



Revalidation Support Team

**The Early Benefits and Impact
of Medical Revalidation:**

Report on research findings in year one

Acknowledgements

The NHS Revalidation Support Team would like to thank the many people and organisations who have participated in or contributed to the research documented in this report. We would like to acknowledge, in particular:

- The 3,500 doctors, appraisers, responsible officers and representatives from designated bodies across England who responded to the RST's surveys on the costs, benefits and impact of medical revalidation during the first year of implementation.
- The 90 doctors and appraisers who participated in focus groups and the 36 clinicians and managers who agreed to be interviewed for research commissioned by the RST from The King's Fund on the impact of revalidation on culture and behaviour. The RST would like to thank the following organisations for their support in arranging these focus groups and interviews:
 - Avon and Wiltshire Mental Health Partnership NHS Trust
 - NHS England Derbyshire and Nottinghamshire Area Team
 - Medacs Healthcare
 - Newcastle upon Tyne Hospitals NHS Foundation Trust
 - Ramsay Healthcare UK
 - NHS England Essex Area Team
 - Surrey and Sussex Healthcare NHS Trust.
- The people interviewed by the Collaboration for the Advancement of Medical Education Research and Assessment (CAMERA) at Plymouth University Peninsula Schools of Medicine and Dentistry on patient and public involvement in revalidation and the 150 respondents to their wider survey on public and patient involvement in the appraisal and governance of doctors.
- Members of the *Medical Revalidation Benefits Working Group* representing:
 - Academy of Medical Royal Colleges and its patient/lay group
 - British Medical Association
 - Department of Health (England)
 - DRC Locums
 - General Medical Council (GMC)
 - Guy's and St. Thomas' NHS Foundation Trust
 - Independent Healthcare Advisory Services
 - Independent Sector Complaints Adjudication Service
 - Manchester Business School
 - NHS Employers
 - NHS England
 - Northern Ireland Executive Department for Health, Social Services and Public Safety
 - Royal College of Physicians (London)
 - Scottish Government Department of Health & Social Care
 - Welsh Government Department for Health for Social Services

Without these contributions, the research and the report would not have been possible.

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Executive Summary

Medical revalidation

Medical revalidation (“revalidation”) was introduced in December 2012 following four decades of discussion and debate and a series of high profile cases in the 1990s in which concerns raised by patients, doctors and other healthcare practitioners had not been properly investigated¹. Revalidation is a statutory requirement that builds on the development of clinical governance since 1998, the introduction of annual medical appraisals for consultants and GPs in 2001-02 and the role of the responsible officer introduced in 2011.

All doctors licensed to practise in the UK are now required to demonstrate every five years that they are up-to-date and fit to practise. This is achieved through regular participation in medical appraisal. To prepare for their appraisal doctors need to assemble and reflect on supporting information that demonstrates they are continuing to meet the attributes specified by the GMC for each of the four domains set out in the *Good Medical Practice Framework for Appraisal and Revalidation*. Some of this supporting information will be provided by patients, colleagues and the organisation(s) for which the doctors have worked during the year. The supporting information is provided to, and reviewed with, a skilled appraiser.

Responsible officers have a statutory duty to ensure that appraisal and clinical governance systems are robust and, once every five years, to use outputs from appraisals and clinical governance information to make a revalidation recommendation to the GMC for each doctor. The GMC then decides whether to renew a doctor’s licence. In cases where a doctor needs to provide additional information or to demonstrate an improvement to his or her practise, the responsible officer can defer the recommendation until this has been completed.

The role of the NHS Revalidation Support Team

The NHS Revalidation Support Team (RST) was established to test, pilot and support implementation of the systems and processes underpinning medical revalidation in England. In 2010 the RST initiated programmes to assess operational readiness in the English health system and design a workable model for revalidation. Findings from this work informed the Health Secretary’s assessment of readiness for revalidation and provided data for an associated cost-benefit analysis.

¹ These included the deaths of children following heart surgery at the Bristol Royal Infirmary, serious professional misconduct of gynaecologist Rodney Ledward, the unlawful retention of organs at Alder Hey and elsewhere in the NHS; and the deaths of a number of patients killed by GP Harold Shipman.

While the changes required to implement medical revalidation involve investment in time and resources, it is anticipated that they will lead to significant benefits for patients and the wider health system, including:

- improved governance of professional development and standards
- improved patient safety
- improved quality of care
- improved effectiveness and efficiency of systems and working practices; leading to...
- improved public trust and confidence in the medical system.

Research overview

In June 2013, the RST started research into the early benefits and impact of revalidation during the first year of implementation. The work has been guided by the following principles:

- Revalidation is a significant new undertaking and requires an evidence-base to inform future decision-making.
- The benefits of revalidation need to be assessed in terms of their impact on patients and the public.
- Implementation of revalidation needs to be supported by regular collection of feedback from people experiencing and delivering the new system on the frontline.

The research identified 18 priority indicators for assessing the impact of revalidation and used them to design surveys for doctors, appraisers, responsible officers and designated bodies. The RST received and analysed a total of 3,500 responses to these surveys. This extensive evidence-base is supported by findings from research commissioned by the RST from The King's Fund on culture and behaviour and from CAMERA on patient and public involvement. It is also supported by the preliminary findings of research carried out in 2013 by the Academy of Medical Royal College's Specialty Guidance Group.²

² See page 11 for further information on these reports.

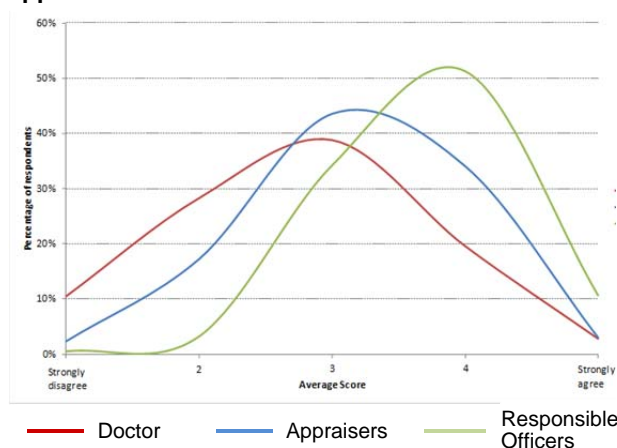
Summary of findings

The research shows that there is considerable support, particularly among responsible officers and appraisers, for the purpose and value of revalidation. This is illustrated in **Figure 1** below.³

The purpose of medical revalidation is to improve the safety, quality and effective delivery of care for patients by bringing all licensed doctors into a governed system that prioritises professional development and strengthens personal accountability.

NHS Revalidation Support Team

Figure 1: Support for the purpose and value of appraisal and revalidation



See page 30 for further information on this chart

Evidence that revalidation is starting to deliver benefits includes:

- an increase in the uptake of appraisal from 63% in 2010-11 to 76% in 2012-13
- an increased focus on the quality of appraisers and the appraisal process
- indicative signs that concerns about a doctor's practice are being identified at an earlier stage.

However the changes are not universally supported by doctors: some of whom feel that the system is not yet relevant to their needs. While appraisal, continuing professional development (CPD) and personal development plans (PDPs) continue to be valued there is anxiety that revalidation may make these activities more procedural and less developmental. Qualitative comments suggest that this is a potentially significant issue that will need to be addressed.

The research also identifies the need for stronger and more effective patient and public involvement in supporting revalidation. This would be enabled by differentiating more clearly between patient feedback, public voice and lay involvement.⁴ Findings in each of these areas are summarised below.

³ See page 30 for additional information.

⁴ Patient feedback includes individual feedback from patients (or their carers or families) required by the GMC and all other patient feedback collated by healthcare organisations. Public voice includes the collective patient voice (usually articulated by representatives) as well as the wider public voice.

- Responses to the RST's surveys, particularly those from responsible officers, agree that the requirement to consider feedback from patients (and/or from carers and members of the patient's family) improves the standard of a doctor's practice. As shown in Figure 7 on page 22 doctors are less positive on this point. Qualitative comments from the RST's surveys point to the need for improvements to current guidance and mechanisms for collecting this feedback.
- Responses to CAMERA's survey provide evidence that the collective voice of patients and members of the public could be made more effective by enabling them to connect more easily with the patient and community groups that represent their views. These groups would also benefit from stronger links with responsible officers in their area.
- Lay involvement is already valued, where it is available, in supporting revalidation. The research suggests that lay members can be engaged most effectively by ensuring they have specific roles and are engaged, trained and supported on a more formal basis.

The impact of revalidation on the culture and behaviours⁵ of doctors in healthcare organisations is a core part of the research. A key finding, as illustrated in **Figure 1**, is that different groups see the impact of revalidation in different ways. These differences have created or at least contributed to uncertainty about the purpose and scope of revalidation. In reality, revalidation is a regulatory measure intended to ensure that doctors participate in and make effective use of regular medical appraisals to strengthen their professional development. For the majority of doctors, it brings their current commitment to professional development and personal accountability into a governed system and requires only acceptance of new process. However, for a minority of doctors it requires a step-change in the way they work. The difference for both sets of doctors is that they now need to demonstrate that they are up-to-date and continue to be fit to practise rather than rely on the unchallenged assumption that this is the case.

Qualitative comments from respondents to the RST's surveys suggest that there is currently a focus on compliance with standard processes. This has led to early issues with the time commitment for doctors and appraisers to collect and provide information and prepare for appraisals and, for responsible officers, required to manage and quality assure the process.⁶ Responsible officers for designated bodies with relatively few doctors identified particular issues with the workload and asserted that it was disproportionate for them to set-up processes and carry out activities that are more

⁵ Culture is defined as "beliefs and stories about the way things are done around here" and behaviour as "the decisions or actions taken by individuals". In most cases, behaviours are conditioned by culture.

⁶ A number of responsible officers also expressed concern about the anticipated increase in workload that will result from the increase in the number of doctors being revalidated in 2014-15 and 2015-16. However, this increase is allowed for in the Department of Health's cost-benefit analysis.

appropriate for larger organisations. This should be balanced with the need for every designated body, irrespective of size, to meet its statutory obligations in relation to the Medical Profession (Responsible Officers) Regulations. Preliminary findings from research carried out by The King's Fund highlights the importance of proactive engagement and leadership in addressing these issues.

The findings set out in this report are focused primarily on the views of doctors, appraisers and responsible officers. Future measurement and research will need to provide a broader context that highlights the views of designated bodies as employers and of patients and the public as beneficiaries.

Recommendations

The findings set out in this report and summarised above have been used to develop the six recommendations outlined below. These are intended, in the first instance, for consideration by the England Revalidation Implementation Board⁷.

Enabling actions for each recommendation are provided at the end of the relevant section of the report and are summarised on page 57. The term 'partners' is used to refer to organisations represented on the English Revalidation Implementation Board and includes the Department of Health, General Medical Council and NHS England.

- **Recommendation 1:** Partners need to reconfirm the intent of appraisal, revalidation and clinical governance and communicate this more clearly to ensure stronger and more meaningful engagement in the process. This needs to be communicated now and throughout the implementation period.
- **Recommendation 2:** Patients and the public need a more powerful role in revalidation. This requires stronger mechanisms for feedback, clearer processes for engagement of lay members and more attention to the collective voice of patients and the public.
- **Recommendation 3:** Responsible officers need to work closely with boards and executive teams to ensure revalidation moves beyond compliance and is used to promote excellence in quality and safety for patients.
- **Recommendation 4:** Partners should identify and share examples of operating models to ensure revalidation is being managed in a way that is proportionate and effective.
- **Recommendation 5:** Systems, protocols and guidance need to be strengthened to provide assurance that information is being used in the most effective way for revalidation

⁷ The England Revalidation Implementation Board (ERIB) is the board carrying responsibility for the implementation of revalidation in England. The Board is chaired by NHS England.

- **Recommendation 6:** Partners need to continue to work together to collect evidence and gain insight on the costs, benefits and impact of revalidation. Research should be prioritised throughout implementation (with annual reports published) culminating in a post-implementation review in 2016-17.

Conclusion

Revalidation brings all licensed doctors into a governed system that prioritises professional development and strengthens personal accountability. Our research shows there is strong support, particularly among responsible officers and appraisers, for the principles and value of revalidation and its ability to improve safety, quality and effective delivery of care for patients. However this is not yet shared universally among doctors: some of whom feel that the system is not relevant to their needs. Therefore, in seeking to assure the quality and impact of revalidation, it will be essential to highlight and incentivise the realisation of benefits rather than simply ensure compliance with the process.

If the recommendations outlined above are accepted by the England Revalidation Implementation Board and lead to effective action, it will address issues identified in the first year of implementation and motivate doctors to engage more actively. By stimulating this engagement, revalidation will contribute to continuing public confidence in the medical profession.

Allan Coffey,
Chief Executive Officer

Ralph Critchley,
**Director, Research and Quality
Improvement**

Introduction

Purpose

This report summarises findings from research carried out on the early benefits and impact of medical revalidation in 2013-14. The findings are presented in sections 1-5 of the report as listed below:

Section 1. Appraisal and supporting processes for revalidation

Section 2. Patient and public involvement in revalidation

Section 3. The impact of revalidation on the culture of organisations and the behaviours of doctors

Section 4. Support for responsible officers and workload

Section 5. Use of information technology and data for appraisal and revalidation.

The report provides an evidence base and recommendations for work to be taken forward to implement a locally adopted framework for quality assurance and to plan, support and monitor the realisation of benefits.

Background

The purpose of revalidation is to provide assurance to patients and the public, employers and other healthcare professionals that licensed doctors are up-to-date and fit to practise. This aim will be achieved through annual appraisal and processes supporting revalidation (as illustrated in **Figure 2** on page 8).

Revalidation is a complex national programme that is being implemented over a three-year period ending in 2016. The majority of licensed doctors will revalidate for the first time during this three-year period. After implementation, licensed doctors will usually be expected to revalidate every five years. The changes, especially during the implementation phase, will require significant investment in time and resources from doctors and healthcare organisations. Furthermore, revalidation is expected to create a net cost to the system during its first four years. However, from 2017, this investment is expected to create a net benefit of around £50-£100 million per year as the full benefits are realised.⁸

The expected benefits of revalidation include:

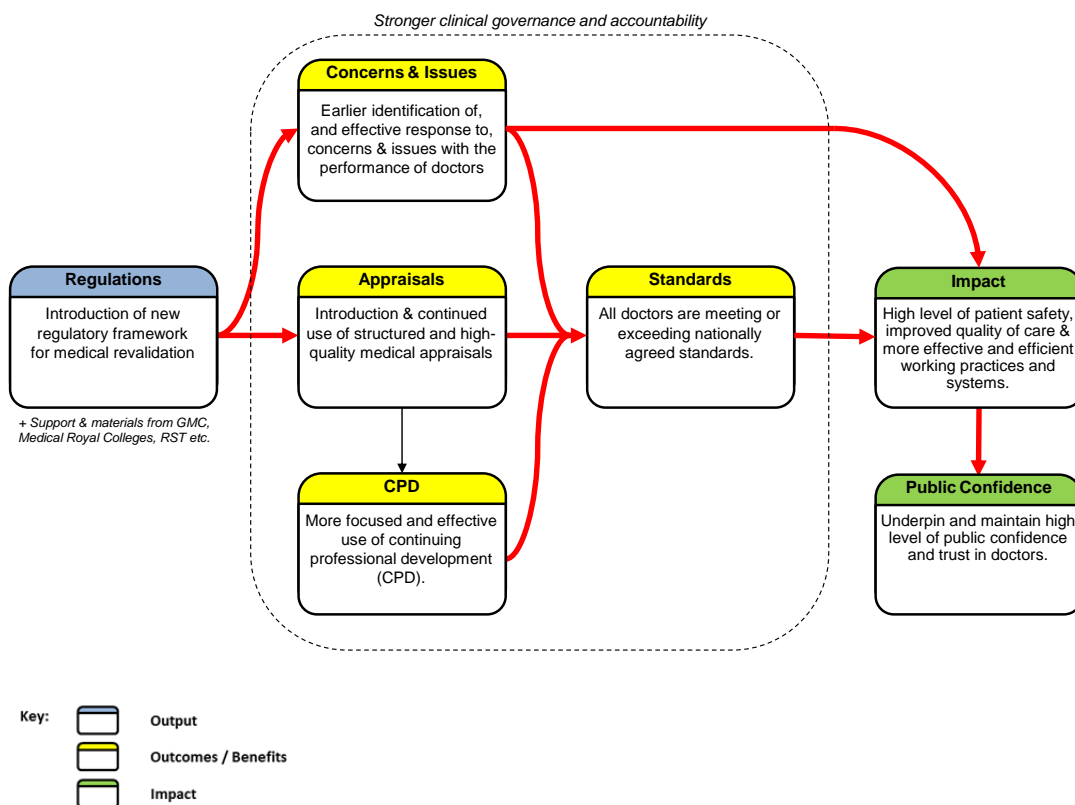
- improved governance of professional development and standards
- improved patient safety

⁸ See Department of Health. 2012. *Medical Revalidation – Costs and Benefits: Analysis of the costs and benefits of medical revalidation in England*. London: Crown copyright for details

- improved quality of care
- improved effectiveness and efficiency of systems and working practices, leading to...
- improved public trust and confidence in the medical profession.

The RST has developed the illustrative outcome and benefits map shown below to explore and communicate plausible connections between revalidation and the impact that it is intended to have and, in particular, to enable shared examination of the assumptions 'underneath' the connecting arrows.

Figure 2: Outcome & Benefits Map (for illustrative purposes only)



Research method

The NHS Revalidation Support Team (RST) initiated research in June 2013 to:

- identify outcomes and early benefits in the first year of medical revalidation
- review the benefits expected to be realised over the next few years
- identify the cultural conditions needed to optimise benefits in different contexts
- validate the expected costs of revalidation and identify opportunities for reducing these costs.

Benefits Working Group

The RST's first step in setting out a method for measuring costs, benefits and impact of medical revalidation was to establish a Benefits Working Group with members listed on the acknowledgements page ii.

The purpose of the group was to:

- help design the RST's research activities in 2013-14
- review and comment on outputs from the research
- assist with transition and mainstreaming of relevant activities.

Measures and indicators

In preparation for the first Benefits Working Group meeting in June, the RST consulted with the Department of Health and GMC to identify 66 indicators that could be used to assess baseline and expected costs and benefits of medical revalidation. These indicators were derived from 16 higher-level 'measures' of outputs and outcomes that were expected to have a positive impact on patient safety, quality of care, effectiveness and efficiency of systems and working practices and, through these, on public trust and confidence in the medical system.

Glossary of key terms

Outputs are usually created by completing specified tasks and activities and are intended to enable or support the achievement of outcomes (from change).

Outcomes are usually achieved as a result of change and the culture / context within which the change takes place. Outcomes can be incentivised but cannot be 'forced' - except through coercion.

Benefit: the reason that a stakeholder likes a particular outcome, or expected outcome. A dis-benefit is the reason that a stakeholder dislikes a particular outcome or expected outcome. An outcome or expected outcome is often a benefit for some stakeholders and a dis-benefit for others. In these definitions benefits and dis-benefits are attributes of an outcome rather than separate entities.

Impact: the indirect or consequential outcome of a change that involves stakeholders who are outside the sphere of influence of the people/organisations leading the change. The benefit associated with an impact is typically stated in general rather than specific terms and is likely to be subject to many complex/competing influences.

The RST commissioned expert advice to help it identify and use the following criteria to prioritise 35 of the 66 indicators:

- **Quality of the data sources** – with respect to availability, timeliness and levels of disaggregation of relevant data
- **Level of attribution** – whether a change in the indicator could be attributed to revalidation
- **Validity** – the extent to which the indicator is defined clearly and is valid for the intended measure.
- **Time of expected realisation** – whether the related benefit is likely to be seen in the short, medium or long-term.

This initial prioritisation was reviewed in a workshop with the *Benefits Working Group* and pared down to 18 prioritised indicators for use in 2013-14 and a further 13 indicators that could be used in the longer-term.

The 18 priority and 13 longer-term indicators, and their associated measures, are listed in section 7 on 'Future Measurement', which also provides a link to an updated analysis of data available from published sources.

Surveys

The RST used prioritised indicators (for which data was not available from published sources) as the basis of online surveys for doctors, appraisers, responsible officers and designated bodies to collect information on their perspective of the current and expected impact of revalidation. The surveys were tested to ensure their usability and fitness for purpose and then published in October 2013.⁹ The surveys contained both open questions and closed questions and respondents recorded their own answers. The number of responses received for each survey is shown in **Figure 3** below together with the total size of the related population and the number of responses needed to draw statistically significant conclusions at a 95% confidence level with a 5% margin of error (CI).¹⁰ The responses included over 7,000 qualitative comments.

Commissioned research

The RST recognised that information gained from data gathered via the surveys would provide limited information on the impact of revalidation on the behaviours of doctors, the culture of organisations in different contexts and on the role of patient and public involvement in revalidation. Consequently, it commissioned additional research on these topics from The King's Fund and from the Collaboration for the Advancement of

⁹ Copies of the four surveys can be found in the NHS Revalidation Support Team. 2014. *The Early Benefits and Impact of Medical Revalidation: Technical Annex*. London: NHS Revalidation Support Team.

¹⁰ See *Technical Annex* for methodology and details for statistical analysis

Medical Education Research and Assessment (CAMERA) based at Plymouth University's Peninsula Dental and Medical School.

Figure 3: Number of responses to the RST's surveys

Survey	Number of responses		Size of population ¹¹	Responses needed for a CI of 95% ± 5%
	Number	% of population		
Doctors	2,499	2%	161,453	384
Appraisers	719	4%	16,998	376
Responsible Officers	192	34%	572	145
designated bodies	124	20%	621	238
Total	3,534			

The King's Fund designed and conducted 14 focus groups and 36 interviews at seven sites selected by the RST from a range of settings.¹² The King's Fund is publishing an independent report on the findings and recommendations from their research. Information on culture and behaviour in this report is based on the RSTs interpretation of preliminary findings documented by the Kings Fund prior to writing their report and on qualitative responses to the RSTs surveys. See www.kingsfund.org.uk/revalidation2014 for a copy of The King's Fund's report.

CAMERA collected detailed responses from interviews and a survey from 150 respondents and are publishing an independent report on their findings and recommendations. These have been provided to the RST and are used to inform this report. See www1.plymouth.ac.uk/peninsula/research/camera/Pages/default.aspx for a copy of CAMERA's report.

Key findings and recommendations in this report are also supported by preliminary results from research carried out in 2013 by the Academy of Medical Royal College's Specialty Guidance Group. This research included: a survey of doctors (appraisees), appraisers and responsible officers who had been involved in an appraisal for revalidation, a focus group for doctors and appraisers and a helpdesk enquiry data collection exercise.¹³

¹¹ NHS Revalidation Support Team. 2013. *Organisational Readiness Self-Assessment (ORSA) report 2012-13* London: NHS Revalidation Support Team

¹² The organisations with whom The King's Fund carried out their research are listed in the acknowledgements on page ii.

¹³ The Academy of Medical Royal College's resources can be found at: www.aomrc.org.uk/revalidation/item/academy-reports-and-resources

1. Appraisal and supporting processes for revalidation

Medical appraisal was introduced as a requirement in the NHS for consultants from 2001 and for general practitioners (GPs) in 2002. Annual medical appraisal is at the centre of the revalidation model and, for the vast majority of doctors, is their most direct contact with the revalidation process. Over the last few years, primarily during preparation for the implementation of revalidation, there has been significant investment in the provision of appraisal for all doctors.

The potential benefits of appraisal to an employee are well-documented and include:

- serving as a guide to performance
- supporting trust between the employee and organisation
- setting goals
- looking at opportunities for improving performance
- determining training needs¹⁴.

Appraisal can, however, be ineffective if the organisational culture is not supportive¹⁵.

The main findings in this section are that:

- more doctors are now engaged in annual medical appraisal
- appraisal, PDP and CPD continue to be valued
- there are mixed views about the role of appraisal as part of revalidation
- there are indicative signs that revalidation is starting to enable earlier identification of concerns.

More doctors are now engaged in annual medical appraisal

The data shown below from the RST's organisational readiness self-assessment (ORSA) exercise in previous years shows a clear upward trend in the uptake of annual medical appraisals¹⁶.

¹⁴ Schraeder, M. et al. 2007. A Critical Examination of Performance Appraisals: An Organization's Friend or Foe? *The Journal for Quality and Participation*, Volume 30 – Number 1: 20-25.

¹⁵ McGivern, G. & Ferlie, E. 2007. Playing Tick Box Games: Interrelating Defences in Professional Appraisal. *Human Relations*, **60** (9) 1361-1385.

¹⁶ Of the doctors who responded to the survey, 92% had received an appraisal in the past year. This self-reported data may not be directly comparable with the results from ORSA and will need to be validated by data collected from designated bodies for 2013-14. Analysis of the data provided by respondents does not show any significant variation between doctors in primary and secondary care settings or between locum and non-locum doctors.

Figure 4: Comparative ORSA appraisal rates

	2010-11	2011-12	2012 - 13
Appraisal rates	63.3%	72.7%	76.1%

The evidence shows that there is still work to do to highlight the benefits of appraisal and ensure that all doctors are participating in annual medical appraisal, in line with the requirement to do so. There has been an increase in completed appraisal rates for all doctor types between March 2011 and March 2013, and improvements in some settings were substantial. The latest ORSA report¹⁷ does however show that there was a surprisingly slow rise in appraisal rates for consultants and staff grade and associate specialist doctors.

Appraisal, continuing professional development (CPD) and personal development plans (PDPs) continue to be valued

The following indicators from the surveys illustrate that appraisal, CPD and PDPs continue to be valued by doctors.

Appraisal

- 80% of doctors agreed or strongly agreed that their appraisal was conducted in a supportive way. (Doctors' survey: Q9)
- 83% of doctors agreed or strongly agreed that their appraiser listened fully to their concerns. (Doctors' survey: Q10)
- 82% of doctors agreed or strongly agreed that their appraiser enabled them to be open and honest about their practice. (Doctors' survey: Q10)
- 64% of doctors agreed or strongly agreed that their last appraisal was a good use of their time. (Doctors' survey: Q12)
- 90% of appraisal 'leads' had noticed improvements in the quality of the outputs of appraisal since the introduction of revalidation, although this was only reported by 43% of appraisers.¹⁸ (Appraisers' survey: Q8)
- 24% of doctors reported that they changed aspects of their clinical practice or behaviour as a result of their last appraisal. (Question 8: Doctors' survey)
- 65% of appraisers said that they had been able to identify and agree specific circumstances in which doctors they appraised could deliver better care or treatment to patients. (Appraisers' survey: Q11)

¹⁷ Organisational Readiness Self-Assessment (ORSA) report 2012-13, p39-40

¹⁸ The survey did not specify any particular criteria for assessing improvements in the quality of appraisal outputs and these are therefore based on the opinions of appraisal leads and appraisers.

Medical appraisal is a process of facilitated self-review supported by information gathered from the full scope of a doctor's work. Medical appraisal is a recognised mechanism that enables doctors to:

- discuss their practice and performance with an appraiser
- demonstrate that they continue to meet the principles and values set out in the GMC's Good Medical Practice Framework for Appraisal and Revalidation
- plan their professional development around their own needs
- contribute to appraisal outputs used to inform the responsible officer's revalidation recommendation to the GMC.

In terms of the quality of appraisals being carried out, a number of positive findings have been identified including that for some doctors appraisal is leading to enhanced reflection on the care provided to patients. There was however a relatively small number of doctors who reported changing aspects of their clinical practice or behaviour as a result of their last appraisal – some positive examples are provided below:

[I changed my clinical practice in three areas:] "The management of diabetes in illness. The management of low back pain. The consultation and how it progresses and becomes successful." Doctor

"Prompted further action as a department to address issues regarding practice of a colleague". Doctor

It is difficult to know what a positive proportion of self-recognised change might be, and further research may be required to understand this point in more detail. Responsible officers were very positive about the quality and benefits of appraisal in generating change in doctors. Some qualitative comments from responsible officers are provided below.

"Big improvement in quality with the advent of revalidation" Responsible officer

"These are early days. As we develop better systems and introduce new practices and embed them, we are getting better at this. Inevitably doctors complain, at times, that this is just about ticking boxes. My approach has been to make appraisal a part of quality improvement." Responsible officer

Continuing Professional Development (CPD)

- 70% of doctors agreed or strongly agreed that CPD enabled them to keep up-to-date with developments in their specialty. (Doctors' survey: Q12)
- 47% of doctors felt that their CPD had a direct and demonstrable impact on the care and treatment they provided. (Doctors' survey: Q12)
- 18% of doctors agreed or strongly agreed that CPD had improved since the introduction of revalidation. (Doctors survey: Q12)
- 81% of responsible officers agreed or strongly agreed that the CPD had improved since the introduction of revalidation. (Responsible officer survey: Q9)

While CPD is seen as positive by most doctors, they did not feel that this was related to revalidation. This finding contrasts with the views of appraisers and responsible officers who recognise changes in the quality of CPD since the introduction of revalidation. While there is no direct evidence to explain this difference, it may be that responsible officers see 'improvement' in terms of increased visibility of CPD whereas doctors see 'improvement' in terms of increased availability and perceived relevance of development opportunities. Introduction of revalidation will have increased 'visibility' but, for the majority of doctors, has not increased its availability or relevance.

Personal Development Plans (PDPs)

- 58% of doctors agreed or strongly agreed that PDP reflects the priorities of their personal and professional development. (Doctors' survey: Q13)

The majority of doctors felt that PDPs were a good way of supporting personal development and learning needs and of addressing the needs of the organisation, with a strong focus on the care and treatment of patients.

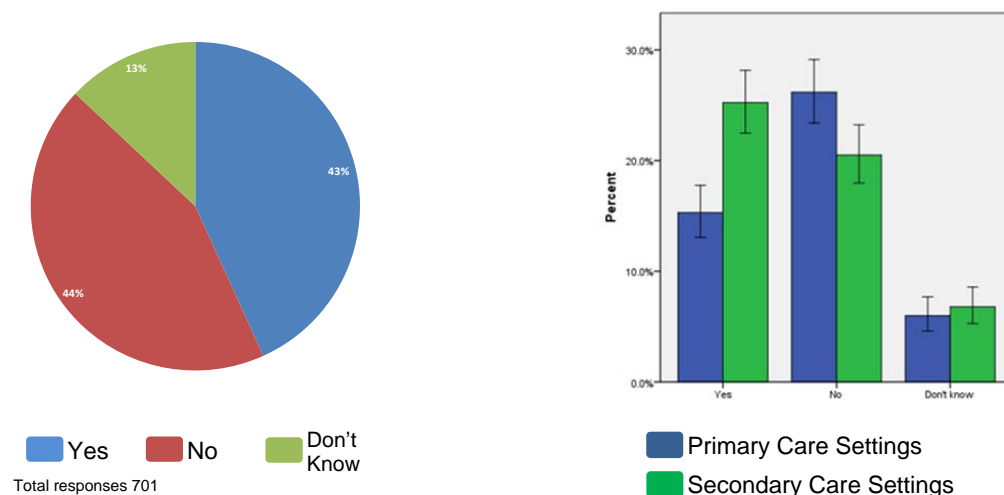
If appraisal and other processes supporting revalidation including CPD are carried out well, they have the ability to motivate a doctor to aspire to higher standards of practice. It will be important to understand how to harness the potential of appraisal more widely among doctors. The King's Fund's preliminary findings suggested that in organisations where revalidation is seen, and supported, as a source for development, engagement in appraisal is more positive and active.

Mixed views on whether revalidation has improved the appraisal process

Findings from the RST's surveys and The King's Fund's qualitative research show that opinions were mixed on whether revalidation has improved the appraisal process. From the surveys, opinions were divided among appraisers as to whether revalidation has improved the appraisal process: 43% agreed, 44% disagreed and 13% did not know. There was a significant difference in these responses between appraisers in

primary care and secondary care – with a higher level of agreement in secondary care. This difference is perhaps unsurprising given the relatively well developed status of appraisal in primary care compared to secondary care¹⁹.

Figure 5: In your opinion, has revalidation improved the appraisal process? (Q10 Appraisers' Survey)



Appraisers responding 'yes' were asked briefly to describe the key improvements. The most significant improvements to appraisal identified, by those who commented, centred on the formalisation of appraisal due to revalidation. In particular, respondents noted that:

- doctors were more engaged with appraisals, due to an increased sense of authority and importance ascribed to appraisal since the introduction of revalidation
- there was an increased focus on reflective practice by doctors
- the new system provides greater clarity, which is often to do with the standardisation of appraisal
- standardisation had also led to increased quality and improved systems, such as the RST's *MAG Model Appraisal Form*
- the requirement for all doctors to receive appraisals was in itself an improvement
- the quality of documentation and feedback has increased.

¹⁹ Appraisal systems were relatively underdeveloped in comparison with those in primary care as detailed in the RST's Organisational Readiness Self-Assessment (ORSA) Report 2012-13

A selection of comments from appraisers to this question is included below.

“More focus on areas that would be of interest to our peers and the wider public.”

“Introduction of the MAG form has had a beneficial impact in my opinion. It has reduced the amount of paperwork for both appraisee and appraiser, and made the presented information more relevant and concise. I imagine revalidation has also encouraged more doctors to engage in a positive manner.”

Some appraisers who responded ‘no’ provided qualitative comments to support their answers. A sample of these is provided below:

“It has made it less developmental and many GPs have become defensive about the process. Too much tick-boxing and not enough genuine reflection on things that will make a difference. The MSF [multi-source feedback] has become unwieldy and prescriptive.”

“Enhanced revalidation includes a judgmental element, whereas true appraisal was formative. This has altered the appraiser/appraisee relationship.”

A common perception identified across the surveys was that the revalidation process is primarily concerned with ensuring that a doctor meets minimum requirements, rather than improving their practice or the care they give to patients.

“Revalidation is a tick-box exercise and I will be happy to do the bare minimum required.” Doctor

“It is designed to provide external assurance of the individual professionalism of the practitioner and indicate that the participant has met minimum standards...it is a hurdle that can be cleared easily.” Doctor

Research suggests that if there is doubt about the value of appraisal or a lack of trust with the employer or the ‘system’, then the process is more likely to be seen as purely procedural²⁰. It is therefore essential that the purpose of appraisal, and the nature of its relationship to revalidation, is communicated effectively and understood widely.

The survey responses raise some concerns about the workload implications for both doctors and appraisers of preparing for appraisal as part of revalidation: this is detailed in the section 5: ‘Support for responsible officers and workload. Doctors may also present more supporting information than is required, which could be mitigated through

²⁰ McGivern, G. & Ferlie, E. (2007) ‘Playing Tick Box Games: Interrelating Defences in Professional Appraisal’, Human Relations, 60 (9) 1361-1385

clearer guidance²¹. There is a need to assist doctors in focusing their efforts and restricting the time taken by the average doctor in preparing for an appraisal.

There are indicative signs that revalidation is starting to enable earlier identification of concerns

This finding is based on a range of indicators from the surveys including those below:

- 21% of respondents to the designated body survey identified more concerns in the year to March 2013 than in the previous year.²² (Designated body survey: Q21)
- 38% of respondents to the designated body survey said that the introduction of revalidation has allowed their organisations to identify concerns at an earlier stage (Designated body survey: Q22).
- 81% of respondents to the doctors' survey said they would be willing to raise concerns about a colleague, if they wished to do so, as part of an appraisal discussion²³. (Doctors' survey: Q11)
- Respondents to the designated body survey indicated that 60% of concerns raised in 2012-13 were grouped as 'low-level' concerns, 30% were 'medium-level' concerns and 10% were 'high-level' concerns.²⁴ (Designated body survey: Q14)

²¹ This point is expressed in p.55 of the RST's report on Medical Appraisal Guide Pilot results (2012) http://www.revalidationsupport.nhs.uk/about_the_rst/rst_previous_projects/Testingandpiloting.php

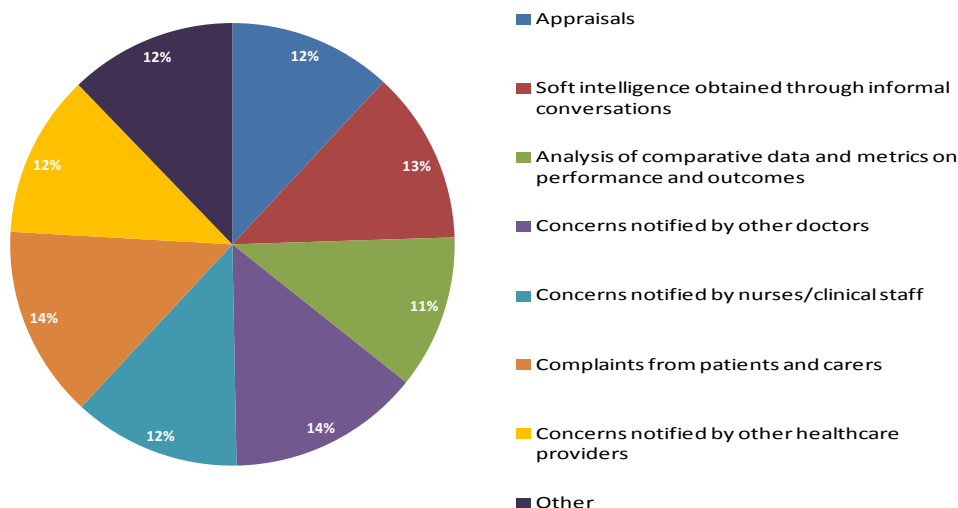
²² Question 21 in the designated body survey only asked for a 'Yes' or 'No' response to the question on whether more concerns were identified in the year to March 2013 than in the previous year and is therefore unable to identify the scale of the change.

²³ This question was intended to assess whether doctors had sufficient trust in the appraisers and, more generally in the appraisal process, to raise concerns about a colleague. In most cases, this would not be necessary or appropriate because concerns should be raised at the earliest opportunity and should not be held back until the appraisal.

²⁴ Data from the RST's Responding to Concerns Survey in 2011 identified 60% of concerns as low-level, 23% as medium-level and 17% as high-level.

Concerns originated from a wide range of sources as shown below:

Figure 6: Concerns originated by source (Designated body survey: Q12)



The majority of concerns about doctors' performance are being identified through improved governance mechanisms rather than through appraisal. It will be important to see whether the percentages change over time. The findings, summarised above, are supported by qualitative comments from the designated body survey, including:

"We can see that the revalidation process will identify concerns earlier over time ... with good links between appraisal leads and area team colleagues." Designated body

"There are more doctors reporting concerns about other doctors." Designated body

"On one or two occasions stress-related issues were identified through interactions with those involved in appraisal, or through lack of engagement with appraisal." Designated body

An important distinction is that appraisal offers the opportunity for doctors to self-identify concerns while clinical governance enables concerns to be identified by others.

Another consideration is that, if clinical governance information has improved in order to support effective appraisal, then appraisal may be supporting the identification of concerns outside of the appraisal process.

A comparison of the data collected here with that collected by the RST's survey on Responding to Concerns in 2011 suggests that there may be fewer high-level concerns and more medium-level concerns. This is indicative that concerns are being identified at an earlier stage and will need to be monitored in the future.

The research focused on the appraisal and supporting processes including the identification and type of concern. It did not consider the nature or efficacy of remedial activities and/or remediation.

Recommendation to enhance appraisal and supporting processes

Recommendation 1: Partners need to reconfirm the intent of appraisal, revalidation and clinical governance and communicate this more clearly to ensure stronger and more meaningful engagement in the process. This needs to be communicated now and throughout the implementation period.

If this recommendation is accepted, it could be taken forward by carrying out the following actions.

- Prepare and publish updated guidance that defines the differences and interaction between appraisal, clinical governance and revalidation. This guidance should explain the role of medical revalidation in bringing all licenced doctors into a governed system that:
 - ensures doctors participate in and make effective use of regular medical appraisals to strengthen their professional development
 - highlights the importance of personal accountability and sets the context within which this is expected
 - prioritises investment required to obtain and integrate information from clinical governance activities and systems.
- Promote appraisal as a developmental activity within a governed system. It should be designed to motivate doctors to aspire to the highest standards of practice, rather than to meet minimum requirements.
- Ensure clinical governance systems are used in a fair, open and transparent way to support appraisal, inform revalidation and identify and respond to concerns about doctors.
- Provide guidance to responsible officers that, in making revalidation recommendations, they should be able to rely on information from clinical governance and outputs from a quality assured appraisal process. It should only be necessary to review appraisal inputs to quality assure the process or when a concern has been raised and additional information is required.

2. Patient and public involvement in revalidation.

This section reviews responses to a question on patient feedback in the RST's surveys²⁵ and the findings of research commissioned by the RST from CAMERA on the broader question of patient and public involvement (PPI) in revalidation and, more generally, in the appraisal and governance of doctors.

The RST has identified three main findings from this research:

- patient feedback needs to be a more effective part of the appraisal and revalidation process
- the public's voice needs to be represented more strongly in revalidation
- lay involvement is essential to the processes supporting revalidation and participants need to be engaged on a more formal basis.

CAMERA's research identified considerable confusion over the meaning and use of 'patient and public involvement'. This finding is illustrated by the following quotes²⁶.

"There is a strong sense that PPI has been adopted as commonplace 'management speak'; a rubber stamp for inclusive process, which has rendered PPI conceptually vague. In common parlance, for example, it is used to refer to patient feedback, and typically to patient questionnaires. This facet of PPI is clearly very distinct from lay representation, but the terms remain blurred..."

"We would argue that without clarity of roles, responsibilities and purpose, PPI risks losing its potency as a driver for change and improvement in healthcare via collaboration with patients on various levels"

(CAMERA, 2014, p.9)

It is for this reason that the findings in this section of the report are presented under headings related to patient feedback, public voice and lay members. These terms are defined below.

- **Patient feedback:** Includes information doctors need to collect from patients²⁷ (or their carers or family) to meet GMC requirements for revalidation. It also includes all other information provided by patients (or their carers or family) and collated by healthcare organisations – for example: formal and informal complaints and compliments, responses to the NHS friends and family test and data provided on

²⁵ The relevant question in the RST surveys for doctors, appraisers and responsible officers was whether the requirement to consider patient feedback improves the standard of doctors' practice.

²⁶ Regan de Bere, S. et al. 2014. *Patient and public involvement in medical revalidation* p.9 (ibid). Plymouth: CAMERA at Plymouth University Peninsula Schools of Medicine and Dentistry Medicine.

²⁷ A patient is defined as someone who is receiving (or has recently received) medical care or treatment.

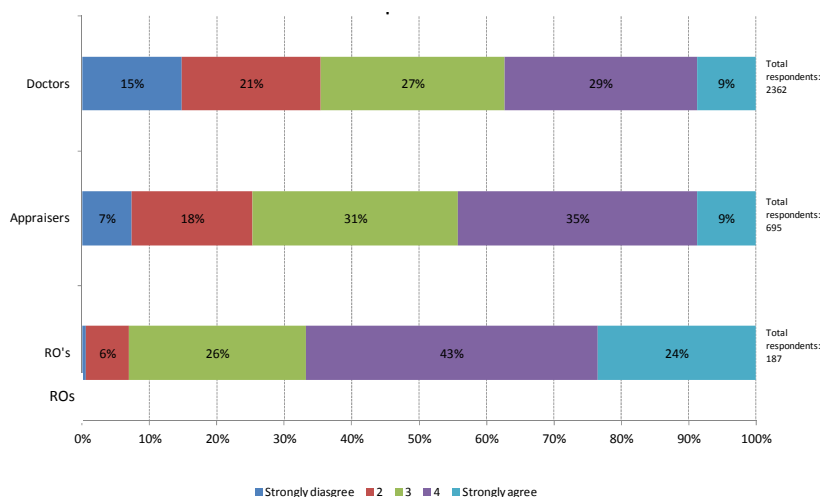
websites such as the 'Care Connect' portal on the NHS Choices website²⁸ and the 'I Want Great Care'²⁹ website.

- **Public voice:** Refers to the collective patients' voice and/or the wider public's voice and is usually articulated by: representatives of local community groups, local and national patient advocacy groups, and local patient groups established by healthcare organisations and statutory groups such as Healthwatch.
- **Lay members:** People from outside healthcare organisations with specific skills or experience who contribute an external perspective to a group or committee. These people may, or may not, be a patient or a representative of patients or the public.

Patient feedback needs to be a more effective part of the appraisal and revalidation process

- 38% of doctors agree or strongly agree that the requirement to consider patient feedback improves the standard of a doctor's practice. (Doctors' survey: Q14)
- 44% of appraisers agree or strongly agree that the requirement to consider patient feedback improves the standard of a doctor's practice. (Appraisers' survey: Q18)
- 67% of responsible officers agree or strongly agree that the requirement to consider patient feedback improves the standard of a doctor's practice. (Responsible Officers' survey: Q9)

Figure 7 – Impact on standard of practice of requirement to consider patient feedback³⁰



²⁸ www.nhs.uk/careconnect/choices

²⁹ www.iwantgreatcare.org

³⁰ The percentages are rounded up to the nearest integer and therefore some of the rows add to 101%

The data above relates to the value of feedback from individual patients as perceived by doctors, appraisers and responsible officers. There is a contrast in views, with responsible officers and appraisers being more positive, and doctors evenly divided on the value of patient feedback. The following qualitative comments from doctors suggest that the less positive views of doctors may be the result of tools and mechanisms that do not yet enable patient feedback to be an effective part of appraisal and revalidation process.

“Patient feedback is a useful tool if applied in consecutive patients ‘after’ the effect rather than during the consultation phase; otherwise, it is a measure of charisma and first impressions, which is not the intent.” Doctor

“I strongly agree that patient feedback could be very helpful in improving doctors’ standards of practice if only relevant and appropriate questions are asked.” Doctor

“Patient feedback is a poor measure of the doctor’s standard of practice. A high score is obtained by responding to the patients’ wants and not their needs.” Doctor

“I feel that the patient feedback collected was not of any use. There is no mechanism to ensure it [the patient feedback] has been filled in by the patient or relatives. In reality, I could have filled in all the feedback and sent it back to the revalidation team via internal post and no one would be none the wiser.” Doctor

“The tools we currently use to get patient feedback are a bit blunt, Whilst they probably will tell me if I have a particularly bad doctor they don’t allow more nuanced feedback that would be helpful to a clinician who wants to improve.” Responsible officer

The current feedback mechanism is usually based on a patient describing their experience of a single consultation, using a questionnaire which is consistent with guidance published by the GMC.³¹ The questionnaire is usually distributed for and collected on behalf of the doctor, though not universally so. The requirement is currently limited to doctors seeking this type of feedback from as few as 18 patients, once during each revalidation cycle, which is normally every five years. Mirroring the view of many doctors, patient groups have expressed concerns about the adequacy of these current arrangements. On 16 July 2012, UK patient organisations issued a statement of support³² for revalidation which also stated:

³¹ GMC. 2014. *Colleague and patient feedback for revalidation* [Online]. [Date accessed: 12 March 2014]. Available from: www.gmc-uk.org/doctors/revalidation/colleague_patient_feedback

³² Academy of Medical Royal Colleges Patient and Lay Group et al. GMC. 2012. *Medical revalidation: a statement of support from UK patient organisations*. [Online]. [Date accessed: 12 March 2014]. Available from: www.gmc-uk.org/Medical_revalidation_a_statement_of_support_from_UK_patient_organisations_FINAL.pdf_49303617.pdf

“Patients are a key resource in helping to improve medical practice. The scope and frequency of patient feedback in the initial revalidation model is, in our view, too limited, but it does establish the principle of patient feedback in the process. We know that many doctors already collect feedback from patients for their appraisals and we expect that all doctors will utilise this resource to help them improve their own practice.”

The concerns of patient organisations include the numbers of patients required to provide feedback; the frequency of feedback exercises; the accessibility of the feedback mechanism to some patients; the administration and independence of the feedback received; and the adequacy of current tools. There was also concern that doctors working in specific areas or specialties may find it difficult to meet the GMC’s requirements, including those doctors working in anaesthetics, pathology, occupational health and laboratory medicine.

“Getting patient feedback when you are an anaesthetist is challenging – for a start, you are a small (though vital) part of the patient experience, but how likely are they to remember you. It must be worse for radiologists and pathologists.” Doctor

The concern perceived by doctors in these specialities can be addressed if patient feedback is defined, as noted earlier, to include feedback from carers and members of a patient’s family. There is a need for the development of the GMC’s existing guidance, including worked examples, particularly for these groups of doctors for whom patient feedback is more of a challenge. These are key parts of the recommendation included at the end of this section and it is anticipated that the Academy of Medical Royal Colleges and the individual medical royal colleges for these specialities would want to contribute to development of updated guidance.

If the mechanism for collecting patient feedback is improved, care needs to be taken to ensure that it is used alongside other sources of patient feedback, including complaints and compliments. Feedback from all sources needs to be collated at an organisational level: some organisations are already providing this on an individualised basis for their doctors. Opportunities for qualitative feedback from patients would also be valuable as part of the process, based on either patients’ own initiative or because patients are encouraged to do so by community organisations. Mechanisms such as the ‘Care Connect’ portal on the NHS Choices website and the ‘I Want Great Care’ website, need to be developed to support provision (and moderation) of qualitative feedback about the experience of patients and their carers and families. Critically, the data collected via these mechanisms needs to be analysed and used to improve services.

The value of patient feedback as part of revalidation will lie in whether doctors alter their practise as a result, leading to changes and improvements in the services received by patients. The challenge will be to enable regular and high quality input from patients, to support doctors in responding to this feedback and for healthcare

organisations to inform patients about the changes and outcomes that have resulted from the feedback.

The public's voice needs to be represented more strongly in revalidation

"The patient voice should be heard and heeded at all times. Patient involvement means more than simply engaging people in a discussion about services. Involvement means having the patient voice heard at every level of the service, even when that voice is a whisper" Don Berwick³³

The following data is taken from CAMERA's survey into patient and public participation in the appraisal and governance of doctors.

- 92% of lay and organisational respondents to the survey said that the general public was 'not at all' aware of the revalidation of doctors. (Patient and public survey: Fig 10)
- 96% of lay and organisational respondents to the survey considered it important for lay members to be able to represent the point of the general public and 94% the ability to represent a collective patient view. (Patient and public survey: Table 10 and Appendix 4)
- 85.2% of lay members and 82.5% of organisations felt recent experience of being a patient was a key element of the lay role (Table 8 and 9, Appendix 4)

CAMERA's finding that there was almost no public awareness of the revalidation of doctors echoes the findings of research commissioned by the RST and carried out by The King's Fund and Ipsos MORI³⁴ at the start of 2012. This earlier research showed that the public assumed and expected some form of formal oversight for doctors already existed and went on to suggest 'that greater awareness of this system will improve people's confidence in doctors'³⁵.

It seems likely that a greater awareness of revalidation will allow the collective voice of patients and the public to be represented more strongly in the appraisal and the governance of doctors. Furthermore, confusion about the different facets of PPI may be restricting the current level of engagement. This confusion, discussed in the introduction to this section, is illustrated in the following quotes.

³³ Berwick, D. et al. 2013. *Improving the Safety of Patients in England*. London: Crown copyright, p.18.

³⁴ Ipsos MORI & The King's Fund. 2012. *Patient and Public Involvement in Revalidation: Assuring confidence in revalidation*.

³⁵ *ibid* p.46

“Lay involvement is not the same as patient involvement. These terms are often used interchangeably and mean different things. Lay involvement has a role to play in good governance. Patient involvement ensures that the patient voice is heard and that services and professional practice has the patient and their experiences at its centre.”

(CAMERA, 2014, p.61)

“... for patient representation recent patient experience and involvement in patient groups are useful. For lay involvement, this is not crucial.”

(CAMERA, 2014, p.54)

The collective voice of patients and the public needs to be a key component in the governance of healthcare and therefore of revalidation as a mechanism for regulating and improving the quality of care. However, the disparate nature of how the public expresses its view presents a challenge. To address this challenge, healthcare organisations need to develop and publicise mechanisms for individual patients to contribute to the collective voice required to support revalidation and, at the same time, enable responsible officers to build and sustain links with local community groups, local representatives of national patient advocacy groups and members of the local Healthwatch.

Lay involvement is essential to the processes supporting revalidation and participants need to be engaged on a more formal basis³⁶

The research carried out by CAMERA focused on lay involvement in the processes supporting revalidation. In this context, lay involvement in revalidation is less about being a current patient and more about possessing and applying relevant skills and attributes in supporting and critiquing aspects of the revalidation process. Key findings from CAMERA’s research include the following points:

- 81% of respondents agreed that “lay representatives could make a significant contribution towards the appraisal and governance of doctors, with both lay and organisational representatives equally expressing a similar view.” (Fig 11, page 41)
- Respondents felt that there should be lay involvement in quality assurance of appraisal (77%); steering groups responsible for governance (74%), organisational response to significant events (70%), and response to complaints about doctors (69%). (Table 4, Appendix 4)
- Lay involvement is a scarce resource, and respondents felt that it would add greatest value in steering groups responsible for governance (86%) and in quality assurance (82%). (Table 5, Appendix 4)

³⁶ For the purposes of their research CAMERA define lay as “a general term of reference for the involvement of people who are non-professional or non-specialists...Lay representation is less about being a current patient and more about possessing and applying relevant skills and attributes.” (CAMERA p.10)

- 67% of respondents agreed that the “effectiveness of lay representation could be improved by introducing national co-ordination of the role” and 76% in “conjunction with greater management of the role”. (Fig 13 &14)

Lay involvement was deemed to be extremely valuable in processes supporting revalidation as it provided an external and independent perspective. The evidence suggests that more effective engagement will require greater specificity in the role and remit of lay members. This is illustrated in the qualitative comment below:

“...you have a role description; you know what it is that you’re supposed to do and what it is that you’re supposed to deliver on...”³⁷ Lay member

CAMERA made useful recommendations around the recruitment, training and support for lay members. These include developing a clear role description, clarity on the personal requirements needed to undertake the role, having in place clear recruitment procedures and making sure that lay members are inducted into the role. Lay input into developing these processes will be important.

The research also suggested that formalisation of the role and an increase in responsibility would require more investment in recruitment, training and potentially, remuneration. This is illustrated in the following qualitative comments:

“If somebody as a lay person comes in from out of the cold without pre-knowledge of the environment and as importantly, without the organisation having any knowledge of the individual, then there must be some kind of mentoring or process of induction.”
Lay member

“...if you are going to go through a very robust appointment process and you are going to get people who have the skills and the capabilities and the behaviours and the capacity to be able to do the work, there is going to have to be some payment involved. Not huge...but some recompense in there. [...] I think that if there isn’t some recompense in there a lot of potential talent will be lost.” Lay member

There is an opportunity for lay members³⁸ to ensure that outcomes from appraisals and revalidation are at the centre of improvements to services. One way in which this can happen is to ensure that they are participating in regular meetings which review collated feedback and outcomes from the appraisal and revalidation process and from clinical governance and responding to concerns.

³⁷ CAMERA p.38

³⁸ This opportunity should also apply to patient representatives from community and advocacy groups and members of the local Healthwatch.

The RST is also developing simple guidance to support healthcare organisations in strengthening patient and public involvement in medical revalidation. The guidance will include resources and signposting, which can be used in supporting best practice within organisations.³⁹

Recommendation to strengthen patient and public involvement

Recommendation 2: Patients and the public need a more powerful role in revalidation. This requires stronger mechanisms for feedback, clearer processes for engagement of lay members and more attention to the collective voice of patients and the public.

If this recommendation is accepted, it could be taken forward by carrying out the following actions.

- Review and strengthen the GMC's guidance for individual patient feedback to increase its perceived value and to enable greater choice in the way it is collected. In carrying out this review, partners need to:
 - consult with the Academy and Medical Royal Colleges to identify a practical way to provide patient feedback for doctors who do not engage with patients or their carers or families.
 - encourage a dialogue between doctors and representatives of patient and community groups to agree on improved forms of patient feedback.
 - consider increasing the number of patients from whom doctors are required to obtain feedback and/or the frequency with which this feedback is obtained.
 - establish clearer criteria for acceptable feedback
 - provide case studies of collection of feedback
 - identify and provide improved mechanisms for collecting patient feedback (as noted above) without a significant impact on doctors' workloads.
- Provide individual patients with easily accessible mechanisms that allow them to record their experience of specific doctors without waiting for the formal feedback process required by the GMC.
- Ensure that responsible officers arrange for their organisations to engage with patient and community groups to hear and respond to the wider public voice.

³⁹ NHS Revalidation Support Team. 2014 (pending publication). *Strengthening Patient and Public Involvement in Revalidation: Guidance for healthcare organisations*. London: NHS Revalidation Support Team.

- Encourage increased lay involvement in the processes that support revalidation. Lay members need to be recruited through a formalised engagement process and have a clear remit and role.
- Healthcare organisations need to provide feedback to patients and the public on the outcomes of their revalidation processes.

3. The impact of revalidation on the culture of organisations and the behaviours of doctors

This section reviews the early impact that revalidation is having on the culture of healthcare organisations and the behaviours of doctors. The findings are based on an analysis of qualitative comments provided by respondents to the RST's surveys, and a review of preliminary findings from qualitative research undertaken by The King's Fund. The RST has identified three main findings from the research:

- revalidation is seen in different ways by doctors, appraisers and responsible officers
- organisations are currently focusing on compliance
- the success of revalidation in realising the expected benefits and impact requires proactive leadership by boards and executives in all settings and organisations.

In measuring the impact on culture and behaviour, and attributing changes to revalidation, it is acknowledged that this is a necessarily qualitative exercise, based on collecting and analysing the views of those people experiencing and delivering revalidation on the frontline.

Revalidation is seen in different ways by doctors, appraisers and responsible officers

The following diagram illustrates the different ways in which revalidation is seen by doctors, appraisers and responsible officers.

Figure 8: Positive attitudes of different groups to appraisal and revalidation

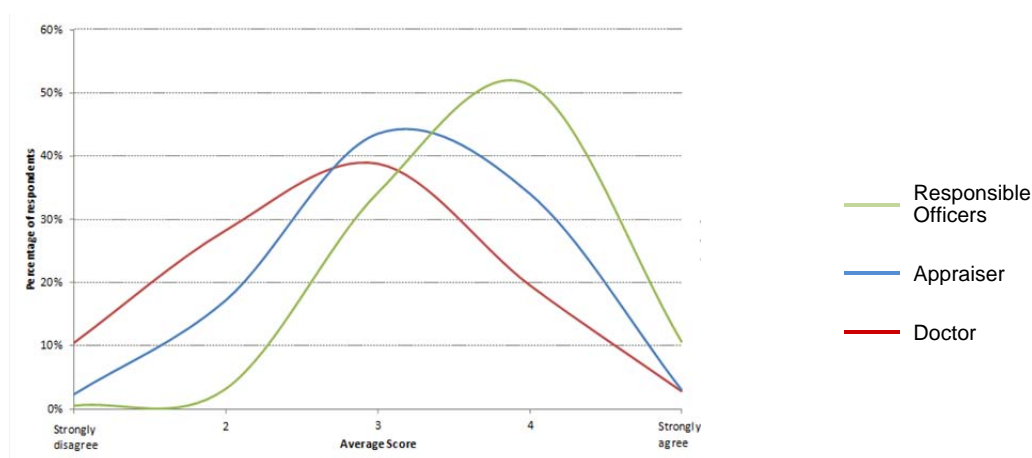


Figure 8 is based on the level of agreement or disagreement with the following statements.⁴⁰ Analysis of the underlying data does not identify any substantive difference between respondents working in primary and secondary care settings.

1. Appraisals are a good way of improving a doctor's clinical practice.
2. Appraisal is likely to help doctors respond to concerns at an earlier stage.
3. The requirement to consider patient feedback improves the standard of a doctor's practice.
4. If appraisals are carried out well, they motivate doctors to aspire to the highest standards of practice.
5. The quality of continuing professional development undertaken by doctors has improved since the introduction of revalidation.
6. The requirement for revalidation makes it easier to respond to concerns about patient safety and poor quality of care.
7. The revalidation process will improve the standards of doctors' practice.

There are a range of different views amongst doctors, appraisers and responsible officers about the purpose and scope of revalidation. These include perceptions that revalidation is:

- an administrative or transactional (or 'tick-box') process
- an additional mechanism for performance management
- synonymous with appraisal and its supporting processes
- about identifying doctors whose performance raises concerns
- a lever for wider quality improvement.

The following qualitative comments from the RST's surveys illustrate some of these differences.

"Too much tick-boxing and not enough genuine reflection on things that will make a difference." Appraiser

"Revalidation has imposed more tick-boxing and summative roles. It has turned us more into policing service." Appraiser

"The full effect of this process is of course untried on a large scale. I watch the outcome with interest. I believe we already had good performance management and safety"

⁴⁰ See the Technical Annex for the level of agreement/disagreement with each statement.

monitoring systems in place before revalidation came along so I am not expecting any surprises or major changes.” Responsible officer

“Appraisal is now nothing more than a stick with which to beat the medical profession... The revalidation system needs to focus on problem doctors.” Doctor

“Very structured re areas that need to be covered and has given more importance to appraisal and encouraged everyone to see it positively and also ensure e.g. audits and feedback obtained.” Appraiser

“These are early days. As we develop better systems and introduce new practices and embed them, we are getting better at this. Inevitably doctors complain, at times, that this is just about ticking boxes. My approach has been to make appraisal a part of quality improvement.” Responsible officer

The different perceptions noted above suggest that revalidation is being used in different ways in different organisations. This echoes the findings noted earlier in the report (p.14) about the different perceptions of responsible officers and doctors on the impact that the introduction of revalidation has had on the appraisal process and CPD. These differences have created, or at least contributed to, uncertainty about the purpose and scope of revalidation and have led some doctors to:

- obtain, prepare and provide more information for appraisals than might previously have been necessary; and/or
- choose not to raise issues in appraisal that reflect lessons learnt but that may also be interpreted as poor performance.

These behavioural responses need to be addressed by reconfirming and widely communicating the purpose, scope and value of revalidation and clarifying its interaction with appraisal and clinical governance. Qualitative comments from the surveys and preliminary findings from focus groups facilitated by The King’s Fund suggest that this communication will also need to resolve anxiety that revalidation will lead (and allow) appraisers and responsible officers to make decisions based on their own personal preferences, compliance with process and the constraints of the system.

In reality, revalidation is a regulatory measure intended to bring doctors into a governed system that: (a) ensures doctors participate in and make effective use of regular medical appraisals to strengthen their professional development; and (b) enables stronger personal accountability. For the majority of doctors, revalidation requires only acceptance of a new process; however, for a minority of doctors it requires a step-change in the way they work. The difference for both sets of doctors is that they now need to demonstrate that they are up-to-date and continue to be fit to practise rather than rely on the unchallenged assumption that this is the case.

The requirement for doctors to demonstrate that they are up-to-date and fit to practise changes the dynamic of appraisals and CPD and our research suggests that it might be the main source of tension in implementing revalidation. This needs to be acknowledged and addressed when reconfirming and communicating its purpose, scope and value.

Organisations are focusing on compliance

The King's Fund's preliminary findings point to many designated bodies investing in the development of standard policies, processes and systems to support the implementation and quality assurance of medical revalidation. While some reported significant improvements, others also expressed concern that the introduction of standardised processes increasing the time commitment. This finding is supported by the following qualitative comments from the RST's surveys:

"The MAG form which is now used as the standard within our appraisal system encourages pre-appraisal preparation [by the] appraisee in terms of documentation, contemplation and reflective as well as a good reflective discussion to guide personal development. We have just started appraisal experience feedback and initial responses are encouragingly positive." Responsible officer

"The workload associated with the role appears to be increasing, especially with the standardised approach to appraisal and training." Responsible officer

"The training has been good and the networking meetings are potentially valuable - but only if they are used for additional training and to develop common language and standards through discussion of cases. There is a danger that this could become an industry in itself which would make the job harder for those of us with other commitments (e.g. medical director)." Responsible officer

Many appraisers and responsible officers had less difficulty with the use of standard processes because these make it easier to monitor and track the documentary evidence needed by the responsible officer to make his or her recommendation for each doctor and mitigate the risk of a poorly informed recommendation. However, the requirement for documentary evidence, particularly where this is not seen to provide much value, may change the dynamic of an appraisal from a positive and responsive discussion between the appraiser and appraisee to one in which attention is, at least in part, focused on checking and confirming what has been discussed. This change is likely to lead to missed opportunities for an open discussion that includes, for example, conversation about a doctor's health and well-being.

"... It has become much more a tick-box and checking exercise and is much less personally developmental and empowering." Appraiser

Many change initiatives start by requiring compliance with standard processes and procedures to make activities simpler to carry out and easier to monitor and manage. It is important that these standards are kept under review to ensure that process does not dominate and that local variations and improvements can develop for particular groups of users. If designated bodies do this, they will still need to demonstrate compliance with fundamental standards set out in the NHS England Revalidation Team's (proposed) quality assurance framework.

As revalidation becomes more embedded, responsible officers and designated bodies will need to assure themselves and the public of the quality of the processes used to support revalidation recommendations. It is anticipated that the system regulators (e.g. Trust Development Agency, Monitor, and Care Quality Commission) would have a role in helping healthcare organisations provide this assurance.

The success of revalidation in realising the expected benefits and impact requires proactive leadership by boards and executives in all settings and organisations

In many organisations the responsible officer (who is, or works for, the medical director) has been able to prepare for revalidation with support from colleagues responsible for human resources and information technology. The focus of the work has been on reviewing and developing policies, procedures and practical arrangements for enhanced appraisals and improved clinical governance and, as such, has not required close and regular involvement from the board or executive team as a whole. Now that the new arrangements are in place, the focus needs to move to quality assurance and the realisation of local benefits; these activities will require the boards and the executive team to be engaged more actively.

“...appraisal training is only part of the picture - having the right skill mix in one's staff is another - it is difficult to get across to managing directors and non-medical board members the importance of these soft skills in one's workforce.”

These activities might include:

- clear communication on the purpose and scope of appraisal and revalidation
- creating a stronger and more effective feedback mechanism (and culture)
- defining local benefits and taking action to realise local benefits (and align with wider aims and goals for which boards and executive teams are responsible).

Ultimately, the manner in which revalidation is implemented within an organisation and the culture developed around it will determine whether or not local benefits are realised. Creating additional external demands on an organisation may only result in displays of compliance rather than a genuine motivation to make systems safer or

improve quality⁴¹. Aligning revalidation with a local commitment to excellence and patient care will help ensure that doctors feel valued as part of the process and that it contributes towards service improvements for patients. The King's Fund report focuses on this area and provides recommendations for leaders on how to drive realisation of these benefits.

Recommendation on cultural and behavioural changes

Recommendation 3: Responsible officers need to work closely with boards and executive teams to ensure revalidation moves beyond compliance and is used to promote excellence in quality and safety for patients.

If this recommendation is accepted, it could be taken forward by carrying out the following actions.

- Encourage responsible officers to engage proactively with their boards and executive teams and gain agreement for revalidation to be seen and used as a catalyst for cultural change. This is likely to have the greatest impact on organisations that do not yet have robust systems and processes for appraisal and governance.
- Identify and share practices that highlight the value of connecting appraisal, clinical governance and revalidation as part of a governed system.
- Publish updated guidance for responsible officers recommending that they should be supported by an independent lay member of the board or executive team. This person should ensure that the quality, outcomes and benefits of revalidation and its supporting processes are monitored on a regular basis at board and executive meetings; and that, where action is required (to improve quality, optimise outcomes or increase realisation of benefits), it is led by a director, carried out effectively and completed on a timely basis.
- Encourage responsible officers to arrange external quality assurance of their appraisal, clinical governance and revalidation processes. This is likely to include peer to peer reviews and benchmarking against comparable processes in other organisations with a similar profile. It may also include an extension to the work of/support provided by the system regulators (e.g. Trust Development Agency, Monitor, and Care Quality Commission).

⁴¹ Culture and behaviour in the English National Health Service from the blunt end to the sharp end: findings from a large multi-method study, Dixon-Woods et al, BMJ 2013

4. Support for responsible officers and workload

This section reviews responses to questions in the RST's surveys on the workload of doctors, appraisers and responsible officers on appraisal and revalidation, and clinical and administrative support for these activities.

Key findings from the surveys show that:

- A significant number of organisations have created new posts or changed existing roles to support revalidation.
- Responsible officers are concerned about increased workload.
- Doctors and appraisers are taking longer than expected to prepare for and carry out appraisals.

While the numbers of responses from doctors, appraisers and responsible officers were sufficiently large to provide representative samples, this was not the case for responses from designated bodies.⁴²

A significant number of organisations have created new posts or changed existing roles to support responsible officers

- 85% (102) of the designated bodies that responded to the survey had made some arrangement to provide clinical and/or administrative support for their responsible officers. (Designated body survey: Q4a)
- Of the 102 designated bodies that had made some arrangements to support their responsible officer, 53% had created new posts, 36% had changed existing job descriptions and 51% had informally extended roles. The arrangements in many of the designated bodies include two or all three of these activities. (Designated body survey: Q4b)
- 62% of the responsible officers who responded to the survey said that they had delegated at least part of their responsibilities to a deputy responsible officer or to a deputy/associate medical director and/or had appointed a revalidation manager or officer – sometimes with additional staff – to co-ordinate the process. (Designated body survey: Q4c)

The data shown above supports the assertion on page 33 that many designated bodies have invested in the development of standard policies, processes and systems to support the implementation and quality assurance of medical revalidation. The cost of this investment is discussed later in this section and, as suggested by the following

⁴² The number of responses and total population for each survey is given in the Introduction to this report on page 11.

comment, is expected to increase as the workload increases in years two and three of the first revalidation cycle.

“The Medical Director’s Office Business Manager role originally included a provision for the management of revalidation alongside other duties. However, in practice, revalidation and appraisal take up the majority of the post holder’s time. A temporary administrative assistant has been brought in and it is envisaged a further 1.5 - 2 administrative posts will be required to maintain momentum as numbers increase.”

Large NHS Hospital Trust

Preliminary findings from research commissioned by the RST from The King’s Fund noted that investment in revalidation has included significant investment in designated personnel to support implementation of the process and the provision of additional infrastructure.

Responsible officers are concerned about increased workload

Responsible officers who responded to the survey provided the following data on their current workload:

Figure 9: Responsible officers’ workload by number of doctors with a prescribed connection

Number of doctors with a prescribed connection (Overall avg = 384)	% of 191 responsible officers respondents	Average hours spent per week on revalidation-specific activities for all doctors with a prescribed connection (rounded to nearest ¼ hour)				
		Mean	Median	Mode	Min	Max
1 – 9	23%	2.50	2.50	2	1	10
10 – 99	23%	4.00	3.50	2	1	15
100 – 999	43%	6.25	4.00	2	1	24
1,000 +	11%	10.50	7.50	8	2	40
All	100%	5.50	4.00	2	1	40

The data shown above suggests that on average responsible officers spend between 2½ and 10½ hours per week on revalidation-specific activities with an overall average across all respondents of 5½ hours per week. Comparing the averages with the median and maximum values shown in the table suggests that the distribution of hours is positively skewed with a relatively large number of low values and small number of comparatively high values.⁴³ It is notable that the average hours per week per doctor with a prescribed connection appears to decrease very rapidly with an increase in the

⁴³ In positively skewed distributions the average value is higher than the median and the frequency curve has a compressed peak to the left and an extended tail to the right.

number of doctors; however, the data needs to be interpreted with care and is likely to be influenced by the level of support requested by/provided for the responsible officer.⁴⁴

Responsible officers for small organisations with relatively few doctors with a prescribed connection expressed concern about the disproportionate amount of time required to establish processes and procedures applicable to larger organisations and to attend training and network events. This is illustrated in the following qualitative comments.

“We are only a small organisation and it seems to be inappropriate to be expected to devote as much time and have processes in place that much larger organisations need. Occupational health is a small speciality and although there are risks to employees and the public these are not on the scale of for example surgical specialities.” Responsible officer

“Increasing demand to attend meetings and networking events regarding responsible officer role. These events are often of little practical value and appear to be a lack of understanding of the effect it has on workload, particularly in a small organisation.”
Responsible officer

Responsible officers in organisations in the independent sector highlighted the disparity between the work required for doctors with prescribed connection and the additional revalidation-related work required for doctors with practising privileges; this is illustrated in the following qualitative comment.

“Although I have only 42 doctors who have elected to have [the named organisation] as designated body; over 1000 consultants within [the named organisation] have practicing privileges separate to their NHS work. The work load and responsibility as RO is a large task with huge responsibilities.”
Responsible officer

“Although I have few doctors there are more than 100 with practising privileges, leading to many multi-organisational forms.” Responsible officer

A number of responsible officers also expressed concern that their workload during year one (2013-14) of implementation is likely to be doubled in years two (2014-15) and three (2015-16) and the doctors who will be revalidated during these years might need more support than those in year one: this is illustrated in the following comments.

⁴⁴ The surveys asked for the type of support provided to the responsible officer but not the average hours per week of support; this data may need to be collected if the surveys are reused.

“The workload is increasing as the number of doctors coming up for revalidation increases. Initially we focussed only on the few doctors scheduled for revalidation in the first months. Because of the lead in time, these were all well-prepared. Now we are getting into the next tranche, some of whom are engaging less positively.”

Responsible officer

“I am concerned that when numbers of recommendations double from 1st April 2014 it will become increasingly difficult to review the amount of information required personally to make a positive recommendation.” Responsible officer

There is no baseline data with which to compare the time that responsible officers spend on revalidation-specific activities⁴⁵ and it is therefore important for the data to be validated against comparable data collected in future research. This future research may need to consider issues including timing of the work carried out by responsible officers during a year (to spread it out) and ways to confirm the attribution of work to revalidation rather than to other activities.

It is noted, however, that the Department of Health’s cost-benefit analysis includes a year-on-year increase in the opportunity cost of responsible officers’ time of 54% in 2014-15 and of a further 61% in 2015-16.⁴⁶

Doctors and appraisers are taking longer than expected to prepare for and carry out appraisals

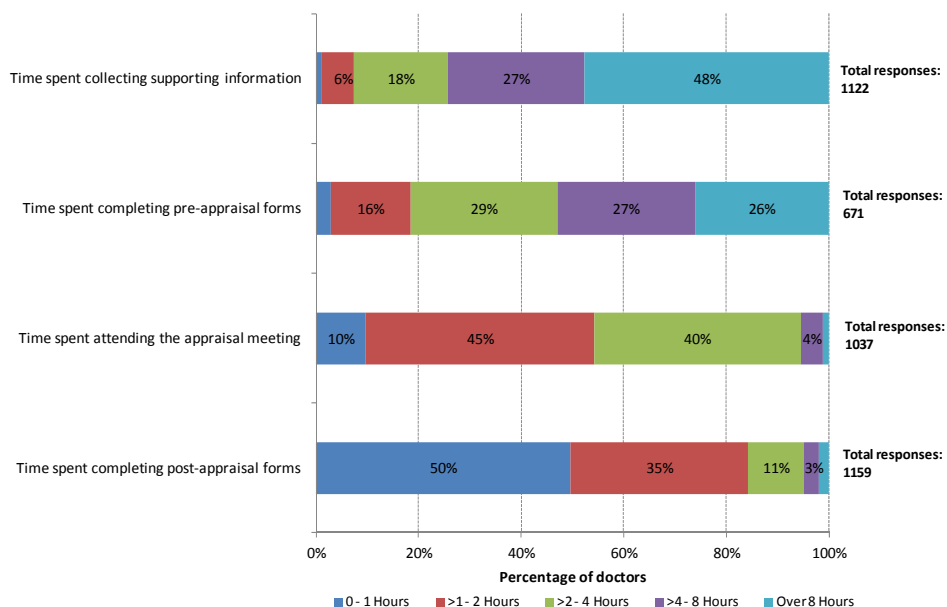
Doctors

The chart included below shows the data from the doctors’ survey for the time taken for different parts of the appraisal process.

⁴⁵ Revalidation-specific activities are assumed to exclude involvement in other leading, monitoring and evaluating clinical governance activities (e.g. clinical audit, identification of/enquiry into concerns based on complaints, soft intelligence, assessment and review of data on clinical outcomes). However, the definition of what is and is not involved may contribute to the differences noted above.

⁴⁶ On an indexed basis: if 2013-14 is 100 then 2014-15 is 154 and 2015-16 is 248.

Figure 10 – Time spent by doctors preparing for and completing their last appraisal



As shown above, the highest proportion of doctors who responded to each question spent more than 8 hours collecting supporting information, between 2-4 hours completing forms, 1-2 hours in the appraisal discussion and 0-1 hours completing post-appraisal forms. These results show that the main demand on their time is the preparation for appraisal. Further analysis of the data (included in the Technical Annex) shows that this result is consistent across specialties and care settings. A qualitative comment from an appraiser highlights this issue:

“I have found that generally the appraisees have spent considerable time completing the documentation for appraisal, but they are often uncertain as to what evidence is sufficient and how it should be presented – a lot of my appraisal time over the last 10 years has been educating appraisees on how to present their evidence – to this end, one standard appraisal toolkit would have been very helpful.” Appraiser

Further discussion of possible reasons for the amount of time required for these activities is included in section 1. Appraisal and supporting processes for revalidation’ on page 12 of this report.

Differences in the format of this question from the questions asked in the RST’s Testing and Piloting project and used to inform the Department of Health’s cost-benefit analysis prevents a like-for-like comparison with baseline data. However, the figures suggest that the overall time spent on appraisal activity by doctors has increased from an average of 9 hours to a mid-point total of 10.5 hours. This is an indicative estimate based on doctors’ experience in year one of implementation and will need to be reviewed and validated over the next few years as part of future measurement. The

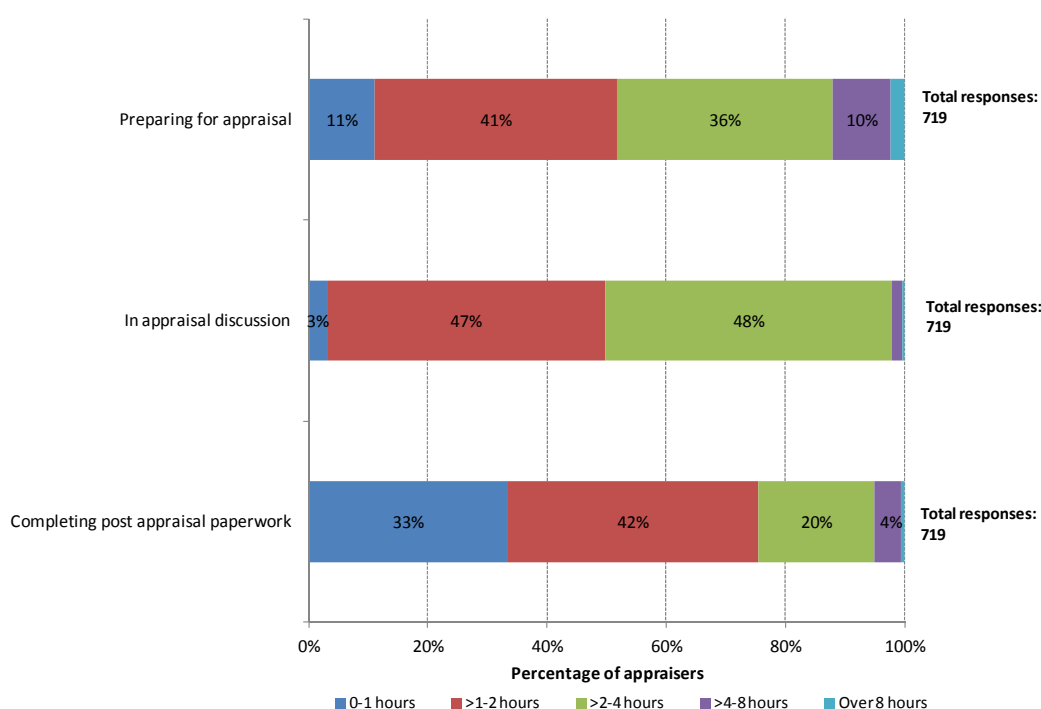
variance is not surprising because, as reported by participants in the RST's Pathfinder pilots, doctors are likely to take less time to prepare for appraisals as they become more familiar with information they need to collect and the information systems they need to use.⁴⁷

Despite these anticipated improvements, it might still be helpful to carry out further research – as part of ongoing monitoring and evaluation of revalidation – to identify specific reasons for the process currently taking longer than necessary.

Appraisers

The chart included below shows the data from the appraisers' survey for the time taken for involvement in the appraisal process.

Figure 11 – Time spent by appraisers on appraisals



In this survey 80% of appraisers spent 1-4 hours preparing for the appraisal, 95% of appraisers spent 1-4 hours in the appraisal discussion⁴⁸ and 70% of appraisers spent 2 hours or less completing paperwork (Appraiser survey: Q2).

⁴⁷ Independent Evaluation of the Medical Revalidation Pathfinder Pilot – Final Report for Department of Health / Revalidation Support Team (2010) page 19.

⁴⁸ It is considered unlikely that many appraisal meetings will have continued for 3 or 4 hours and that the percentage of the respondents that selected the 2-4 hour duration will probably have done so for meetings that were between 2 and 2½ hours. It is recommended that this question is modified before the survey is used in the future to make the options more specific.

Comparisons between primary and secondary care suggest that appraisers in primary care are taking more time to prepare for the appraisal, and in the appraisal discussion than the secondary/tertiary appraisers.

Again, bearing in mind that there is not a like-for-like comparison with the business case, results suggest that longer is being spent in the appraisal discussion (increasing from 1.2 hours to 2-4 hours). This is reassuring as it shows more time is being given by appraisers to the doctors being appraised, suggesting a more thorough approach to appraisal. However, it is important that time spent in appraisal is relative and does not increase beyond what is beneficial in terms of outcomes and cost.

Qualitative comments raised around costs of time spent on appraisal included discussion on the time it actually takes to carry out an appraisal, with appraisers stating that one two-hour appraisal actually equates to half a day and citing the impact that the rate of appraiser payment may have on motivation to remain in the role.

“Appraisal is time-consuming. The only option is to block out whole half days at a time – and this is bound to reduce the amount of time available for other work tasks including clinical work.” Appraiser

“To do a thorough appraisal takes time, and I feel the recent reductions in payments for this [in our area] undermine what we are trying to achieve. It is getting to the point where it hardly makes it worthwhile.” Appraiser

As part of their research The King's Fund heard anecdotally from both appraisers and doctors that time taken for appraisal activities could be distracting doctors from clinical practice. These themes reinforce the RST's recommendation to look at ways to focus time and effort on components of the appraiser roles including finding ways of reducing time taken to prepare for appraisals.

Recommendation on support for responsible officers and workload

Recommendation 4: Partners should identify and share examples of operating models to ensure revalidation is being managed in a way that is proportionate and effective.

If this recommendation is accepted, it could be taken forward by carrying out the following actions.

- Document examples of operating models for different types of designated body. These models should include assumptions on workload and costs and identify the impact of local policies and expectations.
- Review different operating models to monitor and identify any changes that might be needed to ensure revalidation and its supporting processes are being carried out and managed in a way that is proportionate and effective. Review the content of Regional RO Network meetings to focus more time on peer support and find ways to address the different needs of responsible officers working in different contexts.

5. Use of information technology and data for appraisal and revalidation

This section reviews responses to questions in the RST's surveys on information systems and the use of data as part of revalidation. Findings from this section include the following:

- There has been significant investment in information systems to support revalidation.
- There needs to be greater clarity on the specific nature of supporting information used for revalidation.
- There is a need for improved sharing of information between organisations.

There has been significant investment in information systems to support revalidation

- 46% of organisations responding to the survey of designated bodies have invested in information systems⁴⁹, and a further 19% are planning to do so. (Designated body survey: Q6)
- The costs of procuring an information system ranged up to £100K (the mean was £24.4K). The annual costs of maintaining an information system for revalidation ranged up to £50K (mean £8.6K). (Designated body survey: Q8)
- Of those organisations who responded to the survey of designated bodies, 9% had updated an existing information system, 12% had developed a new system based on the RST's *MAG Model Appraisal Form*, 70% had procured a commercial information system, and 9% had developed an in-house system (mainly for patient and colleague feedback). (Designated body survey: Q8)

There was a variety of comments about information systems for revalidation. A number of the comments were positive about information systems used and developed for revalidation.

“Absolutely essential to enable the work to be done.” Responsible officer

“The organisation has developed a fully integrated bespoke appraisal and revalidation system which supports the entire process from portfolio building, appraisal meeting,

⁴⁹ The survey did not include a specific question about the scope of the information systems in which designated bodies had invested or were planning to invest. It is therefore not possible to identify how many of the systems are, for example, limited to management of the appraisal system or to co-ordination of work carried out by responsible officers. It may be helpful to add these questions to the survey if it is reused in future years.

quality review, doctor feedback and the Revalidation process, incorporating an electronic RO form and dashboard.” Responsible officer

“Found e-portfolios helpful as I am dealing with doctors from some distance prior to the meeting. Admin assistance is definitely needed.” Appraiser

“Electronic systems very helpful in supporting the appraisal and revalidation work.”
Responsible officer

However, the qualitative comments also point to concerns about the workload implications and ease of using particular information systems and the risk that the use of electronic systems may lead to a focus on the provision of information at the expense of its content and value.

“The poor functionality, and lack of support from/of the ... system proved a major problem, and we wasted hours, if not days, of valuable time in loading up info, which was of no benefit to ourselves.” Responsible officer

“I fear that the emphasis on modern electronic media detracts from the actual content and value of the information. Examining scanned documents can take far longer than looking through a file of papers.” Responsible officer

The different approaches taken to procuring and using information systems, with a variation in costs, suggest a need to learn from and share experiences to inform future decision-making on procurement.

There needs to be greater clarity on the specific nature of supporting information used

As outlined in section 5: ‘Support for responsible officers and workload’, doctors reported spending more than eight hours collecting supporting information for their appraisal. The following qualitative comments also illustrate some concerns about the types, quantity, quality and value of the information available to them.

“The quality of the supporting information is better but information departments still cannot supply the necessary information for some colleagues to be benchmarked against each other” Responsible officer

“The biggest criticism of the doctors (and myself so far) is the difficulty in obtaining as much supporting data as they would like. Basic data is available, e.g. SI, complaint, activity data. More sophisticated information is not and work continues to address this.”

Appraiser

“We are very dependent on data being submitted to the specialist registers for supporting performance compared with peers.” Appraiser

“The system in place provides useful basic information but still requires triangulation with other sources of information to provide the assurance necessary for recommendations of revalidation. Clinicians working in disparate locations can become frustrated by access issues due to connection capacity.” Appraiser

“Our revalidation software is improving by iteration. The cross link with other clinical governance software which is embryonic or non-existent needs to improve. Collated information on complaints is difficult to obtain for example. Incident reporting is becoming more systematic.” Appraiser

“I am really struggling with the workload, given that I work part time and have a very busy clinical schedule. The detail required seems to increase each year and the computer system sometimes creates difficulties. Sometimes people have uploaded more than 60 pieces of supporting information which all needs to be opened and read.”

Responsible officer

There were also some calls for different types of supporting information and data to be used as part of the revalidation process.

“More information is required on medical outcomes that reflects individual performance and is benchmarked.” Responsible officer

The data and supporting information used as part of the process need to reflect a doctor’s whole scope of work while not creating adding to their time commitment. It will therefore be necessary to understand the efficacy of different types of information and to understand which add most value to patients, doctors and healthcare organisations.

The quotes suggest that doctors may be focusing on the availability and provision of information rather than reflecting on what it is telling them and taking action on the basis of their reflection.

An important study undertaken by the Academy of Medical Royal College’s Specialty Guidance Group⁵⁰ showed that the three most challenging areas for doctors in collecting specific types of supporting information were: patient feedback, quality improvement activity and significant events (for example, critical incidents). While the situation is expected to get easier over time, the production of guidance and worked examples aimed at specific groups and disciplines will go some way to help doctors collect these types of supporting information.

⁵⁰ See reference in footnote 13

National guidance on supporting information does not currently refer to the expected quantity and quality of supporting information which doctors are expected to provide as part of their appraisal portfolio. This creates uncertainty for some doctors who may seek to assemble and reflect on large volumes of supporting information rather than take the perceived risk of supplying too little information as part of the process. Results from the pilots suggest that this behavioural response creates an additional administrative burden for the doctor but also for the appraiser, responsible officer and designated body.

There are options available for mitigating this issue: one option is to clarify national guidance to outline the value of quality and breadth over quantity and another is to ensure that practical examples of supporting information and complete portfolios are made widely available.

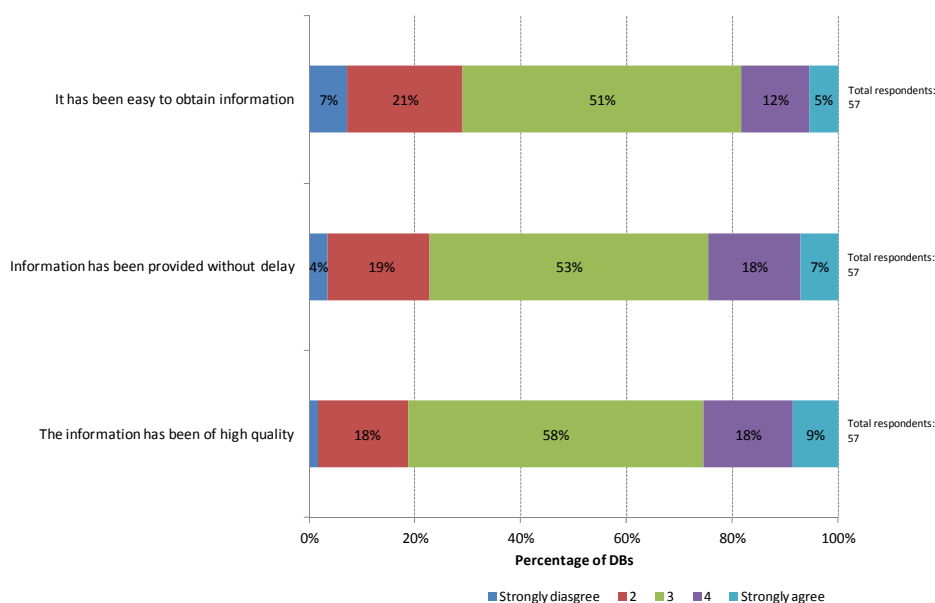
The RST has previously worked with the Faculty of Medical Leadership and Management, the Royal College of Physicians (London) and the Royal College of Surgeons (London) to develop nine example appraisal portfolios.⁵¹ An extension of this work for other specialties will create more practical examples; and new opportunities to develop consider new sources of information.

⁵¹ Available at www.revalidationsupport.nhs.uk/doctors/example_appraisal_portfolios until 31 March 2014 and on the NHS England website from 1 April 2014.

There is a need for greater sharing of information between organisations

As part of the RST's surveys, designated bodies provided the following responses to questions on obtaining information from other organisations to support inquiries and investigations:

Figure 12: Obtaining information from other organisations to support inquiries and investigations (Designated Body Survey, Q16)



This finding is supported by the following qualitative comments:

"It is hard to obtain contact details for the responsible officer; these should be available on the GMC website so that information can be easily passed to those who need to know it."

"A central database or repository where we could see who to contact at each designated body would be very useful."

"It is early days so we are only just now asking for information about prospective employees."

"Information regarding performance and standards of practice is hard to come by and is unreliable also variable and inconsistent other 'processy' type of information is increasingly more easily available."

"Other establishments do not have as robust supporting data as ourselves, so it has been difficult to develop a picture of their practice outside of our working environment"

“In excess of 55 designated body area team transfer requests from other area teams – all on different forms and requesting different information.”

Results from the surveys highlighted ongoing concerns about the sharing of information between organisations, as well as concerns about the reliability and quality of the data provided. There were also practical issues relating to the transfer of information. Results from the survey of designated bodies also showed that the majority of organisations felt neutral about the accessibility and the speed of transfer as well as the quality of information shared between organisations.

There were also comments about the need to standardise information-sharing processes between organisations. The RST’s recently released *Medical Practice Information Transfer Form*⁵² is designed to help facilitate the effective transfer of information. However, appraisal and responsible officer networks will need to be used more effectively to establish standard protocols and guidance for sharing information using such a form.

Recommendation on use of information technology and data

Recommendation 5: Systems, protocols and guidance need to be strengthened to provide assurance that information is being used in the most effective way for revalidation

If this recommendation is accepted, it could be taken forward by carrying out the following actions.

- Build on specialist expertise to identify core organisational data sets and develop worked examples of supporting information and portfolios for appraisal and revalidation.
- Explore ways to make information available to doctors in a format that allows them to focus on reflection rather than on collecting and providing the right data.
- Review the way that information systems are being used to support appraisal, clinical governance and revalidation. Use this review to: identify and address common issues that are creating unnecessary difficulty or additional work; provide consistent feedback to software vendors; inform future procurement; and provide a baseline to assess value for money.
- Develop common standard transfer processes and protocols for sharing this information between organisations.

⁵² RST. 2013 *Medical Practice Information Transfer Form*

6. Future measurement and benefits realisation

The programme of research described in this report was completed in December 2013 ahead of the planned closure of the RST on 31 March 2014.

Comments from a wide range of stakeholders have highlighted the value of the evidence base and findings from the research carried out and commissioned by the RST into the impact of revalidation during Year one of implementation.

Future measurement and benefits realisation depend on continued collection of data and on use of the findings and recommendations in this report to review national requirements and optimise local outcomes. The RST has provided the following three enablers for future measurement and benefits realisation:

- a specification for future research into the wider impact of revalidation
- a framework for future measurement
- a framework for the preparation of a benefits realisation plan.

These are outlined below and have been provided separately to the Department of Health and NHS England.

Future research into the wider impact of revalidation

The RST has worked closely with the Department of Health and their Policy Review Programme (PRP) to secure support and funding for a two year research project evaluating the wider impact of revalidation during the remainder of its implementation. This research will enable the Department of Health to assess the effectiveness of its current policy in relation to medical revalidation of doctors and the role of responsible officers. It is also likely to inform discussions on strengthening regulatory arrangements for other professional groups. The call for research proposals was published in January with a deadline for full applications to be submitted by 25 March 2014⁵³. The research is expected to start in the autumn and be completed by December 2016. The introductory paragraph of the specification for this research is copied below for information.

⁵³ National Institute for Health Research. 2014. *Policy Research Programme: Call for Applications*. [Online]. [Date accessed: 12 March 2014]. Available from: <http://www.nihr.ac.uk/proposals/Lists/NIHR%20Calls%20for%20Proposals/DispForm.aspx?ID=321>

The Department of Health (DH) invites full applications for a single research project to inform the review and continued development of its policy for medical revalidation in England. The requirement is for evidence and insight on the costs, outputs, outcomes, benefits and impact of revalidation⁵⁴, how these are changing over time and what is influencing this change in different contexts. The aim of the research is to establish what works best in managing costs, quality assuring outputs, optimising outcomes, increasing local benefits and creating an effective lever for wider quality improvement. While the research needs to take account of the perspectives of individual stakeholder groups, it should also consider the impact of revalidation on the healthcare system as a whole.

As mentioned in the specification, there are likely to be a significant number of touch-points with research commissioned by the GMC in connection with its evaluation framework, and with research commissioned or carried out by NHS England in connection with its quality assurance framework. Whilst there are key differences between the three areas of research (as outlined below) there may be opportunities for alignment. This could go as far as collaborating on data collection, to minimise burdens and 'survey fatigue' on doctors and organisations.⁵⁵

Figure 13 - Focus areas for research into revalidation

Research commissioned by the Department of Health

- Impact of revalidation and of the process required to enable revalidation on: patient safety, quality of care, efficiency and effectiveness of systems and the confidence and trust of patients in the medical profession.
- Involvement of and impact on healthcare organisations and responsible officers (e.g. board-level engagement, accountability, clinical governance, quality improvement).
- The process and cultural change 'mechanisms' required to optimise outcomes and to realise benefits from revalidation in different contexts.

⁵⁴ 'Revalidation' is used ... [in the research specification] to refer to the wider processes that lead up to and support the responsible officer's revalidation recommendation to the GMC. This includes, but is not limited to: recruiting and training appraisers; development and maintenance of local policies, procedures and systems; providing supporting information for appraisals; carrying out medical appraisals; preparation and monitoring of personal development plans (PDPs); quality assurance of appraisals; identification of and response to concerns and triangulation of soft intelligence; clinical outcomes and other information.

⁵⁵ The specification says that any collaboration between the research commissioned by the Department of Health, the GMC and NHS England would be brokered through the Department of Health and analysis, interpretation and reporting will remain the responsibility of each research team/organisation.

GMC evaluation framework

- Involvement of and impact on individual doctors
- Basis and quality of revalidation decisions made by responsible officers and the GMC.
- Contribution to the GMC's statutory purpose to 'protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.'

NHS England quality assurance framework

- Monitor and assess the extent and quality of activities being carried out by designated bodies (i.e. the organisations with which doctors have a prescribed connection) to enable revalidation.
- Evaluate the impact of mechanisms used to support these activities.

Framework for future measurement

This framework includes:

- the tables of prioritised and longer-term indicators and the higher-level measures with which they are associated (see figures 14 and 15)
- the four surveys published by the RST in October 2013
- an analysis and repository of data available from published sources.

The framework provides comments on the indicators, measures, surveys and analysis of data to highlight updates and changes that NHS England may want to make in using them alongside its quality assurance framework.

Figure 14 - Prioritised indicators for measurement of the impact of revalidation in the short-term

Impact	Measure	Indicator	
Improved patient safety	Remediation activity and cost	1	Remediation rates by type
		2	Remediation cost
		3	Number, type, severity of cases of concerns about doctors
		4	Number of doctors referred to GMC
	Doctors participating in (more) relevant, appropriate and focused CPD	5	Survey a sample of doctors – covering amount, type and relevance of continuing professional development (CPD) participation and whether the associated development needs were identified during appraisal
Improved quality of care	Improved quality of care from doctors	6	Number of complaints
		7	Outcome of complaints from GMC
	Improvements in appraisals	8	Appraisal rates
		9	Percentage of designated bodies that have a medical appraisal policy in place
		10	Percentage of designated bodies that have a process in place relating to fitness to practise evaluations and appraisals
		11	Percentage of doctors that are able to obtain structured feedback from patients and colleagues
		12	Percentage of designated bodies that provide feedback to their appraisers on their performance in the role
	Improvements in clinical governance	13	Percentage of designated bodies that have a governance structure or strategy in place (specific to revalidation)
		14	Percentage of designated bodies that have a governance structure or strategy in place are subject to external or independent review (specific to revalidation)
	Improved effectiveness and efficiency of working practices	Time for appraisal	15
16			Average time cost per doctor: length of appraisal discussion
17			Average time cost per appraiser: preparation time
18			Average time cost per appraiser: length of appraisal discussion

Figure 15 - Additional indicators to be measured in the long term

Impact	Measure	Indicator	
Improved patient safety	Deaths and harm avoided	1	Deaths reported
		2	Serious incidents reported on the National Reporting and Learning System (NRLS)
Improved quality of care	Improved quality of care from doctors	3	Number of claims by type
		4	Number of cases referred to the Litigation Authority by type
		5	Survey estimate by appraisers and ROs of the improvement in quality of care
	Increased doctor work satisfaction and improved tailoring of individual career paths	6	Survey gauging work satisfaction
Improved effectiveness and efficiency of working practices	Avoided suspension	7	Number of suspensions from practice
		8	Number of suspensions from the register
		9	Period of suspensions from practice
		10	Period of suspensions from the register
		11	Cost of suspension to designated bodies
	Litigation savings	12	Number of litigation cases
		13	Litigation costs

It is noted that the Department of Health’s cost-benefit analysis⁵⁶ identified ‘improved public confidence’ as a fourth area in which revalidation would have a longer-term impact. Measures and indicators originally identified to assess this impact were removed following independent advice that too many factors affect public confidence in doctors to infer a direct causal relationship with revalidation. However, the programme may be able to measure the indirect impact on public confidence and trust by reviewing national polls of public confidence in doctors⁵⁷ and/or commissioned research into the impact of revalidation on public confidence and trust in the profession.

Framework for a benefits realisation plan

This framework describes the purpose and standard content of a benefits realisation plan, provides a pro-forma for benefits profiles, connects the RST’s prioritised and

⁵⁶ Department of Health. 2012. *Medical Revalidation – Costs and Benefits: Analysis of the costs and benefits of medical revalidation in England*. London: Crown copyright

⁵⁷ An example is the following poll: Ipsos Mori. 2011. *Trust in Professions 2011*. [Online]. [Date accessed: 12 March 2014]. Available from: www.ipsos-mori.com/researchpublications/researcharchive/2818/Doctors-are-most-trusted-profession-politicians-least-trusted

longer-term indicators with outcomes and benefits and includes guidance on local realisation of benefits by designated bodies.

Co-ordinating research activities

The wide range of people and organisations with an interest in revalidation suggests that there is an opportunity for the Department of Health, General Medical Council and NHS England to convene a working group to supervise research activities and triangulate findings. This group would have an advisory role with each organisation maintaining its own arrangements for oversight.

It is likely that the Benefits Working Group established by the RST could be adapted to form a new 'research and benefits working group', and members retained from the GMC, devolved administrations, British Medical Association (BMA), Academy of Medical Royal Colleges, NHS England and representatives from patients and the public, independent and locum sectors . If partners are able to continue to convene and make active use of a working group to supervise research activities and triangulate findings, the activities are more likely to be better co-ordinated and more effective.

Recommendation on future measurement and benefits realisation

Recommendation 6: Partners need to continue to work together to collect evidence and gain insight on the costs, benefits and impact of revalidation. Research should be prioritised throughout implementation (with annual reports published) culminating in a post-implementation review in 2016-17.

If this recommendation is accepted, it could be taken forward by carrying out the following actions.

- Ensure that the prioritised and longer-term indicators identified by the RST and validated by the research described in this report continue to be used in understanding the impact of revalidation.
- Co-ordinate the range of measurement and research activities to ensure that their scope and purpose is clearly understood by responsible officers and designated bodies.
- Use data collected through measurement and research to track changes that occur as the implementation of revalidation becomes established. Specific attention should be paid to: changes in workload; how quickly concerns are identified; and identifying attributes of the wider process that have the greatest impact on doctors' practice.
- Convene and make active use of a working group of partner organisations to review data collected through measurement, supervise research carried out and commissioned by individual organisations and triangulate findings.

Summary of recommendations

The following is a summary of recommendations and actions provided in each section:

Recommendation 1: Partners need to reconfirm the intent of appraisal, revalidation and clinical governance and communicate this more clearly to ensure stronger and more meaningful engagement in the process. This needs to be communicated now and throughout the implementation period.

If this recommendation is accepted, it could be taken forward by carrying out the following actions.

- Prepare and publish updated guidance that defines the differences and interaction between appraisal, clinical governance and revalidation. This guidance should explain the role of medical revalidation in bringing all licenced doctors into a governed system that:
 - ensures doctors participate in and make effective use of regular medical appraisals to strengthen their professional development
 - highlights the importance of personal accountability and sets the context within which this is expected
 - prioritises investment required to obtain and integrate information from clinical governance activities and systems.
- Promote appraisal as a developmental activity within a governed system. It should be designed to motivate doctors to aspire to the highest standards of practice, rather than to meet minimum requirements.
- Ensure clinical governance systems are used in a fair, open and transparent way to support appraisal, inform revalidation and identify and respond to concerns about doctors.
- Provide guidance to responsible officers that, in making revalidation recommendations, they should be able to rely on information from clinical governance and outputs from a quality assured appraisal process. It should only be necessary to review appraisal inputs to quality assure the process or when a concern has been raised and additional information is required.

Recommendation 2: Patients and the public need a more powerful role in revalidation. This requires stronger mechanisms for feedback, clearer processes for engagement of lay members and more attention to the collective voice of patients and the public.

If this recommendation is accepted, it could be taken forward by carrying out the following actions.

- Review and strengthen the GMC's guidance for individual patient feedback to increase its perceived value and to enable greater choice in the way it is collected. In carrying out this review, partners need to:
 - consult with the Academy and Medical Royal Colleges to identify a practical way to provide patient feedback for doctors who do not engage with patients or their carers or families.
 - encourage a dialogue between doctors and representatives of patient and community groups to agree on improved forms of patient feedback.
 - consider increasing the number of patients from whom doctors are required to obtain feedback and/or the frequency with which this feedback is obtained.
 - establish clearer criteria for acceptable feedback
 - provide case studies of collection of feedback
 - identify and provide improved mechanisms for collecting patient feedback (as noted above) without a significant impact on doctors' workloads.
- Provide individual patients with easily accessible mechanisms that allow them to record their experience of specific doctors without waiting for the formal feedback process required by the GMC.
- Ensure that responsible officers arrange for their organisations to engage with patient and community groups to hear and respond to the wider public voice.
- Encourage increased lay involvement in the processes that support revalidation. Lay members need to be recruited through a formalised engagement process and have a clear remit and role.
- Healthcare organisations need to provide feedback to patients and the public on the outcomes of their revalidation processes.

Recommendation 3: Responsible officers need to work closely with boards and executive teams to ensure revalidation moves beyond compliance and is used to promote excellence in quality and safety for patients.

If this recommendation is accepted, it could be taken forward by carrying out the following actions.

- Encourage responsible officers to engage proactively with their boards and executive teams and gain agreement for revalidation to be seen and used as a catalyst for cultural change. This is likely to have the greatest impact on organisations that do not yet have robust systems and processes for appraisal and governance.
- Identify and share practices that highlight the value of connecting appraisal, clinical governance and revalidation as part of a governed system.
- Publish updated guidance for responsible officers recommending that they should be supported by an independent lay member of the board or executive team. This person should ensure that the quality, outcomes and benefits of revalidation and its supporting processes are monitored on a regular basis at board and executive meetings; and that, where action is required [to improve quality, optimise outcomes or increase realisation of benefits], it is led by a director, carried out effectively and completed on a timely basis.
- Encourage responsible officers to arrange external quality assurance of their appraisal, clinical governance and revalidation processes. This is likely to include peer to peer reviews and benchmarking against comparable processes in other organisations with a similar profile. It may also include an extension to the work of/support provided by the system regulators (e.g. Trust Development Agency, Monitor, and Care Quality Commission).

Recommendation 4: Partners should identify and share examples of operating models to ensure revalidation is being managed in a way that is proportionate and effective.

If this recommendation is accepted, it could be taken forward by carrying out the following actions.

- Document examples of operating models for different types of designated body. These models should include assumptions on workload and costs and identify the impact of local policies and expectations.
- Review different operating models to monitor and identify any changes that might be needed to ensure revalidation and its supporting processes are being carried out and managed in a way that is proportionate and effective. Review the content of Regional RO Network meetings to focus more time on peer support and find ways to address the different needs of responsible officers working in different contexts.

Recommendation 5: Systems, protocols and guidance need to be strengthened to provide assurance that information is being used in the most effective way for revalidation

If this recommendation is accepted, it could be taken forward by carrying out the following actions:

- Build on specialist expertise to identify core organisational data sets and develop worked examples of supporting information and portfolios for appraisal and revalidation.
- Explore ways to make information available to doctors in a format that allows them to focus on reflection rather than on collecting and providing the right data.
- Review the way that information systems are being used to support appraisal, clinical governance and revalidation. Use this review to: identify and address common issues that are creating unnecessary difficulty or additional work; provide consistent feedback to software vendors; inform future procurement; and provide a baseline to assess value for money.
- Develop common standard transfer processes and protocols for sharing this information between organisations.

Recommendation 6: Partners need to continue to work together to collect evidence and gain insight on the costs, benefits and impact of revalidation. Research should be prioritised throughout implementation (with annual reports published) culminating in a post-implementation review in 2016-17.

If this recommendation is accepted, it could be taken forward by carrying out the following actions.

- Ensure that the prioritised and longer-term indicators identified by the RST and validated by the research described in this report continue to be used in understanding the impact of revalidation.
- Co-ordinate the range of measurement and research activities to ensure that their scope and purpose is clearly understood by responsible officers and designated bodies.
- Use data collected through measurement and research to track changes that occur as the implementation of revalidation becomes established. Specific attention should be paid to: changes in workload, how quickly concerns are identified and identifying attributes of the wider process that have the greatest impact on doctors' practice.

- Convene and make active use of a working group of partner organisations to review data collected through measurement, supervise research carried out and commissioned by individual organisations and triangulate findings.

Report authors:

Ralph Critchley

Paul Ader

Dr Andy Godden

Dr Kerry Ball

The authors would also like to thank the contributions of Beryl Hodgson, Douglas Gilbert, Adrian Morrissey and Julie Pottinger.

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