
The Early Benefits and Impact of Medical Revalidation:

Technical Annex

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Overview

This annex contains the results of the four surveys conducted by the RST to capture the effects of revalidation at the end of its first year of operation. The annex is divided into sections relating to each of the survey groups:

- doctors (appraisees)
- appraisers
- responsible officers and
- designated bodies.

Each section contains the results for each of the questions asked in the survey. Most of the results are quantitative in nature and have been displayed diagrammatically to make them as clear as possible¹. Many of the questions provided categorical answers (Likert scale responses). With this level of measurement, the results should be presented using either a modal or median response. A small number of qualitative questions were also asked. In these cases, we have provided summaries of the key themes emerging from respondents.

Statistical significance

The number of responses received for each survey is shown in the table below. The total number of respondents suggests that we are able to draw statistically significant conclusions based on the results of the surveys (95% confidence interval with a 5% margin of error for all groups except for designated bodies, for which there are only sufficient responses for a 90% confidence interval). However, because none of the questions within each survey were mandatory, the number of responses to individual questions, and the corresponding confidence in the results, varies.

Figure 1

Survey group	Number of responses needed for a 95% confidence interval and a 5% margin of error ²	Number of responses received
Doctors	384	2,499
Appraiser	376	719
Responsible officers	145	192
Designated bodies	238	124

Most of our analysis does not break down the responses into smaller samples based on other characteristics. However, we note that the number of responses received from doctors

¹ Numbers have been rounded and, as a result, the total of the responses may not always equal 100.

² See methodology in the section at the end of this annex.

is sufficiently large to have confidence in analysing the responses of primary and secondary care doctors separately.

This sort of statistical analysis assumes that responses represent a random sample from the relevant population. However, we recognise that it is difficult to avoid all elements of bias in surveys of this nature. There are many factors which might have affected whether people to whom we sent the survey responded or not. For example, we observed that, on average, doctors who responded tended to have been qualified for a relatively long time (25 years). Part of the reason for this is that our survey did not include trainee doctors, who follow a separate appraisal system, but there may also be other factors at work. It was also observed that, on average, respondents to the doctor survey tended to have been appraised more recently than the population as a whole. 92% of respondents to our survey had been appraised within the last year, whereas a recent ORSA³ survey put the proportion at 76%. This may indicate that respondents tend to be more engaged with the appraisal and revalidation process than average. Any bias in our samples may affect comparison with future research.

The margin of error in our results is affected by the number and distribution of responses received for each question. Where appropriate and possible, for each question we have indicated the margin of error for a confidence interval of 95% in a section at the end of this annex. This means that in 19 out of 20 cases, the true figure for the population (e.g. all doctors) will be within the margin of error we have indicated. (That is, if we state that 30% of respondents hold a particular belief with a margin of error of $\pm 5\%$, in 19 out of 20 times the figure for the whole population will lie between 25% and 35%.)

Comparative analysis of general views on the impact of appraisals and revalidation

As part of the surveys for their groups, doctors, appraisers and responsible officers were all asked how strongly they agreed or disagreed with the following positive statements about the overall impact of appraisal and revalidation:

- Appraisals are a good way of improving a doctor's clinical practice.
- Appraisal is likely to help doctors respond to concerns at an earlier stage.
- The requirement to consider patient feedback improves the standard of a doctor's practice.
- If appraisals are carried out well, they motivate doctors to aspire to the highest standards of practice.
- The quality of continuing professional development undertaken by doctors has improved since the introduction of revalidation.

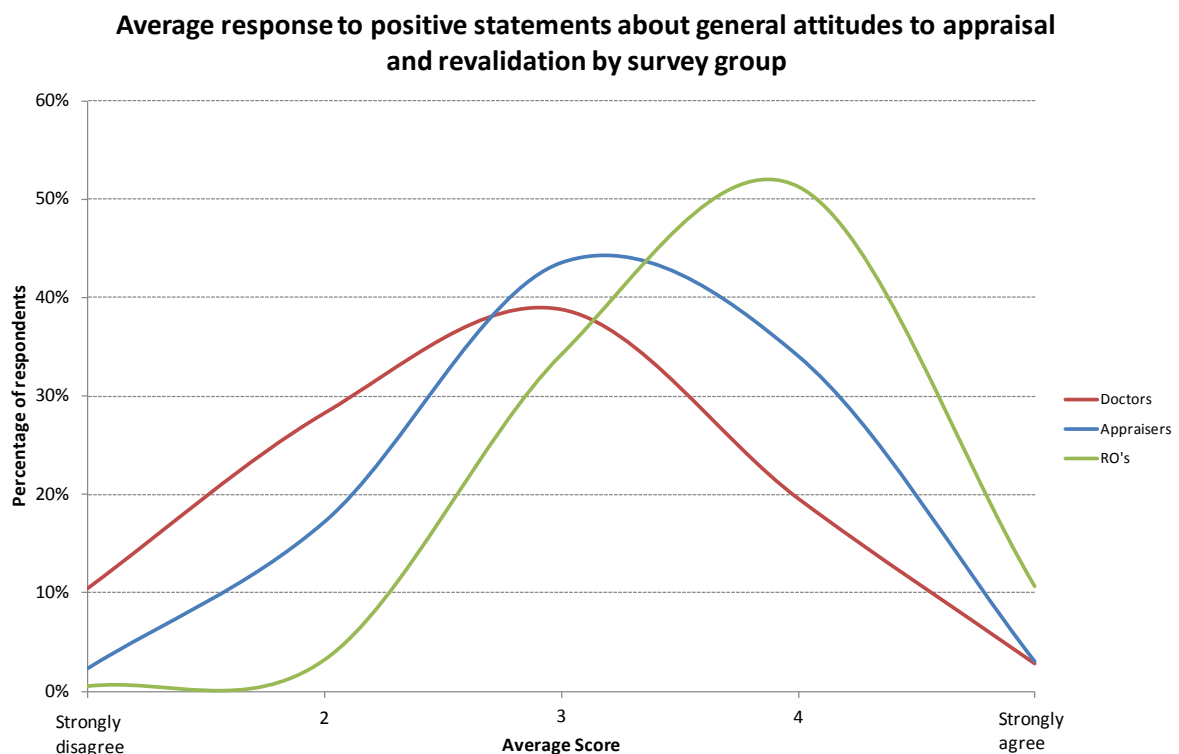
³ *Organisational Readiness Self-Assessment (ORSA) Report 2012-13* (RST, 2013)

- The requirement for revalidation makes it easier to respond to concerns about patient safety and poor quality of care.
- The revalidation process will improve the standards of doctors' practice.

We think that it is useful to consider each survey group's response to this question together to enable comparison.

At a high-level, we have considered the average scores given by respondents from each of the survey groups to the positive statements. The results are contained in figure 2 on page 5.

Figure 2



The results show that, on average, responsible officers have the most positive opinions towards revalidation (62% of average responses are a 4 or a 5), followed by appraisers (37%) and then doctors (23%). These results need to be borne in mind when considering the responses of each survey group in the context of evaluation as a whole. The detailed results for each of the statements by each of the survey groups are contained below.

The Responsible officers' survey contained an additional statement on governance (see last statement on chart) which was not in the other surveys.

Figure 3

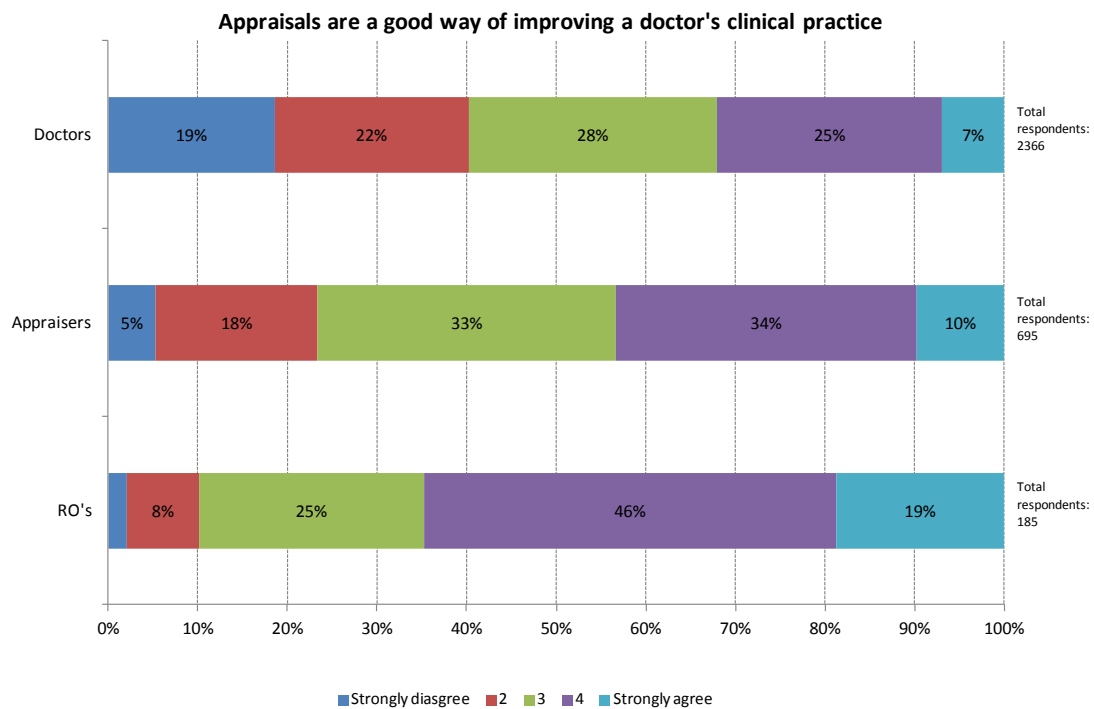


Figure 4

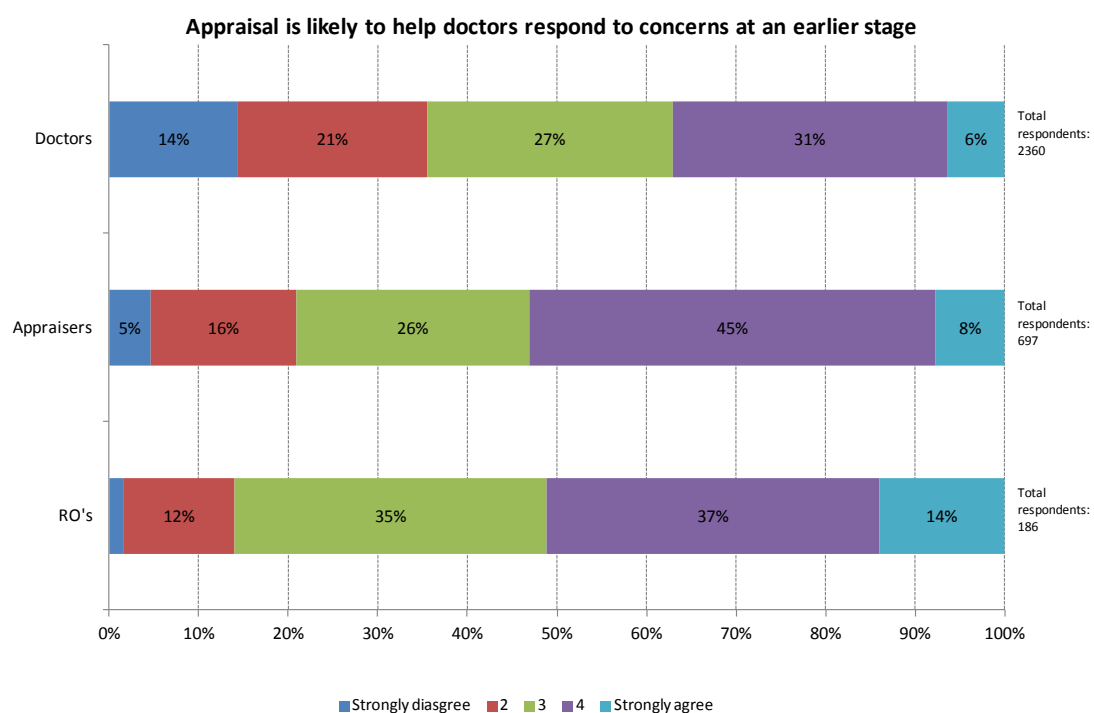


Figure 5

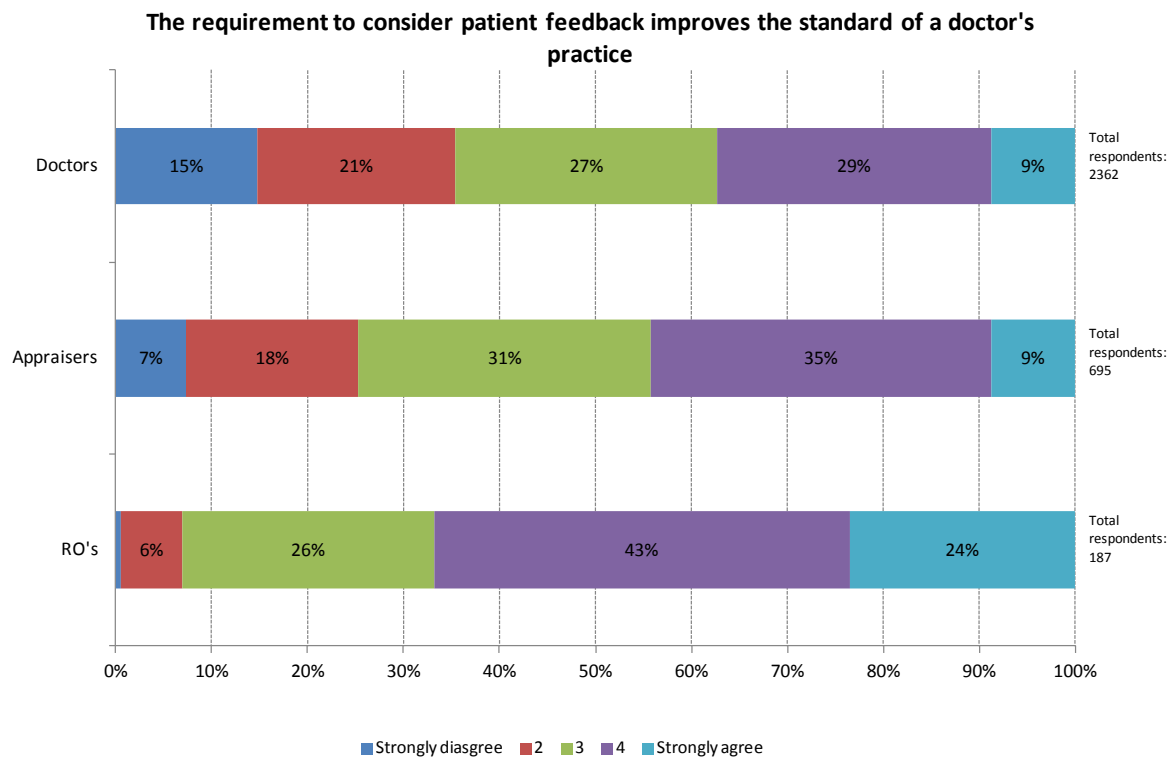


Figure 6

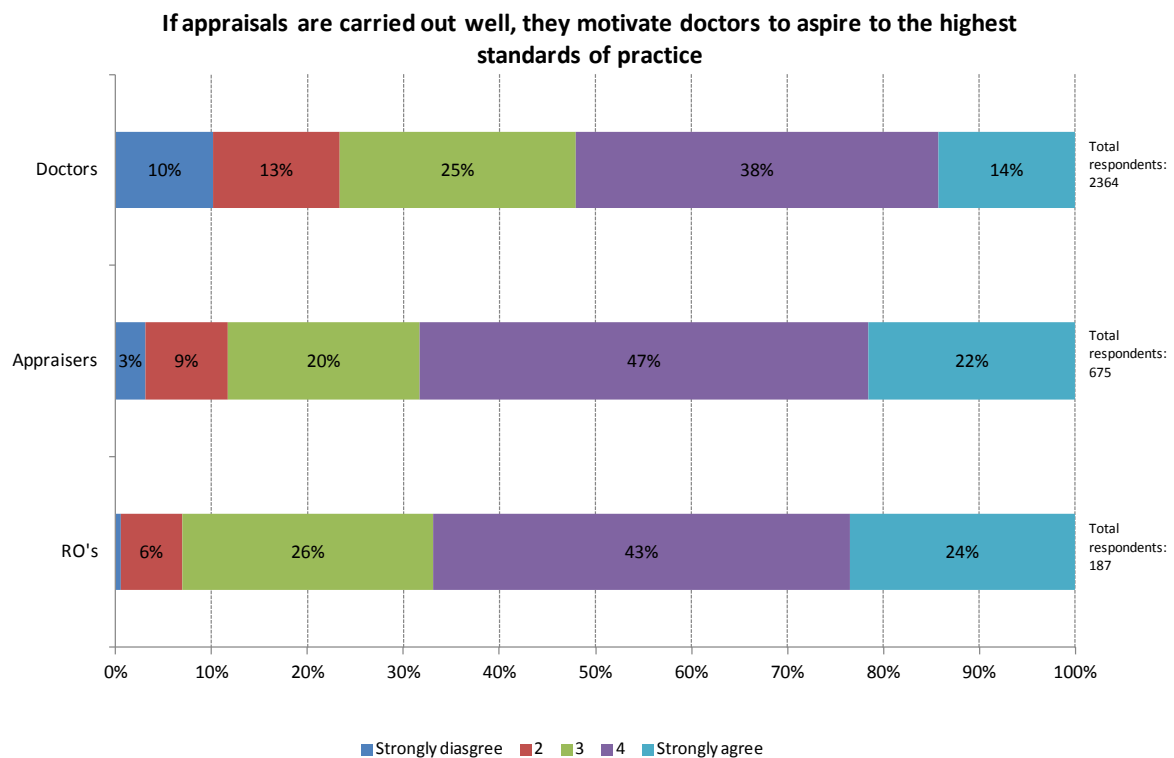


Figure 7

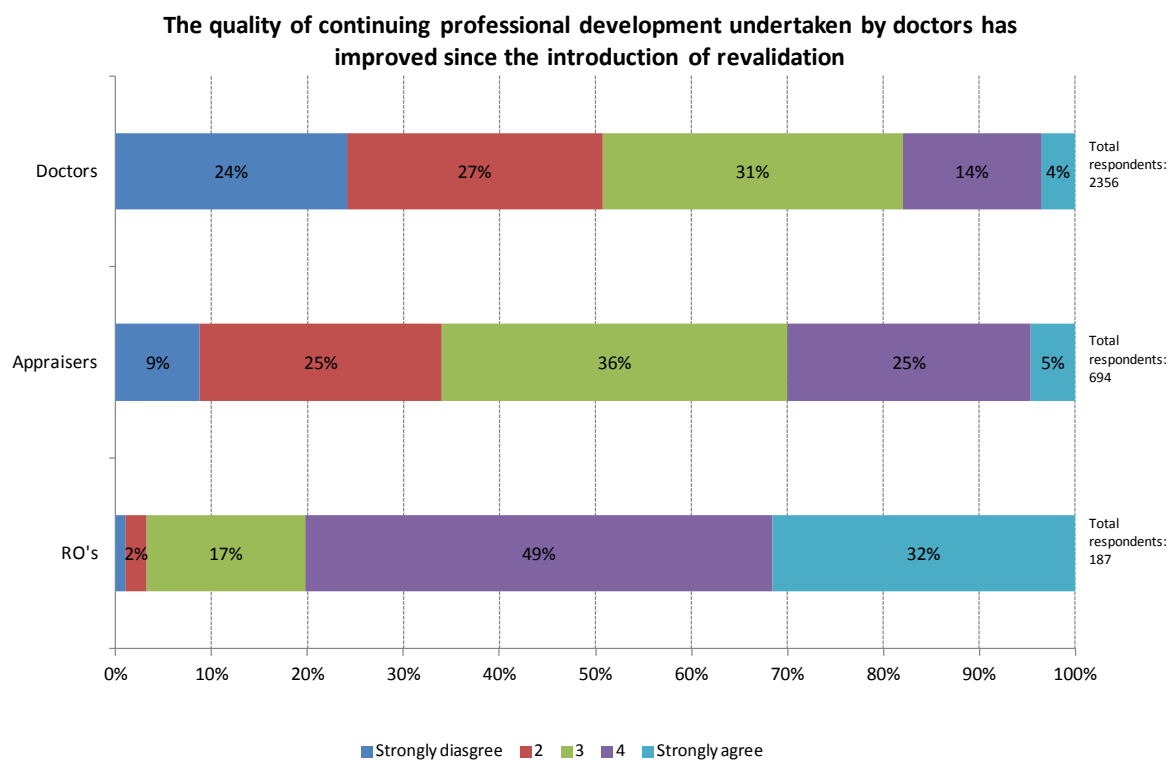


Figure 8

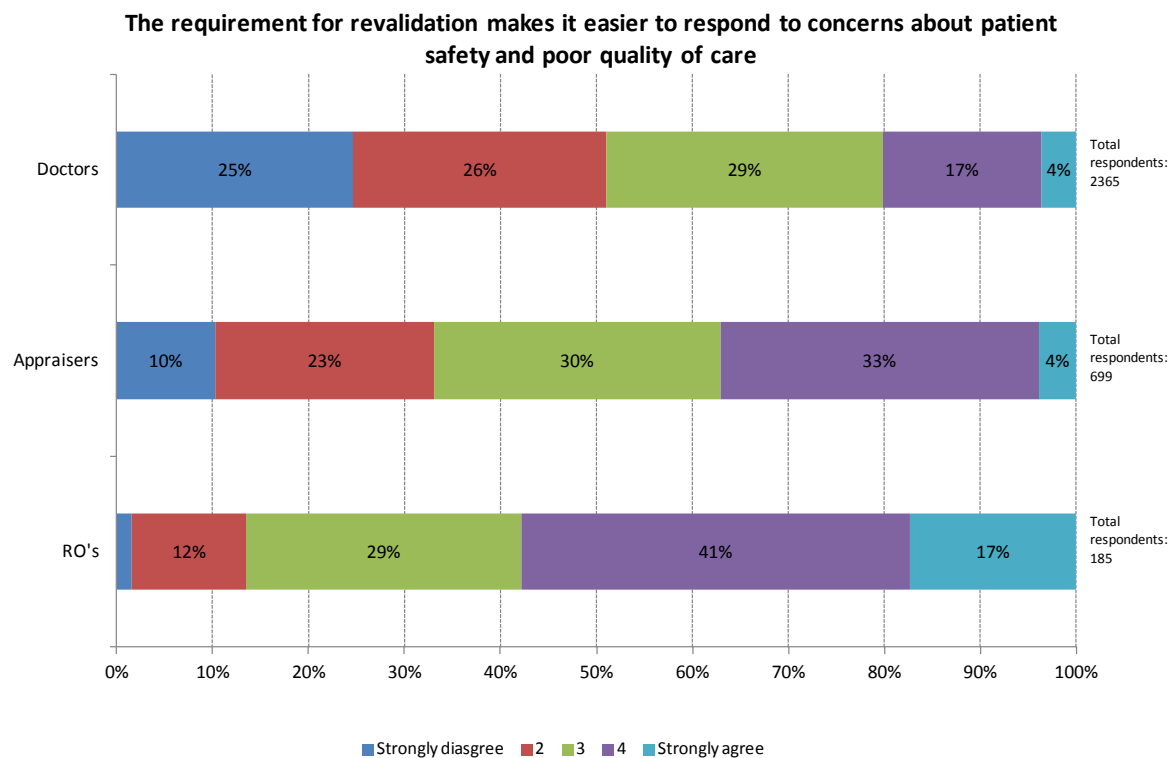
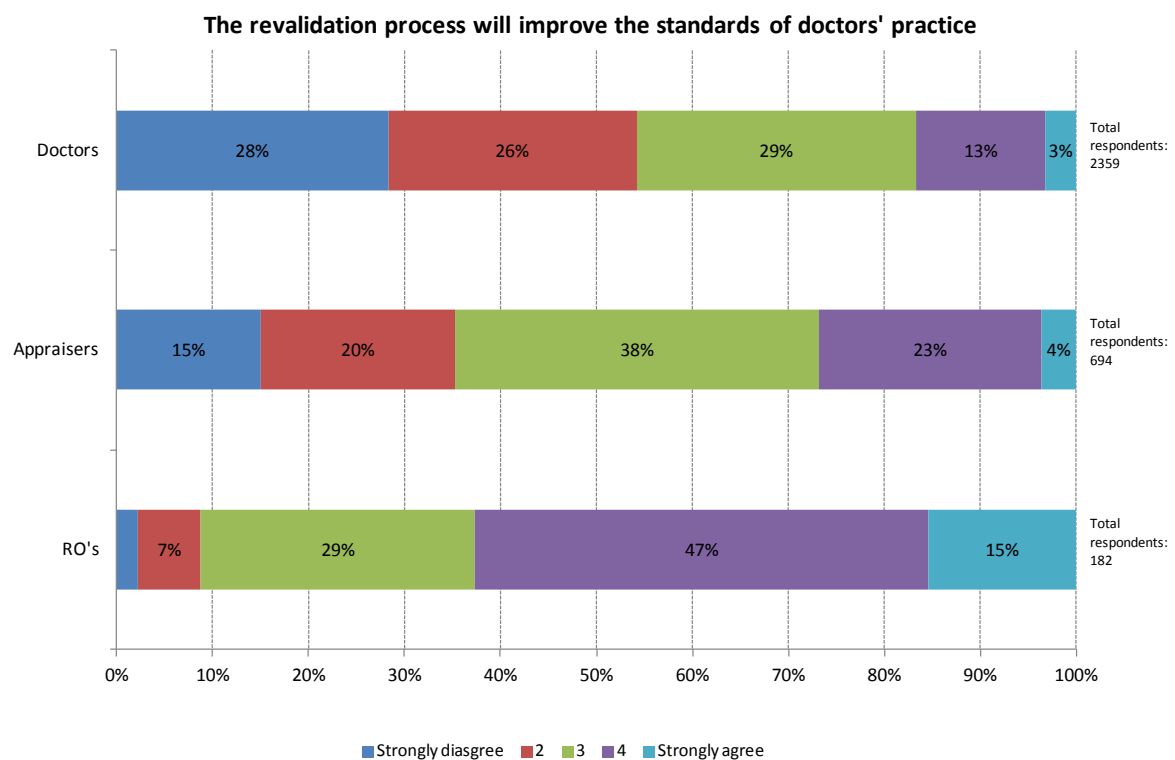


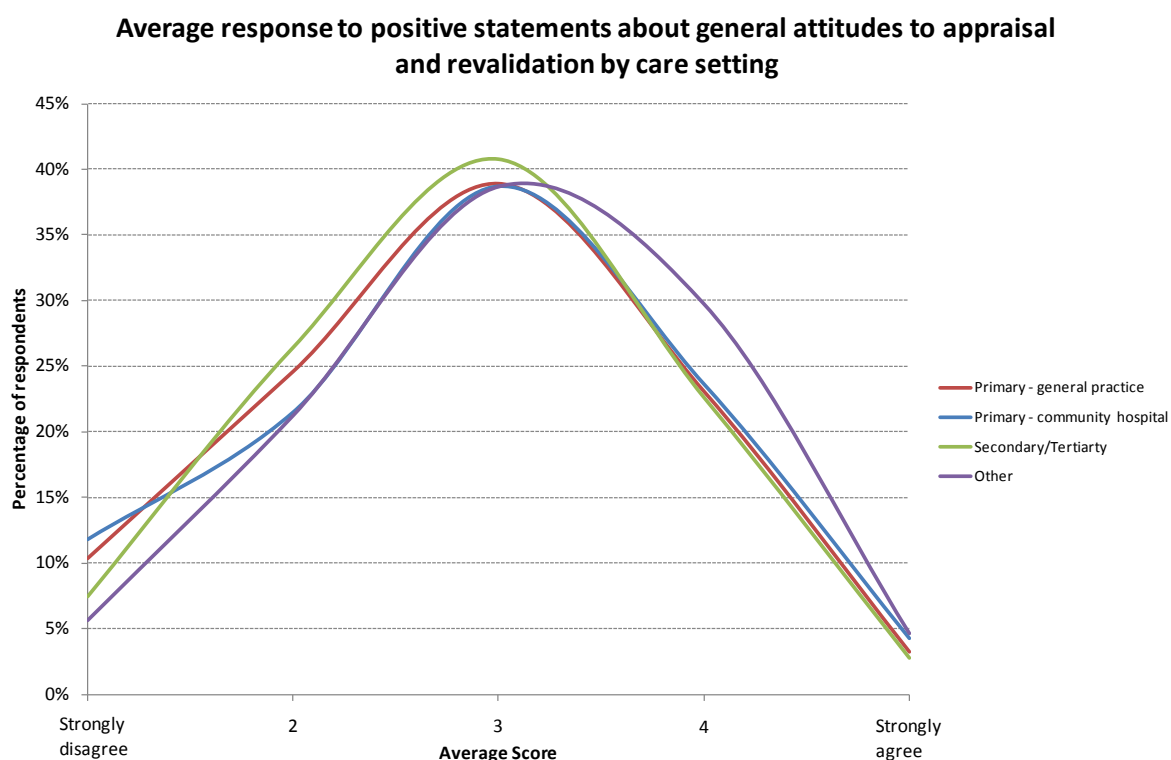
Figure 9



Comparative analysis by healthcare setting

We also compared the views of respondents working in different care settings using the results of the questions about their general views on appraisal and revalidation. The distribution of views about the statements was broadly similar for individuals belonging to GP, community hospital and secondary/tertiary care settings. Those who classified themselves as 'other' were more likely to agree with positive statements about appraisal and revalidation. This is demonstrated in the chart below.

Figure 10



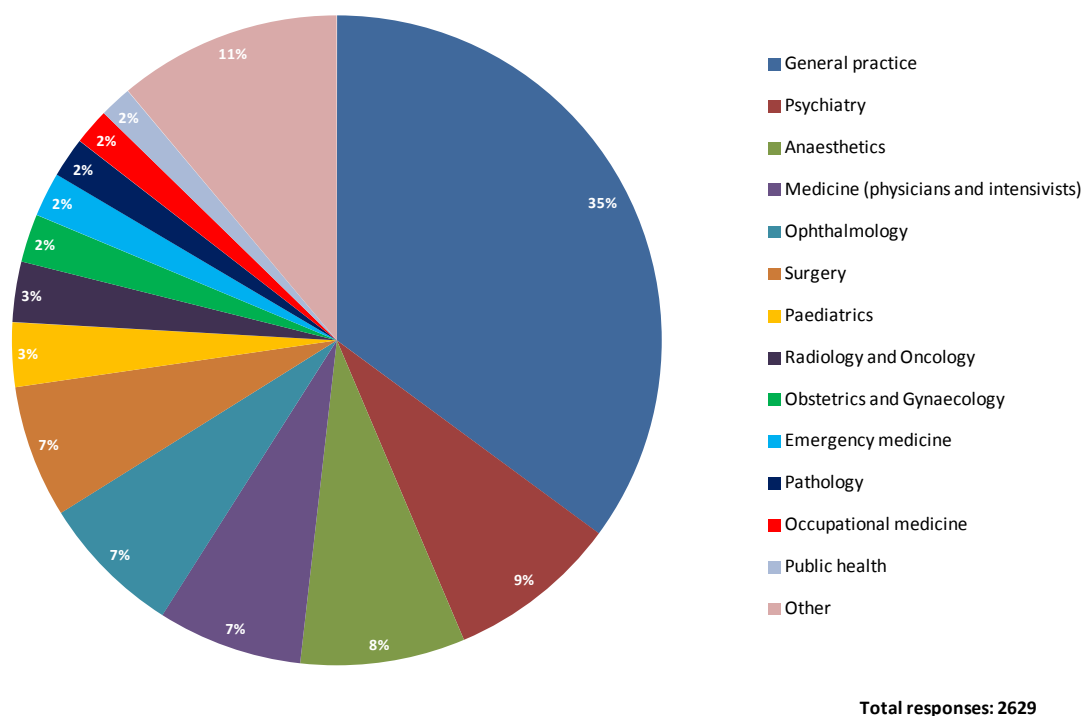
Doctors' survey

About you and your work

1. Please could you let us know the area of medicine you specialise in by ticking the relevant box below?

Results

Figure 11

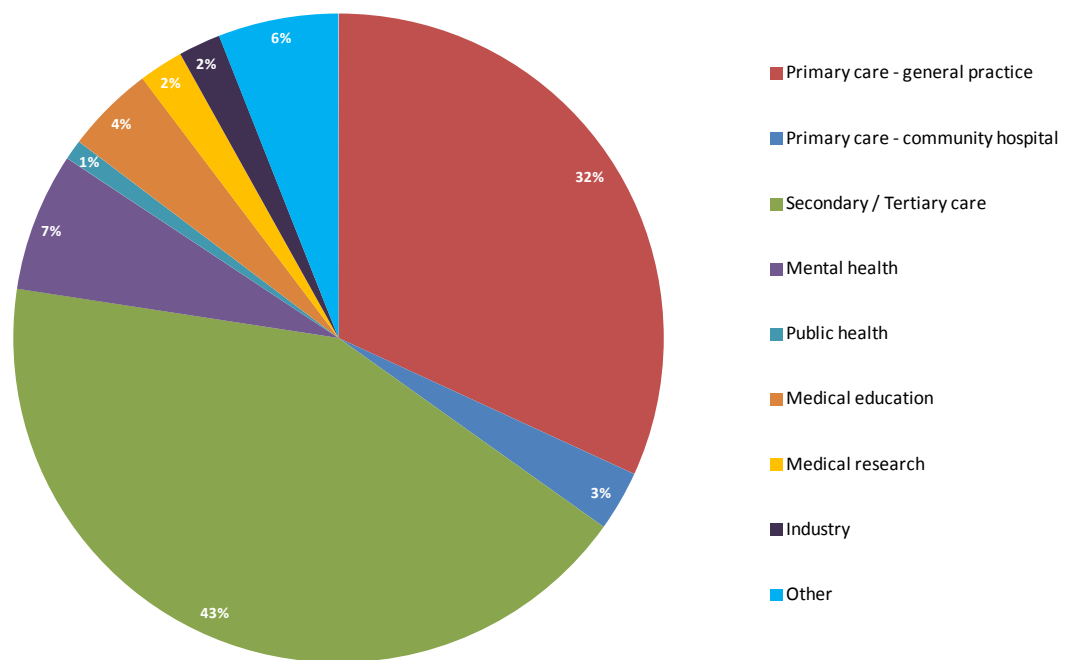


The vast majority (90%) of doctors reported a single specialty, 8.3% of doctors reported no specialty and 1.7% of doctors reported two specialties.

2. In which of the following healthcare settings do you work?

Results

Figure 12



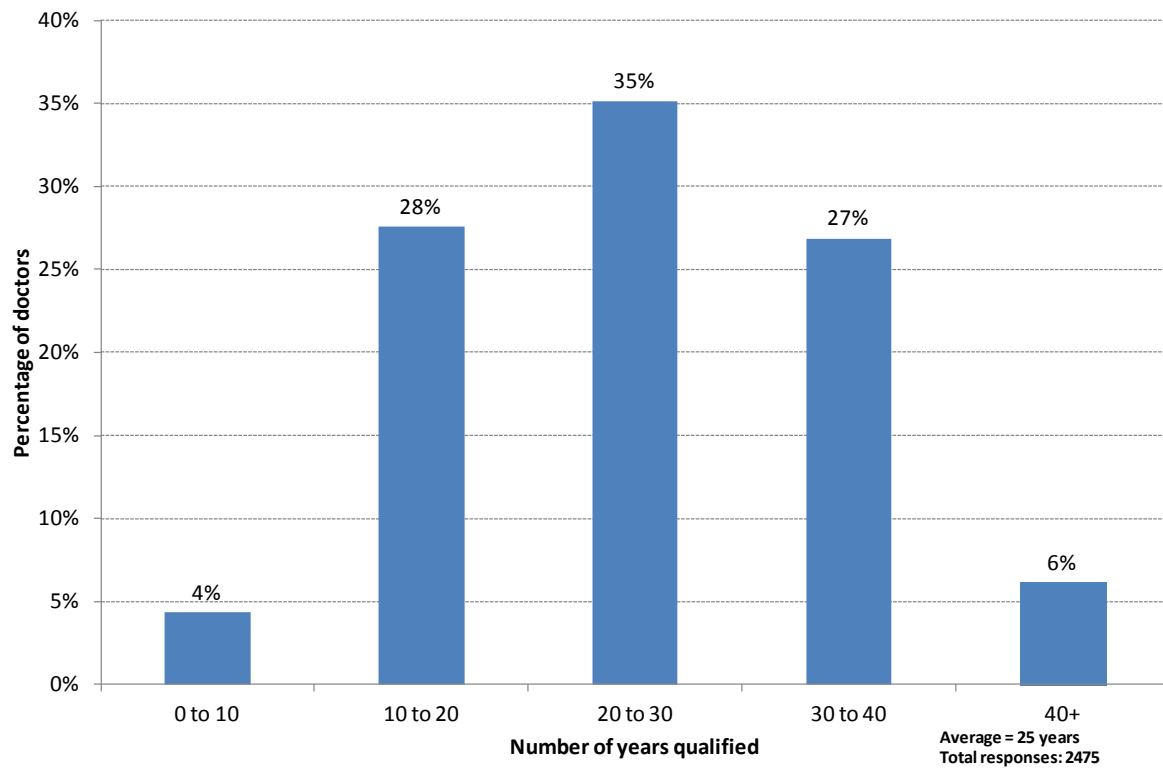
Total responses: 2865

The vast majority (85%) of doctors reported working in a single setting, 8% reported two settings, 2% of doctors reported three settings and 5% did not report a setting.

3. How many years have you been qualified as a doctor?

Results

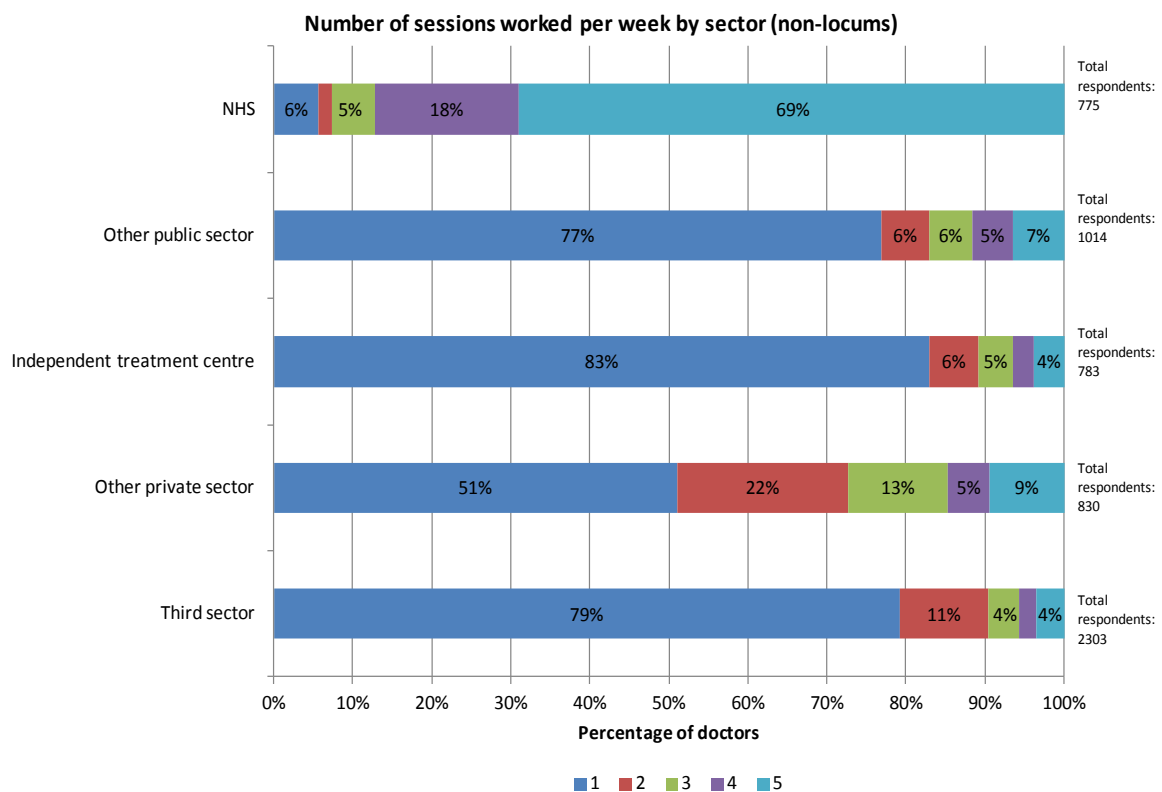
Figure 13



4. Please complete the following table to provide a profile of your current work as a doctor [in relation to treatment setting and number of sessions].

Results

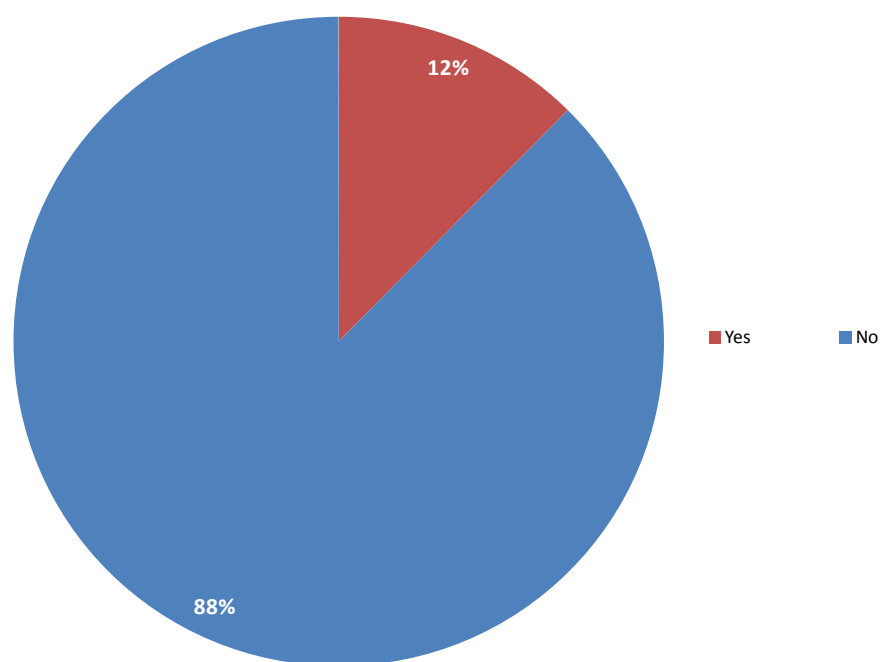
Figure 14



5. Is more than 50% of your work as a doctor carried out as a locum?

Results

Figure 15



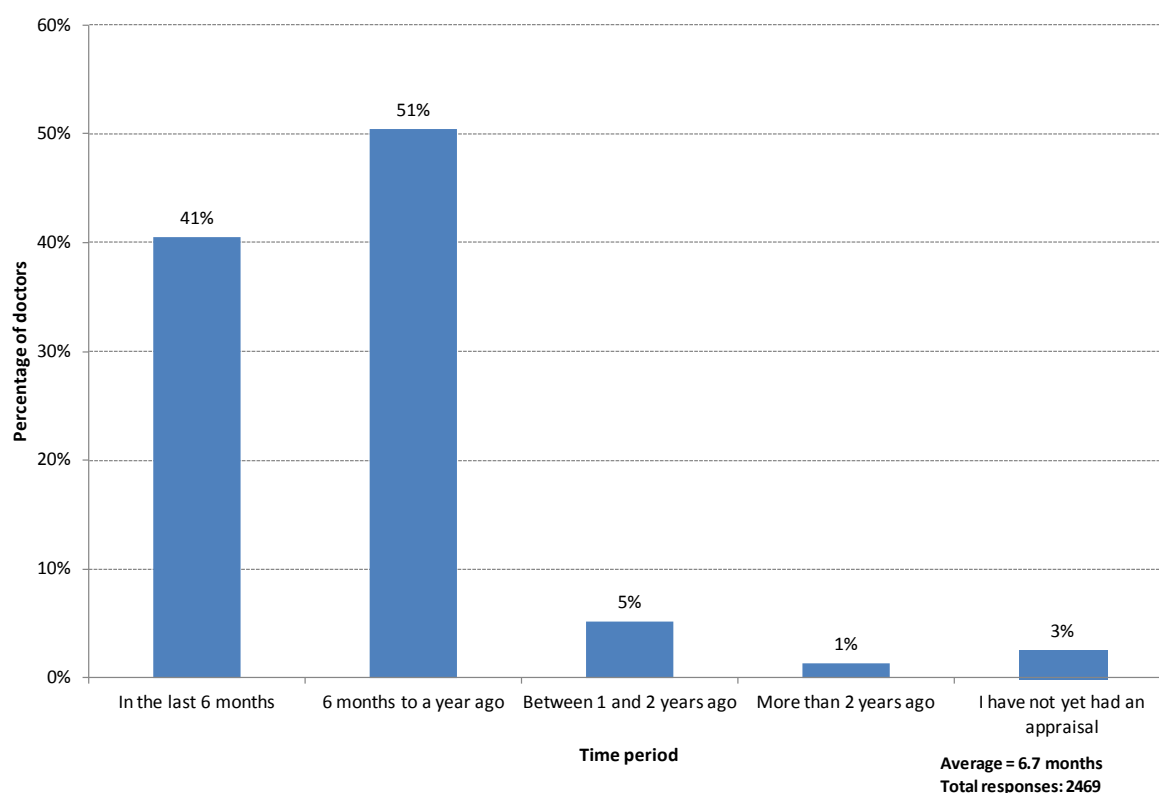
Total responses: 2469

Your last medical appraisal

6. When was your last appraisal?

Results

Figure 16



General comments

Doctors were asked when their last appraisal took place and were given an opportunity to make further comments. Further comments generally fell into three categories, relating to: resources, the appraiser and the appraisal. A selection of responders' comments is included below.

Comments relating to the appraiser and the appraisal:

"My last two appraisals have been quite good. A sensible competent appraiser. I regret to say that a number of the appraisers that I know, I have little respect for as I know their way of working and I know that appraising and appraisal has made no difference to their style or quality of work....sadly. I make sure I pick an appraiser I do not know."

"My appraisal was planned at 14 months post the last one and then cancelled by my appraiser who no longer wished to do it, at the appraisal meeting."

"I have had to have two appraisals within eight months to comply with revalidation. I have had ten years of appraisals so why there was a need to rush an extra one in was beyond me. I was advised in Jan (when I had to do three QIAs in six weeks over Xmas) it would be my last pre-revalidation in November but was then requested to do another in September. I feel I was very poorly advised and found this very stressful."

Comments relating to resources:

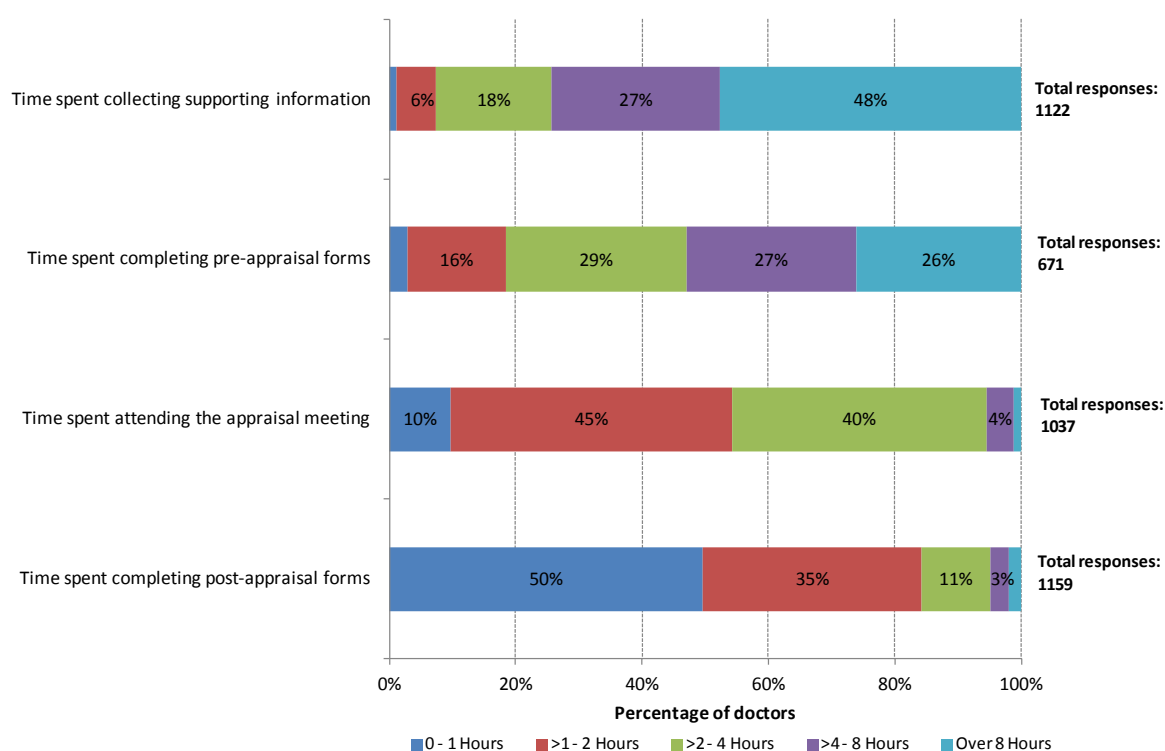
"It is a lot of work. It took me 19 hours of timed work at home in evenings etc. to complete the form(s). Colleagues note the same. If this was done during paid time at work, clinical services would suffer. Is this really a sufficient priority in a cash constrained health service? Is this really what tax payers wish us to spend their money on? Making it biannual would halve the work."

"The amount of work it takes is disproportionate. It just means that I will spend less time treating patients as there is only so much I can do during the week. With the current recruitment crisis and understaffing in out-of-hours care causing a crisis in A&E I really think the GMC should think again and hard. Each hour I spend doing this I could treat six really ill people."

7. For your last appraisal, approximately how many hours did you spend on each of the following activities?

Results

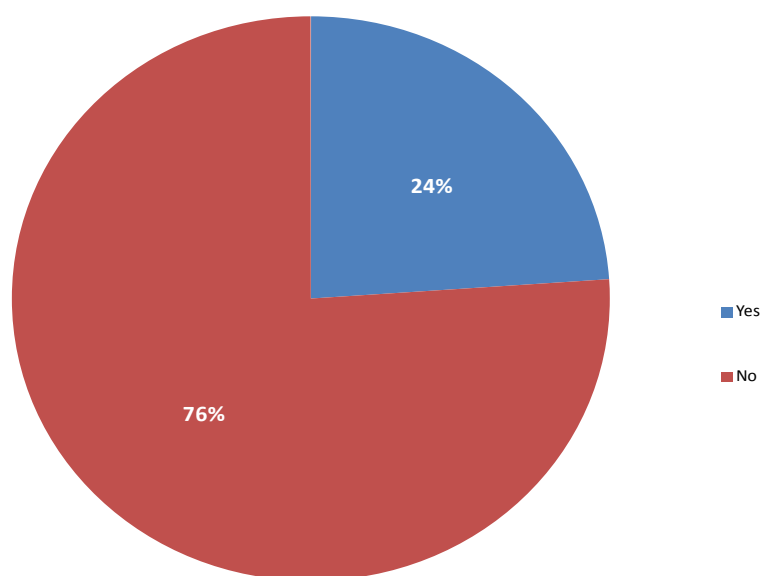
Figure 17



8. Did you change any aspects of your clinical practice or behaviour as a result of your last appraisal?

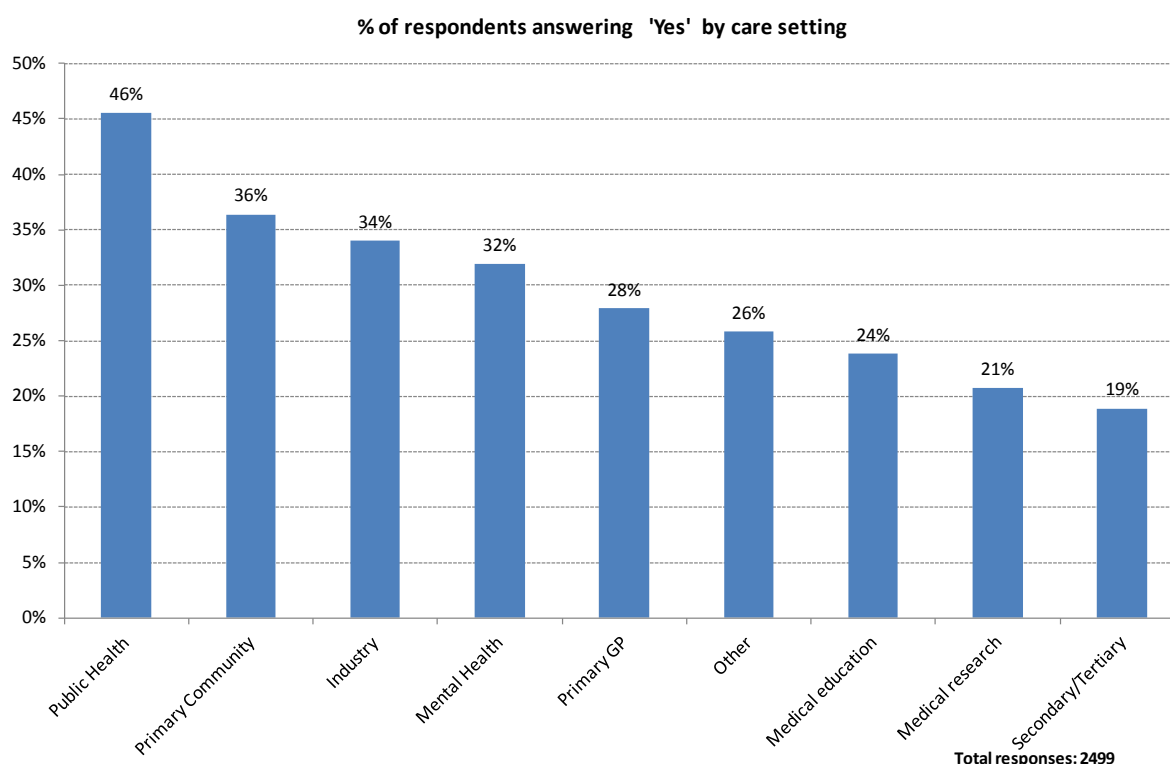
Results

Figure 18



Total responses: 2499

Figure 19



General comments

Doctors answering 'yes' were asked to comment on what they had changed. Many of the doctors reported changes directly relating to how they will prepare for their next appraisal. Doctors also indicated changes to clinical practice and behaviours. A selection of responders' comments is included below.

Comments relating to preparation for the next appraisal:

"I did not change my clinical practice as a result of the appraisal. My behaviour did change regarding preparing for the appraisal. My 'folder of evidence' keeps getting bigger, and the process longer."

"slightly more determined to collect information for next appraisal monthly rather than at the end of the year"

"Were I to undergo another appraisal, I would curtail clinical work to allow time to collect information prospectively."

Comments relating to changes in clinical practice and behaviours:

"Make changes on a continual basis depending on current state of knowledge, meetings, discussions and external advice etc. That is my professional responsibility. So I would say the result of my last appraisal has really minimal to no bearing on the changing of my practice or behaviour."

"I have changed my clinical practice and behaviour as a result of completing and achieving my learning needs, NOT as a result of appraisal. I would learn and improve my skills even if there was NO appraisal at all."

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

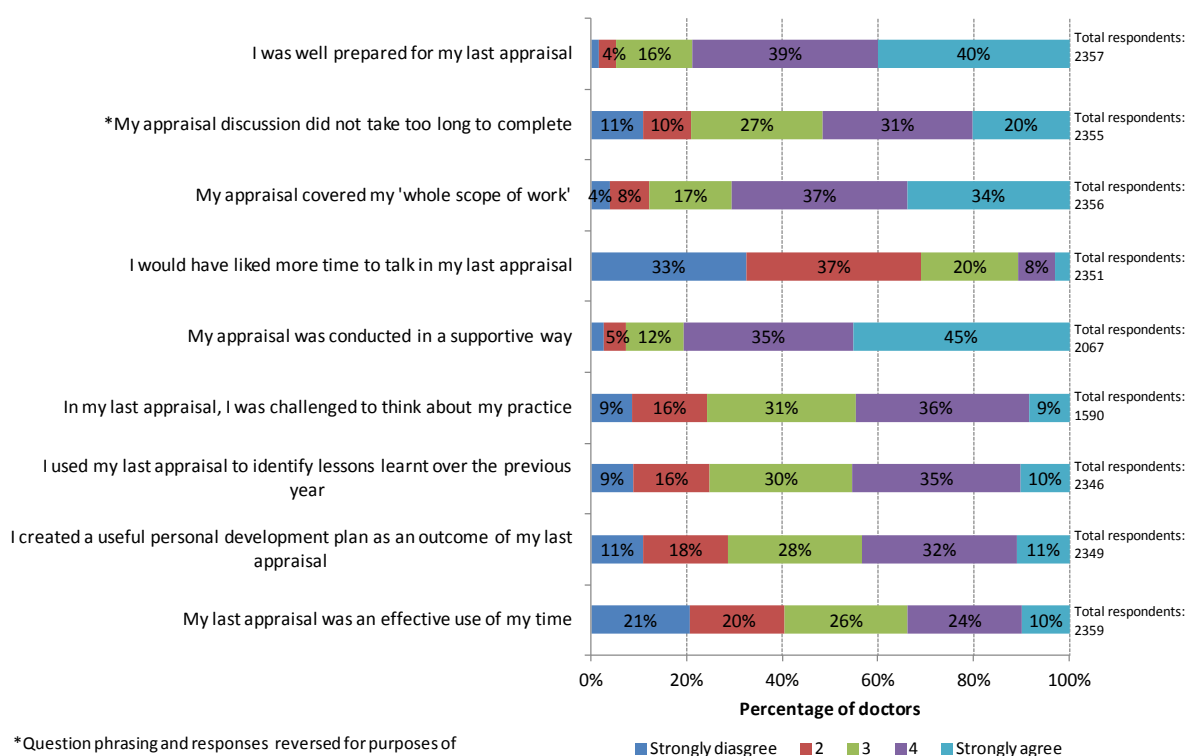
"After my first appraisal I have changed my attitude towards the patients and the nursing staff. I started to study more and more to achieve my goals. I am fully involved all the time in revalidation as I still have plenty of plans for the future."

"I did a lot of work on trying to improve my timekeeping. As part of this I decided to sit in with other GPs in surgery, including those for whom I have enormous respect. I found the experience enlightening in many ways. Both seeing that GPs who I respect performed aspects of the consultation in a very similar way to me (even if they came to different reasoned decisions). Those who did what I considered a thorough and particularly good job also tended to run late (unless they had particular skills like fast touch typing/ v. good IT skills). I came to the realisation that I will tend to run late if 10 min consultations as I am not prepared to compromise my standard of work. I now look for surgeries to work in with longer appointment times/no nurse practitioner often given the more straightforward, less time-consuming work. I think sitting in with other GPs as part of appraisal requirements would be v. valuable to many GPs (and perhaps pick up a few less well performing ones). I last sat in as a trainee and my focus was on very different aspects then."

9. Please indicate how strongly you agree or disagree with each of the following statements [about your last appraisal]

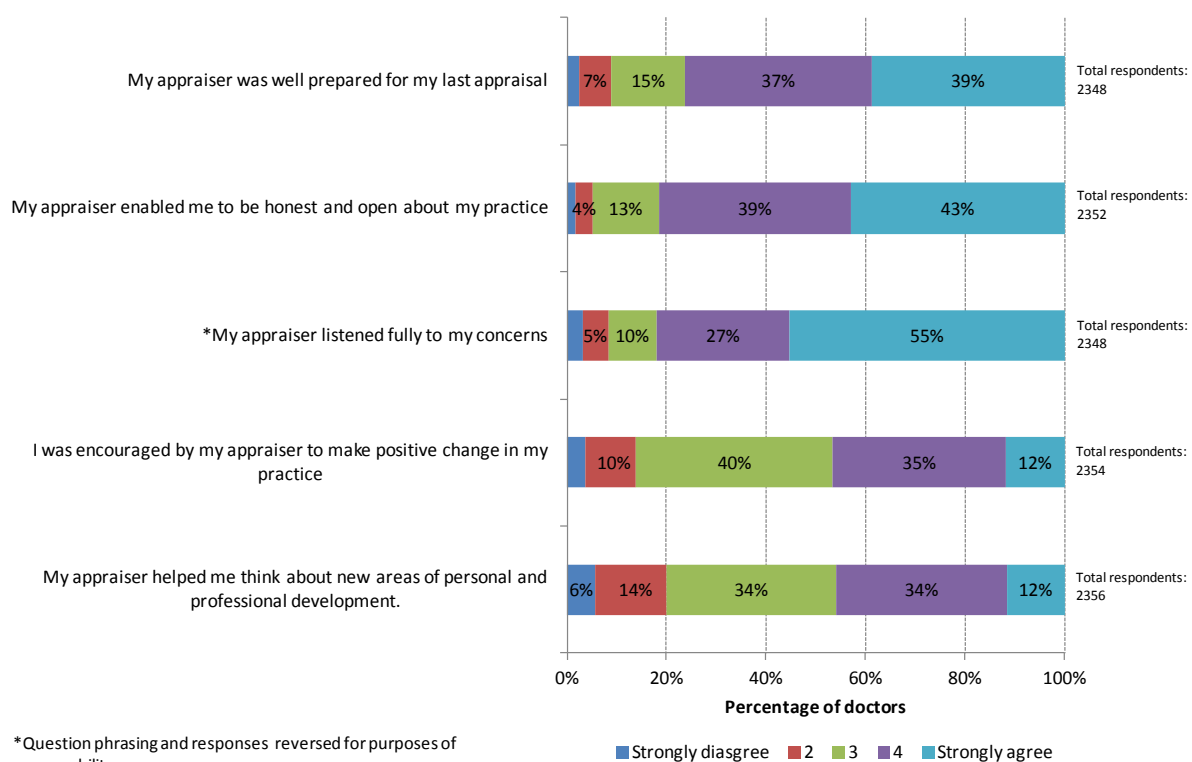
Results

Figure 20



10. Please indicate how strongly you agree or disagree with each of the following statements [about your appraiser]

Figure 21



11. If you had wanted to in your last appraisal, would you have been able to raise any concerns about a colleague, for example about the colleague's conduct, performance or health?

Results

Figure 22

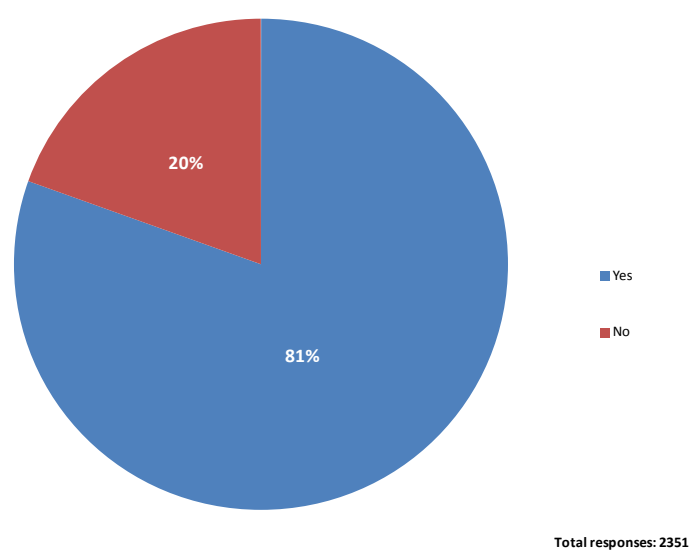
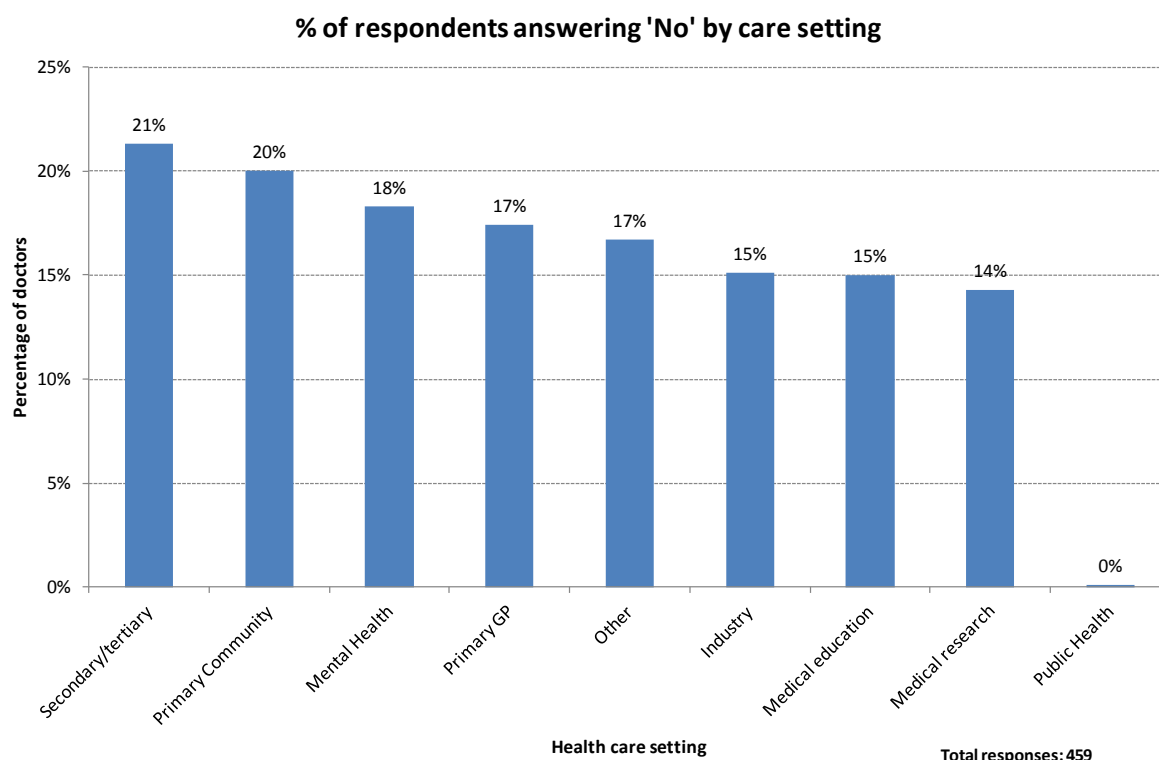


Figure 23



Doctors answering 'no' were asked what, if anything, could have been changed to allow them to raise concerns if necessary. Most doctors felt the appraisal was not an appropriate forum to raise concerns and gave a variety of reasons. Reasons included: the time it takes to report concerns, a lack of confidence in the process to deal with concerns and a lack of trust in the appraiser's confidentiality. A selection of responders' comments is included below.

Comments relating to a lack of confidence:

"...would have little confidence that they would be dealt with in a supportive way. We pay lip service to a 'no blame culture'. I know of colleagues who have been mentally ill and unsupported by a mental health trust whose tactics have prolonged that person's illness."

"I don't believe my employer would have treated my concerns with sufficient sensitivity or have acted appropriately about them."

Comments relating to a lack of trust in the appraiser's confidentiality:

"I did not trust the appraiser nor believe he would have been able to take appropriate action."

"Don't trust appraisers to keep anything confidential, no matter what they say."

Comments relating to time:

"Yes, my appraiser was supportive but it is not necessary to have an appraisal to raise these concerns. There are other established channels."

"My appraisal would not be an appropriate forum to raise concerns about a colleague. This should be done at the time the concerns were noticed. It would be inappropriate to wait up 'til a year to report them."

"If there were clinical concerns regarding a colleague, I would not wait for the appraisal. But there is still no real protection for doctors' whistleblowing (the government avoided legislating for this)."

General comments

Doctors were also invited to give general comments about their last appraisal. It was clear from the comments that the standard of the appraiser had a significant impact on the experience of the appraisee. A significant number of doctors took longer to prepare for their appraisal than stated in guidance and there is scepticism about the benefit of appraisal, particularly since the link to revalidation. A selection of responders' comments is included below.

Comments relating to the standard of the appraiser:

"My appraiser is a good role model and it is his experience and suggestions that has [sic] motivated me to pursue my own goals. I think having a good role model as an appraiser is the most important thing for an appraisee."

"I find that appraisals vary a lot in quality depending on the appraiser. I'm not clear myself about what they are supposed to be."

"My appraiser was more concerned with nit picking the appraisal form and with the looming threat of revalidation than with providing the support I need at the present time."

"Last appraisal was first one in which I actually felt that the appraiser had taken time to read what I had written, which emphasises the huge variation in what constitutes an appraisal. It is quite stressful esp. as the rules for revalidation had just been confirmed so I had little time to tick all boxes also my appraisal was brought forward to allow to sync with revalidation so less time."

"Usefulness of the appraisal depends very much on who does the appraisal."

"Worst appraisal I have ever had. My previous appraisers have all been superb. This appraisal was a waste of my time and I felt cheated as I had put so much work into it."

Comments relating to the time it took to prepare for the appraisal:

“Complete waste of time and effort, adding no benefit to ongoing professional attitude to development/learning/feedback. But increasingly stress inducing given the tie to revalidation.”

“The appraisal is not the main problem, it is the time collecting information and documenting reflection, and jumping through hoops”

“Revalidated in April. It took me around 30 hours of work, mostly in my own time, to prepare for my appraisal. Much of this time was spent collecting data that could better have been provided by management. For example it was not possible easily to download a record of mandatory training.”

Comments relating to the benefit of appraisal:

“Appraisal measures everything except that which actually matters. There is really no attempt to measure clinical knowledge and consultations. I feel deeply depressed about the self-promotion required to show that I am competent. The whole process should be external to the doctor’s self-promotion skills.”

“Appraisal is a tick-box exercise; concerns are not listened to by senior management. I think they would use the data to their own ends and not for the good of patients.”

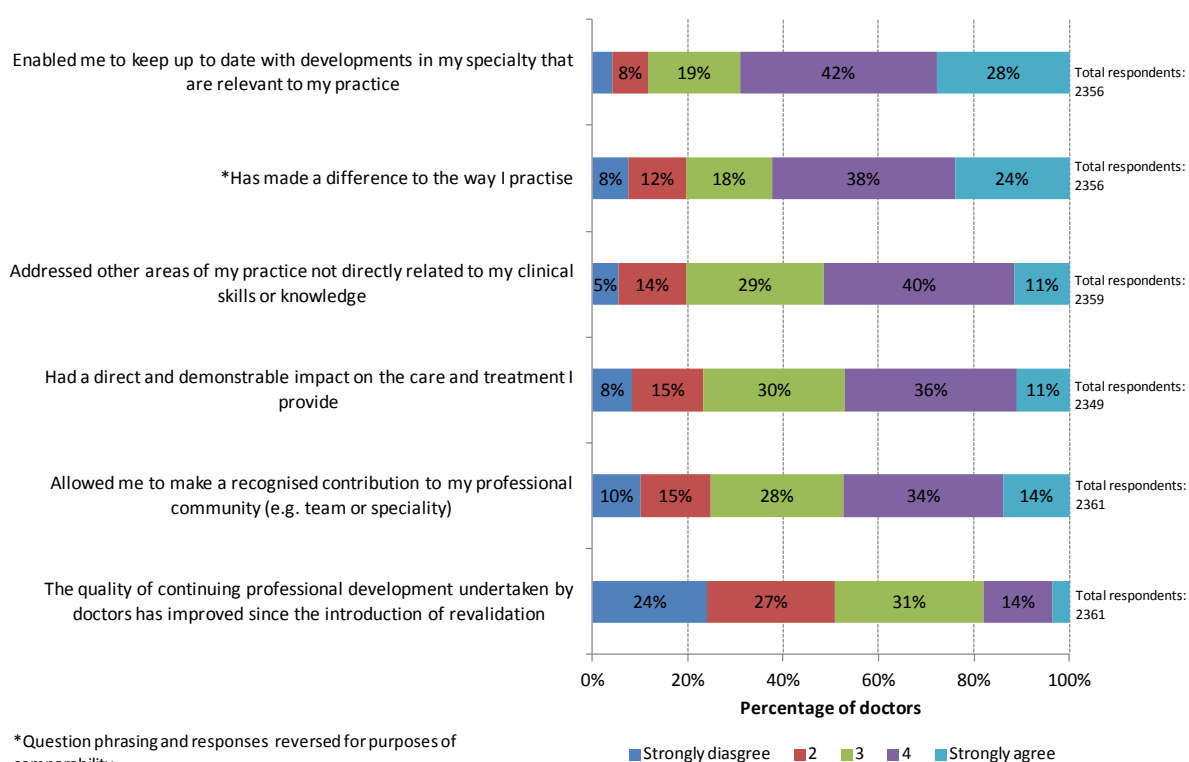
“My appraisal meeting was helpful, but in the overworked environment that is being a consultant just added more stress to use of my time. I reflect regularly on my practice and have done for 28 days. I think my patients would benefit from more of my time spent in their direct care.”

Your continuing professional development

12. Please indicate how strongly you agree or disagree with each of the following statements about the CPD (continuing professional development) you completed in the year prior to your last appraisal.

Results

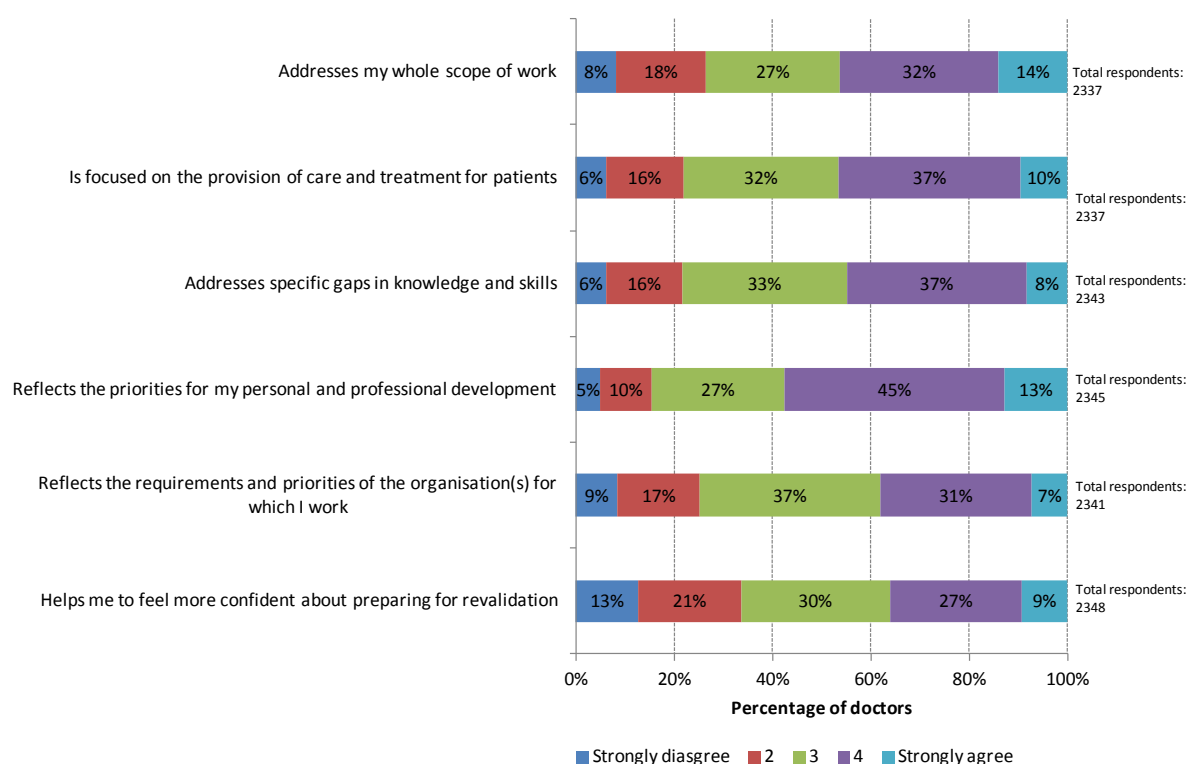
Figure 24



13. Please indicate how strongly you agree or disagree with each of the following statements about the personal development plan (PDP) you prepared following your last appraisal.

Results

Figure 25



General comments

Doctors were also given the opportunity to add any further comments they wished to make on questions 12 and 13. A significant number of doctors mentioned a lack of resources to support their continuing professional development (CPD) and/or personal development plan (PDP). Many respondents felt that there should be more flexibility as needs changed between appraisals. A selection of responders' comments is included below.

Comments relating to a lack of resources:

"The trust is generous enough with study leave but the only way we can really assess which courses to attend and get onto them when we work as long as we do is if locums would be funded for study leave. Otherwise co-ordinating on-call duties swaps/cancellations of clinics and lists together with childcare make it too great a hurdle."

"To be honest I don't think my PDP is used the way it should be. I identify what I think are my training needs, which are supported, but there is no point in identifying any wider needs as my employer makes no effort to support me or my needs at all. Our service is working with only 50% of what we should have for our population and we are so busy clinically that I just do the basics. It's hard to find time to reflect and even harder to work as a team to improve anything as we are constantly told there is no money to improve things, while other services get lots of resources. So I just do a reflective note or two a year."

"CPD is vital for all doctors (as it is for other professional people, such as pharmacists). It is vital for patient care that trusts continue to support and fund CPD. Funding is being cut back across the country. This can only harm patient care."

Comments relating to flexibility:

"CPD/PDP should be an evolving process, whereas I feel that the PDP in particular is focused on me being able to tick the correct boxes for revalidation, and I don't necessarily feel that this is useful/helpful. I accept that it is vital that we keep abreast of developments, and that we record learning activities and reflect on them, but fail to see how collecting points for various activities guarantees that someone is competent to practise."

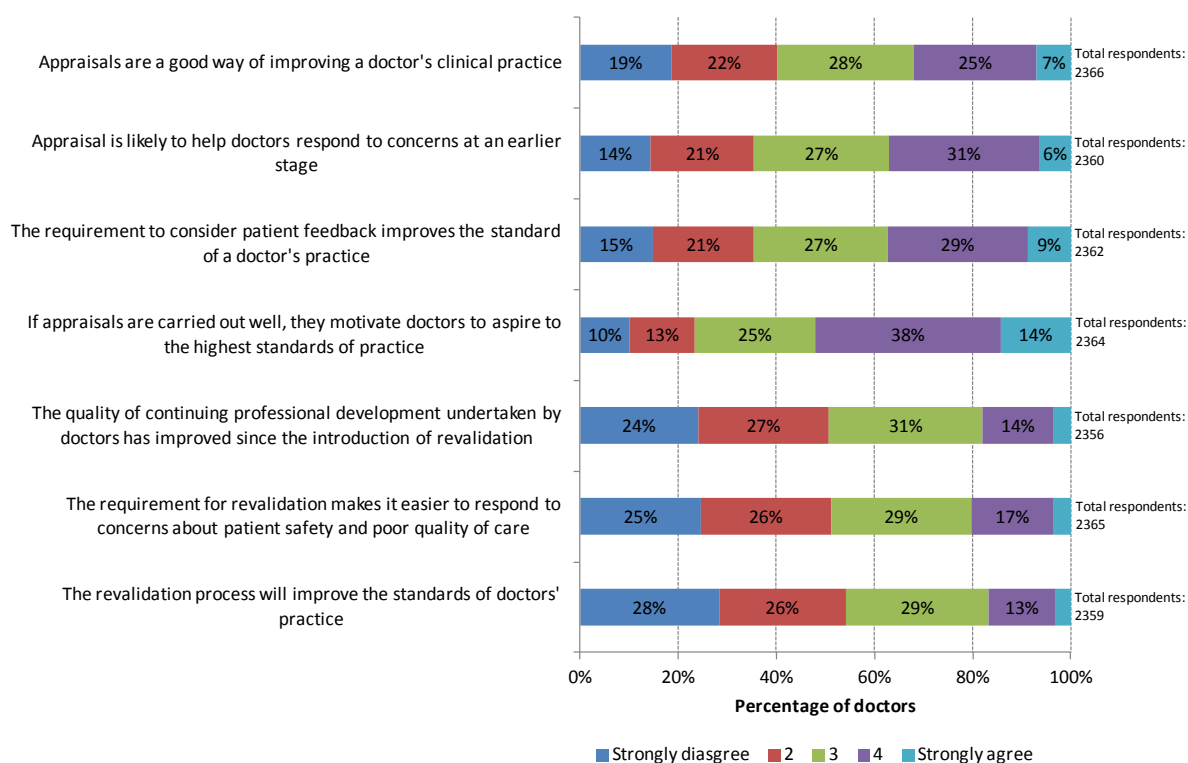
"General practice is very fluid with a huge scope of learning requirement that cannot be covered practically within a rigid PDP/CPD process. However, it helps to give time for reflection but should not be seen as a rigid plan to work off as priorities change throughout the year, and every year, due to external pressures and demands."

“The PDP idea is flawed; if you make a plan for what you intend to learn, it can quickly become irrelevant if the areas you focus on you discover to be less of a gap than you thought. My learning is driven by the clinical needs of my patients and as such cannot be planned in advance of their contact with me. Development plan should be directed by the clinical needs of your practice. How do you know you have a gap in your knowledge until you discover it?”

14. Please indicate how strongly you agree or disagree with each of the following statements [about revalidation]

Results

Figure 26



General comments

Doctors were also invited to provide comments on the overall impact of appraisal and revalidation. A large number of respondents agreed that there was a need to improve practice, but didn't believe the current system of appraisal and revalidation would help in this regard. A large number of the respondents used this space to express their concerns about the length of time the process took them away from their clinical activities. A selection of responders' comments is included below.

Comments relating to the improving practice and the link of appraisal with revalidation:

"I don't think revalidation in itself will help, without improved and watertight appraisal process. Otherwise it is just another tick in the box."

"I do not doubt that an annual discussion with a respected professional could be beneficial and motivational and provide a new perspective or new insight on my career. However, I do not think that appraisal and revalidation as it stands is of any benefit. It will not pick up the poor doctors and takes much valued time away from genuine CPD and demotivates good doctors."

"Appraisal system sounds good in theory, and ran reasonably well before revalidation came in. It works well only IF the appraisers and their organisations are supportive. There is no measure of whether they are supportive, and whether responsible officers are acting in the best interest of individual staff and patients, or to meet their own targets, which often include reduced quality of services (dressed up as reconfiguration). There is too much power invested in responsible officers, which is dangerous, and undermines a sense of individual professionalism."

"Doctors come into the profession and the National Health Service to help people. We reflect on and build on our knowledge all the time as part and parcel of our work that is how medical advancements were happening before appraisal. It is ludicrous to suggest that appraisal has enhanced or somehow reinvented this intrinsic process."

"Personally, I have not found the slightest change to my sense of professional need to adapt when there have been problems, or address issues raised over complications, etc. Feedback has always been important, and revalidation has not had any discernible impact on it."

Comments relating to the time taken away from clinical activities:

“Appraisal is now nothing more than a stick with which to beat the medical profession. CPD is an essential part of being a professional person and very enjoyable. It does influence personal practice, but having to record it, reflect on it and prove that you’re doing it is has huge time and cost implications to the person and to the NHS. I spend each year the equivalent of one of my 3-day working week preparing and doing my appraisal. Surely that time would be better spent seeing the patients? The appraisal system needs to be supportive and realistic. The revalidation system needs to focus on problem doctors.”

“I feel strongly that revalidation and appraisal detract from CPD time and time available for patient care. I cannot see any positive purpose that they serve.”

“Doctors do not have enough time to care for patients. More paperwork and more managers are stopping people from doing their jobs.”

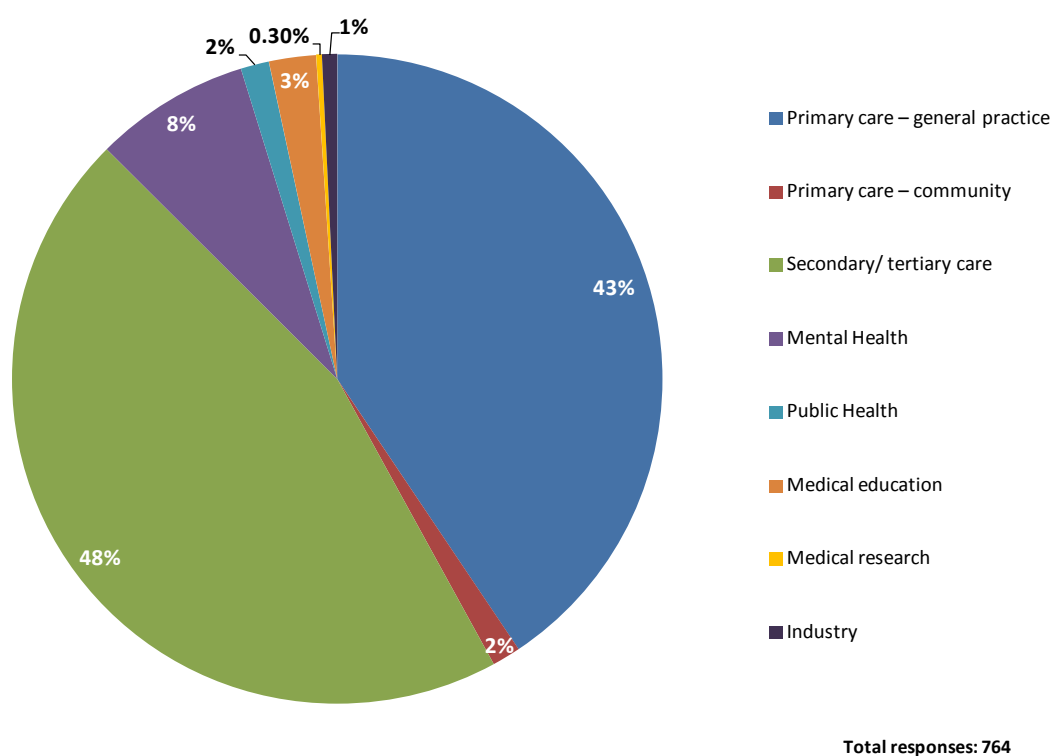
Appraisers' survey

About you and your role as an appraiser

1. In your role as an appraiser, in which of the following settings do you carry out appraisals?

Results

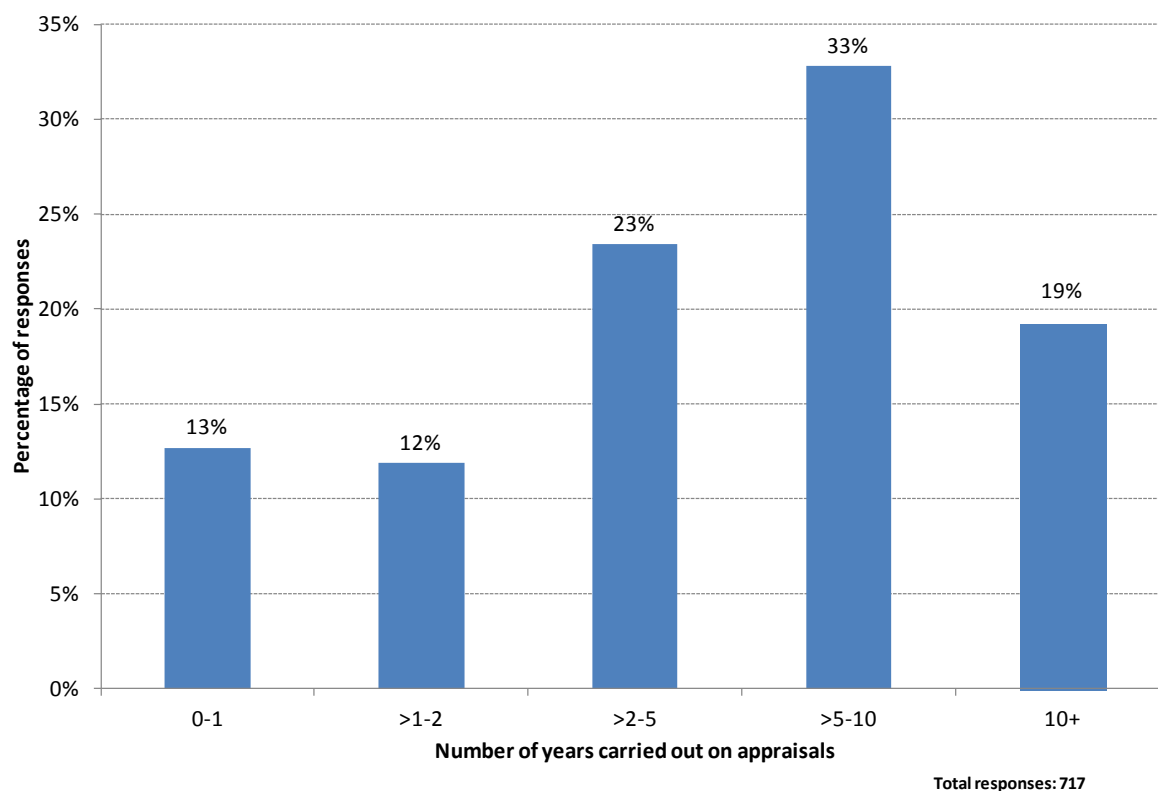
Figure 27



2. For how many years have you carried out appraisals?

Results

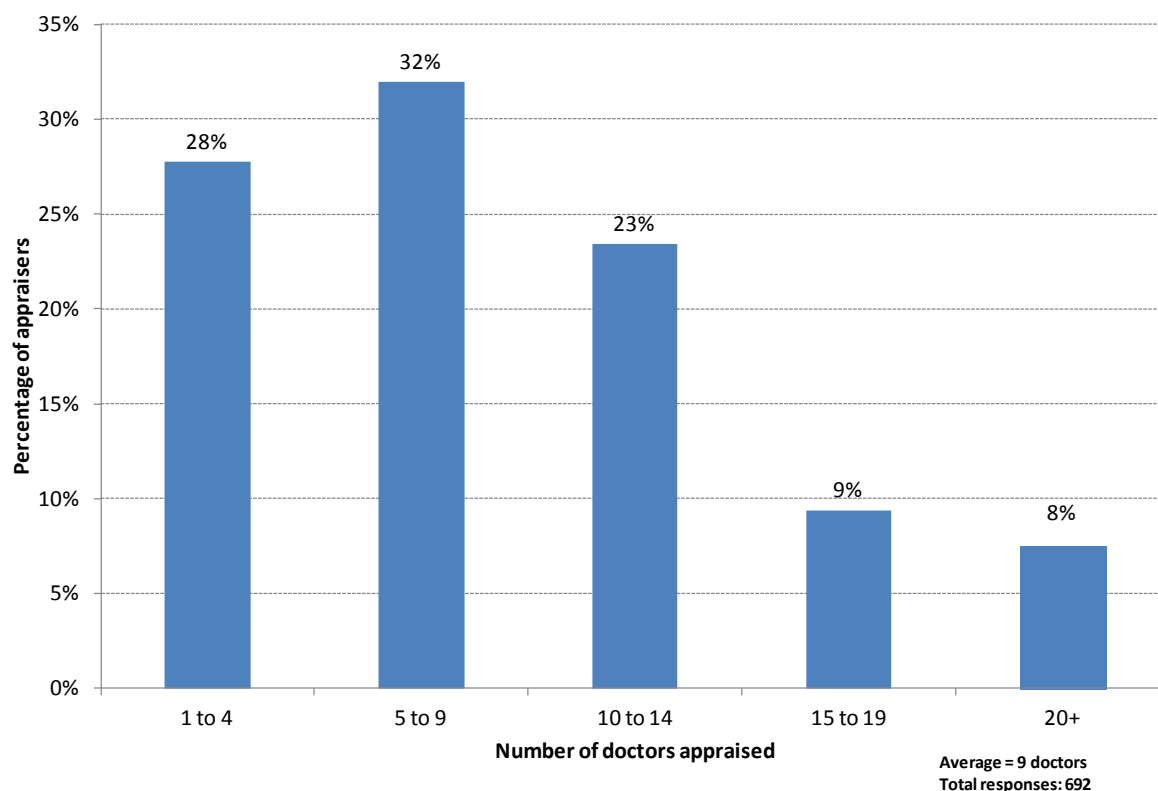
Figure 28



3. How many doctors did you appraise between April 2012 and March 2013?

Results

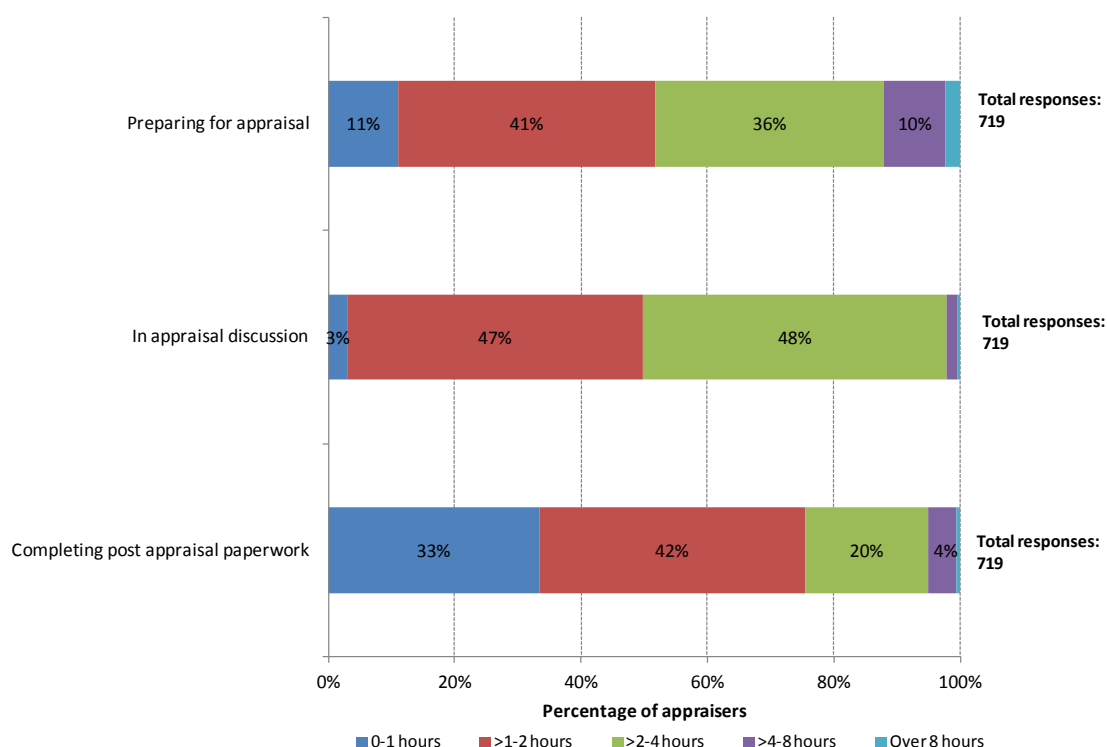
Figure 29



4. On average, approximately how much time do you spend on the following activities for each appraisal?

Results

Figure 30



If you also spent a significant amount of time travelling to appraisal meetings, in addition to your normal travel to work, please indicate an average time required for each appraisal.

The response to this question was very broad, with a huge variation in the times submitted for extra travel time and some doctors reporting very high travelling times.

Appraisers were asked to respond in an open text box making statistical analysis difficult. However, given the broad range of responses, with some appraisers reporting very extensive travelling times, we know that travel time is a significant factor for a number of appraisers and should be considered when examining appraisers' workload.

General comments

Appraisers were also invited to provide comments on the questions in this section and/or their workloads. Most responses commented on the length of time taken to conduct appraisals, particularly in relation to preparation time. Many respondents also commented on the variability of the time taken to conduct appraisals. This is often dependent upon whether doctors are used to collecting high-quality evidence. Many appraisers were also concerned that they had not been allocated any or enough time to undertake appraisals, resulting in under-remuneration, less clinical time and longer hours. Remuneration was an important factor for appraisers who commented in this section.

In relation to workload, appraisers commented on increases in administration tasks and paperwork. A significant number of respondents also commented on systems, particularly the new MAG Model Appraisal Form (MAG form). Many respondents commented that changes to or introductions of systems had created some difficulties or increased workload, but many also commented that the MAG form had increased quality or efficiency through clarification and standardisation.

A selection of responders' comments to this question is included below.

Comments relating to time element of workload:

"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."

"The initial preparation is very laborious as two of my four appraisees are overseas doctors who have never had appraisals before. This is necessitating a large amount of time to support them in their preparation."

"The additional time and expense of travelling is a big commitment that is not recognised in the reward structure for appraisals in primary care."

Comments relating to administration element of workload:

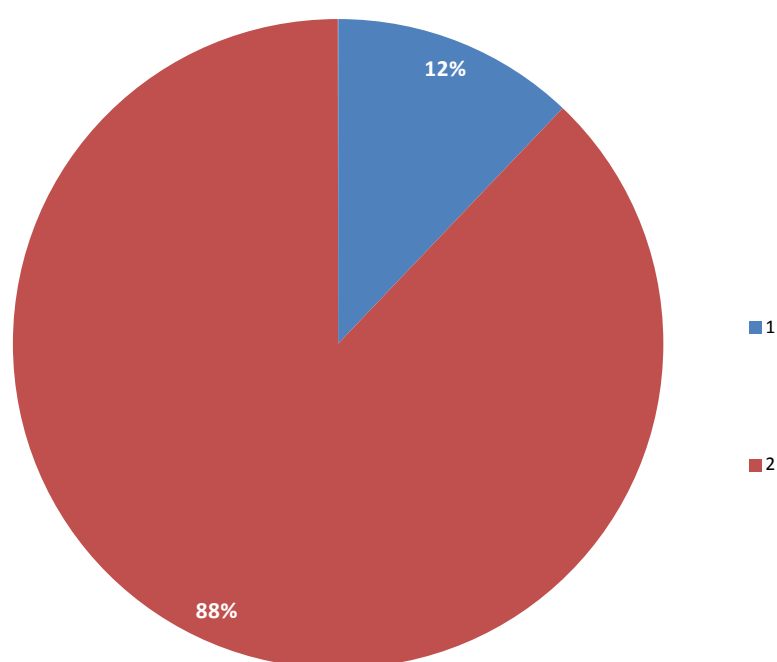
"Since the change in the toolkit, there are many more attachments to open, this is time-consuming but I do feel by the time I get through the information I can spot areas where the appraisee may need more signposting/support."

Review and quality of appraisals (appraisal lead)

5. How many appraisers are you an appraisal lead for?

Results

Figure 31

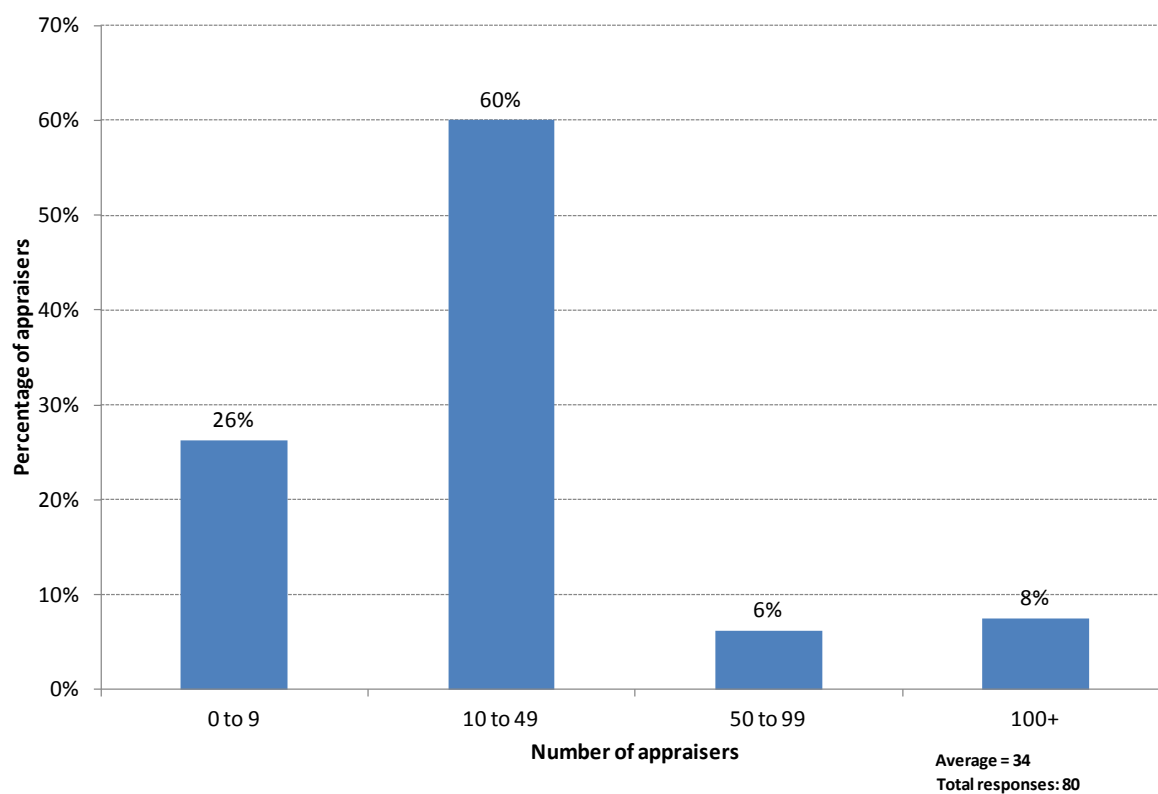


Total responses: 718

6. How many appraisers do you currently have contact with each month?

Results

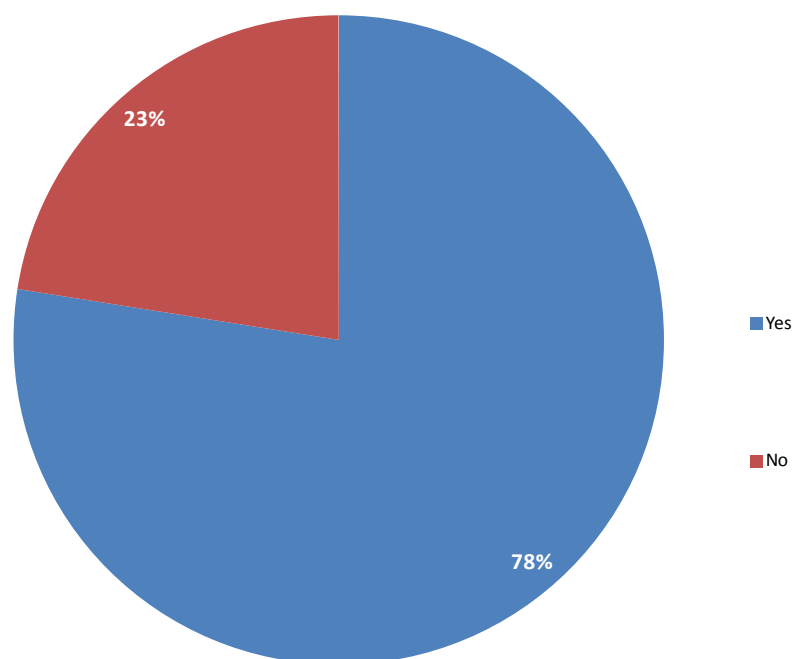
Figure 32



7. Do you or colleagues in your organisation carry out a systematic review of the quality of appraisal outputs?

Results

Figure 33

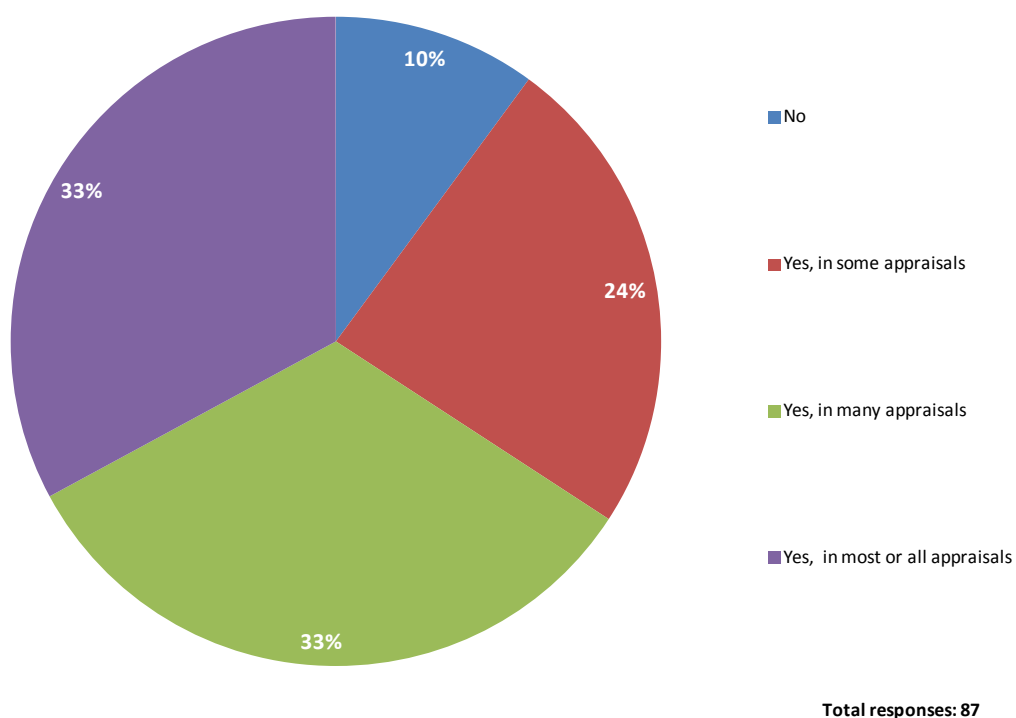


Total responses: 80

8. In your opinion, has the quality of appraisal outputs increased over the last year?

Results

Figure 34



General comments

Appraisers were also invited to provide comments on the questions in this sections and/or, more generally, about the review or quality of appraisals. Few respondents chose to provide comments. Those that did were very positive about improvements to the quality of appraisal outputs, based on successful appraiser training. However, some respondents expressed concern that the discursive element of appraisals has not improved. Respondents also mentioned improvements to systems and strong support, including training for appraisers. A selection of responders' comments to this question is included below.

Comments relating to the positive improvements in the quality of appraisal:

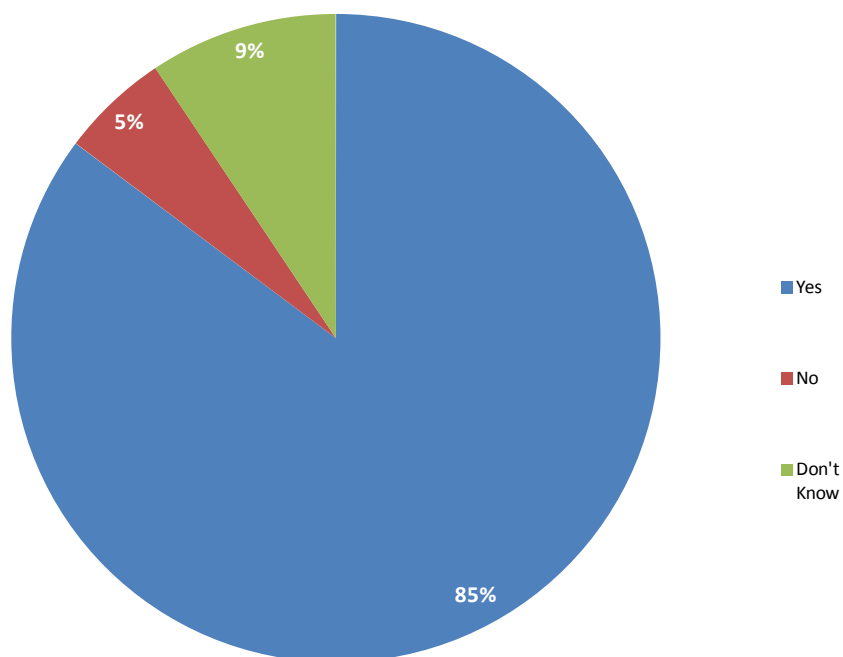
"The process has become much more robust and the advent of a national appraisal policy will serve to unify the requirements across England and support the work of appraisal leads. We have an excellent GP tutor network in the north who do the QA [quality assurance] of 10-12 appraisers each and every year and any concerns are shared with the area team. Underperforming appraisers (very few of these left now) are reviewed very closely and usually agree to leave the role if they can't improve their performance. The question about how many appraisers I have contact with is not a good one – I see almost all at various training events over the year – the tutors do hands-on reviews with all of theirs each year – I am happy to deal with email queries at any time and do a lot of these."

"Required quite a bit of training and upgrading for some to take revalidation into account but all working well now. Problems may arise in two years' time when we need to shuffle appraisers and appraisees."

Review and quality of appraisals (appraisers)

5. Does someone in your organisation or designated body act as an appraisal lead?

Figure 35

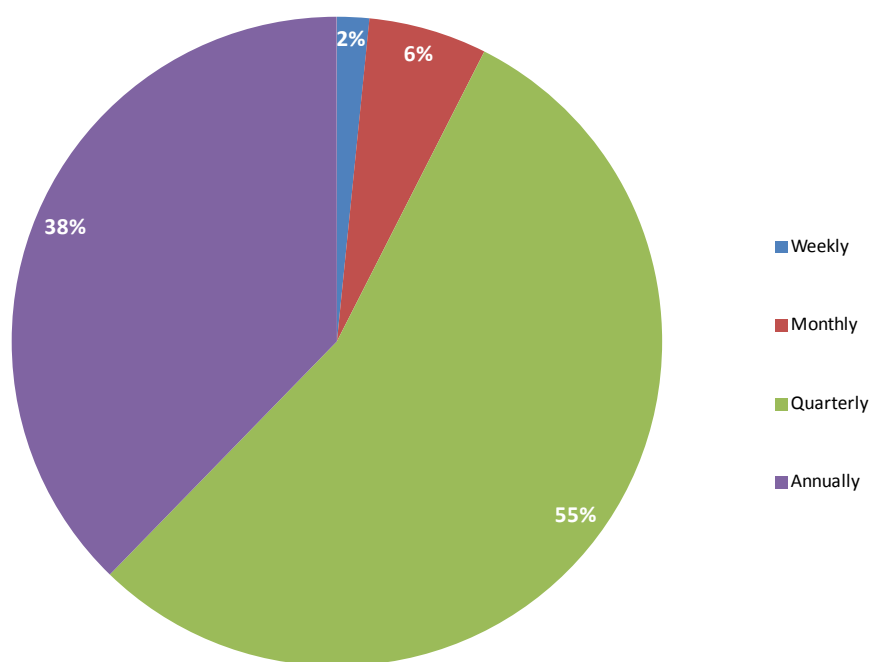


Total responses: 630

6. If yes, how often do you have planned contact with your appraisal lead?

Results

Figure 36



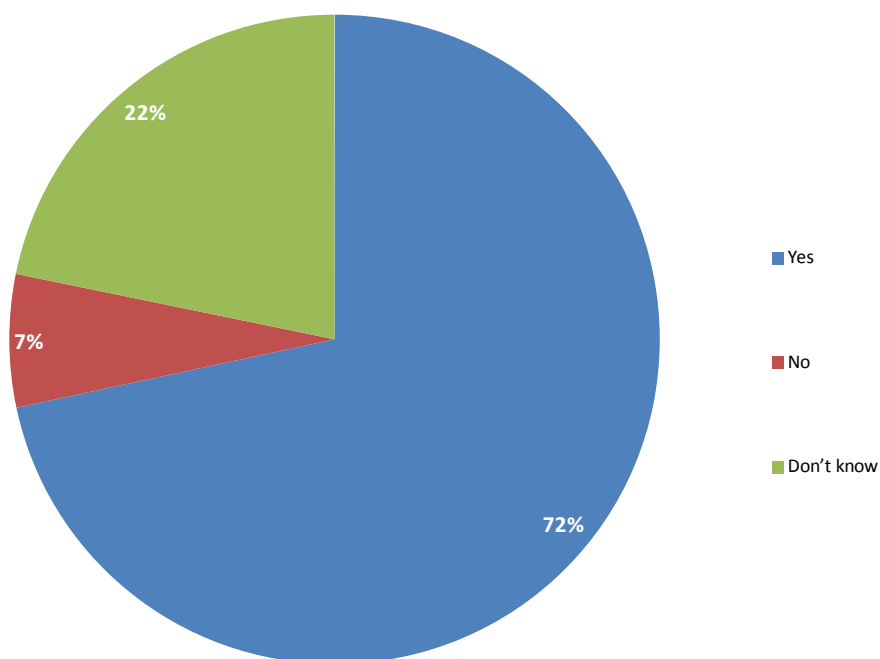
Total responses: 537

Appraisers who planned contact on a different basis or who did not yet have any planned contact were asked to provide further details. Many of those who did were unsure about the amount of contact time they had, or marked the comment box 'don't know' or 'N/A'. The most popular response was that appraisers had not had, or were not planning to have, any meetings with their appraisal lead. A large group reported that they met with their appraisal lead on an ad hoc basis, as necessitated by demand rather than time. Many reported that they did not have, or were unsure if they had, an appraisal lead. A large number also reported that they used email to communicate with the appraisal lead. Only one person indicated that they used the phone for planned contact.

7. Does your organisation carry out a systematic review of the quality of appraisal outputs?

Results

Figure 37

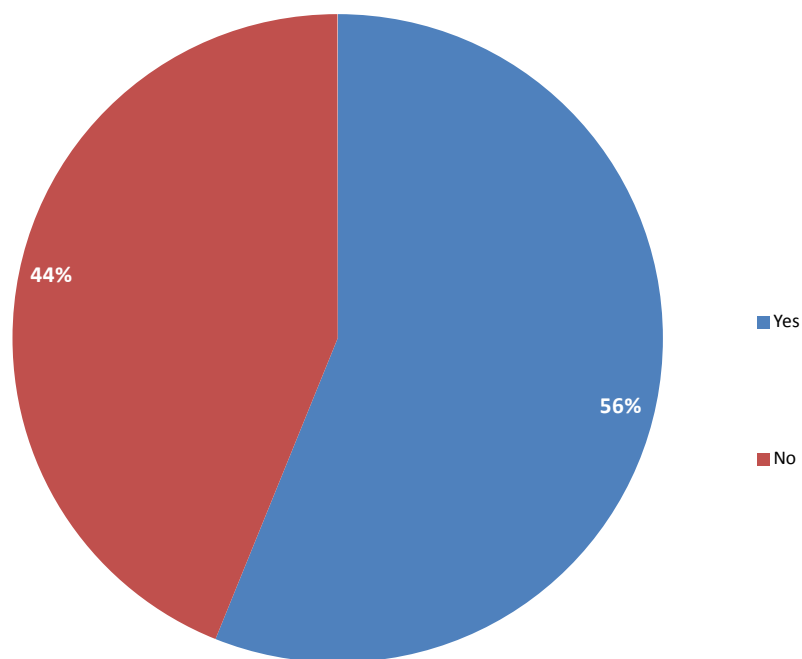


Total responses: 537

8. Have you received feedback from your appraisal lead on any of the appraisals you have carried out in the last year?

Results

Figure 38

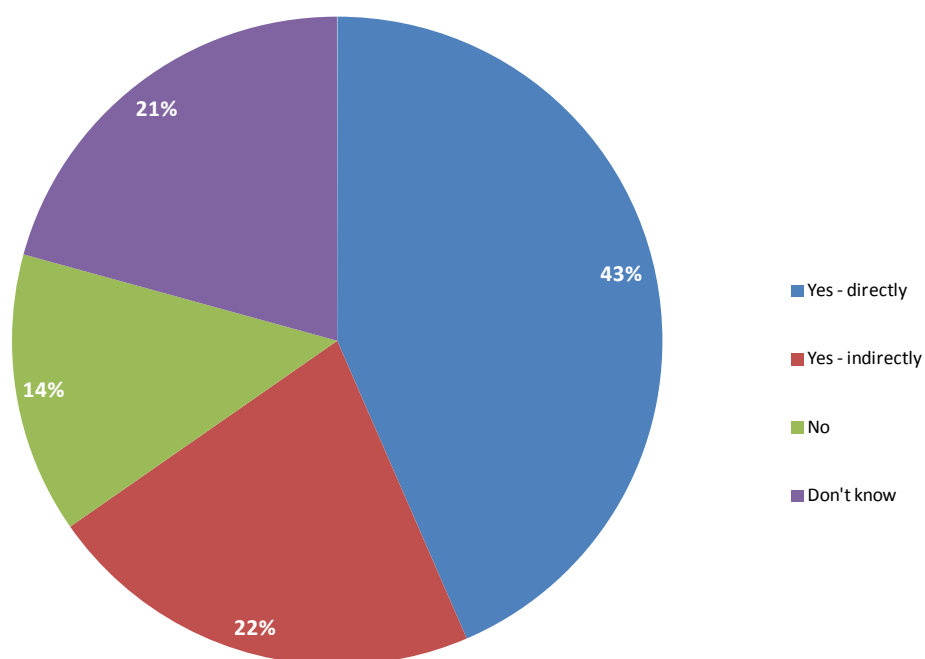


Total responses: 620

9. If you received feedback, did it help you improve the way you carry out appraisals?

Results

Figure 39



Total responses: 444

General comments

Appraisers were also invited to provide comments on the questions in this section and/or, more generally, about the review or quality of appraisals. A large number of those who commented had received feedback on the quality of their appraisals from their appraisal lead, many of whom also commented that it was of a high quality. A significant number also commented that they had not received any feedback at all from their appraisal lead. Some appraisers also reported that they had received feedback from the doctors that they had appraised. Although not directly related to revalidation, a number of respondents to this question discussed the difficulties of organisational change, particularly regarding the quality of systems and process in place for appraisal review. A selection of responders' comments to this question is included below.

Comments relating to the high quality of appraisal review:

"Strength and possible areas of improvements are highlighted. We have one to one meeting at least once a year and appraisal network meeting two to three times a year in addition to NW Deanery workshop once a year. One to one meeting takes place with the appraisal lead."

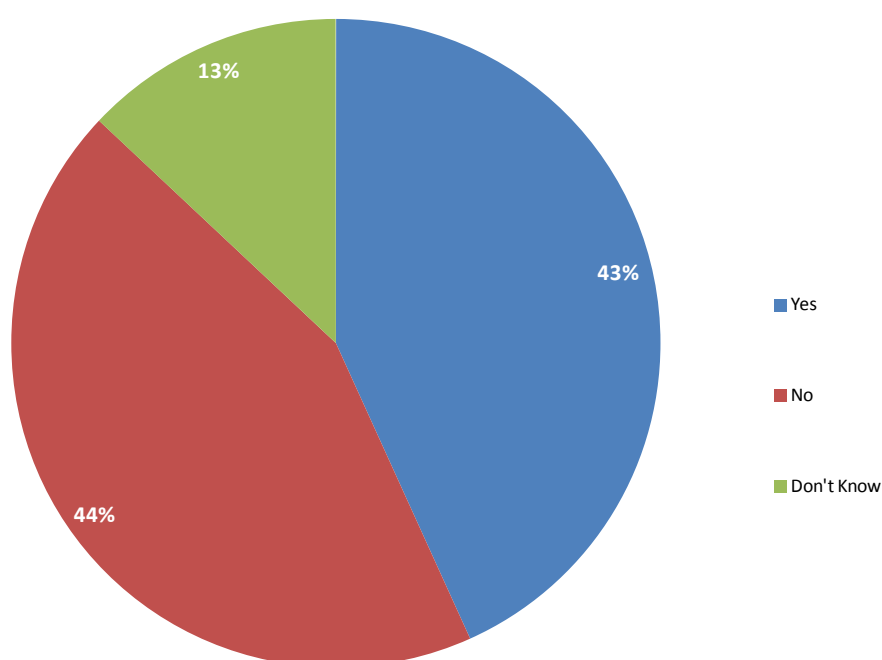
"The supporting documents are a crucial element of the appraisal. Feedback from appraisals I have done have highlighted the quality of the SDs. Other elements, such as the PDP and appraisal discussion, are equally important but more intuitive to the appraisee and appraiser."

The appraisals you have carried out

10. In your opinion, has revalidation improved the appraisal process?

Results

Figure 40



Total responses: 701

Appraisers responding 'yes' were asked to briefly 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, that systems had been improved, particularly the MAG form, and many respondents cited the requirement for all doctors to receive appraisals as an improvement
- the quality of documentation and feedback had increased.

A selection of responders' comments to this question is included below.

Comments relating to the standardisation effect of revalidation leading to improved appraisal:

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

"We had a very robust appraisal process in our department already, but I think it brought up the standard of appraisal in other departments to our level in O&G [obstetrics and gynaecology]."

"Better quality information supplied by appraisers."

Comments relating to the standardisation effect of revalidation leading to worsened appraisal:

"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/appraiser relationship."

"Revalidation has imposed more tick-boxing and summative roles. It has turned us more into policing service. This means that GPs will not reveal some of the issues that actually will lead to poor performance such as stress and dispute. This results in a lack of earlier intervention which will improve patient safety. I think overall it has a negative impact."

Comments relating to increased formalisation of appraisal:

“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.”

“More formal, more structured, more meaningful.”

“It formalises what was previously done in good appraisals. Too many appraisals in the past were of poor quality and therefore meaningless.”

“More specific areas, considers all roles of the doctor and scope for all work done.”

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

Comments relating to increased engagement of doctors:

“More focused. More evidence provided to justify comments such as ‘I have always had good relationships with colleagues’. Keeps doctors on their toes!”

“Appraisees are generally more engaged with the process, and are becoming clearer about the quality and quantity of information required for submission.”

“Focused attention to specific issues relevant to fitness to practise. Helped spreading the value of reflective learning and reflective practice. Ensured universality and uniformity of the appraiser process to achieve the commonality of a successful revalidation.”

11. For the doctors you have appraised, have you been able to identify and agree specific ways in which doctors can deliver better care or treatment?

Results

Figure 41

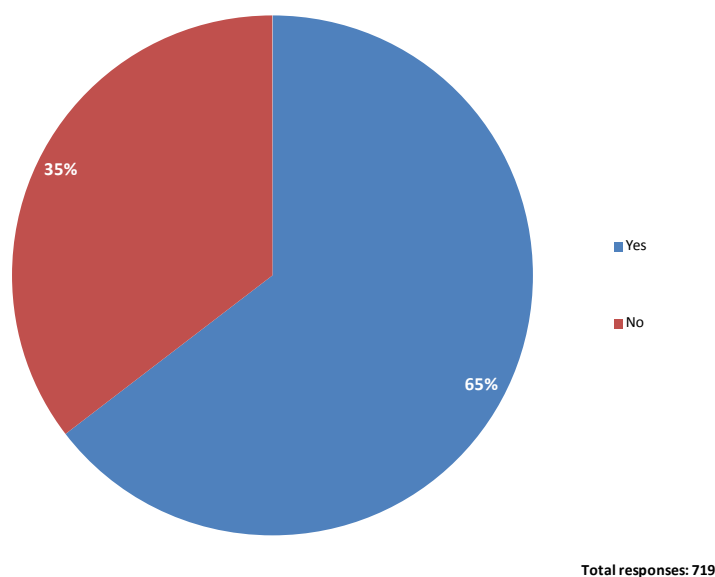
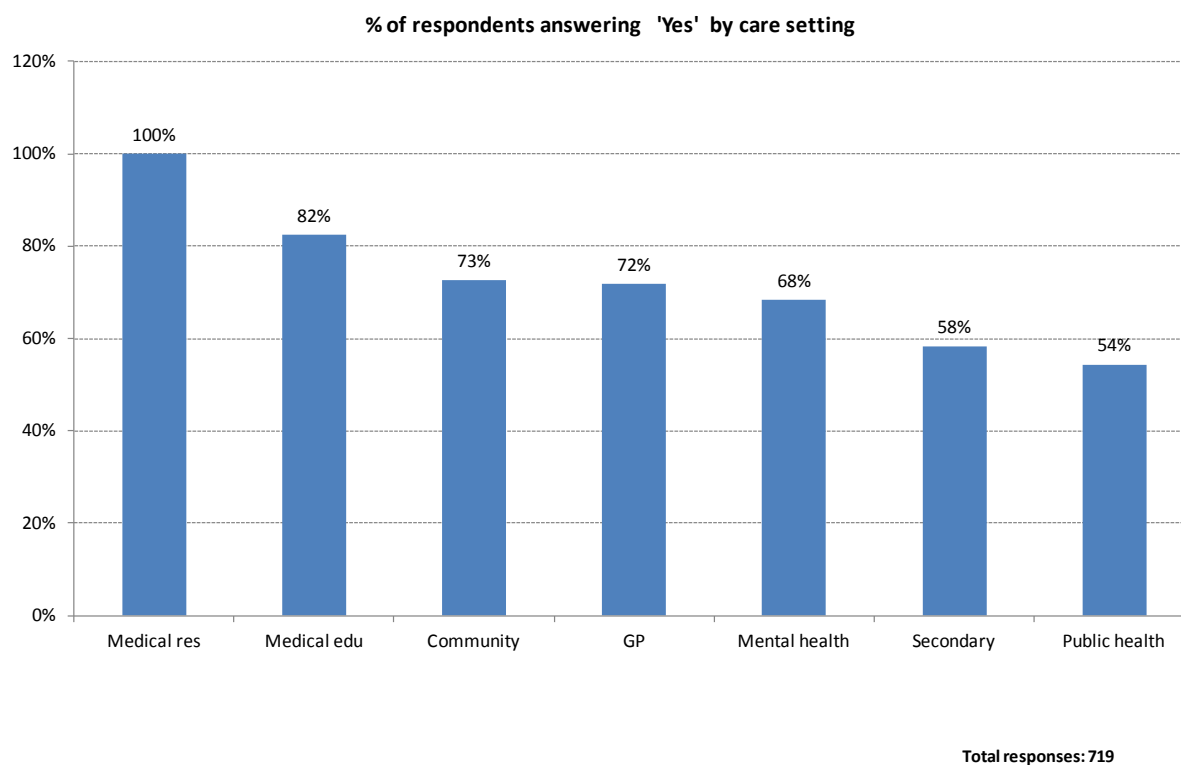


Figure 42



Appraisers responding 'yes' were asked to provide some anonymised examples of what had been identified and agreed. A very broad range of responses was received. The most significant theme related to the need for doctors to reflect on, review and audit their practice. It is noticeable that there is particular strength to the formal end of the review spectrum with many respondents citing audit. Goal-setting was another popular example and respondents had often agreed that appraisees should attend relevant courses or engage in other forms of learning. Other popular responses included setting objectives regarding documentation and clinical objectives, personal health and workload, and communication, particularly with colleagues. Other less popular examples included staff governance, research and significant events. A selection of responders' comments to this question is included below.

Comments relating to increased reflection, review and audit of doctors:

"The major way is for doctors to identify what they would like to develop, and what they need to improve on, identify where weaker areas lie in order to improve these and build on their strengths and special interests. It is also important to develop themselves and maintain interest and wellbeing for their long-term careers as well as maintaining and developing a broad and regular personal educational programme which is manageable and able to be sustained. It is also important to identify if GPs are mixing with colleagues as the nature of general practice can lead to isolation and this is becoming more noticeable with the increased patient workload, longer surgeries and less time for contact with colleagues."

"Almost always agree doctors will audit outcomes of treatment"

"When discussing results of PSQ and MSF [multi-source feedback] ways in which to improve arise. Also audit is a good tool for looking at ways to improve."

Comments relating to strengthened documentation of doctors:

"One of my appraisals is for a doctor who is somewhat chaotic. He neither keeps good records nor does he make good plans. The process of sitting with him, getting him to think through his data/records, order them, and then make a plan for the future works. If that didn't happen, I very much doubt that he would make plans for the future, and would wander from one thing to the next."

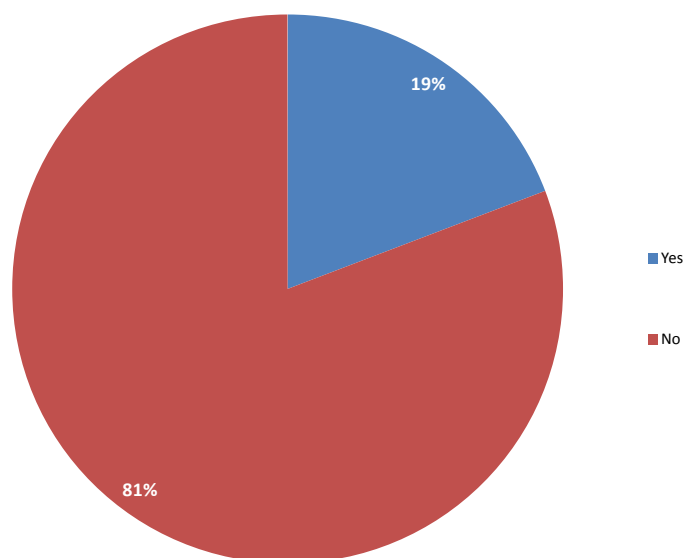
Comments relating to improved clinical processes:

“Very difficult to provide specific examples as it is mostly around educational issues, or the improvement of processes within the surgery, these can range from different arrangements in the waiting room to reduce the risk of the wrong patient being called in, to the development of a widget for the computer system so that there is a special warning about prescribing NSAIDs [non-steroidal anti-inflammatory drugs] to patients on Warfarin.”

12. Did you identify any issues about doctors you appraised between April 2012 and March 2013 that you needed to discuss with the responsible officer or his/her team?

Results

Figure 43



Total responses: 693

If yes, for how many doctors have you sought advice from the responsible officer or a member of his/her team?

Results

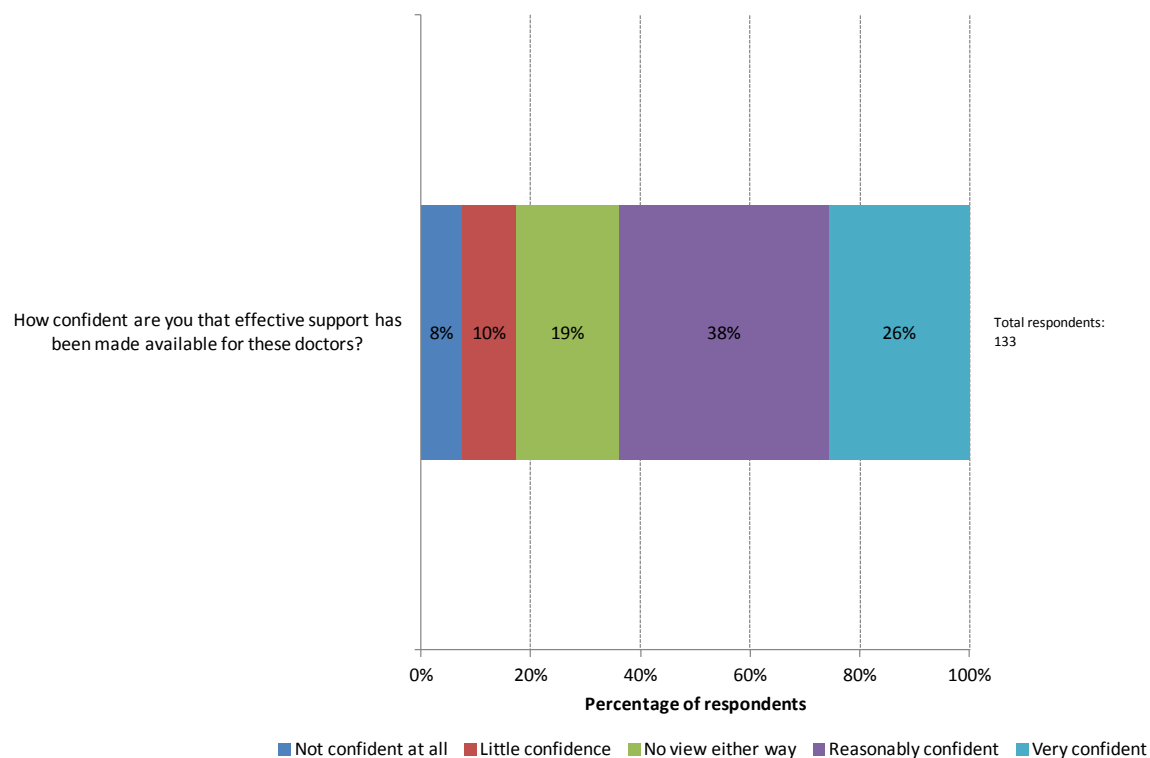
Number of doctors	1	2	3	4	5	6
Number of respondents	87	31	6	2	2	1

Average: 1.48

13. If you answered yes to the previous question, how confident are you that effective support has been made available for these doctors?

Results

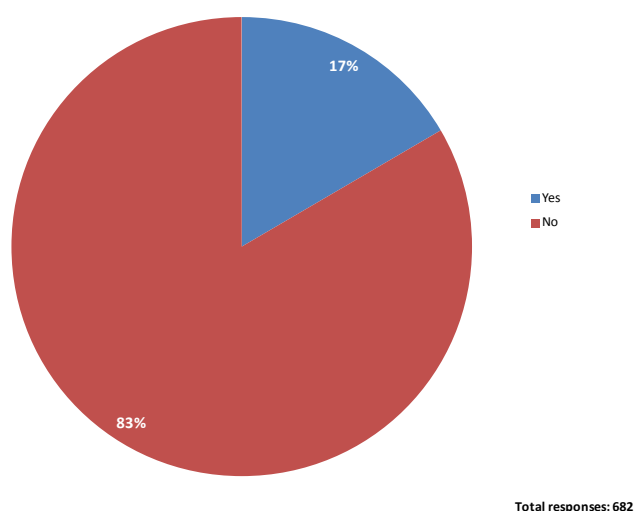
Figure 44



14. Did any of the doctors you appraised between April 2012 and March 2013 express any concerns about the behaviour or performance of a colleague?

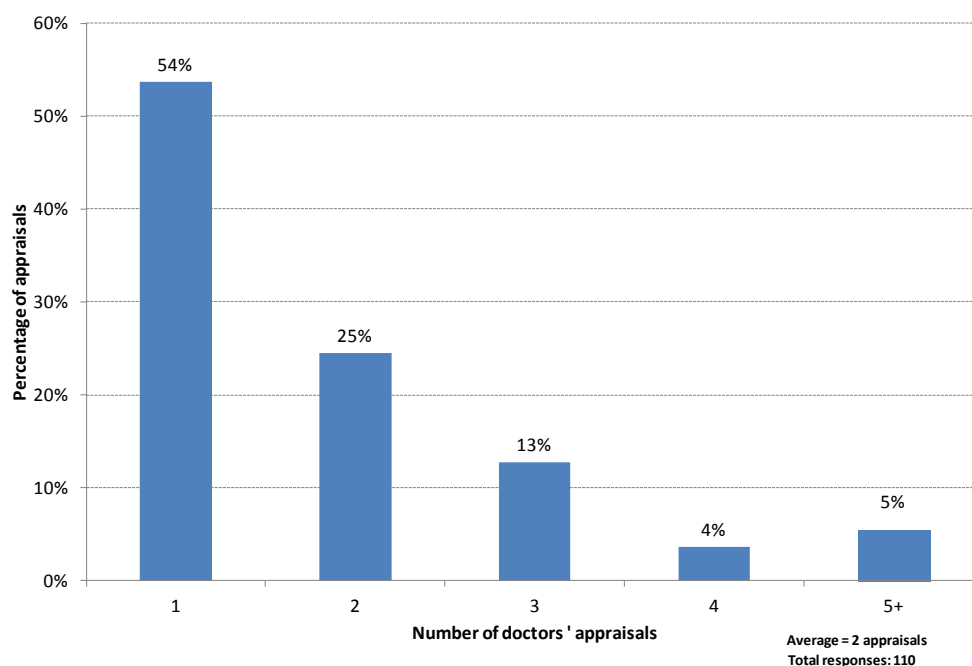
Results

Figure 45



If yes, in approximately how many appraisals has this happened?

Figure 46



15. In cases where doctors express concerns about the behaviour or performance of a colleague, what action(s) have you taken or would you take, if any?

Results

This question asked about two different types of scenario: actions taken and actions that would be taken. Responses did not usually indicate to which of these they were referring. Most of the respondents to this question commented that they had, or would have, discussed a raised concern with a colleague. In descending order of preference, these would be with: the responsible officer or medical director, the appraisal lead and the clinical lead. Several respondents would have also discussed the matter informally or directed the appraisee to existing support or regulations. Some would have, or had, contacted the GMC directly.

Respondents also discussed the role of appraisal as a trusted place, separate from the workplace. Many commented that they listened and offered support to doctors and included actions within the appraisal plan. A few commented that raising concerns was not appropriate within the appraisal setting.

A large number of respondents also commented that their response was dependent upon the scale or type of concern raised. Some respondents commented that there were existing mechanisms in place for raising concerns, or undertook their own research. A selection of responders' comments to this question is included below.

Comments relating to contacting the medical director, appraisal lead or clinical lead:

"I would want to cross-reference the concerns to see if they were valid. If so, then the medical director should be contacted."

"Clinical lead. If important and the appraisee would not take further I would discuss with the clinical lead and expect him/her to action."

"Would depend on the behaviour. Generally if it were a cause for concern (e.g. GMP [Good Medical Practice]) I would suggest that they should discuss it with their clinical director or the medical director, as appropriate. I would follow it up with the individual some time later to see if they had done so."

Comments relating to contacting the GMC:

“Remind the doctor of GMC guidance on actions where patient risk is identified. Suggest making a team decision as to appropriate action if others are also aware of the behaviour causing concern. Contact the appraisee a few weeks after the appraisal to see if appropriate action had been taken.”

Comments relating to existing reporting mechanisms:

“I would deal with this outside the appraisal process and either stop the appraisal or arrange to discuss at a different time. What other action I took would depend on the nature of the concern.”

Appraisers were also invited to provide comments about their answers to the questions in this section or, more generally, about the appraisals they have carried out. This was the most open question in the survey.

As a result, the responses were highly varied and covered all aspects of the appraisal, sometimes providing the most personal insights collected in this survey. The most popular themes related to support for individual doctors, such as concerns and stress, health and the need for a work-life balance. Some respondents also commented that appraisals were not flexible and could resemble a 'tick-box' exercise. Respondents also discussed new systems, workload and reflective practice. A selection of responders' comments to this question is included below.

Comments relating to appraisal and CPD:

“Many doctors are being forced to spend hours on mandatory training which has very little relevance to their speciality and does not benefit patient care. This is usually to the detriment of more relevant CPD which is neglected because they have used all their SPA time on unnecessary mandatory training.”

“The appraisal process has become more difficult and there have been a lot of changes. I welcome the new structure with appraisal teams and increased communication with the appraisal lead team as I think it is important and helpful to identify concerns early and for us all to improve our skills and share experience and knowledge, but there is a need for support and development for doctors generally and there is a need for clarity and simple processes to facilitate this whole process.”

“As a small organisation granting practising privileges we are unable

to support doctors where we have serious concerns and would simply stop granting them practising privileges. We work with doctors to address minor concerns and this is alongside our company performance reviews which provide a mechanism for reviewing performance and striving for improvements.”

Comments relating to documentation:

“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.”

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

Comments relating to ‘tick-box’ exercises:

“Revalidation has devalued the usefulness and effectiveness of appraisals; it has become much more a tick-box and checking exercise and is much less personally developmental and empowering. Appraisals need to stay developmental and personalised and should make a doctor feel positive about themselves and their work and career with the aim of constant improvement and willingness to challenge themselves and others.”

Comments relating to support for concerns about individual doctors:

“I regret the limited declarations required on health and probity. Previous forms asked for more exploration of doctors’ views and behaviours in relation to these areas, which was often revealing and led to useful formative discussions.”

“As a small organisation granting practising privileges we are unable to support doctors where we have serious concerns and would simply stop granting them practising privileges. We work with doctors to address minor concerns and this is alongside our company performance reviews which provide a mechanism for reviewing performance and striving for improvements.”

Comments relating to training for appraisers:

“As stated above it has provided me with a wonderful opportunity to learn from other colleagues. I am not necessarily suggesting that there is no advantage in appraisal or revalidation but it may take a while before systems become robust to provide what is expected.”

The continuing professional development (CPD) of doctors you have appraised

16. In the past two years, have you noticed any improvement to the continuing professional development completed by doctors you have appraised?

Results

Figure 47

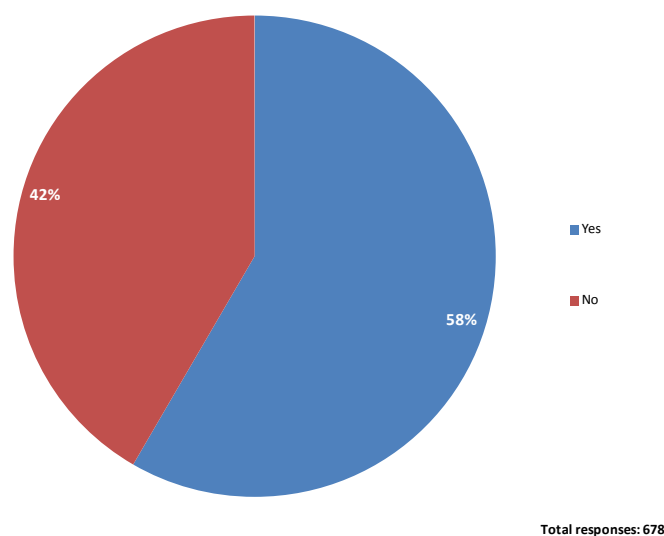
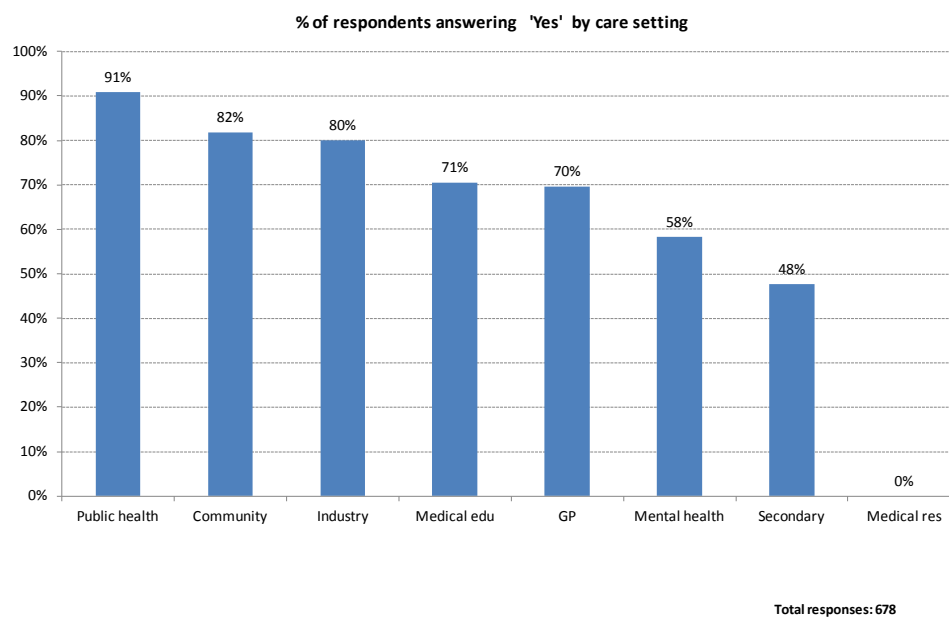


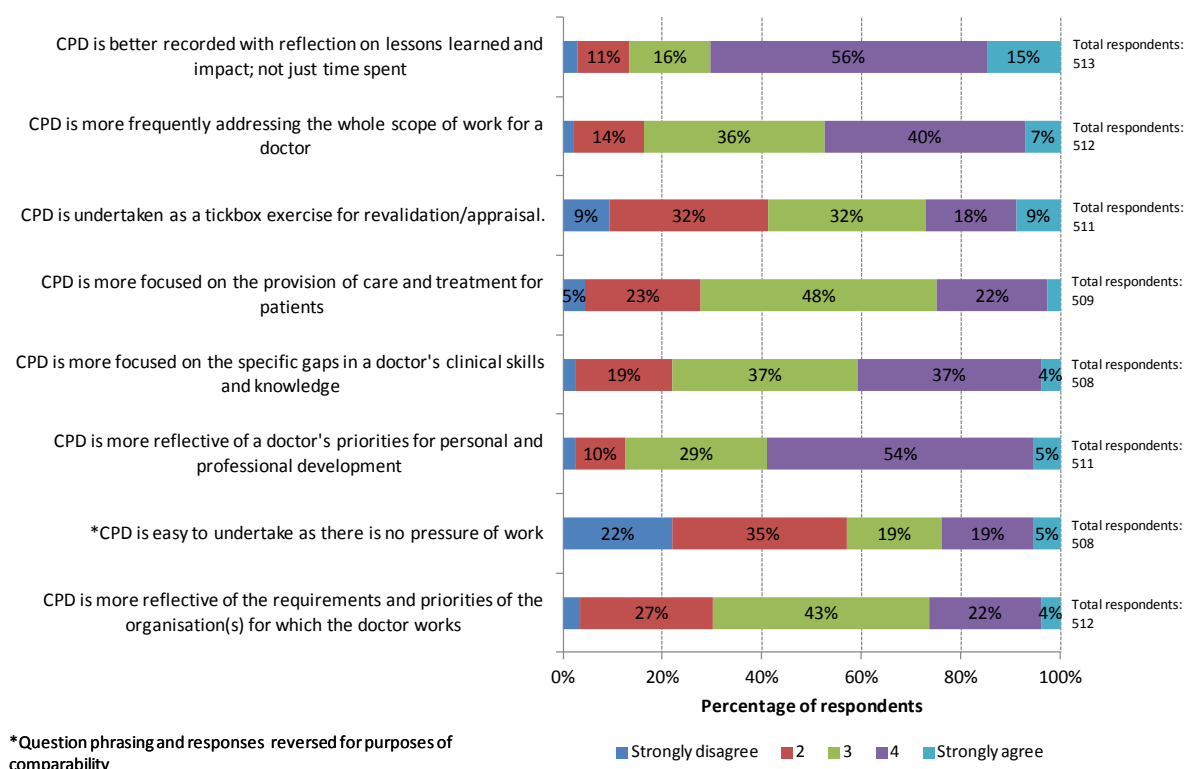
Figure 48



17. If yes, please indicate how strongly you agree or disagree with each of the following statements regarding continuing professional development (CPD) carried out by the doctors you have appraised

Results

Figure 49



Respondents were also invited to provide additional comments on questions 16 and 17. Most of those who did focused on the quality of continuing professional development (CPD). Respondents commented that there was a large variation in the quality of CPD and good CPD requires a focus on the doctor and their organisation(s). While quite a few respondents commented that there was improved reflection on the doctors' practice, some respondents commented that not enough reflection was undertaken, and others commented that CPD outcomes were too reflective or 'soft'. A relatively common comment was that there was insufficient funding for CPD and some respondents commented that not enough time was allocated for CPD. Another common response was that there was little or no change to CPD, often because it was of existing high quality and consistently well completed. A selection of responders' comments to this question is included below.

Comments relating to improved CPD:

“CPD and mandatory training was done extremely well in dept. and in appraisal prior to revalidation and this has continued. The new College CPD electronic diary has made it even better.”

“My experience is that in PH CPD has generally been well completed for a number of years. However, the areas of improvement have been about inclusion of whole scope of work and better reflection. However the latter is more a reflection of the FPH audit and the good work of our local CPD co-ordinator that the result of the revalidation processes per se.”

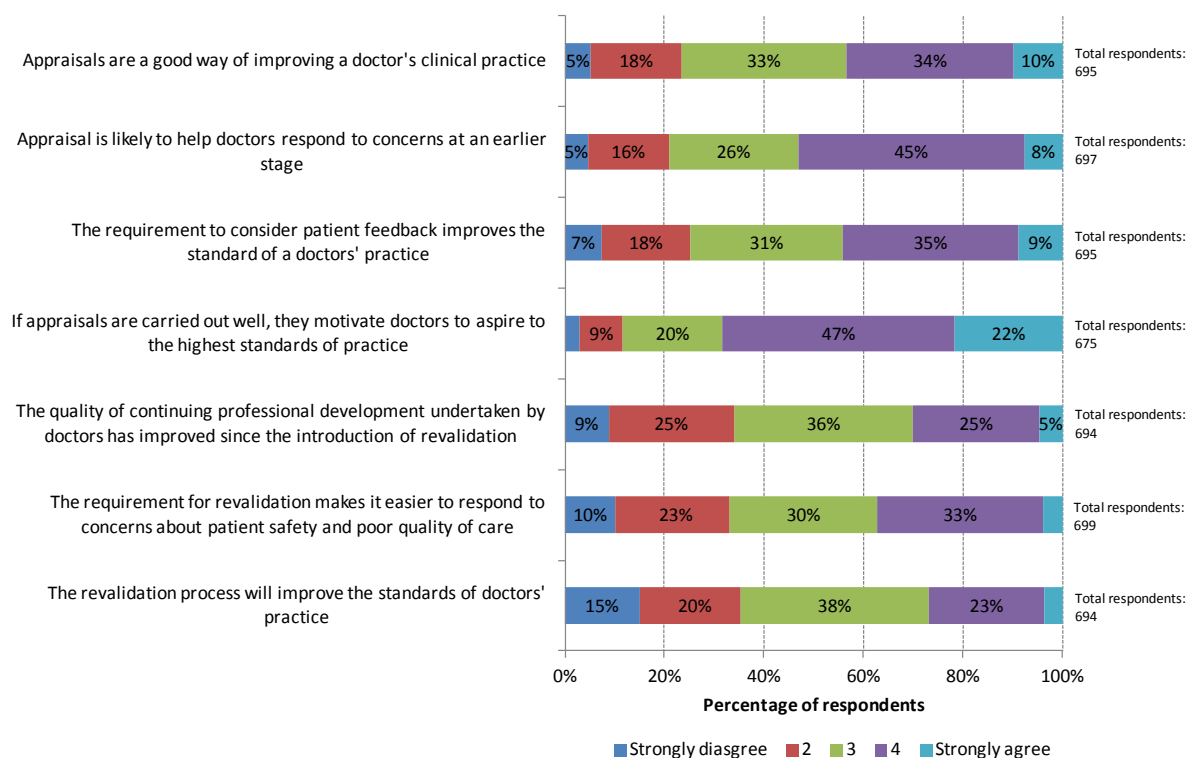
Comments relating to reflection:

“I don't like the ‘reflection’ element – what is it after? Sounds introspective and self-analytical. I can understand the desire to get away from just recording time spent but this turns people off a lot.”

18. Please indicate how strongly you agree or disagree with each of the following statements

Figure 50

Results



General comments

Respondents were invited to provide comments on their answers to this question or, more generally, on the overall impact of appraisal and revalidation. The comments provided were very varied. There was no dominant theme and the areas mentioned included: overall change, feedback, CPD and PDP, doctors, documentation, time and workload and organisation and appraisal. The majority of comments in this section were negative and the most common complaints included: the burden of the workload, low impact of revalidation and the view that appraisals are 'box-ticking' exercises.

A number of positive comments were also received. These included: improved documentation, improvements to underperforming doctors' standards and improved engagement. There was much disagreement between respondents' comments. A selection of responders' comments to this question is included below.

Comments relating to 'box-ticking' or summative appraisal

"The more appraisal is allied to revalidation and the more it becomes a checking exercise, the less it is likely to be seen by doctors as supportive and encouraging. At last doctors are beginning to engage with appraisal and becoming more open with their appraisers. All this may be undone if appraisers come to be seen as policemen."

"Appraisal started out as a worthwhile valuable exercise and appeared to help doctors who were stressed, overworked and alienated from the NHS by the demands of the system, but revalidation has constrained the process turning it into just one more thing to stress the already overworked and alienated doctor. It would probably be better if appraisal stayed formative and developmental and revalidation was entirely an electronic IT-based system. But then appraisers would no longer be funded.., so just one more thing to stress [about]."

Comments relating to improved appraisal and doctors' practice:

"Revalidation means that all doctors will have annual appraisals, which must be an improvement. The quality of the supporting information is better but information depts. still cannot supply the necessary information for some colleagues to be benchmarked against each other. The patient and colleague feedback will allow reflection by that doctor and hopefully improve standards of care as long as the feedback is professionally facilitated."

"The formal process of revalidation help should weed out a minority of poorly performing doctors who previously were able to fly 'under the radar,' but crucially only if the doctor has performed a recent audit of their own clinical work and if the appraiser is aware of the 'gold standard' to which that audit should be compared. I believe that nothing else in the appraisal and revalidation system is significantly going to stop patients being harmed by poor clinical performance."

Designated bodies' survey

About your designated body

1. Please could you provide the name of your designated body

Not for publication. Analysis by sector below.

Figure 51

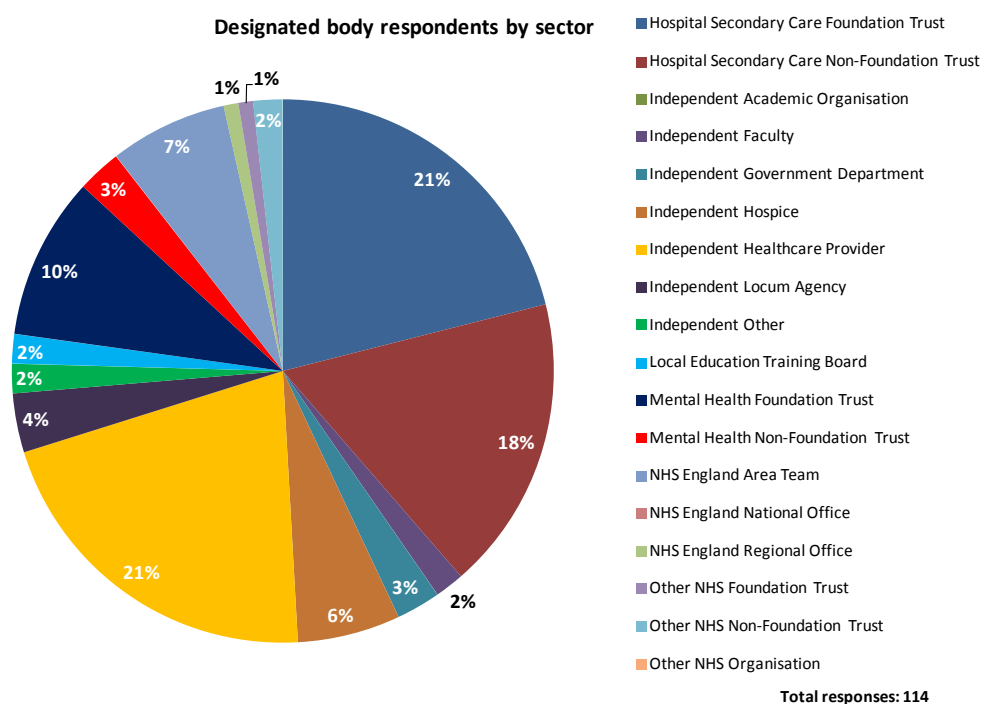
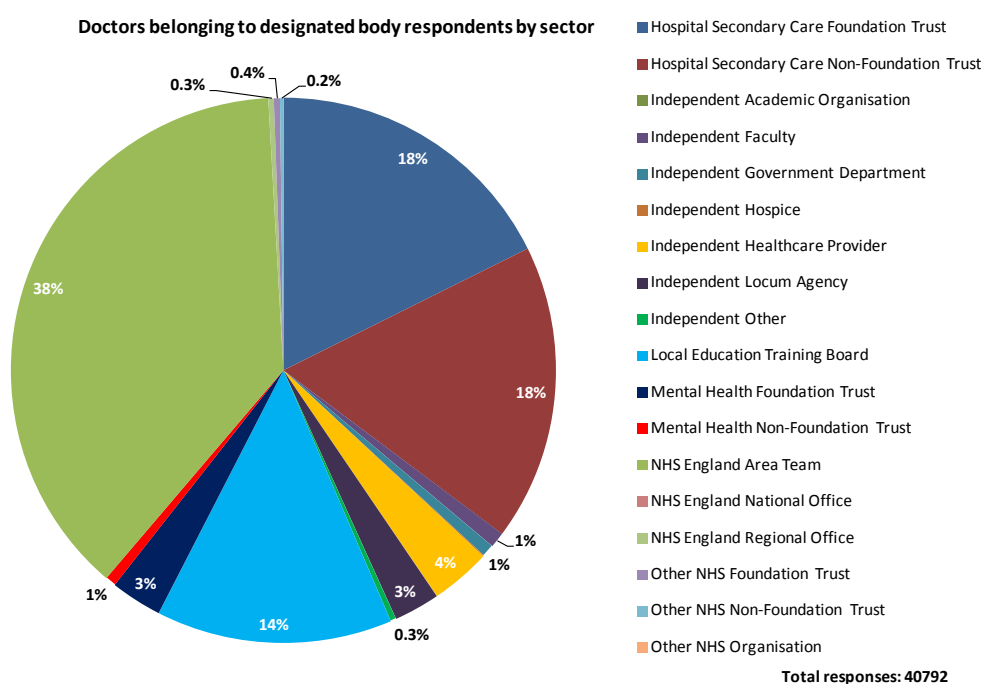
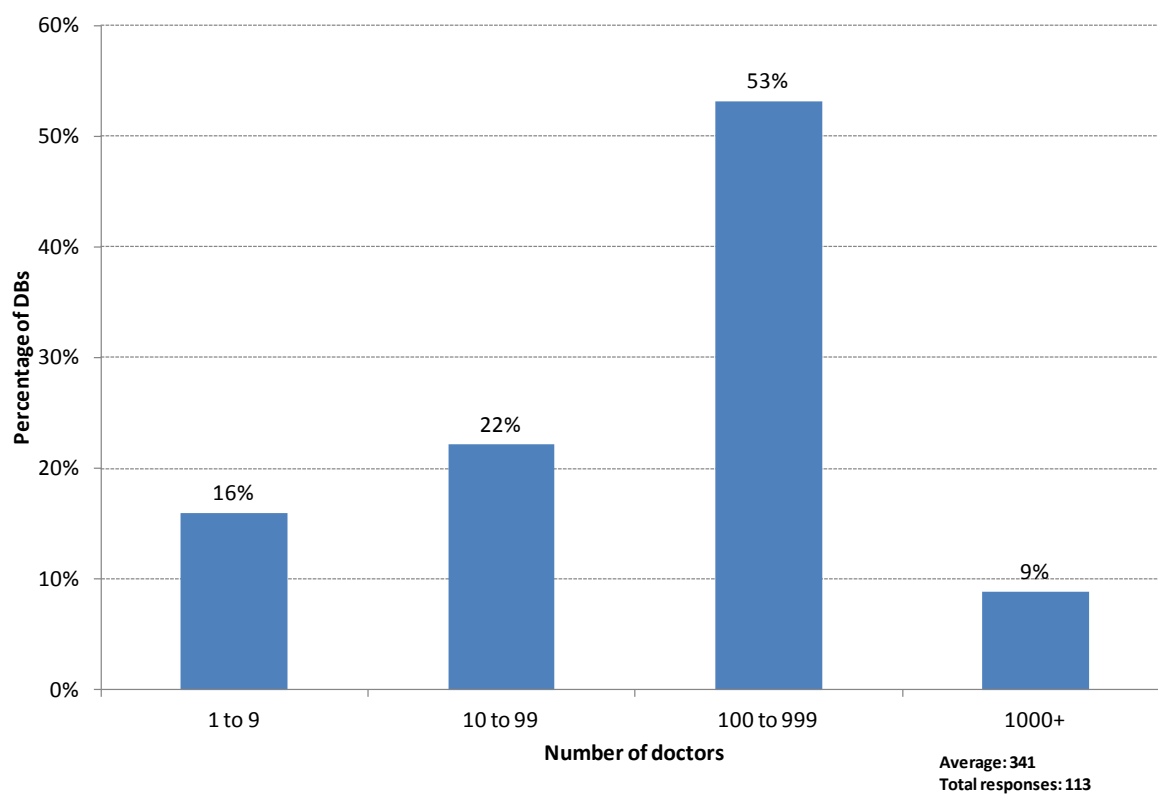


Figure 52



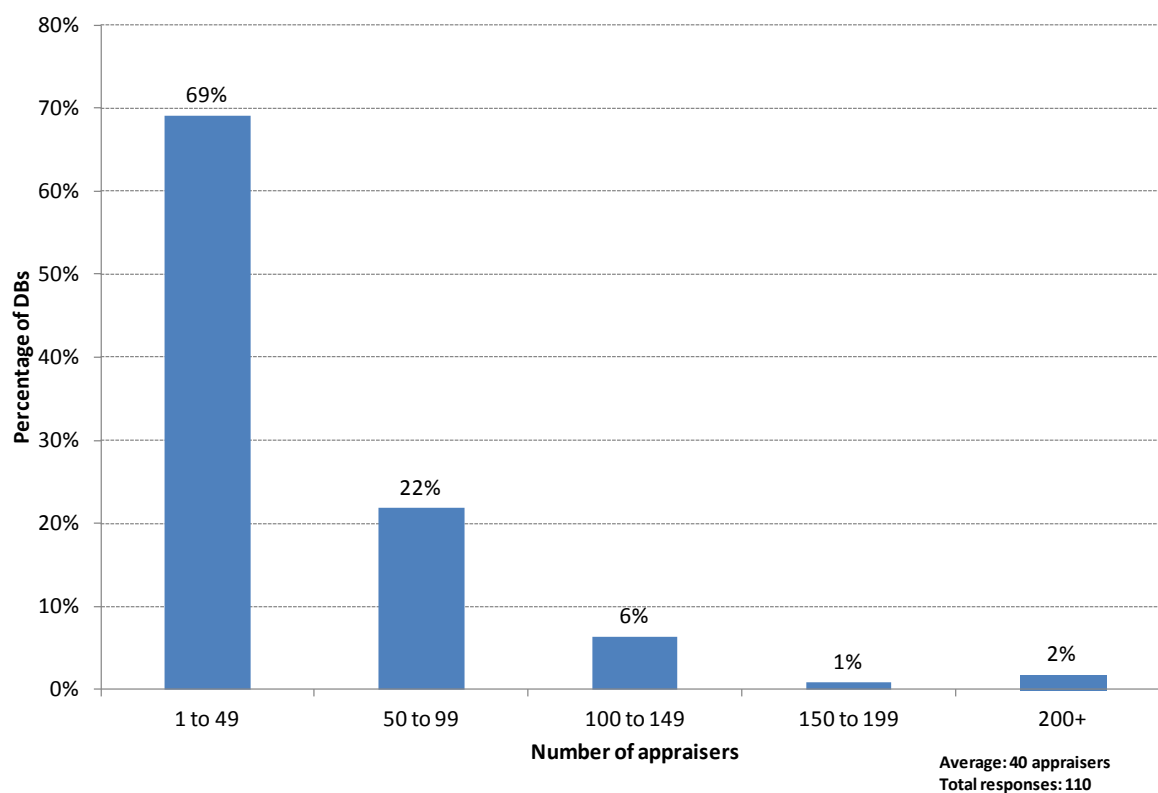
2. How many doctors currently have a prescribed connection with your designated body?

Figure 53



3. How many active appraisers do you have available within your designated body?

Figure 54

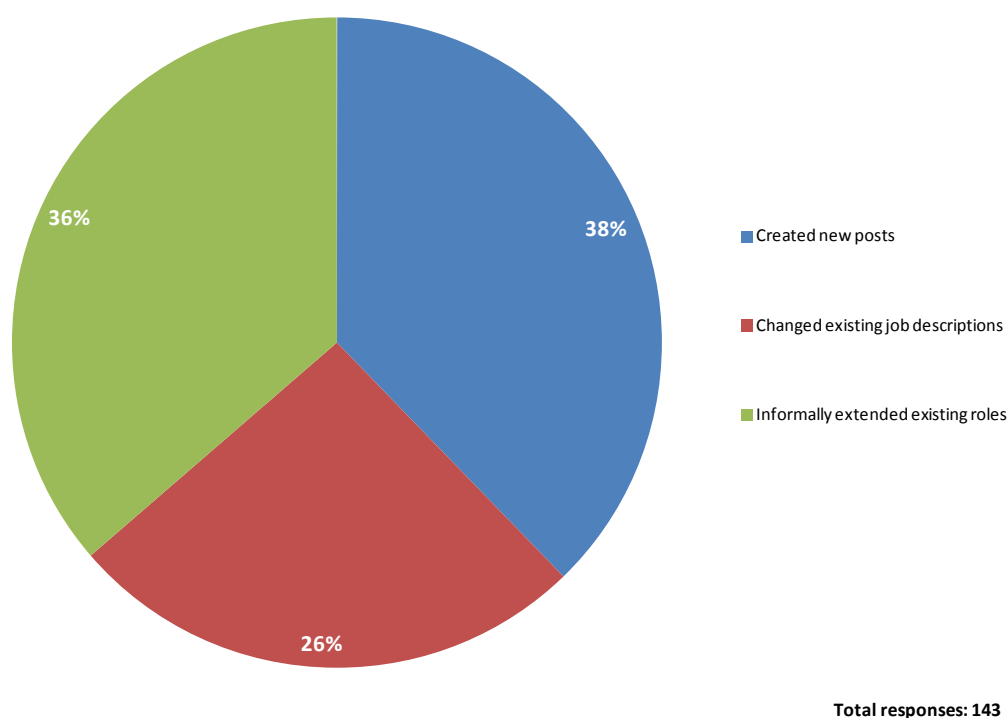


Providing support for the responsible officer

4. Has your organisation taken any of the actions listed below, to support the responsible officer, in introducing or carrying out work for revalidation?

Results

Figure 55



Respondents were asked to describe the new posts created and/or the changes that had taken place.

Just over 100 designated bodies (DBs) responded to this qualitative question and described a wide range of changes. These are summarised below:

- A medical director's job description updated to reflect the responsible officer's role
- Appointment of associate medical directors (AMDs)
[In 7 of the 10 designated bodies making these appointments they were noted as involving 2 PAs (i.e. 2 sessions per week).]
- Appointment of an "assistant director of medical revalidation and clinical governance" – at a relatively large NHS trust
- Appointment at a large NHS trust of a chair for a medical appraisal and revalidation committee

Revalidation Support Team

- Appointment of an appraisal lead (in nine designated bodies) with the requirement for additional appraisers and/or for training of appraisers. A small number of responses mentioned that the designated body had decided to provide time in appraisers' job plans to enable them to carry out their role to a high quality. Other designated bodies talked about extending or absorbing the additional time for appraisals in the job plans for clinical directors. This is illustrated in the following comments:

"Consultant appraisers have been given some time in their job plan for their appraiser responsibilities - less than half a PA per month."

"Absorbed increased appraiser time into existing clinical director roles, expanded number of appraisers"

"Agreed funding to remunerate appraiser time to ensure appraisal of high quality and done by a group of committed individuals".

- Appointment of new posts and extension of existing roles to provide a substantive revalidation lead, revalidation manager or revalidation officer to manage the new processes
- Extension of the existing role of HR managers, medical staffing managers, medical workforce managers and compliance managers to manage appraisal and revalidation processes. (Note: compliance managers appeared to be relevant for locum agencies and a social enterprise organisation, rather than local area teams or NHS trusts.)
- In nine designated bodies appointments/extensions were referred to as 'project roles' implying that they were temporary and focused primarily on ensuring that the new processes were introduced properly.
- The requirement for new or additional administrative support was mentioned by 24 designated bodies.
- There is an underlying message in some of the comments that the new process has required more management and administration than was originally expected and that workload is likely to increase further during the remainder of the revalidation cycle. This is illustrated by the following comment, from a large NHS hospital trust:

"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."

- Comments from private or third sector designated bodies with relatively few doctors expressed concern with the cost of the work. Two comments reflecting this theme are included below:

Revalidation Support Team

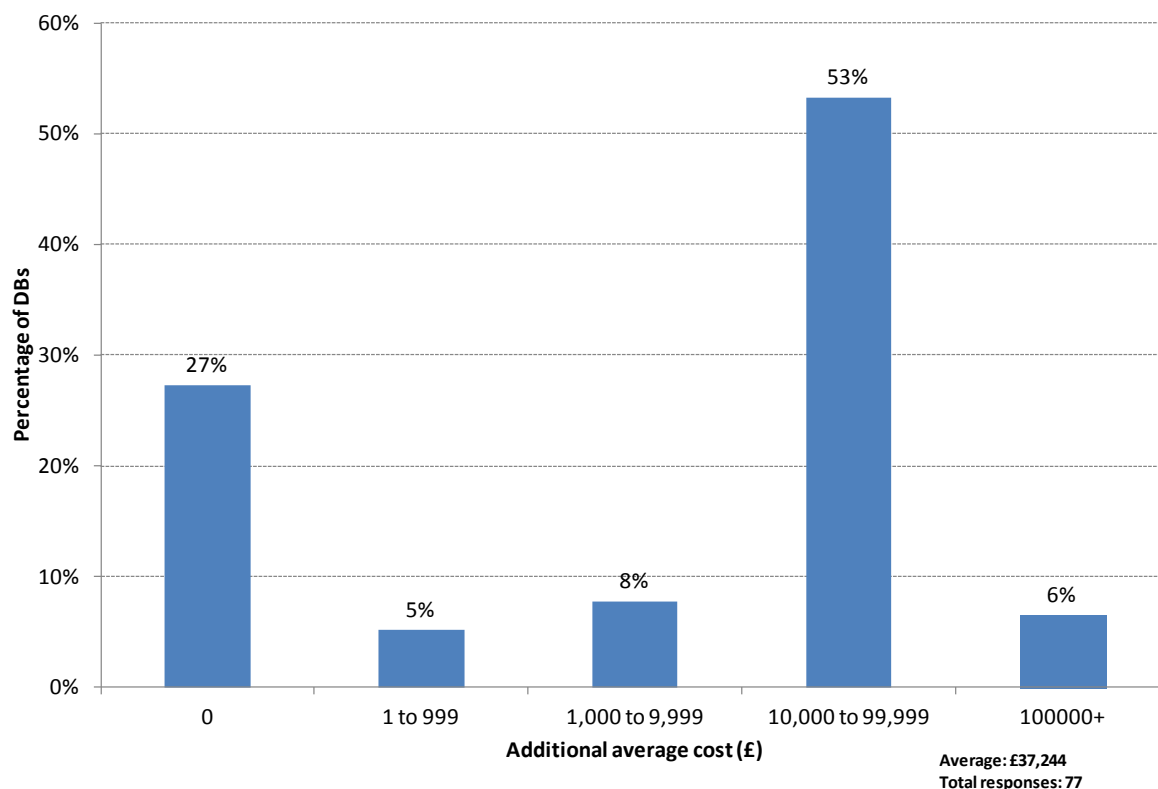
“Our Medical Director is our responsible officer this was done informally. We are not made aware of what extra payment will the Medical Director will receive for this role.”

“Main impact has been the need for training as responsible officer, and lost income from clinical practice”

5. As a result of these changes [actions from previous question] what additional annual cost has been (or will be) incurred?

Results

Figure 56

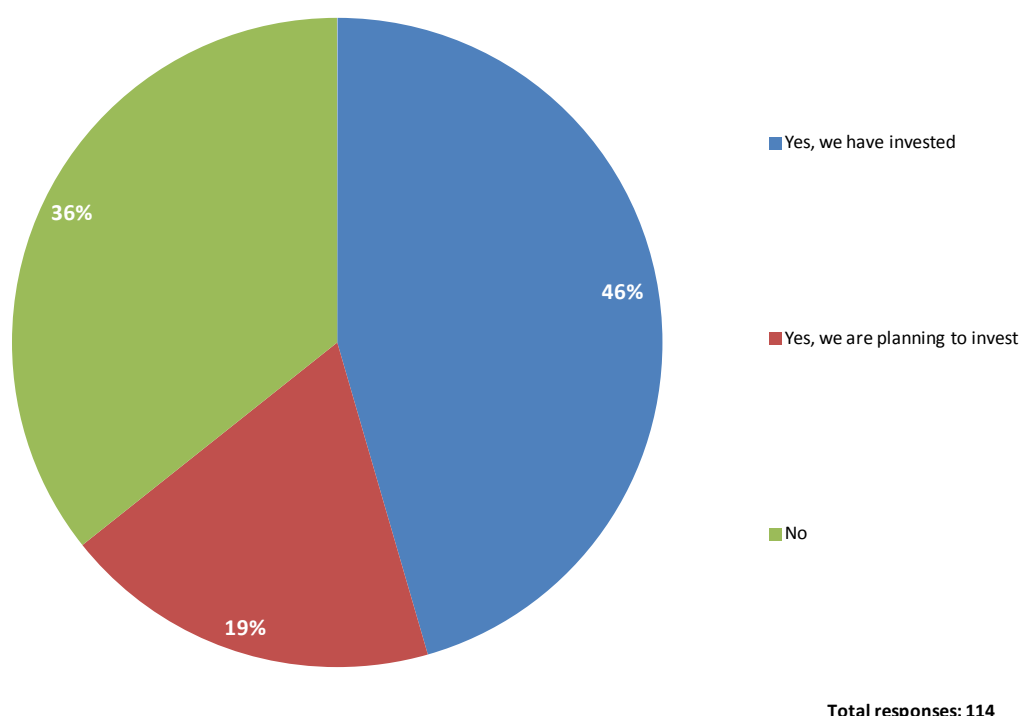


Use of information systems to support revalidation

6. Have you, or are you planning, to invest in an information system to support revalidation?

Results

Figure 57



7. What investments did you make in information systems?

Results

All 50 of the designated bodies that had already invested in information systems responded to this question. These responses are analysed below.

Figure 58

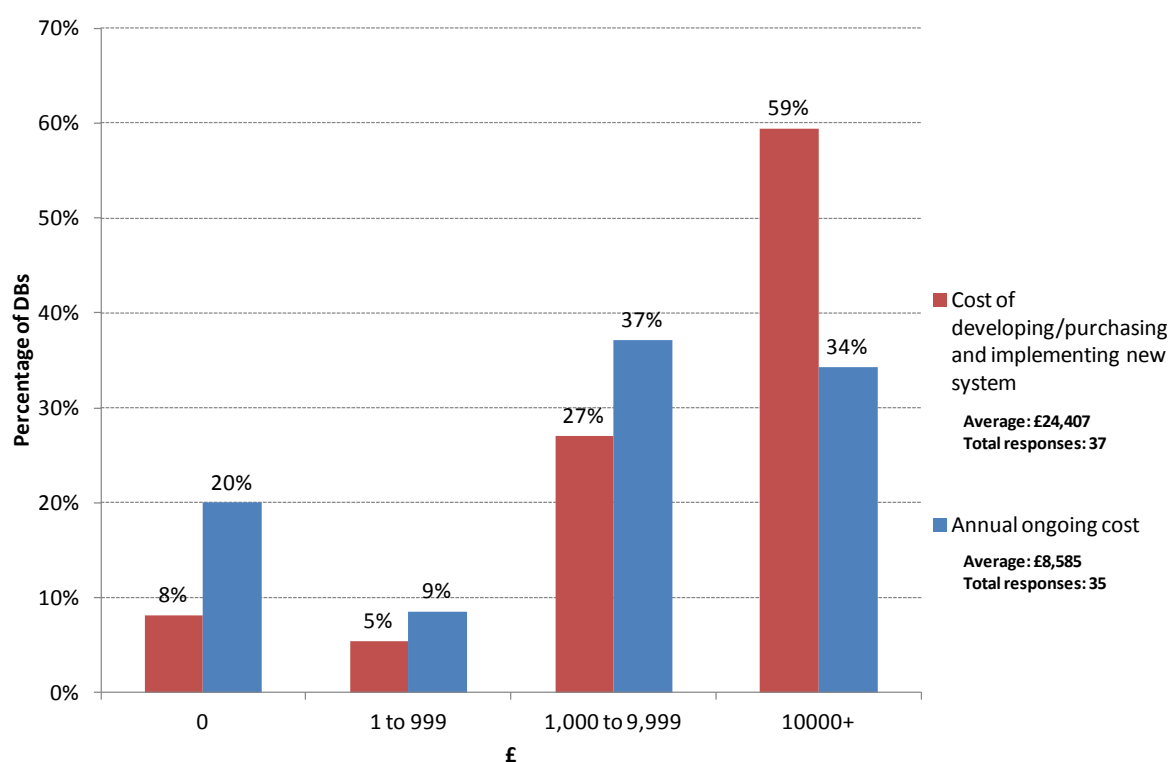
Type of investment	Number of designated bodies	Percentage of respondents
Updated an existing system	4	8%
Used MAG form to develop own system	5	10%
Purchased a commercial licence	30	60%
Developed an in-house system (mostly for patient and colleague feedback)	4	8%
Other/unknown	7	14%
TOTAL	50	

8. What was the approximate cost of purchasing/developing and implementing the new system?

9. What is the approximate annual ongoing cost for using and maintaining the system?

Results

Figure 59

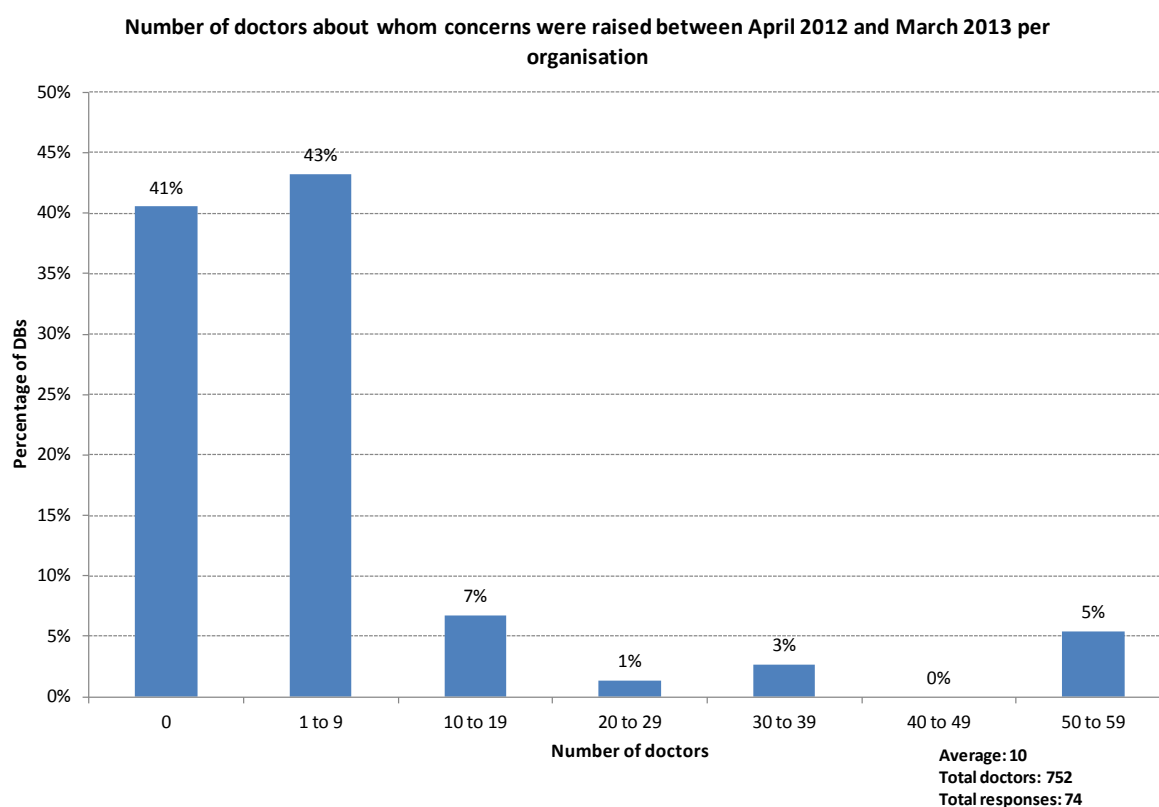


Number and type of concerns identified between April 2012 and March 2013

10. How many doctors had concerns identified about them between April 2012 and March 2013?

Results

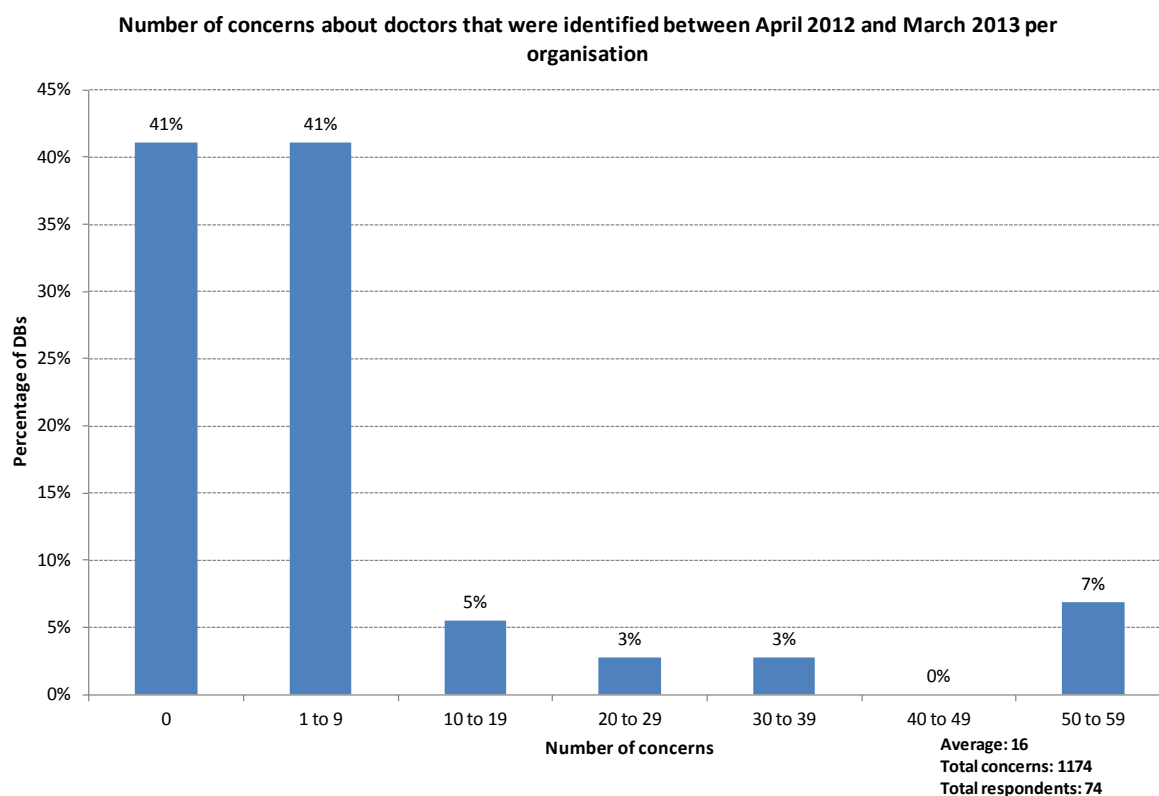
Figure 60



11. How many concerns about doctors were identified between April 2012 and March 2013?

Results

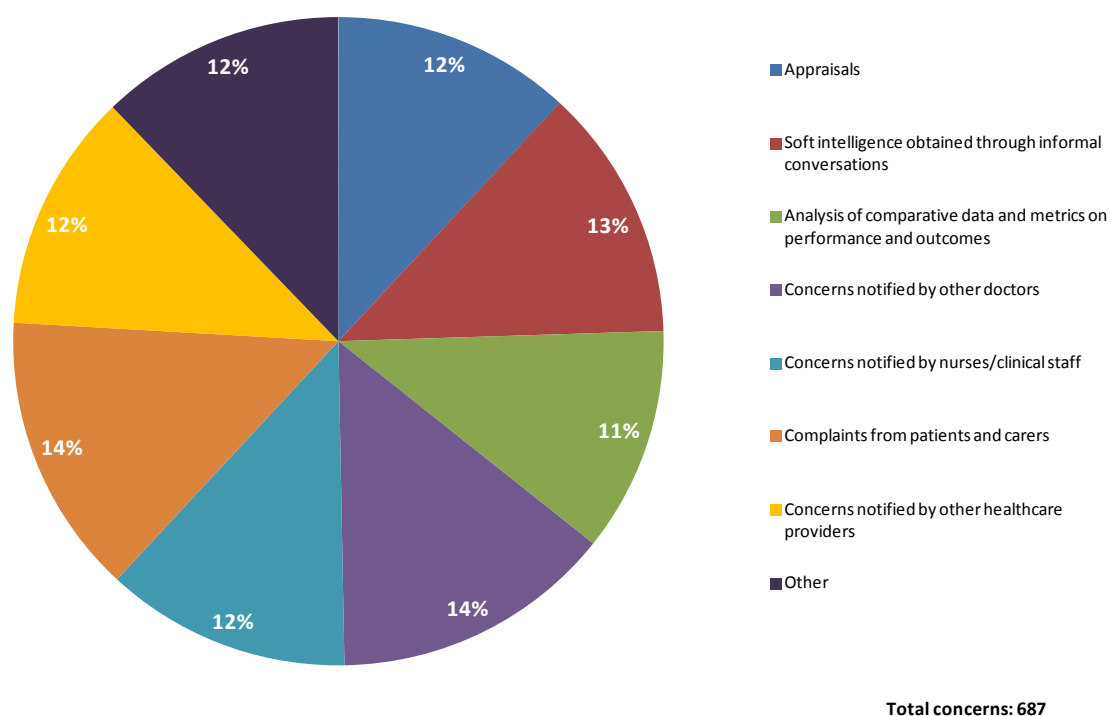
Figure 61



12. How many of the concerns originated from each of the following sources?

Results

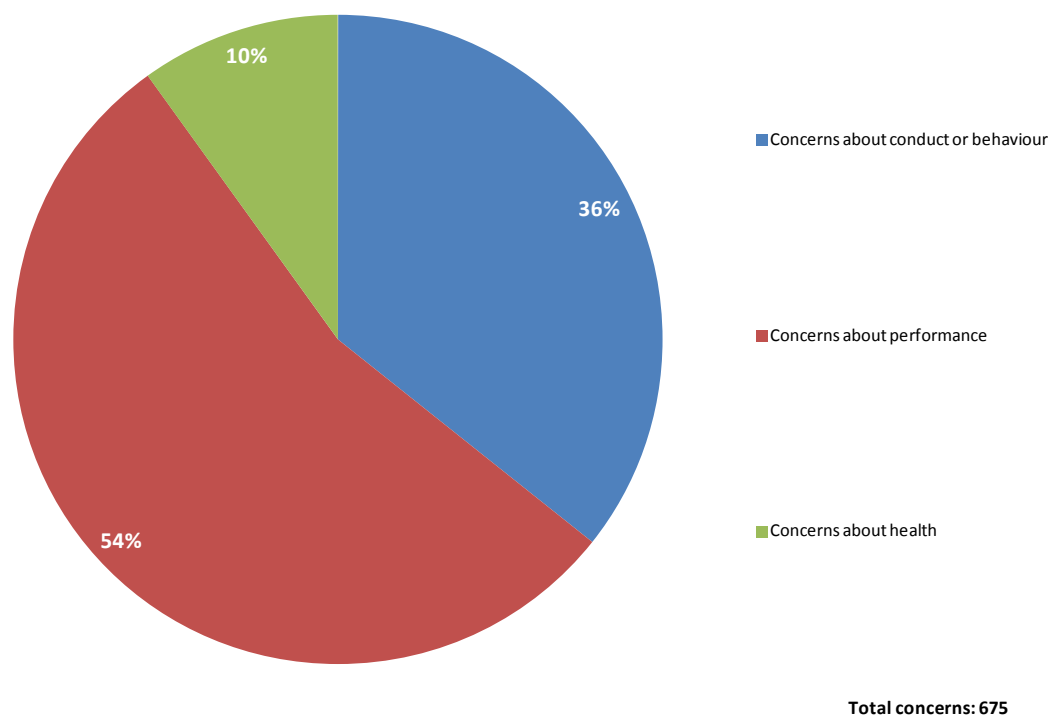
Figure 62



13. How many concerns were associated with each of the following categories?

Results

Figure 63



14. How many concerns were identified at each of the three levels described below?

Low-level:

Concerns where there has been no harm to patients or staff and the doctor is not vulnerable or at any personal risk. Organisational or professional reputation is also not at stake but the concern needs to be addressed by discussion with the doctor. This might include one of the following: clinical incidents, complaints or poor outcome data.

Medium-level:

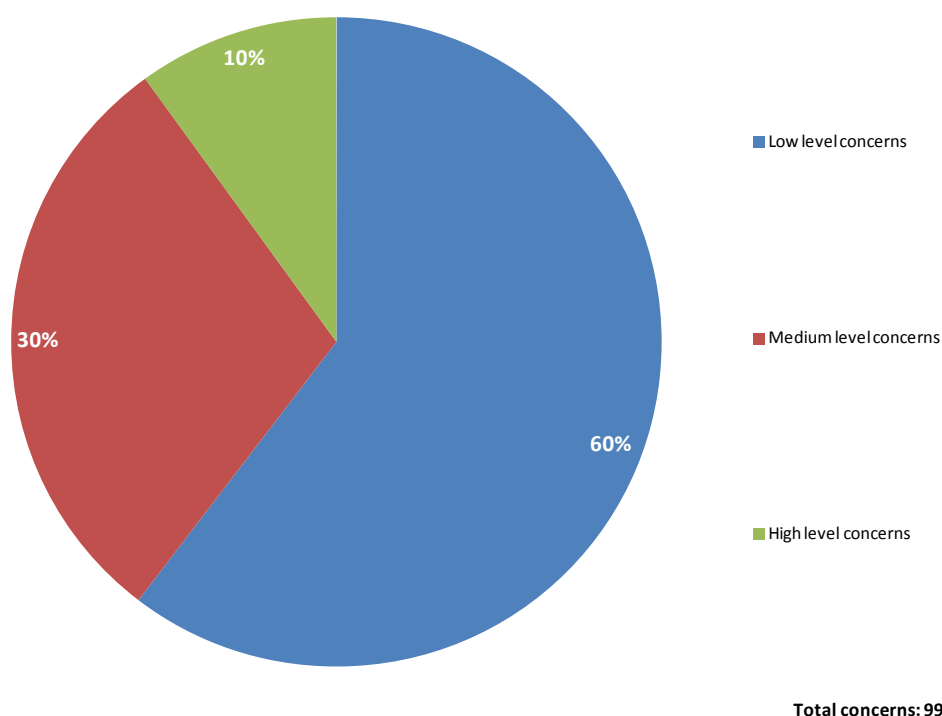
Concerns where there is potential for serious harm to patients or staff; or the doctor is at personal risk. Organisational or professional reputation may also be at stake.

High-level:

Patients, staff or the doctor have been harmed. Other high-level concerns include: criminal acts, referrals to the GMC that require investigation and medium-level concerns in which there is also a serious untoward incident or complaint that requires formal investigation.

Results

Figure 64



General comments on number and type of concerns identified

Designated bodies were invited to provide comments on their answers to the questions in this section and, more generally, about the number and type of concerns identified. Six of the comments are included below.

Types of concern

"Large number of prescribing related concerns."

"One doctor: concerns were raised ... still being investigated by GMC but practising within the trust with no restrictions. One doctor: concerns picked through serious incidents and investigated but no formal action was required."

"Concerns were of behaviour and relationships with team, poor evidence of adhering to diagnostic process and one formal complaint, which was upheld relating to misdiagnosis. Health concerns only developed later in the process."

Process for identifying and responding to concerns

"The high-level concern was first identified through soft intelligence, then visible in numbers and finally followed by complaints, confirming by triangulation the initial soft intelligence"

"Doctor himself contacted us [a locum agency] to tell us he had been involved in a clinical incident."

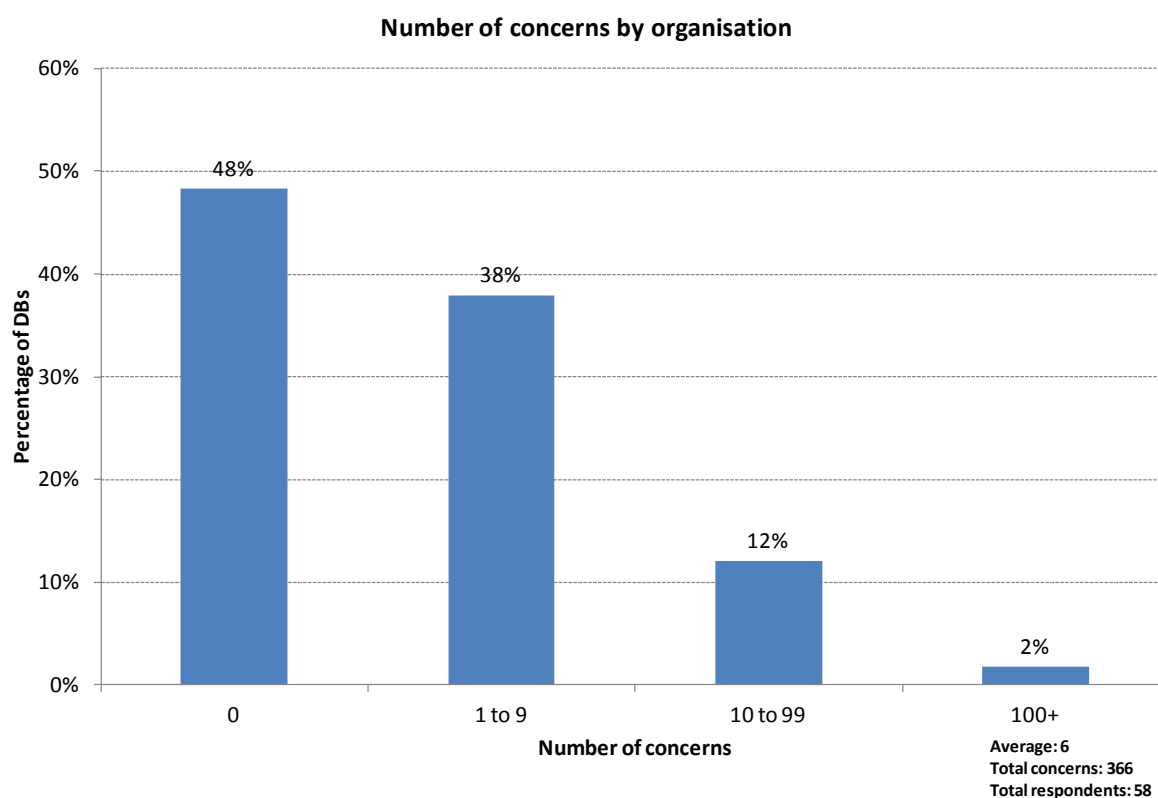
"Two doctors where suspension has been lifted and conditions imposed but finding it impossible to find work with conditions attached. Numerous conversations about funding for remedial support."

Responding to concerns identified between April 2012 and March 2013

15. How many concerns identified between April 2012 and March 2013 required formal investigation as defined in your local policy for responding to concerns?

Results

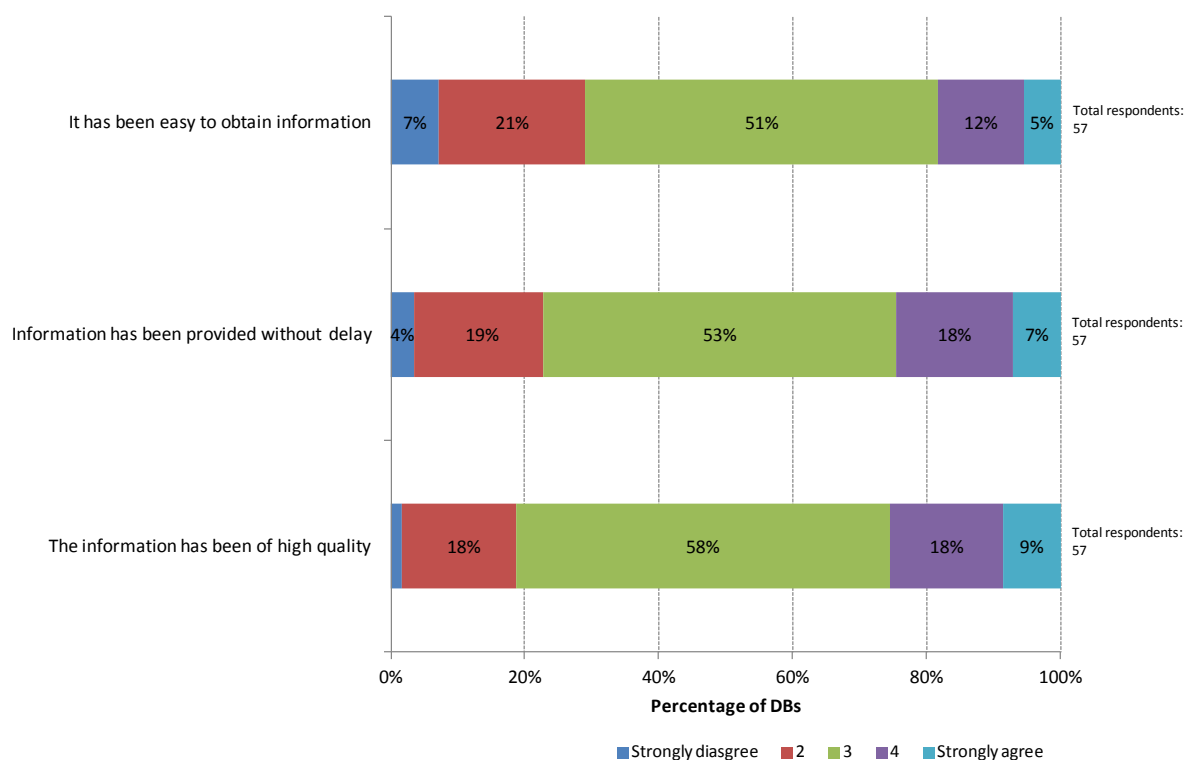
Figure 65



16. To what extent do you agree or disagree with the following statements about obtaining information from other organisations to support inquiries and investigations?

Results

Figure 66



General comments about obtaining information from other organisations

Designated bodies were invited to provide further comments on their answers to the previous question. Seven responses are included below in four groups: knowing who to contact, local support, differences in quality and issues/need for further development.

Knowing who to contact

"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."

Local support

"We have received great support from our responsible officer and the local trust and have had opportunity to share policies/procedures and information with the support team at the trust." [Mid-sized hospice]

"GMC liaison service very helpful."

Differences in quality

"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."

Issues/need for further development

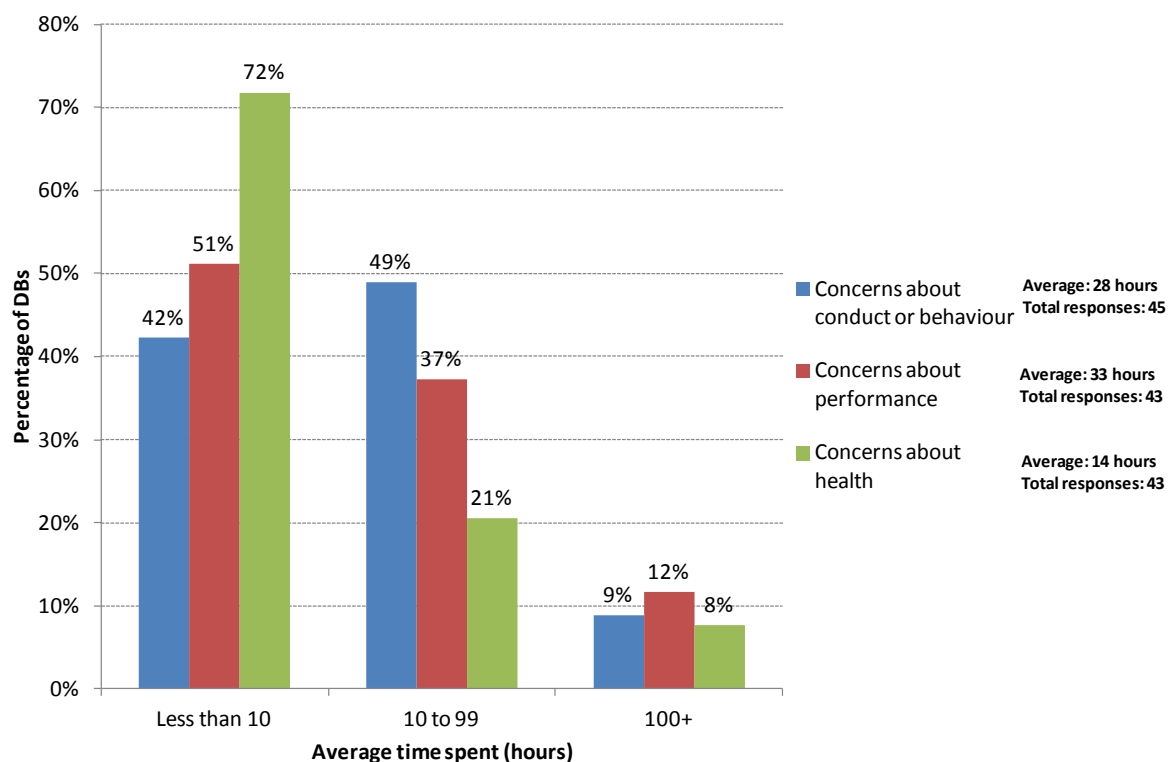
"It is early days so we are only just now asking for information about prospective employees."

"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."

17. Please record the average time spent per doctor, between April 2012 and March 2013, inquiring into or investigating concerns in each of the following categories (in hours)

Results

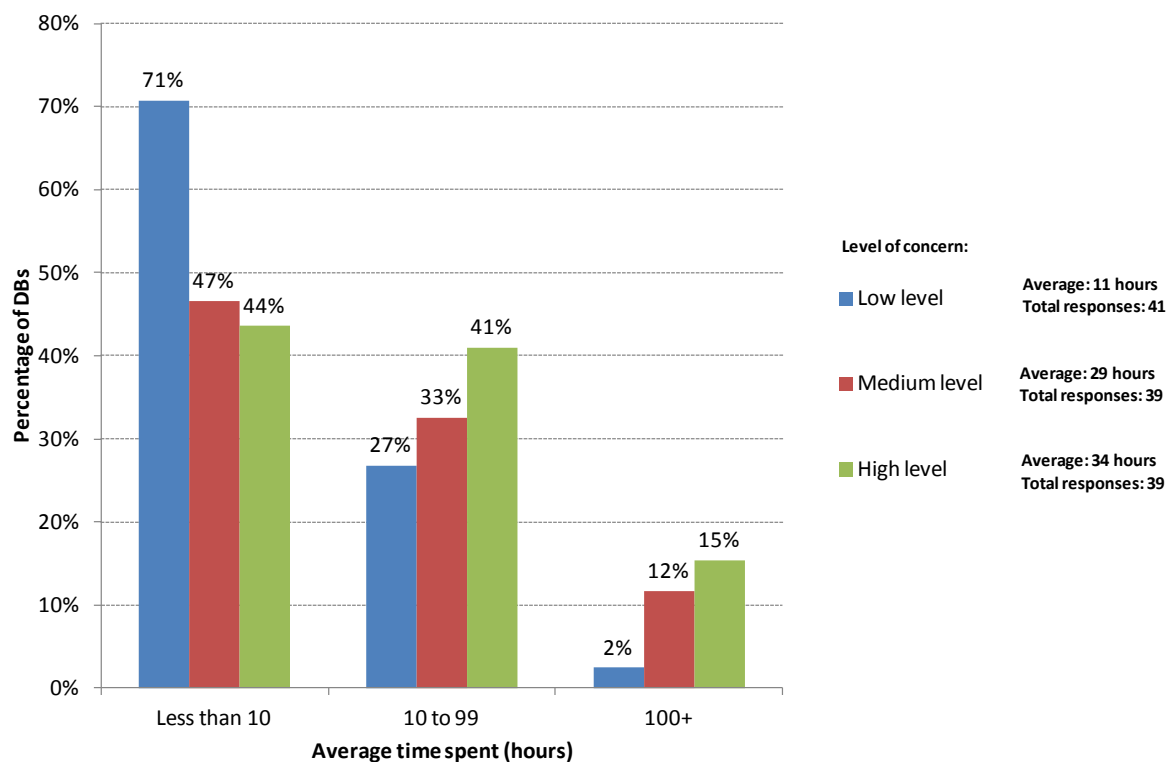
Figure 67



18. Please record the average time spent per doctor, between April 2012 and March 2013, inquiring into or investigating concerns at each of the following levels (in hours)

Results

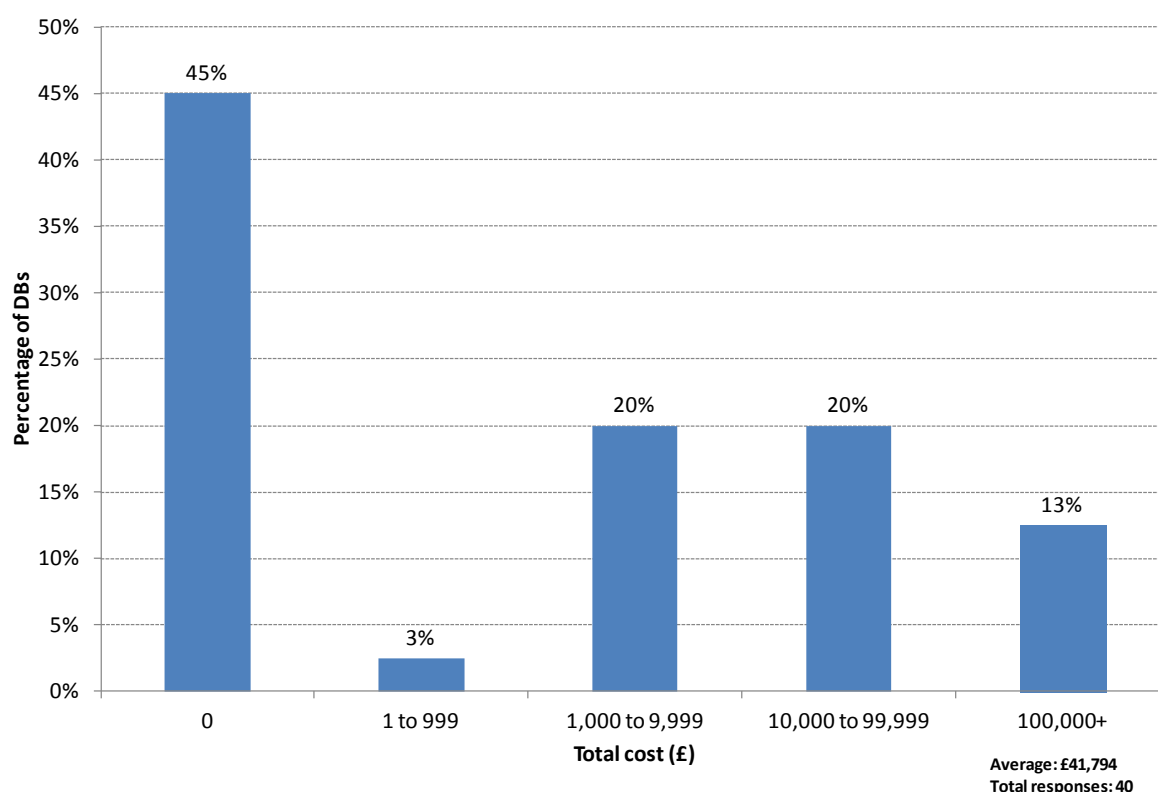
Figure 68



19. What was the total cost in £ to the designated body for responding to the concerns identified between April 2012 and March 2013?

Results

Figure 69



Designated bodies were asked to provide further details about the breakdown of the costs. Seven responses are included below under two headings: opportunity cost of inquiries and investigations and cost of locum cover and remedial support. Two other responses referred to the cost of specialist support for investigations including specialist opinion, medical examinations and legal fees.

Opportunity cost of inquiries and investigations

“Includes combined costs of governance and medical director salaries, but excluding addition input from CEO.” [Private hospital]

“We lost time spent by employees on other things whilst investigating these cases - no additional costs.”

“Our costs are difficult to evaluate but it is primarily gathering information and writing up documentation.”

"Time to investigate more an opportunity cost as it isn't funded directly."

Cost of locum cover and remedial support

"Locum cover for absence due to sickness."

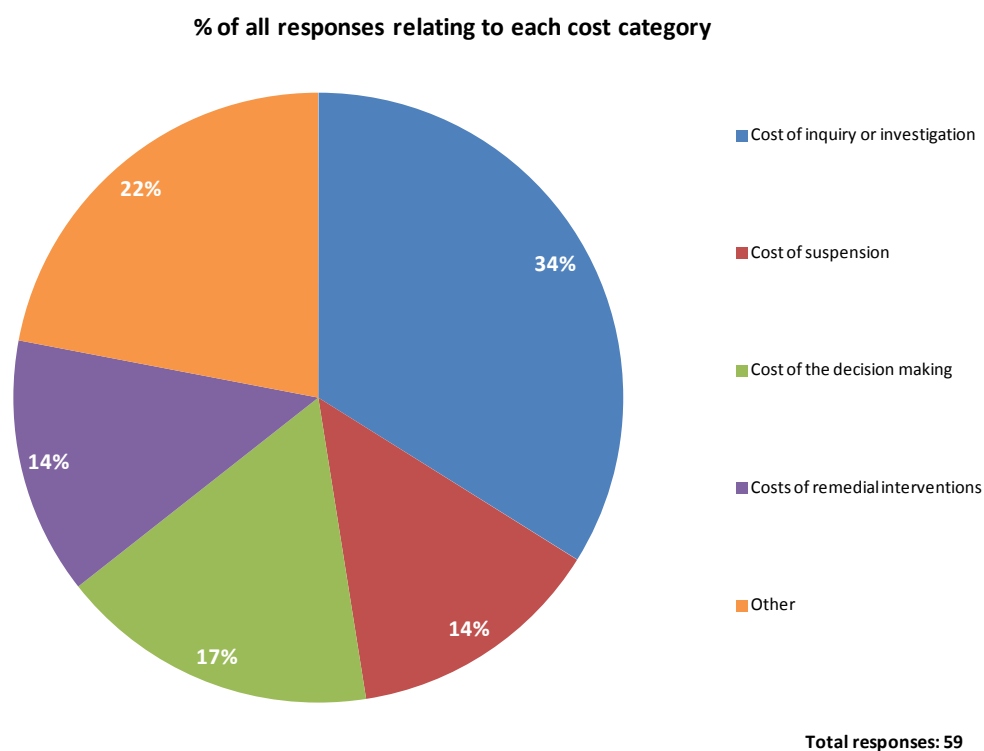
"The highest cost is for back-fill as we had to use agency locum on both occasions."

"Involvement of other resources to support resolution (e.g. HR staff, occupational health). Locum cover for absence due to sickness. Cost including locums circa £200k."

20. Please tick which of the following is included in the cost you provided above

Results

Figure 70



General comments about responding to concerns

Designated bodies were invited to provide comments about the questions in this section or, more generally, about responding to concerns. Seven responses are included below under two headings: difficulty in obtaining the relevant data and issues associated with the process of identifying and responding to concerns.

Difficulty in obtaining the relevant data

“Area team is an amalgamation of five PCTs [primary care trusts] in which information was recorded differently. The information requested cannot be extrapolated from the information provided during the transition.”

“Very difficult to quantify and apportion costs, because much of the function is performed on an ad hoc basis as cases come to light. However, organisations need a comprehensive governance infrastructure in order to investigate, assess and support this function.”

“The data captured by human resources will not, in all instances, capture the low-level, informal concerns raised, that are dealt with departmentally. The costs involved and time spent should also be heavily caveated as only direct costs (e.g. exclusion costs) are measurable. Other indirect costs of admin support, material resources, lost revenue, agency back-fill costs, on-costs etc. that may be captured by some trusts if Service Line Reporting is available, are not available in this instance.”

Issues in identifying and responding to concerns

“I found referral to NCAS [National Clinical Assessment Service] causes considerable delay. We get entangled with their processes rather than focus on the doctor's problems. This includes their insistence on repeating health assessment even when our occupational health has undertaken similar assessment and could not identify a problem.”

“Some people presented themselves as independent case investigators and I am very unhappy with the quality of their investigation but this is now remedied as we have trained investigators and case managers.”

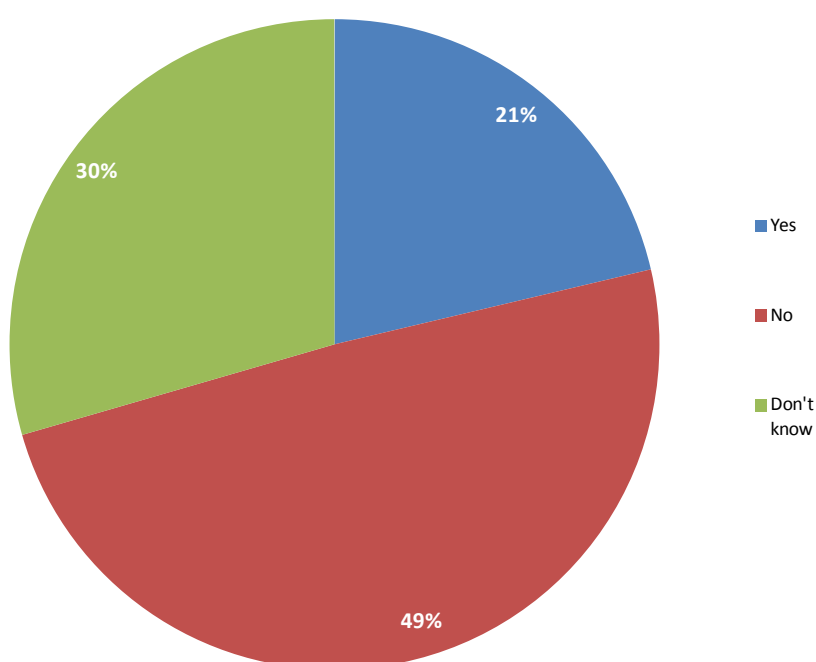
“There is considerable inconsistency in the threshold of raising concerns even in the same organisation and this brings to us the fairness of this – both to those who are identified and those who are still practising – for consistency, maintaining national guidance is essential.”

Impact of revalidation

21. Were more concerns identified between April 2012 and March 2013 than in the previous year?

Results

Figure 71



Total responses: 61

Designated bodies answering 'yes' to this question were asked to what they might attribute this increase. Four responses are included below. A further response highlighted the potential impact of issues being about the work of teams rather than the work of individuals and suggested that this leads to a stronger motivation to identify concerns that affect the team.

"More patient complaints via PCTs and GMC."

"More focus attributed to improving quality in primary care."

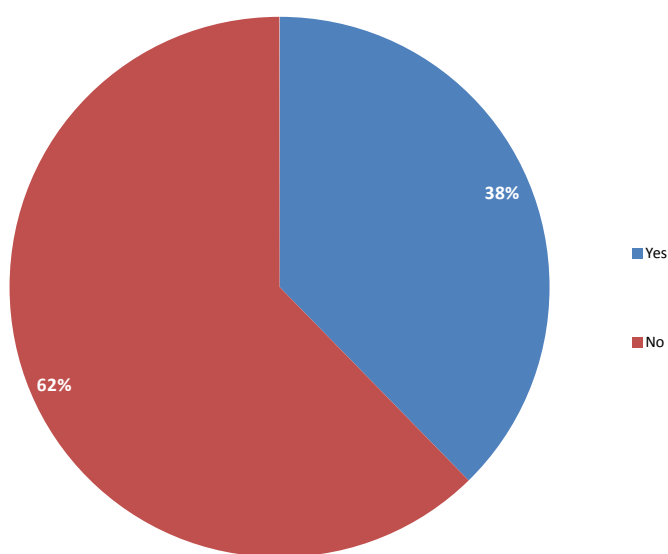
"Improved safety culture. Input of responsible officer."

"Role of AMD and Education Manager in facilitating staff to raise concerns at an earlier point."

22. In your opinion, has the introduction of revalidation allowed your organisation to identify concerns at an earlier point in their development?

Results

Figure 72



Total responses: 61

Designated bodies were invited to provide additional comments on their answers to this question.

Comments from designated bodies that referred to revalidation allowing earlier identification of concerns are included below under three headings: impact of stronger links between people, change in the way things are done and doctors' engagement with appraisal and audit.

Impact of stronger links between people

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

"Not the process of revalidation itself but the availability of the GMC Employment Liaison Officer."

Change in the way things are done

“There are more doctors reporting concerns about other doctors.”

Doctors' engagement in appraisal and audit

“Revalidation encourages doctors to participate in appraisal and audit.”

“On one or two occasions stress related issues were identified through interactions with those involved in appraisal, or through lack of engagement with appraisal.”

Comments from designated bodies that felt revalidation has **not** allowed earlier identification of concerns are included below.

“Concerns are addressed as they arise in this organisation. Appraisal (and revalidation) should not be the time to first address concerns or significant issues”.

“It has made no difference because we already had robust systems in place.”

“Appraisal might allow this more than the act of revalidation.”

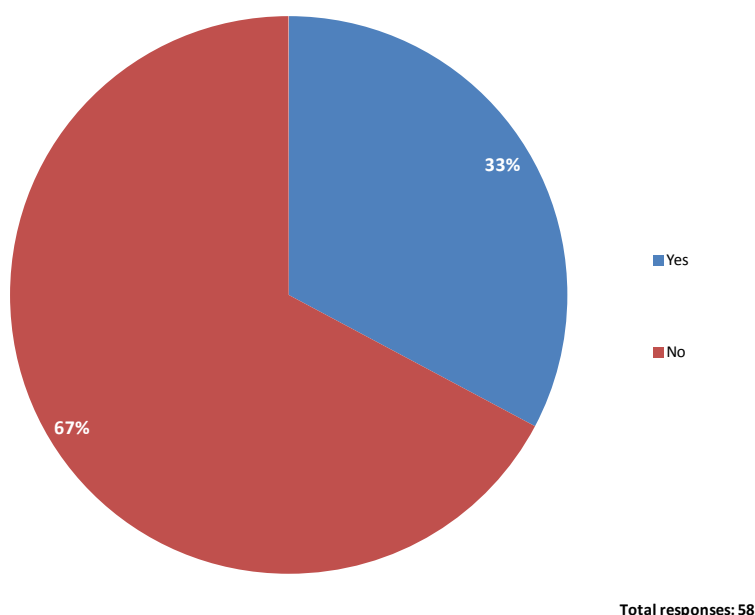
“We are a small organisation and any concerns are very visible and therefore addressed quickly.”

“The responsible officer is such a new role that concerns are not raised with the responsible officer or designated body.”

23. In your opinion, has revalidation allowed your organisation to provide a faster and more effective response to concerns?

Results

Figure 73



General comments

Designated bodies were invited to provide additional comments on their answers to this question.

Four comments from designated bodies that said that revalidation has allowed a faster and more effective response to concerns are included below:

“Now a more consistent approach to responding to concerns.”

“We made use of colleagues who had done the case investigator training.”

“Management structure has developed and [is] more responsive to concerns.”

“Introduction of a Responding to Concerns Panel in the trust...”

Four comments from designated bodies that said that revalidation had **not** allowed a faster and more effective response to concerns are included below. Three other respondents said that it made no difference because they already had robust systems/processes in place,

www.revalidationsupport.nhs.uk

although one of these respondents indicated that the increased responsible officer to responsible officer contacts were positive.

“Response to any concerns is within the various complaints/concerns processes within the organisation. Revalidation has not affected these and would not in itself be expected to do so.”

“Not frequent enough and we have other ways of keeping track through clinical governance.”

“Appraisal and revalidation does not affect how we deal with concerns or how quickly we respond to them. It may identify issues that may have been overlooked e.g. stress and this allows us to deal with the issue, but it does not affect the speed at which the issue is dealt with.”

“Responding to concerns is based on risk-assessment and revalidation data does not affect this to any great degree, although it is considered, and appraisal information has been helpful to identify, for example, where a doctor has worked and scope of practice.”

General comments on the introduction or impact of revalidation

Designated bodies were invited to provide further comments about the introduction or impact of revalidation. Ten of the responses are included below under three headings: time and size of organisation, impact and value and concerns.

Time and size of organisation

“It’s designed for large organisations with big administrative departments. The time responsible officers in small organisations with just one or two doctors spend in training attending meetings etc. is out of proportion to the number of doctors we supervise.”

“Much time spent in attending meetings and linking with the responsible officer and trust, with the feeling that very small designated bodies like ourselves are often forgotten. Fortunately our trust has been excellent in providing support.”

“We fully understand the requirements and the benefits that revalidation will bring however [it is] heavily focused on NHS hospitals with large numbers of doctors and therefore the impact on smaller organisations was not fully considered. We feel that there could have been greater consultations with representatives from small organisations before introduction.”

Impact and value

“We already have robust clinical governance arrangements for all staff (not just doctors) with monitoring by CQC [Care Quality Commission]. However, in general I feel revalidation has ensured doctors formally look into their working practices and this can only be a positive move.”

“We have found this to be a positive move for our organisation. We have everything prepared and are now ready for the doctors who will require us as their designated body.”

“Revalidation adds to the existing strong corporate governance structure in our organisation.”

“The trust had policies and procedures in place since 2003 and has used AQMAR⁴ and ORSA assessment tools to develop the trust's approach to medical appraisal.”

“Not aware of proven benefit as yet.”

⁴ Assuring the Quality of Medical Appraisal for Revalidation (RST, 2009) was the precursor to the [Organisational Readiness Self-Assessment](#) (RST, 2010)
www.revalidationsupport.nhs.uk

Concerns

“The biggest impact to us will come over the next couple of years as senior doctors who took early retirement from the NHS are not prepared to work through the revalidation process and will not practice once their date is passed. These have been a key source of valuable locums which we will lose. In addition, some overseas doctors are finding the process too difficult and so will also be lost from the pool.”

“I think revalidation is going the right direction of improving standards and safety. My concern is that the level 2 and level 3 responsible officers⁵ don't keep a lid on those they have appointed to lead in each cluster as I see that processes are becoming more and more important and if not checked it will become an industry to satisfy the obsessionality of individuals. I am keeping a watch on this in my cluster!”

⁵ Refers to responsible officers operating at a regional and national level.
www.revalidationsupport.nhs.uk

Responsible officers' survey

About you and your role as a responsible officer

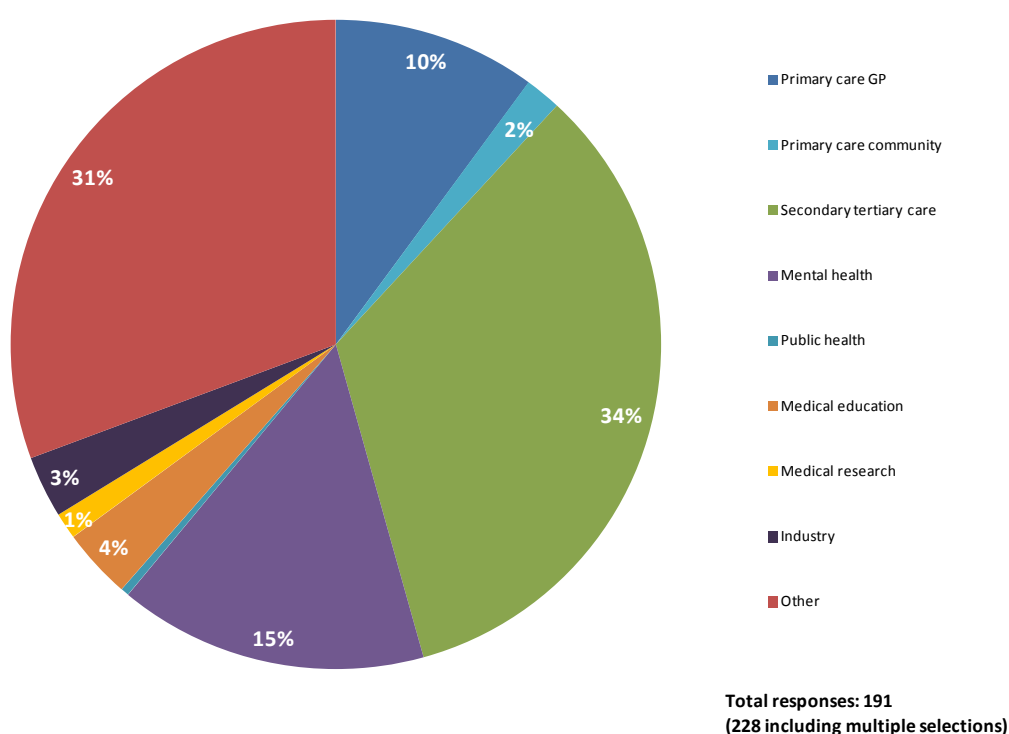
1. Please write the name(s) of the designated body(ies) for which you are currently the responsible officer

Not for publication.

2. What type of organisation(s) are you currently the responsible officer for?

Results

Figure 74



84% of respondents reported that they were responsible officer for a single type of organisation. 14% reported that they were responsible for two different types of organisation, while a further 2% reported that they were responsible for three or more types.

Out of the 191 responsible officers who responded to the survey, 70 said that they acted as a responsible officer to doctors in a setting that was not specified in the survey. These 'other' settings are listed in the following table. In 23 of the entries, the 'other' setting was additional to one or more of the specified settings; in the remaining 47 entries, the responsible officers worked exclusively in the 'other' setting.

Figure 75

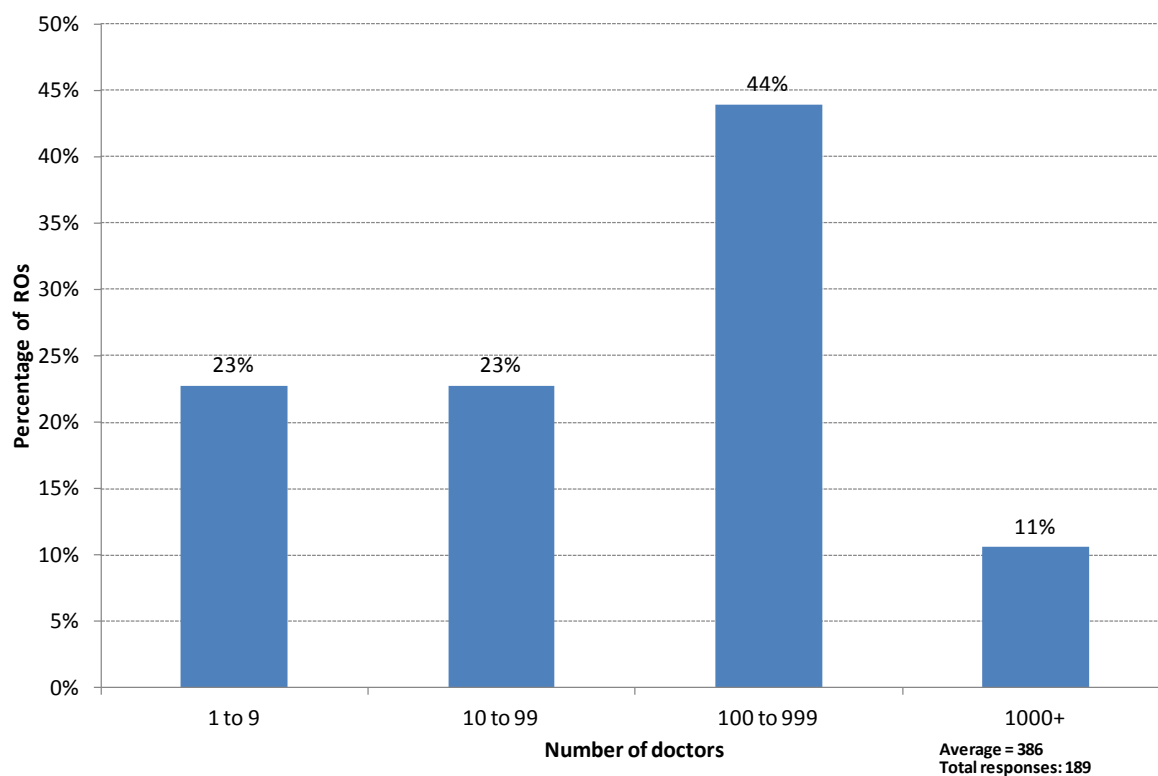
Settings	Frequency
Independent sector (specialist services)	15
Hospice	13
Community services	12
Locum/staffing agency	8
Charity/third Sector	6
Government department/agency/regulator	6
Mental health services	4
Independent sector (acute)	3
Industry (cruise ships)	1
Level 2 responsible officer	1
Medical education	1
TOTAL	70

Your workload as a responsible officer

3. How many doctors are you currently the responsible officer for?

Results

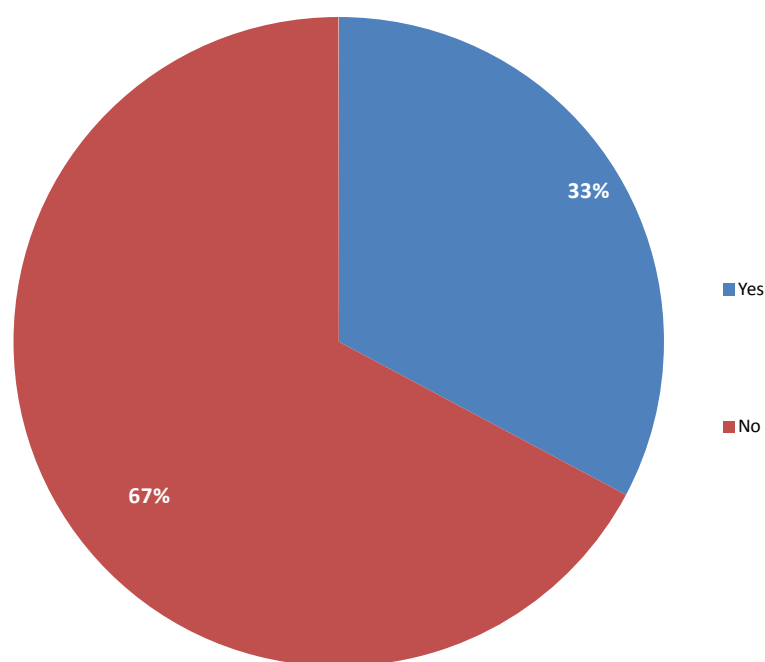
Figure 76



4. Do you delegate any part(s) of your responsible officer role?

Results

Figure 77



Total responses: 189

Responsible officer answering 'yes' were asked to describe the duties they had delegated and to whom they had been delegated.

Out of the 191 responsible officers who responded to the survey, 62 said that they delegated duties to other people. All but one of these described the duties they delegated and/or the role(s) of the people to whom the duties were delegated. However, as illustrated below, the details are described in a wide range of different ways and it is not practicable (or useful) to provide the frequency of different configurations.

Duties delegated to others

"Recruitment responsibilities partly delegated to the Medical HR Manager and Additional Staffing Manager."

"Case Manager role is now carried out by the Medical Director and other Medical Case Managers."

"Appraisals, responding to GMC enquiries, revalidation-readiness delegated to organisation revalidation admin teams."

"My Associate Medical Director manages the process and checks the forms. The clinical directors have appraisal leads in each directorate. The process is reviewed and overseen by a committee which I chair."

"Assisted with quality assurance by AD Revalidation and by five lead appraisers. Recommendations for revalidation to GMC are screened by the aforementioned team."

"I delegate almost all the duties to two associate medical directors who job share the role. I remain ultimately responsible for making the recommendations to the GMC"

"Minor delegation to deputy responsible officer in times of conflicts of interest or absence."

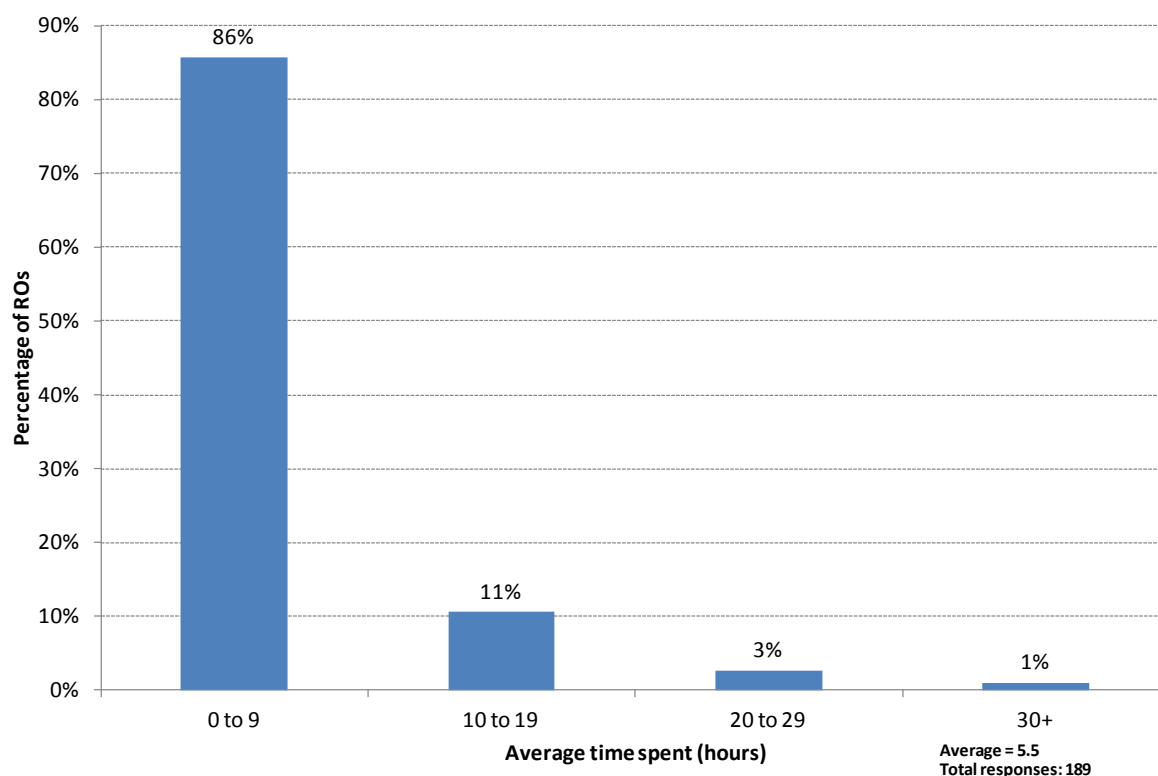
"Associate Medical Director for Appraisal and Revalidation. He runs and quality assures the appraisal system, he confirms to me if doctors due for revalidation have successfully completed their appraisal and 360 and there are no outstanding concerns".

"I have a deputy director of performance (medical) who performs the associated performance management of contractors and runs the PSG. This leaves me free to perform the responsible officer function without prejudicing the decision."

5. On average, approximately how many hours a week are dedicated to matters relating specifically to revalidation?

Results

Figure 78



General comments on workload as a responsible officer

Responsible officers were invited to comment on any of the questions in this section or more generally, about the workload of responsible officers.

Responses centred around eight headings:

- size of designated body
- mismatch with expectation
- variability and seasonality
- impact of standardisation
- stress and external pressures
- increase in number of revalidations in 2014
- inability to combine the responsible officer role with other roles
- drawing the line between revalidation and other activities.

Size of designated body

“Given how few doctors I am responsible officer for, the workload - e.g. expectation to attend 3/4 responsible officer meetings a year etc., is very significant.”

“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.”

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

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

Mismatch with expectation

"This is far more than I envisaged and is due to the amount of work that I do which cannot be delegated owing to the intricacy and requirement of the responsible officer regulations." [Current estimate is 2 hours per week for 71 doctors, no delegation]

"Much more onerous than billed originally and to do the job ideally I should spend even more time." [Current estimate is 4 hours per week for 260 doctors, no delegation]

"The administrative burden of revalidation has been universally underestimated."

Variability and seasonality

"Would only be 1-2 hours a week if it were not for a doctor with current performance issues."

"This is hugely variable, with peaks of activity to review policies or address concerns raised. Although whole weeks can go by with no specific responsible officer activity, a responsible officer network meeting can take all day, including travel."

"The responsibilities are seasonal and the period from January – March [is] especially busy in ensuring appraisals completed etc."

"Workload and time taken is variable. There is a surge in activity from individual doctors during the build up to the revalidation date."

Impact of standardisation

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

"The time spent on managing 'concerns' has increased with the introduction of revalidation as matters that might previously have been dealt with more 'informally' by my team now need a much more formal response in order to be recordable and contribute to revalidation decisions."

"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)."

Stress and external pressures

“Responsible officer role is time-consuming, stressful and involves a lot of time out of the trust on responsible officer mandatory training, network attendance, conferences etc.”

“The workload and responsibility as responsible officer is a large task with huge responsibilities.”

“Unfortunately revalidation has appeared at a time of unprecedented change in the NHS, and my own personal work load (aside from revalidation) has increased significantly. This work includes managing large reductions in resources and services, and maintaining quality in an increasingly risk averse environment.”

Increase in number of revalidations in 2014

“We have only two doctors revalidating this financial year; next year we have a large cohort. Things will get busier and I would expect to triple the amount of time I currently spend on this.”

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

Inability to combine the responsible officer role with other roles

“I am finding it increasingly more difficult to combine the role of responsible officer with a full time clinical duty as consultant psychiatrist; and this is after part of the role has been delegated to others as above.”

“Workload as a clinician (50%), executive director, deputy CEO, Caldicott Guardian AND responsible officer is too much. Revalidation being an overly bureaucratic process gets left till last..; to do it properly would take many hours.”

Drawing the line between revalidation and other activities

“It depends on where you draw the line as some work re governance processes work would need to be done regardless of revalidation but is implicitly linked to the processes.”

"I spend most of my time on different aspects of performance monitoring and management of the doctors. It is a core aspect of the job. Revalidation is only a final sign off that all is satisfactory."

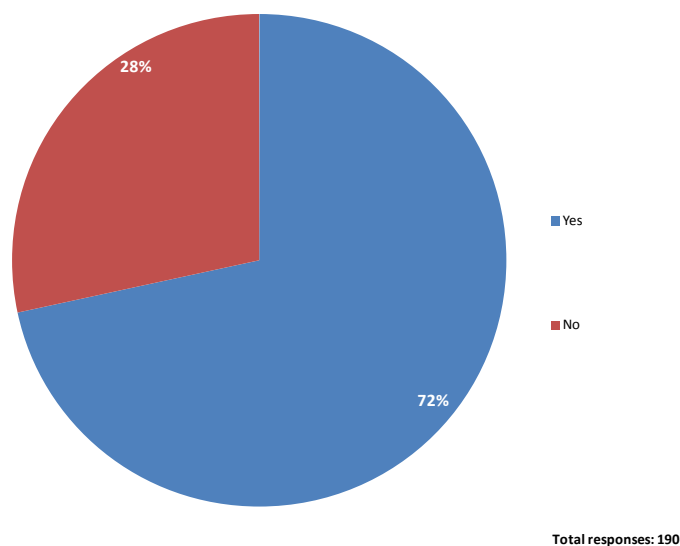
"The responsible officer role is of course much wider than revalidation - I have not included all the time spent on the wider governance, patient safety responsibilities of the responsible officer."

Use of information systems to support revalidation

6. Do you, or the people to whom you delegate duties, use an information technology system to manage the information required to make revalidation recommendations?

Results

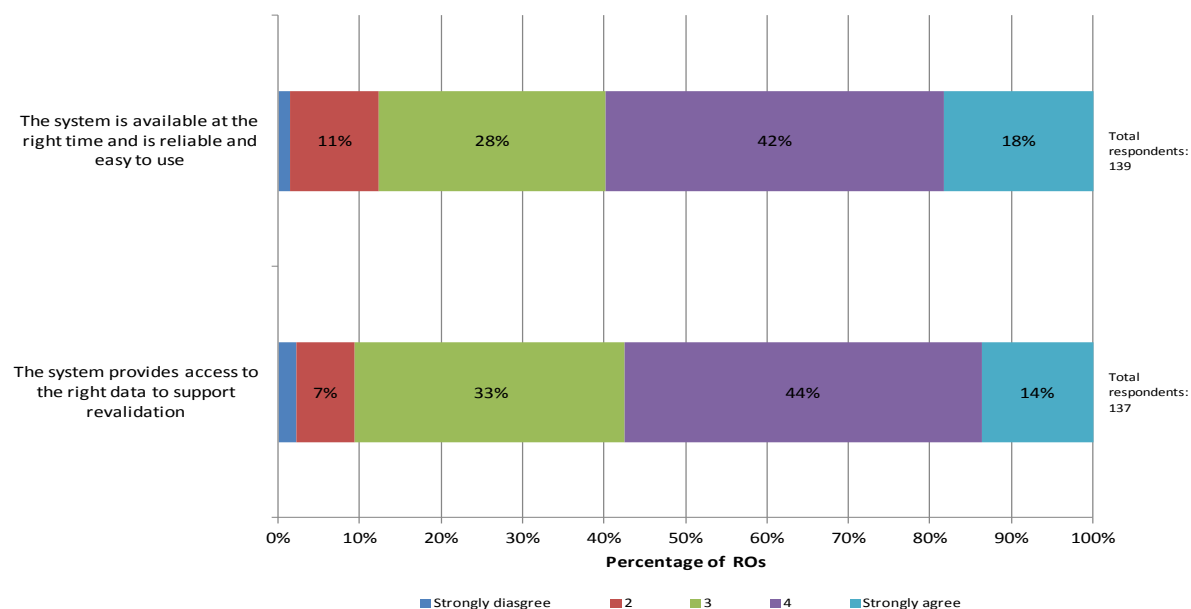
Figure 79



7. If yes, to what extent do you agree with each of the following statements?

Results

Figure 80



General comments about the use of information systems

Responsible officers were invited to comment on any of the questions in this section or more generally, about the use of information system to support revalidation. Fifteen of the qualitative responses are included below in groups based on the respondents' answers to the questions: 'To what extent do you agree that the system provides access to the right data to support revalidation?' and 'To what extent do you agree that the system is available at the right time and is reliable and easy to use?' These questions are referred to below as 'criteria'.

Strong agreement on both criteria

"Absolutely essential to enable the work to be done. Resistance from some doctors to using the system is a problem at times. But we insist."

"GMC Connect is particularly intuitive and easy to use."

"The organisation has developed a fully integrated bespoke appraisal and revalidation system which supports the entire process from portfolio building, appraisal meeting, quality review, doctor feedback and the revalidation process, incorporating an electronic responsible officer form and dashboard."

Strong agreement on one criteria and agreement on the other

"We have needed to adapt our information systems to ensure they do contain all the necessary information at the point when recommendations are to be made."

"Electronic systems very helpful in supporting the appraisal and revalidation work."

Agreement on both criteria

"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."

"I have devised own spreadsheet." [49 doctors in designated body]

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

Neutral on one or both criteria

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

“Not been all I would have hoped for. Currently running both paper and IT process and considering returning to paper based across the board for simplicity.” [319 doctors with a prescribed connection]

“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.”

“We are developing an in-house product as the costs of the commercial products make their long term use undesirable”

“Getting prescribed doctors used to using the system is the issue; the system itself is very good.”

Disagreement on one or both criteria

“We are working on the development of IT systems and we are in the early stages but on the right path.”

“It is slow and cumbersome; FAQs do not give answers to revalidation sections.”

The following notes highlight the key points in the comments:

- Where designated bodies are using an information system, some of them are using commercial systems, some have developed or are developing an in-house system and others are using a mixture of both types of system with clerical/administrative procedures added around the edge as necessary.

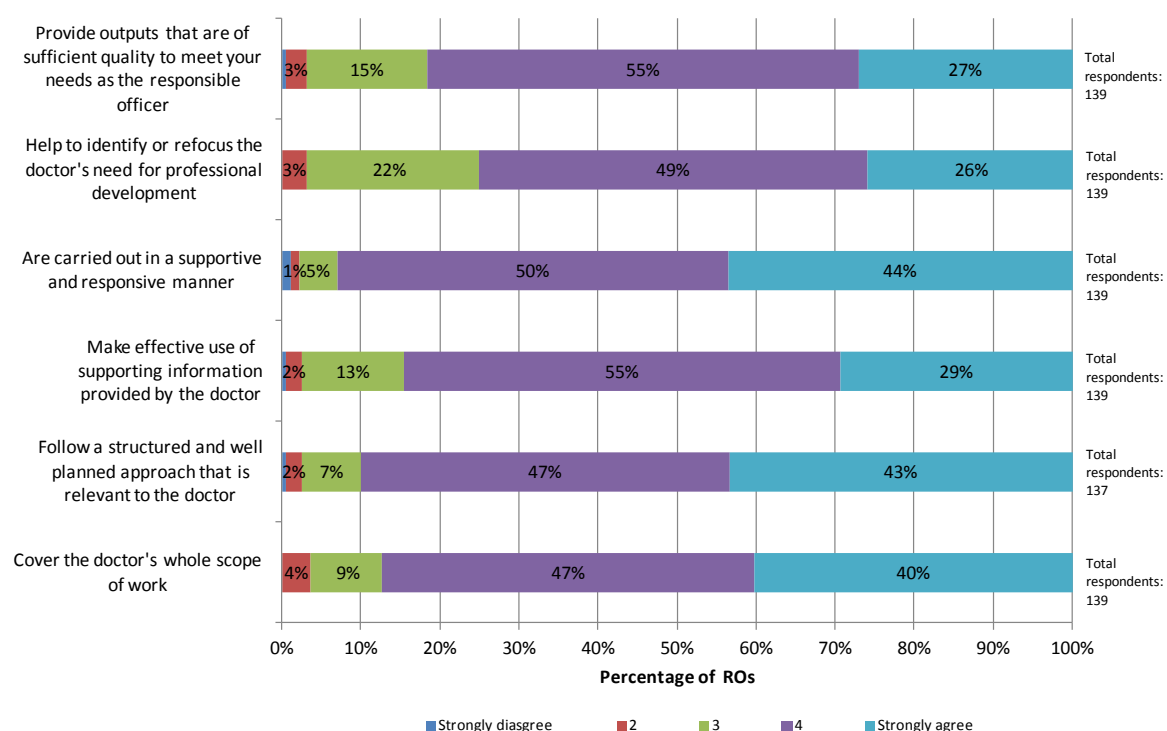
- A number of small designated bodies and a couple of medium-sized designated bodies are using, or reverting to, spreadsheet and paper-based systems. One respondent said: "I fear that the emphasis on modern electronic media detracts from the actual content and value of the information. Examining scanned documents can take far longer than looking through a file of papers".
- A designated body in an industry setting has decided that it needs to create its own system because the commercial systems for appraisal and revalidation are designed for the NHS and do not meet their needs.
- One respondent suggested that they would eventually need to develop their own in-house system to avoid the long-term costs associated with the use of a commercial system.
- Two respondents referred to the eventual/anticipated development of a national system. A couple of respondents said that they needed to insist that doctors use their system and it was necessary to provide training for this purpose. One or two other designated bodies reported that this difficulty was made worse because they had inherited a number of different systems from organisations that had previously had separate arrangements for governance.
- In connection with using a specified system, one respondent asked if there might be a data protection issue if doctors used a system that was not owned by their employer.

Quality of appraisals in your designated body

8. To what extent do you agree with each of the following statements about the quality of appraisals carried out in your designated body?

Results

Figure 81



General comments on quality of appraisals

Respondents were invited to provide additional comments about their answers to question 8 or, more generally, on the quality of appraisals. Responses centred on five headings:

- access to supporting information
- use of the RST MAG Model Appraisal Form
- general comments on appraisals
- general comments on appraisers
- quality of appraisals, revalidation and system as a whole.

The number and breadth of these comments demonstrate the strength of the evidence base.

Access to supporting information

“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.”

“We have excellent appraisers and access to good quality outcome data. The admin team supporting me are first class which is vital to role.”

“It would be helpful if royal colleges/faculties produced a practical and feasible minimum data set required for each specialty and provided benchmarking for these outcomes.”

“The organisation provides appraisees with PALS/SUI /CPD/audit data.”

“There needs to be a better link between the primary care complaints process and the responsible officer database - so that I can be assured doctors are discussing and reflecting on complaints”

“Biggest issue is obtaining supporting information of a satisfactory depth and breadth”

“People not having done a formal 360 feedback is the commonest cause of deferral.”

Use of the RST MAG form

"The appraisals themselves have improved enormously by using the RST MAG as a format."

"The MAG form which is now used as the standard within our appraisal system encourages pre-appraisal preparation from to 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."

"The MAG form is very useful and user-friendly"

"The MAG form offers a structured and well-planned approach to appraisal and is uniformly used across the trust. However some groups such as clinical academics, SAS doctors and other non-consultant grade colleagues have found it harder to evidence their activities. Improved guidance and more training and support for appraisers should rectify this in 2013-14."

General comments on appraisals

"There has been universal feedback from appraisees that the experience has been a positive one and very enjoyable, which has been rewarding. The appraisal summaries have generally been of good quality and are continuing to improve. The biggest enhancement has been clear documentation in the summary and PDP of outstanding items/evidence required in that cycle - making it easier for the appraiser the following year (and the responsible officer)."

"We are getting there, as I have been checking every appraisal personally and returning back those which need additional action. I work with the training provider and provide feedback to appraisers and we are making good progress in ensuring more and more robust outputs." [142 doctors with a prescribed connection]

"I have no problem with the appraisals that we carry out, but there are difficulties in the agreed (BMA) appraisal policies. These difficulties include the need to rotate appraisers every three years (very problematic in small directorates), the disconnection of appraisal from line management, the types of info that can be used or is available regarding an individual doctors performance to support the quality agenda."

"Appraisals follow a structured but generic approach with generic paperwork so is not tailored to the individual at all and the doctors feel the process therefore is impersonal."

"Older, long established doctors struggle with the concept of a PDP,

but a good appraiser can deal with this.”

“New system. Both appraisers and appraisees on learning journey in terms of using the opportunities presented for reflection and learning”

“Appraisal is still developing and needs to become embedded in the consultant psyche. ...”

“This year, I am having [a] 1:1 with every doctor before recommending revalidation because the appraisals are not yet as rigorous as I need and the electronic system is only just being launched.”

General comments on appraisers

“I have two good appraisers who are robustly performance managed by myself.”

“We need ongoing national/regional training programmes for appraisers so the bar is gradually raised, without it being seen to be an employer-based exercise.”

“Obviously variable, though most are very good. Following a review of the first year, we will be asking a few appraisers to step down.”

“Our appraisers are experienced and quality assured. The initial and ongoing training to achieve this is expensive. The NHS England regulations allow for non-clinical appraisers which would be a retrograde step.”

“We have a panel of appraisers, all of whom are fully trained, mostly in-house and we have developed a culture of committed people working to high standards.”

“The quality is at present very much appraiser dependent. We are rationalising our appraisers to only those who are prepared to tackle the 'difficult areas'. We are moving to two reviewers of the documentation submitted before the actual appraisal.”

“The good appraisers are excellent but quality assurance is going to be a problem especially for the difficult doctors.”

“It is difficult within the independent sector to find doctors that have sufficient knowledge of training and education to act as appraisers. 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 ones workforce.”

“The appraisers we use are not internal to the organisations so specific care is made to ensure that they are satisfactory.”

"We do not perform appraisals within the organisation. Doctors with a designated connection are required to organise appraisals from accredited organisations, but the quality varies."

Quality of appraisals, revalidation and system as a whole

"With only a small cohort of doctors, I feel this is an area where we can have quite high confidence in quality."

"All appraisal portfolios are subjected to a full quality review, measured against the six minimum requirement of the first cycle of revalidation and the GMC framework. This provides me with the assurance when I am making my recommendations that a doctor's appraisal has met the standard to go towards supporting a positive recommendation. This process has resulted in identifying doctors early on who do not meet the basic criteria and afforded them time to rectify this situation with close support of the appraisal lead."

"The quality of appraisal has continued to increase within our trust. There is a problem in maintaining appropriate quality control of the appraisal process and appraisers."

"On the back of revalidation we have significantly improved the quality and consistency of our appraisal system."

"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. To this end, I have appointed a new associate MD [medical director] for quality improvement who will work closely with the revalidation AMD/responsible officer and team to help with this. The aim is to ensure appraisal is made to be directly relevant to doctors improving their practice through QI [quality improvement], CPD [continuing professional development] etc."

"This is an iterative process where we have worked to ensure that the appraisals are of a standard that they fulfil our governance requirements. The continuing challenge is that the quality continues to develop and meet the needs of the clinician in a personalised manner whilst providing assurance to the responsible officer."

"Main issue within primary care is the weak level of clinical governance oversight of performance. Not only is it not systematically in place for NHS England yet, but when all up to scratch it will remain focused on the practice as a unit and not the individual (pertinent as responsible officer)."

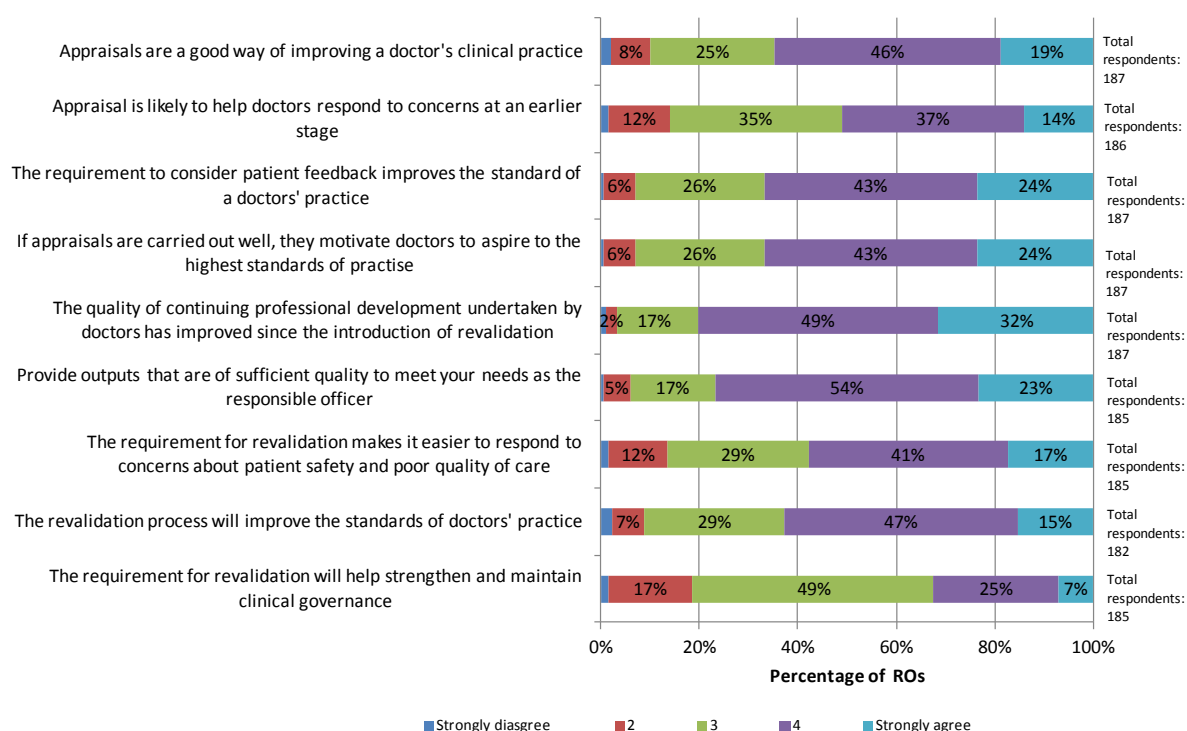
"This is a developing process. There are two issues here: first the fitness of appraisal to identify those doctors that can be recommended for revalidation or otherwise; here the bar is relatively low so the information that is returned to the responsible officer is sufficient. The second issue is to improve the quality of care through enabling doctors to function more efficiently and effectively within healthcare systems; this is a far more difficult challenge and success requires a lot more than a good appraisal process. We need to work to improve the process to contribute to improvement."

Your view on the overall impact of appraisal and revalidation

9. To what extent do you agree with the following statements [about the impact of appraisal and revalidation]?

Results

Figure 82



General comments on the overall impact of appraisal and revalidation

Respondents were invited to provide additional comments on their answer to question 9 or, more generally, about the overall impact of appraisal and revalidation. 61 responses are included below under the following 10 headings. The number and breadth of these comments demonstrate the strength of the evidence base. (The figures in parentheses are the number of responses under each heading.)

- Value of revalidation (12)
- Impact on culture, behaviour and the wider system (11)
- Purpose and value of appraisal (5)
- Quality of appraisals and appraisers (7)
- Connection with clinical governance (3)
- Measurement and impact (5)
- Identifying and addressing concerns (6)
- Independence of responsible officers (1)
- Impact on CPD (3)
- Patient feedback (9)

Value of revalidation

“Poor doctors will remain poor – insight is the prime issue with regard to poor performance and this will not be resolved by the current process. If we really want to progress this we need a greater level of support and insight into performance across the board and the process to 'make' doctors engage in remediation. Luckily good doctors remain good and want to improve and this helps them - and the vast majority fall into this category.”

“We could achieve the above far easier than going through revalidation... good performance reviews and job planning with a better contract would do it.”

“A better definition of non-engagement with revalidation would be helpful.”

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

“I believe revalidation will lead to significant improvements in quality of care, and our ability to monitor good (and poor) performance of colleagues.”

“In my view the jury is still out. In our trust we already had strong governance systems, and responded robustly to patient concerns and safety issues. In this regard revalidation has added little. The problem

with the revalidation process is that it is only as good as the info presented and gathered. For example the 360 feedback is still largely governed by doctors giving out forms to patients and favoured staff and I've yet to pick up issues from this process. The info we can collect e.g. complaints and SUI's largely reflect aggregated data from teams (reflecting modern NHS practice), and very rarely allows us to drill down to individual doctors performance. There is therefore an over reliance on soft data (and line management experience) which is now being broken by the mandatory rotation of appraisers."

"A very costly exercise for little gain as poorly performing doctors will be reported to GMC as in the past. My practice is no better or worse than before appraisals and revalidation came into being."

"It is hard to disagree with any of the above statements. It is however important that effort and resource use are proportionate. We need a way so more effort and resources are spent on those at the lower end of the performance distribution and less on those in the upper end."

"It is still very early to see the real potential impact and benefits to patients."

"I believe that revalidation is an important step in the right direction – ensuring doctors reflect on what they can do to improve their working practices."

"Appraisal and revalidation needs to be quickly expanded to include all clinicians e.g. nurses, AHPs etc."

"As mentioned before it is an expensive exercise in time and money for little gain. To put it another way I have not become a better doctor with the introduction of appraisals or revalidation."

Impact on culture, behaviour and the wider system

"I feel that revalidation will change market forces. It will provide a more articulate framework in which to manage doctors who are outliers, though perhaps not outright 'bad'. I am already finding that this is affecting the way doctors behave when presented with concerns; in my experience they have become quite polarised either responding well and acting quickly themselves, or fighting against the suggested concern and therefore making themselves unemployable. I think within one cycle we will have a cohort of doctors who find themselves on the wrong side of a circle which encompasses organisations with high expectations of clinical governance. I feel the NHS will, by default almost, be inside this circle and those organisations that are outside the NHS will not want to find themselves outside the circle I have described and so won't employ these outlying doctors."

"Its strength lies in earlier identification of problems and in enhancing ownership of this by the doctor for early intervention and action."

"I do not think that appraisal improves practice for the 50% of doctors who are above average. It is a chore that they can undertake fairly easily. However for those below average it does provide a regular stimulus to improve and to seek help if there are issues to be addressed."

"The system is becoming increasingly democratic and could become a method of holding responsible officers to account."

"There is a potential for conflict in the independent sector between commercial interests of private healthcare companies and robust appraisal. This needs to be addressed better."

"Appraisal is still seen by the majority as a paper-pushing exercise; it will take a long time to bed into the psyche and become a normal part of daily practice. Hence average responses above accept that governance will be improved by default (rather than by design). Failing doctors will be amongst the most diligent to prove they are competent so may not improve standards of practice; the standards will just be recorded better."

"I am reasonably optimistic that as the process develops there are likely to be improvements that may in part be attributable to revalidation. However in the short-term most doctors see appraisal as a means to an end: to meet their obligations to their employer and to the GMC."

"In neither of the main acute organisations where I work has the culture of having a robust discussion about linking CPD to the PDP been embedded yet. From discussions at responsible officer network meetings I am not sure it is embedded elsewhere either. It requires a concerted change in approach with active support from BMA and royal colleges to help responsible officers and other senior clinicians to push this change forward."

"At present many doctors feel revalidation is a hurdle and if you ask them if it was a 'positive' experience afterwards they will likely say yes as they were 'glad to get it over' rather than looking forward to the challenges set."

"Whilst my responses on appraisal and revalidation are very positive, I am becoming increasingly aware of differences in primary and secondary care (and within the latter, between specialities) in terms of the ways in which doctors work together and support each other. This is going to create large differences in the utility of these processes to improve clinical practice and professional development."

"Formative appraisal used to be very useful to all concerned. Summative approach becomes a box-ticking survey of training and hard facts, with important 'soft' skills ignored. Shipman would have scored highly."

"I think the 'formalisation' of concerns I have seen following revalidation may prove to be a double edged sword as it has decreased the willingness to deal with things close to the patient on an informal basis, whilst raising the visibility of concerns to a higher level."

Purpose and value of appraisal

"A bit of a scattergun at first sight. Appraisal is about assurance for me and the trust and guidance for the doctor."

"The private sector cannot afford to wait for an annual appraisal to better clinical practice, motivate doctors or to respond to patient safety only on an annual basis. The appraiser, appraisal preparation and appraisal time is precious hours that doctors don't see patients and patients don't see doctors. I am of the opinion that we cannot really afford the latter."

"Although appraisal is a part of QI, and therefore does contribute to improving standards of practice, I am not sure that appraisal plays an important role in responding to patient safety or poor practice: these are much more relevant to performance assessment and routine service monitoring, complaints, SUIs etc."

"Many of our doctors are extremely good, but even they can find ways of improving their practice by going through rigorous appraisal and revalidation."

"It is a constructive process, but the best appraisal results tend to involve the most committed individuals. It can still be perceived as a paper exercise and as yet I am not yet convinced that it will identify and engage those that are not committed. It would be useful to repeat this exercise in two years correlated with objective evidence e.g. complaints, SUIs etc."

Quality of appraisals and appraisers

"Enhanced appraisal and appraisal outside a specialty and rotating appraisers all tend to improve the quality of the discussion."

"We need better peer-reviewed review of doctors' clinical outcomes and decision making processes."

"Close scrutiny of the outputs of appraisal has helped to identify learning needs in the appraisers."

"In the independent sector it is new to many doctors and can be challenging for those working part-time with a limited sphere of practice. Certain domains can be hard to populate (e.g. taking part in quality assurance and improvement) if you only see six outpatients a week."

"I think it is hard to move away from a tick-box exercise. Doctors who have been consultants for some time struggle with the reflection required."

"The quality of the appraisal in relation to these questions very much depends on the quality of the evidence presented by the doctor and we are still in a situation where appraisers don't necessarily have access to a common data set regarding doctors' performance which is independent of what the doctor presents as evidence."

"Revalidation has focused the organisation and doctors on appraisal. The quality of appraisal has similarly been improved by the up-skilling, monitoring and commitment of appraisers. Appraisal should have a positive effect on development and performance - but it will be a long process to demonstrate this for most doctors."

Connection with clinical governance

“The [organisation] does not employ the doctors for whom it is responsible, which raises challenges in relation to clinical governance.”

“Must be informed by data. We have good CG [clinical governance] – revalidation won't change that much here but I can see it will elsewhere. To be successful it must be rigorous and 'have teeth.'”

“If appraisal is done to robust high standards and is underpinned by good clinical governance systems, it can meet the points above and in my trust it has.”

Measurement and impact

“Another important question: “Who will measure the improvement in standards of doctor's practice, and how? What are the baseline standards against which such improvement will be judged?” I am pleased to see the National Medical Director taking a lead at last, but I remain sceptical that it will ever be shown that revalidation has improved standards any more than any other regulator or inspector does.”

“Too early to comment on impact of revalidation.”

“Some of this is unproven but an act of faith which I am happy to share. Revalidation and appraisal is part of the answer but not all of it.”

“The answers to these questions are unproven but I am not yet convinced.”

“For the majority of doctors revalidation and appraisal will make little difference.”

Identifying and addressing concerns

“Concerns should be picked up long before appraisal if the organisation is coherent.”

“Appraisal will assess practice and identify areas for change, however I would expect that performance or practice issues would be identified when they occur and I would be concerned that usual management procedures had fallen down if the first indications of poor practice were identified at appraisal.”

“Appraisal should never be the vehicle to address governance or performance concerns and it is a shame if doctors only consider their training needs because of appraisal. However, for the minority of doctors where there are serious concerns, the requirements of appraisal for revalidation may very well have an impact on doctors who otherwise may not have engaged or may have failed to take notice of concerns about their practice. Where they fail to respond it will be easier to address performance or behaviour but, cynically, this may be because of the more structured relationship between employers and the GMC through the ELS [Employer Liaison Service].”

“Poorly-performing doctors will and should be managed outside revalidation and I do not believe that the requirement for revalidation will make it any easier to respond to concerns about patient safety and care quality. Most medical directors will, within six months of assuming the role, be aware of those doctors who are poorly performing and will be actively managing processes to address concerns.”

“It is a shame there is not more support from NCAS or the GMC when a doctor has performance issues. For the doctor I am working with, after local investigation it is clear he is unsafe to work without daily face-to-face supervision, yet we have no one to supervise (he is the only doctor in his team) and NCAS cannot formally assess him for six months, which is a ridiculous situation to have to deal with. Despite him also being scheduled for court appearance with prescribing fraud in [month deleted] the GMC are also refusing to take any action. Such issues are very hard for small employers to sort out!”

“Revalidation has forged a link between appraisal/revalidation and the GMC which is helpful in the management of the doctor about whom there are concerns. Revalidation is not only a process of identifying such a doctor but a means by which that doctor can be held to account by accelerating the revalidation process.”

Independence of responsible officers

“Responsible officers are often employed in a management post within the organisation they represent thus they are not independent; this is the same in most cases with appraisers and runs the risk that any problems with 'systems' will be ignored. This has been shown in the debate following the problems in Mid Staffs and revalidation – unless followed exactly – will not change this.”

Impact on CPD

“CPD is different to what it was and there is not the funding that was available years ago. It is more focused and relevant, which may have the knock on effect of reducing wide clinical knowledge.”

“I think most doctors were already following their own colleges CPD requirements before revalidation so its implementation per se has not changed that much.”

“It is too early to answer the question on the quality of CPD since revalidation. We are just starting the first annual appraisal after revalidation was introduced in December 2012. By early 2014 there will be information to make a judgement.”

Patient feedback

“The requirement to consider patient feedback is important to many specialties but COMPLETELY irrelevant to some, yet it [is] still required; this, for example, is pointless.”

“360 degree feedback has in my experience been dreaded by most hospital doctors but they were usually pleased with the results, particularly patient comments.”

“The patient feedback can easily be fixed [and] it should be random. The cost of the expensive paper the questionnaires are printed on is ridiculous considering the number that is to be sent out nationally. Having them collated by a third party is also too expensive. These should be taken electronically wherever possible. The problem with the whole process [of patient feedback] is that there is absolutely no funding to allow it to happen.”

“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.”

“In some specialities the patient feedback does not always reflect a doctor's good practice, mainly when doctors have to set limits (say 'No') to patient's inappropriate requests because they are not for the best interest of the patient's health. These requests could involve medications, certificates, letters etc.”

“Patient feedback is clearly critical for those in clinical practice but only a few Industry physicians are still in direct contact with patients, so this is less relevant.”

“Patient feedback should be more than once in every five years.”

“The 360 feedback is still largely governed by doctors giving out forms to patients and favoured staff and I’ve yet to pick up issues from this process.”

“The GMC patient questionnaires are useless. We use ‘I Want Great Care’⁶ which is MUCH more useful, but not all doctors [are] happy with this.”

⁶ www.iwantgreatcare.org
www.revalidationsupport.nhs.uk

Margins of error

Overview

This section contains the margins of error for the statistics presented in the technical annex. The margins of error in our results are affected by the number and distribution of responses received for each question. Where appropriate and possible, for each question we have indicated the margin of error for a confidence interval of 95%. This means that in 19 out of 20 cases the true figure for the population (e.g. all doctors) will be within the margin of error we have indicated. (That is, if we state that 30% of respondents hold a particular belief with a confidence interval of $\pm 5\%$, in 19 out of 20 times the figure the whole population will lie between 25% and 35%.)

The margins of error (MOE) have been calculated using the formula $MOE = z \sqrt{\frac{p(1-p)}{n}}$

Where:

- p is the sample proportion
- n is the sample size
- z is the z-score for the 95% confidence interval (1.96)

Margins of error have not been calculated where $np < 5$ or $n(p-1) < 5$ as the sample size is too small for this method to be appropriate.

Margins of error have also been adjusted using the finite population correction (FPC), to account for the added precision gained by sampling close to a larger percentage of the population. The finite population corrections have been calculated using the equation $FPC = \sqrt{\frac{N-n}{N-1}}$

Where:

- N is the population size
- n is the sample size.

To adjust for a large sampling fraction, the FPC is factored into the calculation of the margin of error, which has the effect of narrowing the margin of error. We used the following estimates of population sizes obtained from a recent *Organisational Readiness Self-Assessment (ORSA)* report⁷:

Survey group	Population size
Doctors	161,453
Appraiser	16,998
Responsible officers	572
Designated bodies	621

This method assumes that the survey respondents represent random samples drawn from these populations. The margins of error we have calculated are set out over the following pages.

⁷ *Organisational Readiness Self-Assessment (ORSA) report 2012-13* (RST, 2013)
www.revalidationsupport.nhs.uk

Doctors' survey

Q1

Specialty	
General practice	35.10%(±2%)
Psychiatry	08.50%(±1%)
Anaesthetics	08.20%(±1%)
Medicine	07.20%(±1%)
Ophthalmology	07.10%(±1%)
Surgery	06.60%(±1%)
Paediatrics	03.20%(±1%)
Radiology and oncology	03.00%(±1%)
Obstetrics and gynaecology	02.40%(±1%)
Emergency medicine	02.20%(±1%)
Pathology	02.00%(±1%)
Occupational medicine	01.80%(±1%)
Public health	01.60%(±0%)
Other	11.10%(±1%)

Q2

Setting	
Primary care - general practice	31.90%(±2%)
Primary care - community hospital	03.00%(±1%)
Secondary/tertiary care	42.60%(±2%)
Mental health	06.90%(±1%)
Public health	01.00%(±0%)
Medical education	04.40%(±1%)
Medical research	02.20%(±1%)
Industry	02.10%(±1%)
Other	06.00%(±1%)

Q3

Number of years qualified	0 to 10	10 to 20	20 to 30	30 to 40	40+
	4.32%(±1%)	27.50%(±2%)	26.80%(±2%)	26.80%(±2%)	06.10%(±1%)

Revalidation Support Team

Q4

	NHS	Other public sector	Independent treatment centre	Other private sector	Third sector
1	5.70% (±2%)	76.90% (±3%)	83.00% (±3%)	51.00% (±3%)	79.20% (±2%)
2	1.70% (±1%)	6.00% (±1%)	6.10% (±2%)	21.70% (±3%)	11.20% (±2%)
3	5.40% (±2%)	5.50% (±1%)	4.50% (±1%)	12.60% (±2%)	3.90% (±1%)
4	18.20% (±3%)	5.10% (±1%)	2.60% (±1%)	5.30% (±2%)	2.20% (±1%)
5	69.00% (±3%)	6.50% (±2%)	3.80% (±1%)	9.40% (±2%)	3.50% (±1%)

Q5

Yes	12.43% (±1%)
No	87.57% (±2%)

Q6

Time Period	
In the last 6 months	40.50% (±2%)
6 months to a year ago	50.50% (±2%)
Between 1 and 2 years ago	05.20% (±1%)
More than 2 years ago	01.30% (±0%)
I have not yet had an appraisal	02.50% (±1%)

Q7

	Time spent completing post-appraisal forms	Time spent attending the appraisal meeting	Time spent completing pre-appraisal forms	Time spent collecting supporting information
0 - 1 hours	49.70% (±3%)	09.80% (±2%)	02.90% (±1%)	01.10% (±1%)
>1 - 2 hours	34.70% (±3%)	44.50% (±4%)	15.53% (±2%)	06.30% (±1%)
>2 - 4 hours	10.80% (±2%)	40.30% (±4%)	28.63% (±3%)	18.30% (±2%)
>4 - 8 hours	02.90% (±1%)	04.40% (±2%)	26.79% (±3%)	26.70% (±3%)
Over 8 Hours	02.00% (±1%)	01.10% (±1%)	26.15% (±3%)	47.60% (±3%)

Q8

Yes	24.00% (±2%)
No	76.00% (±2%)

Q8 – If yes, by care setting -

Public health	45.50%(±2%)
Primary community	36.40%(±2%)
Industry	34.00%(±2%)
Mental health	31.90%(±2%)
Primary GP	27.90%(±2%)
Other	25.80%(±2%)
Medical education	23.80%(±2%)
Medical research	20.70%(±2%)
Secondary/tertiary	18.90%(±2%)

Q9 - *Question phrasing and responses reversed for purposes of comparability

	My last appraisal was an effective use of my time	I created a useful personal development plan as an outcome of my last appraisal	I used my last appraisal to identify lessons learnt over the previous year	In my last appraisal, I was challenged to think about my practice	My appraisal was conducted in a supportive way	I would have liked more time to talk in my last appraisal	My appraisal covered my 'whole scope of work'	*My appraisal discussion did not take too long to complete	I was well prepared for my last appraisal
Strongly disagree	20.70%(±2%)	11.00%(±1%)	08.90%(±1%)	08.60%(±1%)	02.60%(±1%)	32.50%(±2%)	03.90%(±1%)	10.90%(±1%)	01.70%(±1%)
2	19.90%(±2%)	17.60%(±2%)	16.00%(±1%)	15.80%(±2%)	04.70%(±1%)	36.70%(±2%)	08.40%(±1%)	10.10%(±1%)	03.70%(±1%)
3	25.70%(±2%)	28.00%(±2%)	29.80%(±2%)	31.10%(±2%)	12.10%(±1%)	20.20%(±2%)	17.10%(±2%)	27.40%(±2%)	15.90%(±1%)
4	24.00%(±2%)	32.40%(±2%)	35.20%(±2%)	36.10%(±2%)	35.40%(±2%)	07.80%(±1%)	36.80%(±2%)	31.40%(±2%)	38.80%(±2%)
Strongly agree	40.10%(±2%)	11.00%(±1%)	33.80%(±2%)	02.90%(±1%)	45.20%(±2%)	08.50%(±1%)	10.10%(±1%)	20.20%(±2%)	09.80%(±1%)

Q10 - *Question phrasing and responses reversed for purposes of comparability

	My appraiser helped me think about new areas of Personal and professional development.	I was encouraged by my appraiser to make positive change in my practice	*My appraiser listened fully to my concerns	My appraiser enabled me to be honest and open about my practice	My appraiser was well prepared for my last appraisal
Strongly disagree	05.80%(±1%)	03.70%(±1%)	03.10%(±1%)	01.70%(±1%)	02.40%(±1%)
2	14.10%(±1%)	10.20%(±1%)	05.20%(±1%)	03.50%(±1%)	06.50%(±1%)

Revalidation Support Team

3	34.30%(±2%)	39.60%(±2%)	09.70%(±1%)	13.20%(±1%)	14.90%(±1%)
4	34.20%(±2%)	34.70%(±2%)	26.80%(±2%)	38.70%(±2%)	37.40%(±2%)
Strongly agree	11.60%(±1%)	11.80%(±1%)	55.20%(±2%)	42.80%(±2%)	38.80%(±2%)

Q11

Yes	81.00%(±2%)
No	19.00%(±2%)

Q12

	Enabled me to keep up to date with developments in my specialty that are relevant to my practice	Has not made any difference to the way I practise	Addressed other areas of my practice not directly related to my clinical skills or knowledge	Had a direct and demonstrable impact on the care and treatment I provide	Allowed me to make a recognised contribution to my professional community (e.g. team or speciality)	The quality of continuing professional development undertaken by doctors has improved since the introduction of revalidation
Strongly disagree	04.20%(±1%)	24.00%(±2%)	05.40%(±1%)	08.40%(±1%)	10.10%(±1%)	24.10%(±2%)
2	07.50%(±1%)	38.40%(±2%)	14.30%(±1%)	14.90%(±1%)	14.60%(±1%)	26.70%(±2%)
3	19.20%(±2%)	18.00%(±2%)	28.90%(±2%)	29.70%(±2%)	28.00%(±2%)	31.30%(±2%)
4	41.50%(±2%)	12.00%(±1%)	40.10%(±2%)	36.00%(±2%)	33.50%(±2%)	14.40%(±1%)
Strongly agree	27.70%(±2%)	07.60%(±1%)	11.40%(±1%)	11.00%(±1%)	13.80%(±1%)	03.50%(±1%)

Q13

	Addresses my whole scope of work	Is focused on the provision of care and treatment for patients	Addresses specific gaps in knowledge and skills	Reflects the priorities for my personal and professional development	Reflects the requirements and priorities of the organisation(s) for which I work	Helps me to feel more confident about preparing for revalidation
Strongly disagree	08.20%(±1%)	06.20%(±1%)	06.10%(±1%)	05.00%(±1%)	08.50%(±1%)	12.70%(±1%)
2	18.20%(±2%)	15.60%(±1%)	15.60%(±1%)	10.30%(±1%)	16.70%(±1%)	20.90%(±2%)
3	27.30%(±2%)	31.70%(±2%)	33.40%(±2%)	27.20%(±2%)	36.60%(±2%)	30.30%(±2%)
4	32.30%(±2%)	36.90%(±2%)	36.70%(±2%)	44.70%(±2%)	31.00%(±2%)	26.90%(±2%)
Strongly agree	14.00%(±1%)	09.60%(±1%)	08.30%(±1%)	12.80%(±1%)	07.20%(±1%)	09.30%(±1%)

Q14

Revalidation Support Team

	The revalidation process will improve the standards of doctors' practice	The requirement for revalidation makes it easier to respond to concerns about patient safety and poor quality of care	The quality of continuing professional development undertaken by doctors has improved since the introduction of revalidation	If appraisals are carried out well, they motivate doctors to aspire to the highest standards of practise	The requirement to consider patient feedback improves the standard of a doctor's practice	Appraisal is likely to help doctors respond to concerns at an earlier stage	Appraisals are a good way of improving a doctor's clinical practice
Strongly disagree	28.27%(±2%)	24.70%(±2%)	24.07%(±2%)	10.20%(±1%)	14.75%(±1%)	14.40%(±1%)	18.55%(±2%)
2	25.90%(±2%)	26.40%(±2%)	26.66%(±2%)	13.10%(±1%)	20.70%(±2%)	21.10%(±2%)	21.68%(±2%)
3	29.16%(±2%)	28.80%(±2%)	31.32%(±2%)	24.70%(±2%)	27.30%(±2%)	27.40%(±2%)	27.73%(±2%)
4	13.48%(±1%)	16.60%(±1%)	14.43%(±1%)	37.70%(±2%)	28.50%(±2%)	30.70%(±2%)	25.15%(±2%)
Strongly agree	03.18%(±1%)	03.60%(±1%)	03.52%(±1%)	14.30%(±1%)	08.80%(±1%)	06.40%(±1%)	06.89%(±1%)

Appraisers' survey

Q1

Health sector appraisals carried out	
Primary care – general practice	43.10%(±3%)
Primary care – community	01.50%(±1%)
Secondary/ tertiary care	48.30%(±3%)
Mental health	08.20%(±2%)
Public health	01.50%(±1%)
Medical education	02.50%(±1%)
Medical research	00.30% (small sample)
Industry	00.80%(±1%)

Q2

Number of years carried out appraisals		
0-1	12.70%(±2%)	12.70%(±2%)
>1-2	11.90%(±2%)	11.90%(±2%)
>2-5	23.40%(±3%)	23.40%(±3%)
>5-10	32.80%(±3%)	32.80%(±3%)
More than 10	19.20%(±3%)	19.20%(±3%)

Q3

	0 to 5	5 to 10	10 to 15	15 to 20	20+	Total
No. of doctors appraised	192	221	162	65	52	692
	27.75%(±3%)	31.94%(±3%)	23.41%(±3%)	9.39%(±2%)	7.51%(±2%)	

Q4

	Preparing for appraisal	In appraisal discussion	Completing post appraisal paperwork
0-1 hours	11.10%(±2%)	03.00%(±1%)	33.40%(±3%)
>1-2 hours	40.60%(±3%)	46.80%(±3%)	42.10%(±3%)
>2-4 hours	36.30%(±3%)	48.10%(±3%)	19.60%(±3%)
>4-8 hours	09.70%(±2%)	01.80%(±1%)	04.40%(±1%)
Over 8 hours	02.30%(±1%)	00.30%(small sample)	00.60%(small sample)

Review and quality of appraisals (appraisal lead)

Q5

1	12.00%(±2%)
2	88.00%(±2%)

Q6

No of appraisers	0 to 10	10 to 100	100+
	22.37%(±9%)	69.74%(±10%)	7.89%(±6%)

Q7

Yes	78.00%(±9%)
No	22.00%(±9%)

Q8

No	10.10%(±7%)
Yes, in some appraisals	24.10%(±9%)
Yes, in many appraisals	32.90%(±10%)
Yes, in most or all appraisals	32.90%(±10%)

Review and quality of appraisals (appraisers)

Q5

Yes	86.00%(±3%)
No	05.00%(±2%)
Don't know	09.00%(±2%)

Q6

Weekly	01.60%(±1%)
Monthly	05.90%(±2%)
Quarterly	54.80%(±4%)
Annually	37.70%(±4%)

Q7

Yes	71.70%(±4%)
No	06.60%(±2%)
Don't know	21.80%(±3%)

Q8

Yes	56.00%(±4%)
No	44.00%(±4%)

Q9

Yes - directly	1	43.47%(±4%)
Yes - indirectly	2	21.85%(±3%)
No	3	13.96%(±3%)
Don't know	4	20.72%(±3%)

Q10

Yes	43.00%(±4%)
No	44.00%(±4%)
Don't know	13.00%(±2%)

Q11

Yes	65.00%(±3%)
No	35.00%(±3%)

Q12

Yes	19.00%(±3%)
No	81.00%(±3%)

Q13

Not confident at all	07.50%(±4%)
Little confidence	09.80%(±5%)
No view either way	18.80%(±7%)
Reasonably confident	38.30%(±8%)
Very confident	25.60%(±7%)

Q14

Yes	17.00%(±3%)
No	83.00%(±3%)

If yes, in how many appraisals –

1	2	3	4	5+
53.64%(±9%)	24.55%(±8%)	12.73%(±6%)	3.64% (small sample)	5.45%(±4%)

Q15 - qualitative

Q16

Yes	58.00%(±4%)
No	42.00%(±4%)

Q17

	CPD is better recorded with reflection on lessons learned and impact; not just time spent	CPD is more frequently addressing the whole scope of work for a doctor	CPD is undertaken as a tick-box exercise for revalidation/appraisal	CPD is more focused on the provision of care and treatment for patients	CPD is more focused on the specific gaps in a doctor's clinical skills and knowledge	CPD is more reflective of a doctor's priorities for personal and professional development	CPD is difficult to undertake because of the pressures of work	CPD is more reflective of the requirements and priorities of the organisation(s) for which the doctor works
Strongly disagree	02.92% (±1%)	02.34% (±1%)	09.39% (±2%)	04.52% (±2%)	02.56% (±1%)	02.35% (±1%)	05.31% (±2%)	03.52% (±2%)
2	10.53% (±3%)	13.87% (±3%)	31.90% (±4%)	23.18% (±4%)	19.49% (±3%)	10.18% (±3%)	18.50% (±3%)	26.76% (±4%)
3	16.18% (±3%)	36.33% (±4%)	31.51% (±4%)	47.54% (±4%)	37.20% (±4%)	28.57% (±4%)	19.09% (±3%)	43.36% (±4%)
4	55.56% (±4%)	40.43% (±4%)	18.40% (±3%)	22.20% (±4%)	36.81% (±4%)	53.62% (±4%)	35.04% (±4%)	22.46% (±4%)
Strongly agree	14.81% (±3%)	07.03% (±2%)	08.81% (±2%)	02.55% (±1%)	03.94% (±2%)	05.28% (±2%)	22.05% (±4%)	03.91% (±2%)

Q18

	Appraisals are a good way of improving a doctor's clinical practice	Appraisal is likely to help doctors respond to concerns at an earlier stage	The requirement to consider patient feedback improves the standard of a doctor's practice	If appraisals are carried out well, they motivate doctors to aspire to the highest standards of practise	The quality of continuing professional development undertaken by doctors has improved since the introduction of revalidation	The requirement for revalidation makes it easier to respond to concerns about patient safety and poor quality of care	The revalidation process will improve the standards of doctors' practice
Strongly disagree	05.31% (±2%)	04.62% (±2%)	07.34% (±2%)	03.03% (±1%)	08.79% (±2%)	10.22% (±2%)	14.99% (±3%)
2	18.08% (±3%)	16.31% (±3%)	17.99% (±3%)	08.67% (±2%)	25.22% (±3%)	22.88% (±3%)	20.32% (±3%)
3	33.29% (±3%)	25.97% (±3%)	30.50% (±3%)	19.94% (±3%)	36.02% (±3%)	29.78% (±3%)	37.90% (±4%)
4	33.57% (±3%)	45.45% (±4%)	35.40% (±3%)	46.82% (±4%)	25.36% (±3%)	33.24% (±3%)	23.20% (±3%)
Strongly agree	09.76% (±2%)	07.65% (±2%)	08.78% (±2%)	21.53% (±3%)	04.61% (±2%)	03.88% (±1%)	03.60% (±1%)

Designated bodies' survey

Q1

Health sector	No. designated bodies	No. doctors
Hospital secondary care foundation trust	21.05%(±7%)	17.64%(±0%)
Hospital secondary care non-foundation trust	17.54%(±6%)	17.59%(±0%)
Independent academic organisation	00.00%(small sample)	00.00%(small sample)
Independent faculty	01.75%(small sample)	00.92%(±0%)
Independent government department	02.63%(small sample)	00.72%(±0%)
Independent hospice	06.14%(±4%)	00.06%(±0%)
Independent healthcare provider	21.05%(±7%)	03.57%(±0%)
Independent locum agency	03.51%(small sample)	02.73%(±0%)
Independent other	01.75%(small sample)	00.33%(±0%)
Local education training board	01.75%(small sample)	13.97%(±0%)
Mental health foundation trust	09.65%(±5%)	03.04%(±0%)
Mental health non-foundation trust	02.63%(small sample)	00.63%(±0%)
NHS England area team	07.02%(±4%)	37.90%(±0%)
NHS England national office	00.00%(small sample)	00.00%(small sample)
NHS England regional office	00.88%(small sample)	00.32%(±0%)
Other NHS foundation trust	00.88%(small sample)	00.36%(±0%)
Other NHS non-foundation trust	01.75%(small sample)	00.20%(±0%)
Other NHS organisation	00.00%(small sample)	00.00%(small sample)

Q2

No. doctors	0 to 10	10 to 100	100 to 1000	1000+
	15.93%(±6%)	22.12%(±7%)	53.10%(±8%)	8.85%(±5%)

Q3

No. years qualified	0 to 50	50 to 100	150 to 200	200 to 250
	75.24%(±7%)	22.86%(±7%)	0.95%(small sample)	0.95%(small sample)

Q4

Created new posts	47.40%(±7%)
Changed existing job descriptions	32.50%(±7%)
Informally extended existing roles	45.60%(±7%)

Q5

Number of years qualified	0 to 1000	1000 to 10000	10000 to 100000	100000+
Percentage of doctors	32.47%(±10%)	7.79%(±6%)	53.25%(±10%)	6.49% (small sample)

Q6

Yes, we have invested	45.50%(±8%)
Yes, we are planning to invest	18.80%(±6%)
No	35.70%(±8%)

Q7 – No calculations

Q8 and Q9

	0 to 1000	1000 to 10000	10000+
Annual ongoing cost for using and maintaining the system	28.57%(±15%)	37.14%(±16%)	34.29%(±15%)
Cost of purchasing/developing and implementing new system	13.51%(small sample)	27.03%(±14%)	59.46%(±16%)

Q10

0 to 10	10 to 20	20 to 30	30 to 40	40 to 50	50 to 60
83.78%(±8%)	6.76%(small sample)	1.35%(small sample)	2.70%(small sample)	0.00%(small sample)	5.41%(small sample)

Q11

0 to 10	10 to 20	20 to 30	30 to 40	40 to 50	50 to 60
82.19%(±8%)	5.48%(small sample)	2.74%(small sample)	2.74%(small sample)	0.00%(small sample)	6.85%(±5%)

Q12 – Assumed that the true population of concerns is infinite.

Source	
Appraisals	11.90%(±2%)
Soft intelligence obtained through informal conversations	12.60%(±2%)
Analysis of comparative data and metrics on performance and outcomes	11.20%(±2%)
Concerns notified by other doctors	14.00%(±3%)
Concerns notified by nurses/clinical staff	12.20%(±2%)
Complaints from patients and carers	14.00%(±3%)
Concerns notified by other healthcare providers	11.90%(±2%)
Other	12.20%(±2%)

Q13

Concerns about conduct or behaviour	38.20%(±4%)
Concerns about performance	37.40%(±4%)
Concerns about health	24.40%(±3%)

Q14

Low-level concerns	60.40%(±3%)
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Medium-level concerns	29.60%(±3%)
High-level concerns	10.00%(±2%)

Q15

Number of doctors	0 to 10	10 to 100	100+
Percentage of doctors	86.21%(±3%)	12.07%(±2%)	1.72%(±1%)

Q16

	It has been easy to obtain information	Information has been provided without delay	The information has been of high quality
Strongly disagree	07.00%(small sample)	03.50%(small sample)	01.80%(small sample)
2	21.10%(±10%)	19.30%(±10%)	17.50%(±9%)
3	50.90%(±12%)	52.60%(±12%)	57.90%(±12%)
4	12.30%(±8%)	17.50%(±9%)	17.50%(±9%)
Strongly agree	08.80%(±7%)	07.00%(small sample)	05.30%(small sample)

Q17

	0 to 10	10 to 100	100+
Average time spent on conduct concerns	42.22%(±14%)	48.89%(±14%)	8.89%(small sample)
Average time spent on performance concerns	51.16%(±14%)	37.21%(±14%)	11.63%(±9%)
Average time spent on health concerns	71.79%(±13%)	20.51%(±11%)	7.69%(small sample)

Q18

	0 to 10	10 to 100	100+
Average time spent on low-level concerns	70.73%(±13%)	26.83%(±13%)	2.44%(small sample)
Average time spent on medium-level concerns	46.51%(±15%)	32.56%(±14%)	11.63%(small sample)
Average time spent on high-level concerns	43.59%(±15%)	41.03%(±15%)	15.38%(±11%)

Q19

	0 to 1000	1000 to 10000	10000 to 100000	100000+
Percentage of doctors	47.50%(±15%)	20.00%(±12%)	20.00%(±12%)	12.50%(small sample)

Q20

Area	
Cost of inquiry or investigation	33.90%(±12%)
Cost of suspension	13.60%(±8%)
Cost of the decision-making	16.90%(±9%)
Costs of remedial interventions	13.60%(±8%)
Other	22.00%(±10%)

Q21

Yes	21.00%(±10%)
No	49.00%(±12%)
Don't know	30.00%(±11%)

Q22

Yes	38.00%(±12%)
No	62.00%(±12%)

Q23

Yes	33.00%(±12%)
No	67.00%(±12%)

Responsible officers' survey

Q1 and Q2

Organisation setting	
Primary care GP	10.10%(±3%)
Primary care community	01.80%(small sample)
Secondary tertiary care	33.80%(±5%)
Mental health	15.40%(±4%)
Public health	00.40%(small sample)
Medical education	03.50%(±2%)
Medical research	01.30%(small sample)
Industry	03.10%(±2%)
Other	30.70%(±5%)

Q3

0 to 10	10 to 100	100 to 1000	1000+
23.16%(±5%)	22.63%(±5%)	43.68%(±6%)	10.53%(±4%)

Q4

Yes	33.00%(±5%)
No	67.00%(±5%)

Q5

0 to 10	10 to 20	20 to 30	30 to 40
(86.17%(±4%))	(10.64%(±4%))	(2.66%(±2%))	(0.53%(small sample))

Q6

Yes	72.00%(±5%)
No	28.00%(±5%)

Q7

	The system provides access to the right data to support revalidation	The system is available at the right time and is reliable and easy to use
Strongly disagree	02.20%(small sample)	01.50%(small sample)
2	07.20%(±4%)	10.90%(±5%)
3	33.10%(±7%)	27.70%(±7%)
4	43.90%(±7%)	41.60%(±7%)
Strongly agree	13.70%(±5%)	18.20%(±6%)

Q8

	Cover the doctor's whole scope of work	Follow a structured and well planned approach that is relevant to the doctor	Make effective use of supporting information provided by the doctor	Are carried out in a supportive and responsive manner	Help to identify or refocus the doctor's need for professional development	Provide outputs that are of sufficient quality to meet your needs as the responsible officer
Strongly disagree	00.00% (small sample)	00.50% (small sample)	00.50% (small sample)	01.10% (small sample)	00.00% (small sample)	00.50% (small sample)
2	03.70%(±3%)	02.10% (small sample)	02.10% (small sample)	01.10% (small sample)	03.20% (small sample)	02.60% (small sample)
3	09.00%(±4%)	07.40%(±4%)	12.80%(±5%)	04.80%(±3%)	21.70%(±6%)	15.30%(±5%)
4	47.10%(±7%)	46.60%(±7%)	55.30%(±7%)	49.50%(±7%)	49.20%(±7%)	54.50%(±7%)
Strongly agree	40.20%(±7%)	43.40%(±7%)	29.30%(±7%)	43.60%(±7%)	25.90%(±6%)	27.00%(±6%)

Q9

	The requirement for revalidation will help strengthen and maintain clinical governance	The revalidation process will improve the standards of doctors' practice	The requirement for revalidation makes it easier to respond to concerns about patient safety and poor quality	Provide outputs that are of sufficient quality to meet your needs as the responsible officer	The quality of continuing professional development undertaken by doctors has improved since the introduction of	If appraisals are carried out well, they motivate doctors to aspire to the highest standards of practice	The requirement to consider patient feedback improves the standard of a doctor's	Appraisal is likely to help doctors respond to concerns at an earlier stage	Appraisals are a good way of improving a doctor's clinical practice
Strongly disagree	01.60% (small sample)	02.20% (small sample)	01.60% (small sample)	00.50% (small sample)	01.10% (small sample)	00.50% (small sample)	00.53% (small sample)	01.60% (small sample)	02.10% (small sample)
2	16.80% (±4%)	06.60% (±3%)	11.90% (±4%)	05.40% (±3%)	02.10% (small sample)	06.40% (±3%)	06.42% (±3%)	12.40% (±4%)	08.00% (±3%)
3	49.20% (±6%)	28.60% (±5%)	28.60% (±5%)	17.30% (±4%)	16.60% (±4%)	26.20% (±5%)	26.20% (±5%)	34.90% (±6%)	25.10% (±5%)
4	25.40% (±5%)	47.30% (±6%)	40.50% (±6%)	53.50% (±6%)	48.70% (±6%)	43.30% (±6%)	43.32% (±6%)	37.10% (±6%)	46.00% (±6%)
Strongly agree	07.00% (±3%)	15.40% (±4%)	17.30% (±4%)	23.20% (±5%)	31.60% (±5%)	23.50% (±5%)	23.53% (±5%)	14.00% (±4%)	18.70% (±5%)