

**Independent Evaluation of  
the Medical Revalidation  
Pathfinder Pilot**

**Final Report**

**Summary Report**

**Department of Health /  
Revalidation Support Team**



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## Independent Evaluation of the Medical Revalidation Pathfinder Pilot

### Report for Department of Health / Revalidation Support Team

This report and the accompanying Technical Annex contain the findings from the independent evaluation of the Medical Revalidation Pathfinder Pilot undertaken between 1 April 2010 and 31 March 2011.



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# Independent Evaluation of the Medical Revalidation Pathfinder Pilot

## Report for Department of Health / Revalidation Support Team

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## Executive Summary

This report has been prepared by Frontline Consultants and Durham University for the Department of Health (DH) and the Revalidation Support Team (RST). It provides details of the evaluation of the Pathfinder Pilots based on the survey data received from March 2010 to 30 April 2011.

The Pathfinder Pilot involved ten pilot sites where over 3,000 doctors undertook strengthened medical appraisal. The evaluation process involved surveying doctors and their employers to establish their experience with the current appraisal system as a baseline, and then conducting a follow-up survey of their experiences with strengthened medical appraisal during the 12-month Pathfinder Pilot. Interviews and focus groups were also held to provide in-depth information.

Over 11,000 of the various survey forms were received. A high response rate was achieved; 2,405 appraisees (79% response rate) responded to the baseline survey, and 2,169 (72% response rate) responded to the follow-up survey. Of the appraisees who responded, 924 (42.7%) are employed in acute care, 927 (42.8%) are in primary care and 210 (9.7%) are in mental health care.

The following are the key findings from this evaluation along with our recommendations for the future.

### Overall conclusions

When asked during the Pathfinder Pilot, there was a statistically significant increase in the levels of agreement with the statement: 'I improved the way I deliver care as a result of my appraisal' for acute and mental health care. In primary care, the level of agreement remained at a similar high level before and after the Pathfinder Pilot.

In acute care, the number of appraisees participating in significant event/case reviews increased from 47% to 75% during the Pathfinder Pilot. In mental health care, the number of appraisees participating in significant event/case reviews increased from 52% to 84% during the Pathfinder Pilot.

There was confidence to make revalidation decisions on the basis of the information provided, as 58% of the responsible officer respondents agreed with the statement 'I would be confident to make revalidation recommendations based on all of the information provided'.

Around half of the organisations will be looking to enhance the way that doctors undertake continuing professional development (CPD) including guidance on the most appropriate CPD and monitoring the effectiveness of that CPD. As CPD is seen by appraisers as one of the most valuable activities for evaluating doctors' standards of practice and planning how to improve patient care, this is a potential benefit in a key area.

Nearly two-thirds of the organisations will be making changes to ensure that remediation has been successful including formalising the process and evaluating the effectiveness of those processes.

### **A simplified system is needed**

Evidence from the evaluation suggests that, whilst some attributes were easier than others, providing supporting information on each of the 12 attributes was difficult for the appraisees, for example because it was not clear what would be suitable supporting information for that attribute, and it was not always easy for appraisers to make an assessment against the attribute.

**Recommendation** – Work should be undertaken to establish which attributes are necessary for appraisal, and to rationalise the information requirements for those attributes.

### **Guidance is required on what supporting information to provide**

Appraisees found it difficult to establish what supporting information was required for some attributes and how much needs to be submitted, and appraisers found it difficult to assess that information. Both appraisees and appraisers indicated that they would value guidance on what supporting information to provide, and would particularly value definitive guidance on the type and standard of supporting information which should be provided for each attribute.

**Recommendation** – Guidance should be produced to ensure consistency of effort and quality.

### **The time required to prepare for the appraisal increased**

In preparing for the appraisal, doctors were required to search out supporting information and become familiar with both the strengthened medical appraisal system and the accompanying toolkit. This took additional time in the Pathfinder Pilot when compared to the previous appraisal system. However, the preparation time was shorter during the Pathfinder Pilot in the University Hospitals of Leicester NHS Trust pilot site where an in-house toolkit was used, although there may be other confounding factors that also influence the time taken within individual pilot sites.

**Recommendation** – The findings from the University Hospitals of Leicester NHS Trust pilot site should be investigated further to see what lessons can be learned for the national roll out.

### **Application of common standards to appraisal is valued**

Doctors valued a common approach to appraisal that would be the same wherever they practised.

**Recommendation** – Any future appraisal system should contain enough specification to ensure commonality of outcomes.

### **Responsible officers welcomed the oversight of appraisal information**

The toolkit provided responsible officers with the ability to look at appraisal information, and make sure that appraisers had appraised their appraisees in a suitable manner. This feature was welcomed by responsible officers.

**Recommendation** – This oversight should be available in the future appraisal system, as responsible officers need to assure themselves that quality is being achieved and maintained.

### **The quality of appraisals improved during the pathfinder Pilot**

Feedback from the evaluation indicates that the requirements for appraisees to prepare and reflect on their practice and for appraisers to review material beforehand had been strengthened. Appraisees' views on their appraisers have become more positive during the Pathfinder Pilot, with statistically significant increases in the levels of agreement for all three health sectors to the statements: 'Appraisers performed the appraisal well' (86% of respondents were in agreement after the Pathfinder Pilot compared with 74% in the baseline) and 'The appraiser was objective' (91% of respondents were in agreement after the Pathfinder Pilot compared with 81% in the baseline).

**Recommendation** – The future appraisal system should maintain these improvements.

### **Pathfinder Pilot organisations and responsible officers were very positive about the potential benefits of revalidation, whilst appraisees and appraisers were less so**

When asked about the benefits of both strengthened medical appraisal and revalidation, responsible officers and pilot organisations were more positive about the benefits than appraisees and appraisers. Over 80% of the responding Pathfinder Pilot organisations and over 70% of the responsible officers expected the full roll-out of revalidation to lead to improved patient safety, improved quality of care and improvements in patient experience. Understanding why there are such differences in perceptions and addressing them would help in the roll out of both a future appraisal system and revalidation.

**Recommendation** – Work should be undertaken to establish why responsible officers and pilot organisations have a much more positive view, and identify what lessons could be learned and communicated to appraisees and appraisers.

### **Working within local networks can reduce the risk of responsible officers having conflicts of interest**

Responsible officers felt that they should not act as responsible officers for every doctor in their organisation (e.g. where they work closely with colleagues), as they felt that the role requires high standards of impartiality. On the limited occasions when this did occur, responsible officers suggested that it could be addressed by having local networks of responsible officers. This underlines the need for robust clinical governance so that responsible officers fulfil their role, including making recommendations to the GMC, in a clear and accountable manner.

**Recommendation** – Responsible officers should work within networks to ensure alternative arrangements for review of doctors' performance can be made where necessary.

### **Responsible officers need continuous access to a range of information to make recommendations**

Responsible officers recognised the need for a range of high quality information to make recommendations. They also recognised the need to be kept continuously alerted to emerging issues. Appraisal is an important source of information. However, it is not the only source of information from which responsible officers will receive information on doctors' practice. Appraisals are annual, but other sources provide alerts on a continuing basis.

**Recommendation** – Information systems be implemented such that responsible officers receive high quality information on a continuous basis so that they are aware of emerging issues with doctors' practice.

### **Key areas for evaluating doctors' standards of practice have been identified**

In the Pathfinder Pilot, appraisers identified the key areas to focus on in evaluating doctors' standards of practice. Appraisers in all three health sectors considered the following as the most valuable activities in evaluating doctors' standards of practice:

- continuing professional development
- audits/informal data review

In acute and mental health care, appraisers also considered feedback from colleagues to be valuable for evaluating doctors' standards of practice. In primary care, appraisers also considered significant event/case reviews to be valuable.

**Recommendation** – The future appraisal system should be prioritised and focused on the areas that are most significant for evaluating doctors' standards of practice.

### **Key areas for planning how doctors can improve patient care have been identified**

The appraisal system both looks backwards in evaluating standards of practice, and also seeks to identify ways which will improve patient care in the future. In the Pathfinder Pilot, appraisers identified the key areas for doctors to focus on in planning how to improve patient care. Appraisers in all three health sectors considered the following to be the most valuable activities in planning how to improve patient care:

- audits/informal data review
- significant event/case reviews

In acute and mental health care, appraisers also considered review of complaints to be valuable, whilst in mental health care and primary care, appraisers also considered continuing professional development to be valuable. These activities are similar to but not exactly the same as those which were found to be valuable for evaluating doctors' standards of practice.

**Recommendation** – The future appraisal system should be prioritised and focus on the areas that are most significant for planning how doctors can improve patient care.

### **Locum doctors are not always able to access supporting information**

Evidence from the evaluation suggests that locum doctors do not always get access to practice information, and it is difficult for them to access supporting information. For example, they are sometimes excluded from practice meetings as they are not employees of the practice, and not given access to the related data. Given that appraisals should focus on doctors' whole practice, the difficulty in obtaining the supporting information makes it difficult for locum doctors to satisfy the appraisal requirements and difficult for appraisers and responsible officers to get a picture of the locum doctors' whole practice.

**Recommendation** – Systems should be developed such that locum doctors get access to the supporting information required to meet the appraisal requirements.

### **Lessons learned by organisations that formalised their appraisal systems as part of the Pathfinder Pilots would be valuable to other organisations that need to formalise their appraisal systems for the roll out of revalidation**

The Pathfinder Pilot has shown that some organisations are advanced in the implementation of formal appraisal systems, whilst others needed to formalise their appraisal systems to meet the requirements of strengthened medical appraisal. This experience will be valuable during the implementation of revalidation, and the lessons learned from the organisations that are well through the process should be shared with other organisations nationally to achieve consistent standards in an efficient manner.

**Recommendation** – The best practices achieved by organisations in the Pathfinder Pilot should be identified and the lessons learned shared with organisations nationally.

# 1 Introduction

This report has been prepared by Frontline Consultants and Durham University for the Department of Health (DH) and the Revalidation Support Team (RST). It provides details of the evaluation of the Pathfinder Pilot based on the survey data received from March 2010 to 30 April 2011.

The key findings are discussed in this report. The evidence base is contained in a separate Technical Annex.

## 1.1 Background to the Pathfinder Pilot

Medical revalidation is a policy that has been devised to enable doctors to demonstrate they are up to date and fit to practice, through a proposed system of strengthened medical appraisal, patient and colleague feedback, and improved clinical governance. The system has been devised to provide a focus for doctors' efforts to maintain and improve their practice and for most it will be a positive affirmation. In future, successful revalidation will be required for a doctor to continue to hold a Licence to Practise.

The purpose of revalidation is to assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and fit to practise. In the model for revalidation the recommendation that a doctor should be revalidated, and effectively re-licensed, will depend on satisfactory completion of five annual appraisals, patient and colleague feedback, evidence of continuing professional development, reviews of complaints and relevant information about clinical outcomes.

Revalidation will build on existing processes, strengthening them to meet the needs of regulation and to ensure greater consistency. For the vast majority of doctors, the more systematic annual appraisal will provide the basis for reflective practice and improvement, an essential developmental process. For the small proportion of doctors about whom there may be concerns (including health, professional practice and professional conduct), the strengthening of local clinical governance and an objective annual appraisal provides the means for identifying problems earlier and either putting in place remediation or, if not possible, taking steps to remove them from clinical practice.

In order to obtain information on the proposed system before implementation of the policy, the 'Pathfinder Pilot' was designed by the Revalidation Support Team (RST) and the Department of Health (DH). Our independent evaluation was asked to look at the following objectives:

1. To test whether the proposed components of medical revalidation, such as strengthened medical appraisal, are practical and as efficient as possible, whilst at the same time achieving the desired outcome
2. To produce an evidence base regarding costs and benefits of each element of medical revalidation, as well as the whole, to shape the development of the policy and inform a full business case to HM Treasury for the implementation of medical revalidation
3. To provide proof of concept and build understanding and support within providers of medical care (the NHS in the first instance), and within the medical profession, for the implementation of medical revalidation

The Pathfinder Pilot involved ten pilot sites. In some sites and organisations, participants were volunteers (referred to as “opt-in” pilot sites), and in some areas and organisations, all qualified doctors were expected to take part in the Pathfinder Pilot (referred to as “opt-out” pilot sites). Each pilot site was supported by one or more Royal Colleges. Details of the ten pilot sites, including which Royal College supported that pilot site, are set out in the table below.

**Table 1 Pilot sites participating in the Pathfinder Pilots**

Pilot site	Organisations	Coverage	Academy / Royal College link
London Deanery (Coordinated pilot)	<ul style="list-style-type: none"> <li>• Bexley NHS Care Trust</li> <li>• NHS Brent</li> <li>• NHS Bromley</li> <li>• NHS Ealing</li> <li>• NHS Enfield</li> <li>• NHS Greenwich</li> <li>• NHS Haringey</li> <li>• NHS Harrow</li> <li>• NHS Hounslow</li> <li>• NHS Kingston</li> <li>• NHS Lambeth</li> <li>• NHS Lewisham</li> <li>• NHS Newham</li> <li>• NHS Redbridge</li> <li>• NHS Southwark</li> <li>• NHS Sutton and Merton</li> <li>• NHS Tower Hamlets</li> <li>• NHS Waltham Forest</li> <li>• NHS Wandsworth</li> <li>• NHS Westminster</li> </ul>	<ul style="list-style-type: none"> <li>• Primary care</li> <li>• Opt in</li> </ul>	Royal College of General Practitioners
NHS Dorset	<ul style="list-style-type: none"> <li>• NHS Dorset</li> </ul>	<ul style="list-style-type: none"> <li>• Primary care</li> <li>• Opt out</li> </ul>	Royal College of General Practitioners
Cornwall (Collaborative pilot)	<ul style="list-style-type: none"> <li>• NHS Cornwall and Isles of Scilly</li> <li>• Royal Cornwall Hospitals NHS Trust</li> <li>• Cornwall Partnership NHS Foundation Trust</li> </ul>	<ul style="list-style-type: none"> <li>• Primary care, acute care, mental health</li> <li>• Primary care – opt in</li> <li>• Secondary care – opt out</li> </ul>	Royal College of Surgeons of England
Mersey consortium (Collaborative pilot)	<ul style="list-style-type: none"> <li>• Aintree University Hospital NHS Foundation Trust</li> <li>• Alder Hey Children’s NHS Foundation Trust</li> <li>• Mersey Care NHS Trust</li> <li>• The Royal Liverpool and Broadgreen University Hospitals NHS Trust</li> <li>• Southport and Ormskirk Hospital NHS Trust</li> <li>• Wirral University Teaching Hospital NHS Foundation Trust</li> </ul>	<ul style="list-style-type: none"> <li>• Acute care, mental health</li> <li>• Opt in</li> </ul>	Royal College of Physicians of London Royal College of Ophthalmologists

Pilot site	Organisations	Coverage	Academy / Royal College link
Northampton General Hospital NHS Trust	<ul style="list-style-type: none"> <li>Northampton General Hospital NHS Trust</li> </ul>	<ul style="list-style-type: none"> <li>Acute care</li> <li>Opt out</li> </ul>	Royal College of Obstetrics & Gynaecologists Royal College of Radiologists
University Hospitals of Leicester NHS Trust	<ul style="list-style-type: none"> <li>University Hospitals of Leicester NHS Trust</li> </ul>	<ul style="list-style-type: none"> <li>Acute care</li> <li>Opt out</li> </ul>	Royal College of Pathologists Royal College of Anaesthetists
Nottinghamshire / Derbyshire	<ul style="list-style-type: none"> <li>Nottinghamshire Healthcare NHS Trust</li> <li>Derbyshire Healthcare NHS Foundation Trust</li> </ul>	<ul style="list-style-type: none"> <li>Mental health</li> <li>Opt out</li> </ul>	Royal College of Psychiatrists
NHS South Central (Collaborative pilot)	<p>Core organisations:</p> <ul style="list-style-type: none"> <li>Milton Keynes whole health economy: NHS Milton Keynes and Milton Keynes Hospital NHS Foundation Trust</li> <li>NHS Isle of Wight whole health economy: St Mary's Hospital, mental health, GPs</li> <li>Royal Berkshire NHS Foundation Trust</li> </ul> <p>All the remaining South Central organisations</p>	<ul style="list-style-type: none"> <li>All health sectors</li> <li>Opt out for core organisations</li> <li>Opt in for all other organisations</li> </ul>	Royal College of Paediatrics and Child Health
NHS West Midlands	All organisations within the region	<ul style="list-style-type: none"> <li>All responsible officers</li> </ul>	Royal College of Physicians of London
Yorkshire and the Humber region (Collaborative pilot)	<ul style="list-style-type: none"> <li>The Leeds Teaching Hospitals NHS Trust</li> <li>NHS Rotherham</li> <li>NHS Sheffield</li> <li>NHS Doncaster</li> <li>Rotherham Doncaster and South Humber NHS Foundation Trust</li> <li>NHS North Yorkshire and York</li> <li>York Teaching Hospital NHS Foundation Trust</li> </ul>	<ul style="list-style-type: none"> <li>All health sectors</li> <li>Leeds – whole division of Surgery and Oncology opt out</li> <li>York – opt in</li> <li>Primary care – opt in</li> <li>Mental health – opt out</li> </ul>	College of Emergency Medicine

The Pathfinder Pilot tested the strengthened medical appraisal process supported by the Revalidation Pilot Toolkit (the 'toolkit'), apart from the University Hospitals of Leicester NHS Trust which used a system developed in-house. The Pathfinder Pilot process did not formally include patient and colleague feedback. Patient and colleague feedback only made up part of the process where organisations already had it in place; it was not mandated for the Pathfinder Pilot.

Responsible officers were not formally required to comment on doctors' fitness to practise as part of the Pathfinder Pilot, but they were provided with the information they would have received and were able to judge whether they would be comfortable to make fitness to practise decisions.

## 1.2 Scope of the evaluation

The evaluation of the Pathfinder Pilot is aimed at evaluating the:

- **Impact** – to establish whether the objectives for the Pathfinder Pilot have been met
- **Process** – to establish how appraisals are being undertaken under the current and proposed approaches; and establish what is working well and what is not working so well and, if not, why not and what could be done better
- **Costs and benefits** – to explore what the differences in costs are between the current and proposed approaches to appraisal and what the associated benefits might be

The evaluation covered the views of the appraisee, appraiser and responsible officer participants of the Pathfinder Pilot. The views of the organisations within the Pathfinder Pilot were established through the use of organisational surveys, discussions with responsible officers (who were typically medical directors) and interviews with pilot leads.

## 1.3 Evaluation approach

Our evaluation approach was designed to establish whether DH/RST's objectives for the Pathfinder Pilot had been met. Our approach used the research methods outlined in Table 2. Further detail on each is included in the Technical Annex.

**Table 2** Research methods used in the evaluation of the Pathfinder Pilot

Evaluation activity		Approach	Contribution to the evaluation
1	Large-scale survey of participants	<ul style="list-style-type: none"> <li>• All participants (appraisers and appraisees) in the Pathfinder Pilot were asked to complete baseline forms covering previous experience of appraisal, and post-pilot forms</li> </ul>	<ul style="list-style-type: none"> <li>• Relatively large number of responses</li> <li>• Data on attitudes, experience of the Pathfinder Pilot and resources requirements</li> <li>• Comparison with the baseline</li> </ul>
2	Large-scale survey of responsible officers	<ul style="list-style-type: none"> <li>• All responsible officers were asked to complete quarterly and final forms on their experience on the Pathfinder Pilot</li> </ul>	<ul style="list-style-type: none"> <li>• Data on attitudes, experience of the Pathfinder Pilot and resources requirements</li> </ul>
3	Organisational forms	<ul style="list-style-type: none"> <li>• The organisations involved in the Pathfinder Pilot completed forms at the start and end of the process</li> </ul>	<ul style="list-style-type: none"> <li>• Data on system requirements and costs</li> </ul>
4	Focus groups	<ul style="list-style-type: none"> <li>• Focus groups were held in each pilot site</li> <li>• In total 83 appraisers and appraisees participated in focus group discussions</li> </ul>	<ul style="list-style-type: none"> <li>• Further exploration of issues emerging during the Pathfinder Pilot</li> <li>• Discussion of ideas for improving strengthened medical appraisal and revalidation</li> </ul>

Evaluation activity		Approach	Contribution to the evaluation
5	Face-to-face and telephone interviews with responsible officers	<ul style="list-style-type: none"> <li>23 interviews (default position was face-to-face but telephone interviews were used where necessary)</li> </ul>	<ul style="list-style-type: none"> <li>Further exploration of issues emerging during the Pathfinder Pilot</li> </ul>
6	Face-to-face interviews with pilot leads	<ul style="list-style-type: none"> <li>Ten interviews</li> </ul>	<ul style="list-style-type: none"> <li>Further exploration of issues emerging during the Pathfinder Pilot</li> </ul>
7	Telephone interviews with participants	<ul style="list-style-type: none"> <li>82 telephone interviews</li> </ul>	<ul style="list-style-type: none"> <li>Further exploration of issues emerging during the Pathfinder Pilot</li> </ul>
8	Written questionnaire responses from Royal College representatives	<ul style="list-style-type: none"> <li>A questionnaire was emailed to each of the Royal College representatives involved in the Pathfinder Pilot</li> <li>Nine responses out of 11 Royal Colleges involved covering seven of the pilot sites were received</li> </ul>	<ul style="list-style-type: none"> <li>Further exploration of issues emerging during the Pathfinder Pilot</li> </ul>
9	Data from the toolkit	<ul style="list-style-type: none"> <li>Data on usage of the toolkit was analysed</li> </ul>	<ul style="list-style-type: none"> <li>Information on the use of the toolkit, amount of supporting information uploaded and outcomes of appraisal</li> </ul>
10	Employer Liaison Officer (ELA) information	<ul style="list-style-type: none"> <li>Face-to-face interviews with ELAs and SHA responsible officers</li> <li>Telephone interviews with staff involved in doctor performance issues (including senior human resources personnel)</li> <li>Web-based survey</li> </ul>	<ul style="list-style-type: none"> <li>Insight into the ELA Pilot held in parallel in Yorkshire &amp; Humberside and the West Midlands</li> </ul>

#### 1.4 The evaluation process

The evaluation process involved surveying doctors and their employers to establish their experience with the current appraisal system as a baseline, and then conducting a follow-up survey of their experiences with strengthened medical appraisal during the 12-month Pathfinder Pilot.

Over 3,000 doctors completed their appraisals as part of the Pathfinder Pilot, and over 11,000 of the various survey forms were received. A high response rate was achieved; 2,405 appraisees (79% response rate) responded to the baseline survey, and 2,169 (72% response rate) responded to the follow-up survey. Of the appraisees who responded, 924 (42.7%) are employed in acute care, 927 (42.8%) are in primary care and 210 (9.7%) are in mental health care.

Some doctors chose not to participate in the Pathfinder Pilot and some participants withdrew before completing the Pathfinder Pilot process. The scope of Frontline's evaluation did not cover following-up non-participants or withdrawals in detail, but forms were supplied that pilot sites could use on a voluntary basis to establish why doctors had chosen not to participate or to withdraw. 93 non-participation forms and 44 withdrawal forms were returned. These forms included the "pre-disposition" questions from the main evaluation, which asked how much doctors agreed with the statements:

- 'Appraisals are a good way of improving an individual's practice'
- 'The proposed revalidation process will improve the standards of doctors' practice'

This allowed comparison of attitudes between non-participants and participants to see if the two groups have different attitudes towards appraisal and revalidation. Analysis shows that the level of agreement with the first statement was slightly higher (but not statistically significant) among non-participants and withdrawals than participants. There was no statistically significant difference between the groups for the second question. More information on this can be found in the Technical Annex at Section 15.2.

Issues relating to the Revalidation Pilot Toolkit have been identified by RST, and are being addressed separately. These are only covered in this report where they impact on the strengthened medical appraisal process, as the focus is on the strengthened medical appraisal proposals being tested through the Pathfinder Pilot process.

## 1.5 How the findings in this report were derived

The following sections contain the key issues from the whole range of evaluation activities. These issues have been identified from a range of sources and aggregated to provide an overall set of findings that capture the views expressed. The sources of the information in the various sections of this report are summarised in Table 3.

**Table 3 Source of information used in identifying the key evaluation issues**

Report Sections		Subsections	Information sources
2	The Appraisal Process	<ul style="list-style-type: none"> <li>• Preparing for the appraisal</li> </ul>	<ul style="list-style-type: none"> <li>• Large scale survey of participants</li> <li>• Focus groups with participants</li> <li>• Telephone interviews with participants</li> <li>• Organisational survey information</li> </ul>
		<ul style="list-style-type: none"> <li>• The appraisal discussion</li> </ul>	<ul style="list-style-type: none"> <li>• Large scale survey of participants</li> <li>• Focus groups with participants</li> <li>• Telephone interviews with participants</li> </ul>
		<ul style="list-style-type: none"> <li>• Writing up and signing off</li> </ul>	<ul style="list-style-type: none"> <li>• Large scale survey of participants</li> <li>• Focus groups with participants</li> <li>• Toolkit data</li> </ul>
		<ul style="list-style-type: none"> <li>• Responsible officer review</li> </ul>	<ul style="list-style-type: none"> <li>• Large scale survey of responsible officers</li> <li>• Face-to-face interviews with responsible officers</li> <li>• Organisational survey information</li> <li>• Toolkit data</li> </ul>
		<ul style="list-style-type: none"> <li>• The Revalidation Pilot Toolkit</li> </ul>	<ul style="list-style-type: none"> <li>• Large scale survey of participants</li> <li>• Focus groups</li> <li>• Telephone interviews with participants</li> <li>• Responsible officer face-to-face interviews</li> <li>• Pilot lead face-to-face interviews</li> <li>• Toolkit data</li> </ul>
3	Responsible officers	<ul style="list-style-type: none"> <li>• Approach to fulfilling the role</li> <li>• Confidence in the revalidation process</li> <li>• Potential conflicts of interest</li> </ul>	<ul style="list-style-type: none"> <li>• Large scale survey of responsible officers</li> <li>• Responsible officer face-to-face interviews</li> <li>• West Midlands focus group</li> <li>• Telephone interviews with responsible</li> </ul>

Report Sections		Subsections	Information sources
		<ul style="list-style-type: none"> <li>Appraising responsible officers</li> </ul>	officers
4	Organisations	<ul style="list-style-type: none"> <li>Support to appraisees</li> <li>Support to appraisers</li> <li>Support to responsible officers</li> </ul>	<ul style="list-style-type: none"> <li>Organisational survey information</li> <li>Telephone interviews with participants</li> <li>Responsible officer face-to-face interviews</li> </ul>
5	Outcomes		<ul style="list-style-type: none"> <li>Large scale survey of participants</li> <li>Responsible officer face-to-face interviews</li> <li>Telephone interviews with participants</li> </ul>
6	Benefits of the strengthened medical appraisal process and revalidation	<ul style="list-style-type: none"> <li>Strengthened medical appraisal</li> <li>Revalidation</li> <li>Individuals</li> <li>Organisations</li> </ul>	<ul style="list-style-type: none"> <li>Large scale survey of participants</li> <li>Organisational survey information</li> </ul>
7	Costs of the strengthened medical appraisal process	<ul style="list-style-type: none"> <li>Individuals</li> </ul>	<ul style="list-style-type: none"> <li>Large-scale surveys of appraisees, appraisers and responsible officers</li> </ul>
		<ul style="list-style-type: none"> <li>Organisations</li> </ul>	<ul style="list-style-type: none"> <li>Large-scale survey of Pathfinder Pilot organisations</li> </ul>
8	GMC Employer Liaison Advisors (ELAs)		<ul style="list-style-type: none"> <li>Face-to-face interviews with ELAs</li> <li>Face-to-face interviews with responsible officers in pilot sites</li> <li>West Midlands focus group</li> <li>Telephone interviews with other staff involved in process</li> <li>Web-based survey of responsible officers in pilot sites</li> </ul>

## 2 The appraisal process

### 2.1 Preparing for the appraisal

#### 2.1.1 Setting up appraisal interview

One of the key comments made in focus groups in relation to setting up the appraisal interview was that appraisers and appraisees need to agree expectations up front (this theme was mentioned on 11 occasions). This includes agreeing dates when supporting information will be available to appraisers for review, and what will be discussed in the appraisal. This is illustrated by the following comment:

“Mutual understanding from both sides about what is expected and needed”  
Focus Group participant

For more information on this, see Section 8.3.2 of the Technical Annex.

#### 2.1.2 Support to appraisees and appraisers

Between 60% and 70% of organisations provided training locally and prepared organisation-specific guidance for appraisers and appraisees. Organisations provided additional training events and material to ensure staff could fulfil the requirements of the Pathfinder Pilot. The majority of the assistance was provided to appraisees and appraisers in the form of training on the toolkit and help to explain the new processes, but appraisal leads and responsible officers also received training and guidance as follows:

- **Appraisees** – workshops, toolkit training, one-to-one training; primarily on the toolkit, but also to explain the new process
- **Appraisers** – toolkit training, one-to-one training; both on the toolkit and to explain the new process
- **Appraisal Leads** – network events and meetings; to introduce the new process
- **Responsible Officers** – training including away days; to introduce the new process and the dashboard

The appraisal lead role was not formally part of the Pathfinder Pilot but some organisations used them to assist appraisers in their work, and they sometimes helped responsible officers to take an overview of appraisal within their organisation.

Organisations also provided training and guidance in order to allow a wide range of doctors (e.g. part-time doctors, locums, GPs with special interests, GPs with other extended roles, disabled doctors, returners from sabbatical / sick leave / maternity leave, doctors working outside the NHS in private practice, doctors working in academic medicine and doctors working overseas) to participate in the Pathfinder Pilot. The resources provided typically included email and telephone support in particular related to the toolkit.

When asked in telephone interviews what additional guidance appraisees would have liked, a range of answers was given, but none received strong support. The areas of guidance mentioned were:

- Applying the strengthened medical appraisal process to clinicians who work in more than one organisation
- Using the toolkit

- How much supporting information is required
- How to define a significant event
- What value to assign to courses attended
- How to self-score
- How to complete a personal development plan
- How to assess personal skills such as communication and delegation
- How to carry out appraisal when the doctor has no patient contact

Additional information on the guidance required on supporting information can be found at Section 3.10 of the Technical Annex, as well as comments arising from the focus groups and interviews at Sections 10.2.2, 10.3.3 and 11.3.2.

Some appraisers were happy with the level of guidance provided. The areas noted in telephone interviews where additional guidance could be useful were:

- What constitutes good supporting information and how to rate it
- How to benchmark performance
- Using the toolkit
- How revalidation works
- How to measure probity

The following comment illustrates the need for guidance on supporting information:

“All of the appraisees provided good quality information, but the amount provided varied hugely - from one person who submitted an additional 12 or so documents to support their appraisal, to one person who submitted over 60...Some guidance on how much information would have been helpful.”

Appraiser large scale survey – post-Pilot form

The additional cost of providing more training is currently not clear as the organisations questioned could not provide a reliable estimate until they understand the final format of strengthened medical appraisal and revalidation. For more information see Section 6.2.3 in the Technical Annex.

### 2.1.3 Specialty frameworks

At the time of the Pathfinder Pilot a number of Royal Colleges had produced speciality specific frameworks as supplementary guidance to the GMC Good Medical Practice framework. These have now been withdrawn and Royal Colleges are providing additional guidance to help specialist doctors identify supporting information for appraisal. However, given the specialty frameworks existed at the time of the Pathfinder Pilot, participants were asked about their use of them.

The majority of the appraisees were aware of the specialty frameworks developed to indicate how doctors in each speciality may satisfy each of GMC's 12 attributes of good medical practice. Feedback from the large-scale survey indicates a perception that simplification of the specialty frameworks might be helpful through the identification of a core set of supporting information.

When asked in telephone interviews whether they had referred to speciality specific guidelines or standards from the Royal Colleges, 50% of the appraisees interviewed said that they had done so, while 32% had not used any specialty-specific guidance (not all interviewees answered this question). A range of reasons were given by the appraisees who did not use this guidance including:

- They already had enough information
- It did not occur to them to look at them

- The frameworks did not cover their particular sub-specialty

When asked in telephone interviews, 53% of appraisers read Royal College guidance in order to prepare for the appraisals they would be carrying out, whilst others did not read any Royal College guidance. 35% of those who read it found it useful. Appraisers' reasons for not reading Royal College guidance to prepare included:

- They felt they were already aware of the contents (four interviewees)
- They felt they had obtained the information from elsewhere (e.g. RST guidance) (three interviewees)
- Their training was sufficient (two interviewees)

#### 2.1.4 Appraisal and the GMP Framework

The strengthened medical appraisal has highlighted to some doctors the need to keep better records to comply with appraisal and clinical governance systems in the future, and that these records will need to be made at the same time as the activities were undertaken.

According to the large-scale survey, the attributes that doctors found most difficult to provide supporting information for were:

- 'Show respect for patients'
- 'Treat patients and colleagues fairly and without discrimination'
- 'Acting with honest and integrity'

It should be noted that the use of patient questionnaires was not formally tested as part of the Pathfinder Pilot. Such questionnaires could provide doctors with the supporting information they need to demonstrate their competence in the patient-related attributes. Appraisers found it most difficult to make an assessment against the following attributes:

- 'Keep clear, accurate and legible records'
- 'Protect patients from any risk posed by your health'
- 'Show respect for patients'
- 'Treat patients and colleagues fairly and without discrimination'
- 'Acting with honest and integrity'

Respondents provided very little information on possible alternative methodologies for assessing these attributes.

The following comment illustrates that some participants found that the domains and attributes did not add to the appraisal process:

"Mechanical assessment against the GMC's 12 attributes is a distraction from the formative aspects of the process."

Appraisee large scale survey – post-appraisal form

Locums were seen as having particular difficulties obtaining supporting information, particularly information relating to the clinical governance of the practices or organisations within which they had worked. As they are not formally employed by the practice or organisation, they noted that they were sometimes excluded from practice or team meetings which discussed clinical governance information, or prevented from accessing that information.

### 2.1.5 Support requirements

Of the 45 organisations that responded, 12 stated that they had to buy new equipment to run the Pathfinder Pilot. This typically involved buying low-cost equipment such as scanners to scan paper supporting information for uploading into the toolkit. Of those 45 organisations, 21 stated that they will need to buy new equipment in the future to maintain revalidation. Whilst organisations were uncertain as to the details of that equipment (without details of how revalidation will be rolled out), encrypted data storage and updated IT systems were suggested.

Of the 45 organisations, 35 stated that they incurred additional administrative costs to run the Pathfinder Pilot. This typically involved:

- Organising appraisers
- Tracking progress (i.e. number of appraisals planned, delivered, feedback form responses)
- Following up with appraisers and appraisees to complete documentation
- Support on toolkit issues.

Of those 45 organisations, 40 stated that they would incur additional administrative costs in the future to maintain revalidation. Of the 40, 31 incurred administrative costs to run the Pathfinder Pilot, whilst nine did not incur such costs. Four organisations incurred administrative costs during the Pathfinder Pilot, but did not envisage incurring further administrative costs. The evaluation did not provide sufficient information to establish whether there is a correlation between the size of the organisation and the costs likely to be incurred and it would be useful if more work was done in this area.

Whilst organisations commented that they would need more detail of the revalidation system, 14 provided estimates of administrative requirements. These ranged from one hour per week of a Band 5 administrator through to a full-time Band 5/6/7.

It would be useful, in the future, to establish whether there is a correlation between the size of organisation and the costs incurred.

### 2.1.6 Time taken preparing for appraisal

The large-scale survey showed that the median times spent by appraisees on collating information and preparing for appraisals increased from their baseline values during the Pathfinder Pilot as follows:

- **Acute care (all pilot sites)** – from eight to 12 hours
- **Mental health care** – from eight to 18 hours
- **Primary care** – from ten to 15 hours

Details of the full distribution of times are given in Section 3.13 of the Technical Annex. Median values have been used throughout this report as they are more applicable to data that contains outlier data.

The PSSRU report *Unit costs of health and social care 2010* has estimated that consultants' typical working time is 1,793 hours per annum and a GPs' typical working time is 1,931 hours per annum. As such, the preparation times represent less than one percent of doctors' typical working time per annum.

The median time taken in preparing for the strengthened medical appraisal (in acute care) by those appraisees who had used the University Hospitals of Leicester NHS Trust

toolkit was ten hours, whereas the median time for those (in acute care) who had used the Revalidation Pilot Toolkit was 15 hours. It would be worth investigating this difference further, as this difference may be due to the difficulties other sites had in operating the toolkit. However, there may be other confounding factors that also influence the time taken within individual pilot sites.

Appraisees were asked in the telephone interviews whether they believed the process would be shorter if they repeated it in subsequent years. 48% of the interviewees agreed that it would be shorter in subsequent years, and 23% disagreed (the remainder were neutral). The reasons given for believing it would take less time in subsequent years included:

- Better knowledge of the systems and processes (mentioned six times)
- The need to upload less information (mentioned six times)
- They would become quicker with practice (mentioned four times)

Three interviewees noted that they would collect their evidence throughout the year rather than in one dedicated exercise, and three interviewees specifically mentioned that toolkit difficulties had made the process longer.

The large-scale survey also identified increases in the median times spent by appraisers on reviewing appraisees' information before the appraisal discussions in the Pathfinder Pilot when compared with the baseline estimate for the previous system as follows:

- **Acute care** – from 1.0 to 2.0 hours
- **Mental health care** – from 1.0 to 2.25 hours
- **Primary care** – from 2.0 to 3.0 hours

## 2.2 The appraisal discussion

### 2.2.1 Reflection

In the telephone interviews, the appraisees were split on the question of whether the reflection part of the process is a useful way of thinking about their practice, with 45% in the telephone interviews agreeing and 41% disagreeing (the remainder were neutral). 20% of those who agreed with this statement noted that it encouraged them to reflect, but 22% of those disagreeing felt that doctors do this anyway or it was unnecessary to reflect on every item of supporting information.

In the telephone interviews, 18% of the appraisers interviewed believed their appraisees had found the reflective sections of the toolkit a useful way of thinking about their practice, while 42% of the appraisers interviewed disagreed that reflection was useful (the remainder were neutral). Five appraisers noted that appraisees' ability to reflect is variable.

One of the responsible officers interviewed noted that doctors need to develop their skills of reflection to get the most out of the system:

"...because it is a very structured approach it will lead to improved practice. However, some learning is required by doctors in the area of self-reflection if they are to get the best out of the new system."

Responsible officer interview

## 2.2.2 Usefulness of activities and supporting information

The activities that appraisees considered to be the most valuable activities for both evaluating doctors' standards of practice and planning how to improve patient care are summarised in Table 4. Table 4 contains a summary of the three activities that received the largest number of mentions from appraisees. Other activities were also considered valuable, and full details are contained in Section 3.9 of the Technical Annex.

**Table 4 Appraisees' most valuable activities for both evaluating doctors' standards of practice and planning how to improve patient care**

Health Sector	Most valuable activities for evaluating doctors' standards of practice	% of respondents placing in top three	Most valuable activities for planning how to improve patient care	% of respondents placing in top three
Acute care	• Continuing professional development	78%	• Audits and informal data review	83%
	• Audits and informal data review	77%	• Probity self-declaration	74%
	• Probity self-declaration	70%	• Continuing professional development (CPD)	71%
Mental health care	• Significant event/case reviews	87%	• Significant event/case reviews	85%
	• Continuing professional development	76%	• Audits and informal data review	76%
	• Audits and informal data review	67%	• Probity/self-declaration	73%
Primary care	• Significant event/case reviews	93%	• Significant event/case reviews	93%
	• Continuing professional development	87%	• Continuing professional development	85%
	• Audits and informal data review	74%	• Audits and informal data review	80%

The following comment from a telephone interview agrees with the numerical assessments shown in the table above:

"It introduced two new aspects; the significant event and case review, which was good"

Appraisee telephone interview

The activities that appraisers considered to be the most valuable activities for both evaluating doctors' standards of practice and planning how to improve patient care are summarised in Table 5. Table 5 contains a summary of the three activities that received the largest number of mentions from appraisers. Other activities were also considered valuable, and full details are contained in Section 4.9.2 of the Technical Annex.

**Table 5 Appraisers' most valuable activities for both evaluating doctors' standards of practice and planning how to improve patient care**

Health Sector	Most valuable activities for evaluating doctors' standards of practice	% of respondents placing in top three	Most valuable activities for planning how to improve patient care	% of respondents placing in top three
Acute care	• Continuing professional development	87%	• Audits and informal data review	84%
	• Audits and informal data review	81%	• Review of complaints	72%
	• Feedback from colleagues	77%	• Significant events/case reviews	77%
Mental health care	• Continuing professional development	84%	• Audits and informal data review	85%
	• Feedback from colleagues	78%	• Significant event/case reviews	77%
	• Audits and informal data review	76%	• Review of complaints	77%
Primary care	• Significant event/case reviews	95%	• Significant event/case reviews	92%
	• Continuing professional development	88%	• Continuing professional development	81%
	• Audits and informal data review	72%	• Audits and informal data review	77%

For information on the areas of activities which were seen as least valuable, see Section 3.9 of the Technical Annex.

When asked in telephone interviews what the bare minimum information required is to carry out an appraisal, appraisers cited the following items most frequently:

- Information on continuing professional development (52% of interviewees)
- Feedback from colleagues (45% of interviewees)
- Audits (24% of interviewees)

Appraisers were also asked what the bare minimum information requirements for revalidation recommendations are, and identified the same pieces of information as being useful for appraisal and for revalidation. More on this can be found at Section 9.4.1 of the Technical Annex.

### 2.2.3 Scoring supporting information

The telephone interviews revealed that, when asked about their views on scoring supporting information, the most popular responses from appraisers were that the scoring system does not add value to the appraisal (the theme was mentioned on 12 occasions) or that rating was difficult (theme mentioned on nine occasions). However 34% of appraisers found rating easy or relatively easy.

While 25% of appraisees in telephone interviews felt that self-scoring their supporting information was useful, 48% felt that it did not add to the process. Self-scoring was generally seen as both subjective and difficult to do properly as it:

- Was subjective (the theme was mentioned on 15 occasions)
- Needed a benchmark to score against (mentioned on seven occasions)
- Did not add any value (mentioned on five occasions)

The comment below is from an appraisee who felt they needed a benchmark for the scoring:

“A bit tricky - it's difficult to know where to score yourself - feedback from the appraiser gives you more insight and provides you with some sort of benchmark for next time”

Appraisee telephone interview

Indications are that requiring appraisers to assess the suitability of individual items of supporting information provided by appraisees does not add significantly to the appraisal process. It may also be contributing to the additional preparation time noted by some appraisers. The following comment suggests that the overall process including scoring is too complex:

“It could be improved by simplifying the whole procedure. It induces anxiety in making sure the forms are filled in rather than stimulate[s] useful reflection on practice.”

Appraiser large scale survey – post-appraisal form

In telephone interviews, appraisees who found the strengthened medical appraisal a better experience than their previous appraisals noted either that it was better structured than their previous appraisals, or that the appraiser being forced to review the supporting information before the discussion was beneficial.

#### **2.2.4 Achieving balance in the strengthened appraisal process**

Appraisees were asked about the balance in their strengthened medical appraisal between reviewing GMC requirements and developing their practice. 66% of the appraisee respondents indicated that the appraisal was balanced between these two requirements, with 19% indicating that it was mainly focused on developing their practice while 16% indicated that it was mainly reviewing against GMC requirements. The following comment shows that some participants valued the structured approach to reviewing practice:

“Although more time consuming, I think the strengthened system is better - it looks at evidence across a wide range of important activities, asks appraisee to provide evidence, has a mechanism for assessing the quality of this (although not clear how reliable or valid that would be), and makes both appraisee and appraiser reflect on the evidence and goals. It also made it easier to develop a structure / format for the appraisal discussion.”

Appraiser large scale survey – post-Pilot form

Interviewees were asked if appraisal can be both formative and summative - 'summative' assessments contribute to progression or continuance in a programme, while 'formative' assessments are for feedback to the individual only, and do not contribute to progression decisions. 68% of appraisees interviewed responded that it could fulfil both functions, although two interviewees noted that appraisal would need to be done skilfully to ensure this, while 18% did not believe both could be covered by the same process. 68% of appraisers interviewed agreed that it could be both formative and summative, and 16% disagreed (the remainder were neutral), although a number felt that achieving both through the same process was difficult to achieve and requires a skilled appraiser.

## 2.2.5 Time spent in appraisal discussions

Whilst the median time spent on appraisal discussions during the Pathfinder Pilot increased by 0.5 hours for mental health (1.5 to 2.0, an increase of 33%) and primary care (2.0 to 2.5, an increase of 25%), the median increased by one hour in acute care (1.0 to 2.0, an increase of 100%).

There was little change in the median time spent by appraisers on the appraisal discussions in the Pathfinder Pilot when compared with the baseline estimate for the previous system. The median increased by 0.5 hours for acute care (1.5 to 2.0 hours, or 33%), increased by 0.25 hours for mental health care (from 1.75 to 2.0 hours, increase of 14%), and remained the same for primary care (2.5 hours).

It is worth noting that, although preparation time for both appraisees and appraisers has increased, the actual appraisal interview has remained at broadly the same length. This could suggest that the additional preparation ensures the interview remains focused despite the additional supporting information supplied for review. This is illustrated by the following comment:

"It was better because it flowed more naturally and the appraiser was able to just click on the relevant bits that we needed to talk about..."

Appraisee telephone interview

## 2.3 Writing up and signing off the appraisal process

Data from the toolkit shows that on average the appraisal write-up was signed-off nine days after pre-appraisal sign-off, and the final sign-off by the appraiser occurred two days after the appraisee signed off the write up.

Suggested improvements made in focus groups to writing up the appraisal discussion included ensuring that the personal development plan is central to the write up (the theme was mentioned on seven occasions) and simplifying the write-up requirements (mentioned on five occasions). For more information on this see Section 8.3.5 of the Technical Annex.

### 2.3.1 Time spent writing up the appraisal discussion

There was no change in the median time spent by appraisers in writing up the appraisal discussions in the Pathfinder Pilot when compared with the baseline estimate for the previous system except in mental health care. The medians remained at 1.0 hours for acute and mental health care, and 1.5 hours for primary care.

## 2.4 Responsible officer review

### 2.4.1 Scope of work

The number of appraisals reviewed by responsible officers varied considerably with 37% of responsible officers responding to the large scale survey looking at 'one to five' records to 8% who reviewed 'greater than 30' records. 71% of responsible officers reviewed between one and 15 appraisals. For more information see Section 5.4 of the Technical Annex.

### 2.4.2 Usefulness of information provided

67% of the appraisers in the large-scale survey were in agreement with the statement 'I felt confident that I was providing sufficient information for the responsible officer to make objective recommendations', with 10% disagreeing with the statement (the remainder were neutral). This corresponded with the view of responsible officers, where 72% agreed with the statement 'I am confident the information available from the strengthened medical appraisals would help me make revalidation decisions' and 10% disagreed with the statement (the remainder were neutral). The following statement shows how responsible officers think of appraisal forming part of the information needed to make revalidation recommendations:

"Appraisal is not the only source of information I would rely on to make these judgements. I have ready access to triangulating information on complaints, incidents and "soft intelligence", which would prompt me to look deeper if required."

RO large scale survey – quarterly form

Quality control of appraisal before the Pathfinder Pilot was variable across organisations. Section 2.1 of the Technical Annex illustrates that the baseline position ranged from organisations which no quality control of appraisals at all, to organisations with well-developed quality control systems. A change which could increase confidence in this area is introducing consistent quality control to ensure appraisals are carried out consistently.

More information on this can be found in Section 4.11.3 of the Technical Annex.

### 2.4.3 Responsible officer dashboard

Responsible officers cited a number of successes of the Pathfinder Pilot, including the ability to obtain more understanding of strengthened medical appraisal and revalidation, the Pathfinder Pilot forcing improvements to their appraisal system, the strengthened medical appraisal being a good process and the availability of the dashboard. The dashboard gave a visual representation of the progress in revalidation for every doctor for whom the responsible officer had responsibility. The responsible officer was able to access specific pieces of supporting information supplied by individual appraisees through the dashboard. The dashboard was totally new to the responsible officers we interviewed, and will be missed after the Pathfinder Pilot has been completed. Responsible officers particularly valued the ability to see progress on all the appraisals in their organisation at a glance, and being able to click through to the detail of individual appraisals where necessary, as illustrated by the comment below:

"We are still early in the process and need to benchmark appraisers assessments. Therefore it is useful to be able to drill down in the pre-appraisal papers to see how appraisers assess supporting information."

RO large scale survey – quarterly form

## 2.5 The Revalidation Pilot Toolkit

A toolkit was used for this pilot. This was a computer-based system designed to help in the storage and organisation of information for the strengthened medical appraisal process. The toolkit was intended for use only within the Pathfinder Pilot.

Whilst the toolkit was outside the scope of this evaluation, participants made many comments on the toolkit; particularly in the early stages of the Pathfinder Pilot where problems were being encountered regularly. Where issues with the toolkit impacted on the appraisal process, these have been captured in this section. Further details are contained throughout the Technical Annex.

### 2.5.1 Ease of uploading information

The key issues raised were:

- **The need to scan paper supporting information to upload it into the toolkit** – many organisations had to purchase scanners, and the scanning process was time consuming
- **The time taken to upload supporting information** – in the early releases of the toolkit, the time taken to upload information was considered to be lengthy, mainly due to slow operation of the toolkit; this improved with subsequent releases of the toolkit

### 2.5.2 Ease of use

The key issues raised were:

- **Repetitive structure of the toolkit** – with every box requiring an entry whether the user considered an entry appropriate or not
- **Problems with saving data early on in the Pathfinder Pilot** – these technical issues caused appraisees to 'lose' data; they were fixed with later releases of the toolkit, but caused problems early on
- **Problems with crashing early on** – these technical issues were fixed with later releases of the toolkit but, early on, led to doctors losing the work that they had done prior to the crash
- **The need to provide an entry in every reflection input box to get the toolkit to move on to the next section** – this was considered to be annoying by some doctors, and 'workarounds' were found to bypass this issue
- **Appraisees did not want the toolkit to be used during the appraisal discussion (three focus groups identified this as an issue)** – such use was considered to reduce the amount of eye contact, be a distraction and put a physical barrier between the appraiser and appraisee

### 2.5.3 Value of the toolkit

Whilst many concerns were raised about the toolkit in the early stages of the Pathfinder Pilot, doctors began to value the toolkit in the later stages. In particular, the following points were made in later stages:

- **There were ten mentions in focus groups and six in appraiser telephone interviews that the toolkit is easy to use** – once the participants had got used to it

- **23% of appraisee interviewees felt that toolkit was a success of the Pathfinder Pilot** – they appreciated the web-based accessible method of collecting their supporting information; these interviewees had often been used a paper-based appraisal methodology before
- **Responsible officers considered the dashboard to be useful (five out of 19 cited it as a success of the Pathfinder Pilot)** – it provided them with an overview of key information

The toolkit's ability to store supporting information being valuable to appraisees is shown in the comment below:

“Useful to have all the stuff in one place. If the toolkit is used as a tool and not the actual appraisal I can see that it could be useful”

Appraiser telephone interview

## 3 Responsible Officers

### 3.1 Approach to fulfilling the role

Responsible officers were split in their approach, with 26% of those interviewed carrying out full reviews of every record, 53% reviewing a sample of records and 42% just looking at the dashboard. For more information see Section 10.2 of the Technical Annex.

### 3.2 Confidence in the revalidation process

In the survey, 72% of the responsible officer respondents agreed with the statement 'I am confident the information available from the strengthened medical appraisals would help me make revalidation decisions' and 4% disagreed with the statement (the remainder were neutral). In addition, 58% of them agreed with the statement 'I would be confident to make revalidation recommendations based on all of the information provided', with 14% disagreeing with the statement (the remainder were neutral). The evaluation did not provide any evidence that responsible officers felt that the information from strengthened medical appraisal hindered them in making revalidation decisions, and negative responses in this area seem to relate to a view that responsible officers can obtain the necessary assurance on doctors' performance from elsewhere. For more information see Section 5.5 of the Technical Annex.

In the interviews, 32% of the responsible officers agreed that appraisal and revalidation will lead to early warning of doctors with performance issues, although 26% felt that the system will not lead to early warnings on performance on its own. Appraisal and revalidation were seen as part of a larger system, although they may help to highlight issues. The fact that revalidation covers five years of performance was seen as helpful by some responsible officers in flagging patterns of problems. Additional information on this can be found at Section 12.6 of the Technical Annex.

The following comment shows that some responsible officers value the ability to identify issues early:

"Being able to identify sub-standard practice at an earlier stage will allow remedial action sooner with a better chance of success."

RO large scale survey – post-pilot form

One responsible officer noted that revalidation may flag doctors who are unable to comply with the requirements of the revalidation system for some reason but there are no underlying performance issues, and that organisations will need to be prepared to deal with such instances.

### 3.3 Potential conflicts of interest or risk of bias

When interviewed, 58% of responsible officers suggested that there are likely to be conflicts of interest which are not resolvable locally, with an additional 16% suggesting that such conflicts of interest are possible, and 21% being sure that there would not be any conflict of interest that could not be solved locally.

The areas noted as potentially causing conflicts of interest are where:

- The responsible officer knows someone well on a personal level
- Conflicts occur between organisational issues and professional issues (for example where a responsible officer in their role as Medical Director is required to implement an organisational change which may be resisted by the appraisees)
- The doctor is already involved in a formal disciplinary process

Doctors are often appraised by colleagues who know them well, for example their direct manager. This is not generally an issue, but in expressing this concern, the responsible officers interviewed were concerned that revalidation seems to require a higher level of objectivity, given the importance of the outcome for individual doctors and the NHS overall.

It was noted that responsible officers will need to work within local networks so that there is a pool of alternative responsible officers where conflicts of interest arise. These networks are currently being set up. This solution to potential conflicts of interest is illustrated by the following comment:

"There needs to be a system to deal with obvious potential conflicts of interest, for example relationships with neighbouring responsible officers."

Responsible officer interview

### 3.4 Appraising responsible officers

The Pathfinder Pilot in the West Midlands specifically looked at the way senior medical managers including responsible officers should be appraised. The work in this pilot site indicated that further development is needed in the appraisal and revalidation standards for senior medical managers. The main points which responsible officers suggested need to be addressed include:

- Additional guidance is needed on the supporting information requirements for the non-medical aspects of senior management roles, given the whole-practice nature of strengthened medical appraisal
- Tools for feedback from clinical colleagues may not be suitable for medical directors
- Medical directors should be appraised by senior medical managers
- Responsible officers felt they should not appraise anyone within their own geographical area or organisation as this could lead to conflicts of interest
- Peer-to-peer support is valuable and should be encouraged
- Any training provided to responsible officers should be closely tailored to their needs and delivered by peers

## 4 Organisations

### 4.1 Approach to appraisal before the Pathfinder Pilot

Analysis of the returns made by participant organisations at the start of the Pathfinder Pilot describing their existing appraisal systems shows that appraisal processes in place across the pilot sites before the start of the Pathfinder Pilot differed from one organisation to another in many respects, although there do seem to be some systematic differences between the health sectors covered by the pilot, with systems in primary care being better developed and more formalised than those in acute care. Mental health organisations seemed to have the least formalised systems before the start of the Pathfinder Pilot, which might in part explain the higher increase in time taken for the strengthened medical appraisal system in this sector. More information on this can be found in the Technical Annex at Section 2.1.

Among the benefits of the Pathfinder Pilot noted by organisations were enhancements to their continuing professional development (CPD) provisions, including tracking which doctors have carried out CPD and evaluating the CPD provided, and formalising remediation processes. The effect of strengthened medical appraisal is likely to bring organisations up towards a common standard in these areas. For additional information see Section 8.5 of the Technical Annex.

### 4.2 Information required by responsible officers

Responsible officers noted that they would value access to additional clinical governance data when assessing doctors' performance, as they do not always have access to this information currently. The following comment illustrates this:

"Would want to ask performance manager if there are any issues – complaints, contractual issues, worries about stress. Appraisal process is very thorough but could do with more performance information"

Responsible officer interview

Additional information on this can be found at Section 10.4 of the Technical Annex.

### 4.3 Quality assurance

One aspect of quality control is ensuring consistency between appraisals. Responsible officers had various thoughts on achieving consistency including:

- Reviewing appraisers' work (the theme was mentioned on six occasions in interviews)
- Training (mentioned three times)
- Observing appraisals (mentioned three times)

One example of a current initiative around consistency is shown in the comment below:

"They are looking at options with the School of Medicine for a third party to attend a sample of appraisal discussions"

Responsible officer interview

Additional information on this can be found at Section 10.5 of the Technical Annex.

#### 4.4 Infrastructure

The most frequently-accessed source of support to responsible officers was provided informally as peer-to-peer. When asked what additional support they would like, responsible officers suggested (one suggestion of each):

- An assistant or deputy responsible officer (particularly in large organisations)
- Administrative support (for example one responsible officer felt that a department made up of a Band 7 and a Band 3 would be the minimum required)
- Peer support
- A panel for making revalidation recommendations made up of senior clinicians – although it should be noted that the Academy of the Royal Colleges has obtained legal advice that this may not be advisable as the recommendation should be responsible officer's decision alone
- A definitive list of the doctors they are responsible for
- Better links with the Royal Colleges, although no indication of the nature of these links was given

## 5 Outcomes for appraisees

Appraisees were asked their level of agreement with a series of statements in relation to the current system (baseline) and strengthened medical appraisal (Pathfinder Pilot). When asked during the Pathfinder Pilot, there was a statistically significant increase in the levels of agreement with the statement: 'I improved the way I deliver care as a result of my appraisal' for acute (from 2.95 to 3.14 on a five-point scale where 1 is "Strongly disagree" and 5 is "Strongly agree") and mental health care (from 3.10 to 3.24 on a five-point scale). In primary care, the level of agreement remained at a similar level (from 3.41 to 3.38 on a five-point scale). More information on this can be found at Sections 3.5 and 8.4 of the Technical Annex.

In the large-scale survey, 52% of the appraisers were in agreement with the statement 'The appraisal identified potential improvements to the way the appraisee delivers care'. This question related only to strengthened medical appraisal.

In interviews, 37% of responsible officers agreed that appraisal and revalidation will give confidence that doctors are fit to practise, whilst 32% disagreed (the remainder were neutral). Those that agreed pointed out that having a process will provide assurance to the public (the theme was mentioned on three occasions), that additional support will be targeted at struggling doctors (mentioned on two occasions), that the appraisal judgement itself is useful (mentioned on two occasions) and that appraisees are required to provide better supporting information (mentioned on two occasions). However, two responsible officers who disagreed with this statement felt that appraisal and revalidation does not give all the assurance needed. Additional information on this is contained in Section 10.6 of the Technical Annex.

In interviews, 32% of responsible officers agreed that appraisal and revalidation might lead to early warning of doctors with performance issues, although 26% disagreed (the remainder were neutral). Appraisal and revalidation were seen as part of a larger system, although they may help to highlight issues. The fact that revalidation covers five years of performance was seen as helpful by some responsible officers in flagging patterns of problems. The following comment illustrates these views:

"...the goal is not to wait for annual appraisal – you should already know as a responsible officer through the performance management system if there are performance issues. All appraisal and revalidation should therefore provide is a check that your performance management systems are working"

Responsible officer interview

Additional information on this can be found in the Technical Annex at Section 10.6.

One interviewee noted that revalidation may flag doctors who are unable to comply with the requirements of the system for some reason although they do not have performance issues, and that organisations will need to be prepared to deal with such instances.

If this appraisal had contributed to a formal revalidation recommendation 15% of the appraisee respondents would have wanted to appeal or challenge aspects of the process. However, the comments attached to this question seem to suggest that many of those who would have considered an appeal were more concerned about short-comings in the process as piloted rather than disagreeing with the outcome of their appraisal. The following comment is typical:

"The issue was triggered by the confusion generated from the toolkit. My appraiser did not have time to read/could not find all my SI [supporting information] and marked some as inadequate."

Appraisee large-scale survey – post-appraisal form

As the vast majority of appraisees rated their appraisers as having performed a good, objective appraisal (see Section 3.5 of the Technical Annex) it seems likely that they would challenge only if there was a recommendation to the responsible officer which may result in difficulties with their revalidation.

Further information on this can be found at Section 3.12.1 of the Technical Annex.

## 6 Potential benefits of the strengthened medical appraisal process and revalidation

### 6.1 Strengthened medical appraisal

In the large-scale survey, participants were asked about their perceptions of the costs and benefits of the process, in order to provide information about the way strengthened medical appraisal and revalidation are viewed. This will help to target the information provided during the roll-out of the successor system. It should be borne in mind that the participants did not have access to information on the costs and overall benefits of the system and therefore this cannot be seen as objective assessment of the actual benefits of the system.

The perceptions of the benefits of strengthened medical appraisal varied considerably between participant types, with responsible officers and Pathfinder Pilot organisations having a more positive view of the benefits of strengthened medical appraisal than appraisees or appraisers. In particular:

- **Pilot organisations** – 66% of the organisations perceived the benefits to be medium-high or high, 25% perceived the benefits as being medium and 19% perceived the benefits as being medium-low or low
- **Responsible officers** – 59% of the responsible officers perceived the benefits to be medium-high or high, 31% perceived the benefits as being medium and 10% perceived the benefits as being medium-low or low
- **Appraisers** – 22% of the respondents perceived the benefits to be medium-high or high, 31% perceived they would be medium and 47% perceived they would be medium-low or low
- **Appraisees** – 21% of the respondents perceived the benefits to be medium-high or high, 33% perceived they would be medium and 46% perceived they would be medium-low or low

Potential benefits identified during the Pathfinder Pilot are summarised in Table 6. Further details are presented in Section 8 of the Technical Annex.

**Table 6 Potential benefits identified during the Pathfinder Pilot**

Potential benefit	Evidence
Increased participation in significant event / case reviews in acute and mental health care	<ul style="list-style-type: none"> <li>• In acute care, the number of appraisees participating in significant event / case reviews increased from 47% to 75% during the Pathfinder Pilot</li> <li>• In mental health care, the number of appraisees participating in significant event / case reviews increased from 52% to 84% during the Pathfinder Pilot</li> </ul>
Potential improvements in the standard of appraisers	<p>Appraisees' views on their appraisers have become more positive during the Pathfinder Pilot, with statistically significant increases in the levels of agreement for all three health sectors in relation to the statements:</p> <ul style="list-style-type: none"> <li>• 'Appraisers performed the appraisal well' (increased from 74% to 86% )</li> <li>• 'The appraiser was objective' (increased from 81% to 91% )</li> </ul>

Potential benefit	Evidence
Potential improvements in the way that doctors deliver care as a result of their appraisal in acute and mental health care	Appraisees' views on the outcome of their appraisals become more positive during the Pathfinder Pilot, with statistically significant increases in the levels of agreement for acute and mental health care in relation to the statement: 'I improved the way I deliver care as a result of my appraisal' (increased from 29% to 40% in acute care; from 35% to 45% in mental health care and 50% to 52% in primary care)
The appraisal discussion is adding value to the assessment process	86% of the appraisers were in agreement with the statement 'The appraisal discussion added value to the assessment process'
Potential improvements in the way doctors deliver care	52% of the appraisers were in agreement with the statement 'The appraisal identified potential improvements to the way the appraisee delivers care'
There is consistency in appraisers and appraisees assessments of supporting information supporting	<ul style="list-style-type: none"> <li>• 76% of the appraisers were in agreement with the statement 'I was confident in my assessment of the supporting information before the appraisal discussion'</li> <li>• 74% of the appraisers were in agreement with the statement 'The appraisee self-assessment of supporting information showed agreement with my assessment of the supporting information'</li> </ul>
Appraisers have identified the key areas to focus on in evaluating doctors' standards of practice	Appraisers in all three health sectors considered continuing professional development and audits and informal data review to be the most valuable activities in evaluating doctors' standards of practice; in acute and mental health care, appraisers also considered feedback from colleagues to be valuable, whilst in primary care, appraisers also considered significant event/case reviews to be valuable
Appraisers have identified the key areas to focus on in planning how to improve patient care	Appraisers in all three health sectors considered audits and informal data review and significant event/case reviews to be the most valuable activities in planning how to improve patient care; in acute and mental health care, appraisers also considered review of complaints to be valuable, whilst in mental health care and primary care, appraisers also considered continuing professional development to be valuable
Confidence to make revalidation decisions on the basis of the information provided	58% of the responsible officer respondents agreed with the statement 'I would be confident to make revalidation recommendations based on all of the information provided'
There will be enhancements to the way the doctors undertake CPD	<ul style="list-style-type: none"> <li>• Around half of the organisations will also be looking to enhance the way that doctors undertake continuing professional development (CPD) including guidance on the most appropriate CPD and monitoring the effectiveness of that CPD</li> <li>• As CPD is seen by appraisers as one of the most valuable activities for evaluating doctors' standards of practice and planning how to improve patient care, this is a potential benefit in a key area</li> </ul>
Organisational changes to ensure that remediation is effective	Nearly two-thirds of the organisations will be making changes to ensure that remediation has been successful including formalising the process and evaluating the effectiveness of those processes

The comment below illustrates the benefit of improving the standard of appraisers:

“Appraisal has always improved practice; unfortunately there has been a huge difference in the quality of appraisals without standards”

Appraisee telephone interview

## 6.2 Overall benefits to the health service as a result of the full roll-out of revalidation

When asked about the potential benefits of the full roll-out of revalidation in the large-scale survey, a similar pattern emerged, with responsible officers and Pathfinder Pilot organisations having a more positive view of the benefits of revalidation than appraisees or appraisers. In particular:

- **Pilot organisations** – over 80% of the responding Pathfinder Pilot organisations expected the full roll-out of revalidation to lead to improved patient safety, improved quality of care and improvements in patient experience
- **Responsible officers** – over 70% of the responding responsible officers expected the full roll-out of revalidation to lead to improved patient safety, improved quality of care and improvements in patient experience
- **Appraisers** – over 35% of the respondents expected the full roll-out of revalidation to lead to improved patient safety and improved quality of care
- **Appraisees** – over 40% of the respondents expected the full roll-out of revalidation to lead to improved patient safety and improved quality of care

Note these questions were asked in a 'yes'/'no' format.

The number and percentage of respondents expecting these benefits to occur are shown in Table 7. The five benefits that were expected by the largest proportion of respondents are shown shaded.

The six benefits that are expected by the highest proportion of respondents are:

- Improved patient safety
- Improved quality of care
- Improved patient trust
- Improvement in quality of clinical information
- Improvement in patient experience
- Reductions in the amount of time it takes to identify and rectify poor practice

The first four benefits in the above list appeared in the shaded areas for all four sets of respondents.

**Table 7 Benefits that appraisees, appraisers, responsible officers and organisations expect to occur within the health service as a result of the full roll-out of revalidation (the five benefits that were expected by the largest proportion of respondents are shown shaded)**

Benefit area	Number of respondents expecting the following benefits to occur			
	Appraisees	Appraisers	Responsible officers	Organisations
Reduction in staff costs		15 (4%)	2 (5%)	1 (2%)
Improvement in patient experience	633 (31%)	90 (25%)	29 (73%)	36 (80%)
Improved patient safety	899 (44%)	136 (38%)	30 (77%)	37 (82%)
Improved quality of care	889 (43%)	127 (36%)	32 (84%)	43 (96%)
Improved patient trust	729 (35%)	115 (32%)	24 (63%)	31 (74%)
Improvement in quality of clinical information	868 (42%)	159 (45%)	31 (79%)	42 (93%)
Reductions in clinical negligence claims	389 (19%)	42 (12%)	11 (31%)	15 (35%)
Reductions in fitness to practise cases	545 (26%)	67 (19%)	15 (41%)	20 (44%)
Reductions in the amount of time it takes to identify and rectify poor practice	735 (36%)	94 (27%)	21 (53%)	26 (58%)
Reduction in complaints received	374 (18%)	48 (14%)	15 (42%)	20 (45%)
Other benefits	213 (10%)	33 (20%)	10 (59%)	7 (44%)

## 7 Costs of the strengthened medical appraisal process

The evaluation produced information on the costs of the baseline system and the Pathfinder Pilot by:

- costing the amount of time that participants said they spent on appraisal
- asking pilot sites directly how much they spend on supporting and quality assuring their appraisal system

This has enabled the production of estimates of the total costs of appraisal, but the data does not allow further separation of costs between aspects of the system being tested within the Pathfinder Pilot, for example the impact of the use of the electronic toolkit on the costs of appraisal.

### 7.1 Individuals

If we assume that consultants in acute and mental health care will be appraised by consultants, whilst GPs will be appraised by other GPs, we can use the survey data regarding time taken for the various stages, and unit cost data from the Personal Social Services Research Unit (PSSRU): '*Unit costs of health and social care 2010*' to provide estimates of the overall additional annual appraisal costs per appraisee. These estimates are shown in Table 8.

**Table 8 Estimated total additional annual cost for each appraisee by sector incurred as a result of undertaking the strengthened medical appraisal in the Pathfinder Pilot**

Sector	Additional costs from appraisee activities (£)	Additional costs from appraiser activities (£)	Total additional cost (£)
Consultant	£495	£165	£756
GP	£506	£161	£667

There is a need to establish whether this is a monetary cost or an opportunity cost.

### 7.2 Organisations

During the Pathfinder Pilot, organisations incurred costs in relation to:

- Staff
- Additional training events / material
- Additional resources to support the full range of doctors
- Equipment
- Administration

The costs incurred vary considerably, and details are provided in Section 2.1.5 of this report and Section 6 of the Technical Annex. Further investigation into the way the components of organisational costs were affected by the Pathfinder Pilot would be useful.

Those organisations that have the most work to do to meet the requirements of the future system may well incur the higher costs. Section 2.1 of the Technical Annex describes typical appraisal systems before the Pathfinder Pilot, and shows that there was considerable variation in the opening position of the participating organisations.

## 8 GMC Employer Liaison Advisers

Two of the pilot sites, Yorkshire and Humberside and West Midlands, were also involved in a parallel pilot of GMC Employer Liaison Advisers (ELAs). The ELAs are experts on fitness to practice employed by the GMC whose role is to provide advice, guidance and support to responsible officers on:

- The systems and information requirements for revalidation
- Considering thresholds for, and issues arising from, remediation needs
- Developing responsible officer networks and other sources of support
- Supporting responsible officers in dealing with doctors in difficulty generally

Frontline carried out a qualitative analysis of the ELA Pilot in order to establish whether responsible officers find ELAs helpful.

### 8.1 Systems and information requirements for revalidation

Responsible officers were asked whether the ELA helped them understand the systems and information requirements for revalidation. The key findings were that:

- The GMC ELAs have been part of the process of developing the systems and information requirements for revalidation
- The SHA responsible officers have found the input of the ELAs to this process useful
- ELAs have been able to pass examples of good practice to Responsible Officers
- Some responsible officers believe that the ELA will be able to provide good support to help them understand the systems required for revalidation in the future

### 8.2 Thresholds for, and issues arising from, remediation needs

Responsible officers were asked whether the ELA helped them to consider the thresholds for, and issues arising from, remediation needs. The key findings were that:

- Responsible officers have found it useful to be able to discuss individual cases in order to decide whether to refer them onwards to the GMC
- The ELAs' ability to provide updates on cases going through the GMC was seen as valuable
- The overall process (both internal to the organisation and external including the GMC) for dealing with doctors with performance issues were considered to take too long
- This aspect of the ELA's role is likely to be particularly valuable when responsible officers are new in post

### 8.3 Responsible officer networks

Responsible officers were asked if the ELA had helped to develop networks or other sources of support for revalidation. The key findings were that:

- This has been seen as a role for the responsible officers themselves rather than the ELA
- The responsible officers have formed networks of support to help them with the Pathfinder Pilot

## 8.4 Dealing with doctors in difficulty

Responsible officers and other staff involved in dealing with doctors in difficulty were asked whether the ELA had provided appropriate support. The key findings were that:

- The ELAs have provided a useful 'sounding board' for responsible officers considering how to deal with doctors in difficulty, although in general Responsible Officers have not changed the proposed route for dealing with the doctor following the discussion
- It will be important to ensure ELAs have sufficient seniority and experience to be able to build the required level of confidence with responsible officers
- It would be helpful if the ELAs were available to other staff involved in dealing with doctors in difficulty (e.g. human resource departments, clinical directors, and deputy medical directors)

## 9 Looking to the future

This report contains a summary of the findings from the Pathfinder Pilot that was undertaken in the first year of piloting medical revalidation. The conclusions and recommendations are presented in the Executive Summary.

The information contained in this report and the accompanying Technical Annex represents a significant evidence base, and should provide a valuable input to the developments in the second year of piloting. In particular, the conclusions provide an indication of what has worked well in the first year and what has not worked so well. There is an opportunity to learn from the lessons identified in this evaluation and address the recommendations in the second year of piloting. Indeed, we are aware that work addressing many of our recommendations is already under way.