr>
<td>2.3 Revalidation requirements</td>
<td>Number of enquiries received:</td>
</tr>
<tr>
<td></td>
<td>Summary:</td>
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<tr>
<td></td>
<td>Comments/Challenging Issues:</td>
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<tr>
<td>2.4 Appraisal</td>
<td>Number of enquiries received:</td>
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<tr>
<td></td>
<td>Summary:</td>
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<tr>
<td></td>
<td>Comments/Challenging Issues:</td>
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<tr>
<td>2.5 Keeping up to</td>
<td>Number of enquiries received:</td>
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<tr>
<td>Date</td>
<td>Summary:</td>
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<td>------</td>
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<tr>
<td>2.6</td>
<td>Review of practice</td>
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<td>2.7</td>
<td>Feedback on practice</td>
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<tr>
<td>2.8</td>
<td>Performance</td>
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<tr>
<td>2.9</td>
<td>Other enquiries (not fitting into the above categories)</td>
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<td></td>
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</tbody>
</table>

**SECTION 3: Further information for the working group**

3.1 Please state the total number of enquiries received as identified in Section 2.

Total number of enquiries: [ ]

3.2 How many of these enquiries were regarded as specialty-specific requiring a response or input into a response from a college or faculty specialty advisor(s)? If a precise figure is not available please state an approximation.

Number of specialty-specific enquiries: [ ]

3.3 Further information for the working group

The intention of this exercise is to provide information to the working group so that they can make recommendations to colleges and faculties in the running of their helpdesks, provision of
revalidation advice and updating of core supporting information guidance. Information collected from this exercise will also feed into the development of core FAQs hosted on the Academy’s website. Any further information to help the working group in its task would be welcomed.

Further information for the working group:

Thank you for your help – please email your completed form to Helen Brownridge (RCP Revalidation Co-ordinator) at Helen.Brownridge@rcplondon.ac.uk
## Types of enquiries defining each of the main framework categories

<table>
<thead>
<tr>
<th>Main Categories</th>
<th>Type of Enquiries – Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Content of practice</strong></td>
<td>• Academic practice&lt;br&gt;• Change of specialty&lt;br&gt;• Extended practice (incl GPwSI)&lt;br&gt;• Independent/private practice&lt;br&gt;• Multi-specialty practice&lt;br&gt;• Non-clinical work&lt;br&gt;• Scope of practice&lt;br&gt;• Unusual roles</td>
</tr>
<tr>
<td><strong>Professional circumstances</strong></td>
<td>• Exceptional circumstances&lt;br&gt;• Locums&lt;br&gt;• Non-NHS settings (e.g. Defence Medical Services)&lt;br&gt;• Out of hours&lt;br&gt;• Part-time working&lt;br&gt;• Retired clinicians&lt;br&gt;• Return to work/time out of practice&lt;br&gt;• SAS queries&lt;br&gt;• Trainees&lt;br&gt;• Working Outside UK/Overseas doctors</td>
</tr>
<tr>
<td><strong>Revalidation requirements</strong></td>
<td>• PCO requirements for revalidation&lt;br&gt;• Revalidation eligibility/non eligibility&lt;br&gt;• SPAs&lt;br&gt;• Supporting information&lt;br&gt;• Time scales and rollout</td>
</tr>
<tr>
<td><strong>Appraisal</strong></td>
<td>• Appraisal dates&lt;br&gt;• Appraisal forms&lt;br&gt;• Appraisal process&lt;br&gt;• Appraisers&lt;br&gt;• Workforce/job planning</td>
</tr>
<tr>
<td><strong>Keeping up to date</strong></td>
<td>• Continuing professional development&lt;br&gt;• CPD/Learning credits&lt;br&gt;• CPD matrix/knowledge areas&lt;br&gt;• Personal development plans&lt;br&gt;• Skills [i.e. keeping skills up to date/re-skilling/re-training]</td>
</tr>
<tr>
<td><strong>Review of practice</strong></td>
<td>• Case reviews&lt;br&gt;• Clinical audit&lt;br&gt;• Clinical outcomes&lt;br&gt;• HES – Hospital Episode Statistics&lt;br&gt;• p-CAT [personal clinical audit tool]&lt;br&gt;• Quality improvement&lt;br&gt;• Significant events</td>
</tr>
<tr>
<td><strong>Feedback on practice</strong></td>
<td>• Colleague feedback&lt;br&gt;• Complaints&lt;br&gt;• Compliments&lt;br&gt;• Feedback from supervision and teaching&lt;br&gt;• GP &amp; Patient Questionnaires&lt;br&gt;• Patient feedback&lt;br&gt;• Multisource feedback (MSF)</td>
</tr>
<tr>
<td><strong>Performance</strong></td>
<td>• Health&lt;br&gt;• Performance concerns&lt;br&gt;• Probit&lt;br&gt;• Remediation</td>
</tr>
<tr>
<td><strong>Other enquiries (not fitting into the above categories)</strong></td>
<td></td>
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</tbody>
</table>