

Public and Patient involvement in Revalidation: Assuring confidence in Revalidation

**Research conducted by Ipsos MORI and
The King's Fund for the RST**

9th March 2012

Legal notice

© 2012 Ipsos MORI – all rights reserved.

The contents of this report constitute the property of Ipsos MORI and the King's Fund.

Ipsos MORI retains all right, title and interest, including without limitation copyright, in or to any Ipsos MORI trademarks, technologies, methodologies, products, analyses, software and know-how included or arising out of this report or used in connection with the preparation of this report. No license under any copyright is hereby granted or implied.

The contents of this report are of a commercially sensitive and confidential nature and intended solely for the review and consideration of the person or entity to which it is addressed. No other use is permitted and the addressee undertakes not to disclose all or part of this report to any third party (including but not limited, where applicable, pursuant to the Freedom of Information Act 2000) without the prior written consent of the Company Secretary of Ipsos MORI.

Contents

Executive summary	5
Main research findings	5
Implications	6
Recommendations	7
Introduction	10
Background to the research	10
Aims and objectives	10
Methodology.....	11
Interpretation of qualitative data.....	12
Report structure	13
Confidence in doctors	15
Perceptions of doctors	15
What people want from their doctor	16
A focus on GPs	20
Understanding of current levels of oversight and regulation...24	
Knowledge of current practices	24
What should be happening?	26
A burden on doctors?	28
The case for change	31
Presenting the case for change.....	31
Immediate reactions.....	31
Training and appraisals.....	33
The system, not the doctor.....	34
Mixing private and NHS work.....	35
Revalidation.....	38
Presenting revalidation.....	38
Immediate reactions	38

Benefits of revalidation.....	40
Concerns.....	42
Next steps	43
Implications	46
Public confidence in revalidation	46
The design of revalidation processes.....	46
Implementation.....	47
Communication	47
Appendix	50
Discussion guide	50
Case studies	57

Acknowledgements

Special thanks go to the participants in London, Bristol, Birmingham and Sheffield who took part in the deliberative events on weekends. Thanks also to Dr Nick Lyons and Dr Chris Hewitt at the RST for explaining why the revalidation policy is being proposed and for presenting the policy itself, as well as Beryl Hodgson at the RST, and to our research partners at The King's Fund, Dr Anna Dixon and Claire Perry, for their vital input into the research design and this report.

Executive summary

Executive summary

Main research findings

There is consensus across all four locations where the work was conducted. This consensus is reflected in how participants currently view doctors, react to the case for revalidation and to the proposed policy itself. While there are some differences of opinion, the similarities are far stronger than any disagreement.

Perceptions of doctors

When thinking of doctors, most people envisage a GP, rather than, for example, hospital specialists or other kinds of doctors. Doctors are highly trusted and people are generally very positive about their doctor. They are seen as knowledgeable, professional and busy.

When asked what gives them confidence in doctors, participants assume doctors' clinical and technical skills are of the required level and focus instead on describing the soft skills. They want doctors to be good communicators, to understand and be familiar with their patients' needs and to be available and accessible.

Perceptions of oversight arrangements

Most assume and expect that some form of formal oversight for doctors already exists, as it does with many other professions. However, knowledge of what this process might be is limited. They envisage that this process involves peer review, patient feedback and some official third party – such as the Department of Health – ensuring a process that is consistently implemented across the medical profession and regularly enforced.

Participants believe that any system of oversight should be consistently applied across all doctors, regardless of their status, work environment or location. It should also take place throughout a doctor's career, ensuring they are up to date with new developments and providing the best care to their patients.

However, participants are clear that any oversight or regulation should not be a burden on doctors and detract from the already limited time they have to treat patients. Participants are acutely aware of the delicate balance between oversight being comprehensive and effective, while not creating unnecessary extra work for doctors.

The case for change

When the need for revalidation is explained to participants by representatives from the NHS Revalidation Support Team (RST), most participants are surprised that compulsory oversight of doctors does not already exist. The lack of such a system serves to undermine the confidence some have in doctors. That said, others are pleased that some form of oversight, in the form of appraisals, does exist, albeit voluntary and inconsistent.

Participants wish to see a system that is mandatory for all doctors and ensures continuous, career-long training and development for doctors. Particular concerns are raised about possible inconsistencies between NHS and private sector doctors.

Interestingly, the consensus view is that it is the system that is at fault, rather than doctors themselves, further reflecting the high levels of trust in and sympathy for doctors people have.

Revalidation

The proposed revalidation policy is generally very well received. Most participants find the policy relatively easy to understand and feel that it addresses their needs, expectations and concerns.

The inclusion of patient feedback within revalidation is met with particular approval. Participants are keen to stress that revalidation should be about helping support doctors and about encouraging them to improve, rather than a system for “weeding out” failing doctors. They feel that it will be of most benefit to non-hospital doctors, operating in less structured or well-supported environments, especially locums.

However, despite a broadly positive reception, some concerns are raised. In particular, participants are keen to avoid creating a bureaucratic burden for doctors, taking time away from treating patients. They question the cost of introducing revalidation, being aware of the financial constraints on spending in the current economic climate. Participants are also keen to be reassured about the independence of the process.

Implications

Given the general enthusiasm for the proposed revalidation policy and yet the surprise at the lack of any formal and compulsory process being in place already, participants feel that the introduction of revalidation should be pursued with some urgency. However, the introduction

of the process should be carefully considered when addressing the non-existence of a prior process.

It should be emphasised that revalidation is designed to support and improve all doctors, regardless of their experience or working environment, across the NHS and the private sector.

In the view of the public, revalidation must be a lean and efficient process that does not overburden already busy doctors or detract from the time they spend treating patients. It should be promoted as a supportive process of quality improvement rather than as regulation.

The process should be about improving the soft skills so valued by patients, as well as the clinical expertise that most people take for granted from their doctor.

Finally, assurances of impartiality must be given. Doctors undertaking appraisal must be seen to be free of conflicts of interest and the process supported by evidence.

Recommendations

The recommendations arising from this study are:

- *The timetable for implementation should not be interrupted. A plan for public information that these processes are being implemented would provide reassurance*
- *Revalidation processes need to assure the public of all doctors' skills, not just clinical knowledge.*
- *Clear processes for managing the outcomes of revalidation need to be outlined and communicated*
- *The processes need to be demonstrated to the public as being efficient and not creating significant time pressures or bureaucratic burden*
- *Revalidation processes must assure or improve quality of practice regardless of the work environment or organisation*
- *An assurance of impartiality must be an important part of the revalidation process.*
- *Any communication about revalidation must be careful not to undermine the existing high levels of trust and confidence in doctors*

- *It needs to be made clear that the processes apply equally to doctors in all settings of practice, whether general practice, hospital specialists or private sector*
- *'Regulation' has negative connotations, being associated with the extra burdens on doctors participants are keen to avoid, whereas 'quality improvement' does not*
- *There is a need to evaluate the costs and explain how revalidation is funded*

Introduction

Introduction

Background to the research

This report presents the findings from a qualitative study assessing opinion on the proposals for the revalidation of doctors among the general public, in advance of approval and funding for revalidation in summer 2012. This important issue was explored through a series of deliberative events with members of the public in January and February 2012. The study was conducted by Ipsos MORI and The King's Fund on behalf of the RST. The King's Fund acted in an advisory role, offering insight and expertise into the research design as well as the analysis and presentation of the findings. This report has been jointly authored by Ipsos MORI and The King's Fund.

Revalidation is a new way of regulating doctors due to be implemented in late 2012. It will be based on effective annual appraisals, with supporting information that includes patient and colleague feedback, and means that every five years the GMC will require a recommendation that a doctor is up-to-date and fit to practise according to the guidelines set out by Good Medical Practice¹.

Aims and objectives

The primary purpose of this project is to test out with the public whether the proposed model of revalidation will give them greater confidence in doctors' fitness to practise than the current procedure. A secondary purpose of the project is to inform the NHS Revalidation Support Team how revalidation will be effectively communicated to the public, patients and carers.

Therefore, the key research objectives of the revalidation study are to:

- Assess the public's knowledge of how doctors are currently regulated;
- Help the public to understand the proposals for revalidation from late 2012 and how these differ from current arrangements;
- Explore the terminology used by the public to talk about revalidation;
- Assess whether proposals for revalidation in England are likely to give public, patients and carers greater assurance and confidence that doctors are up-to-date than the systems currently in place.

¹ http://www.gmc-uk.org/guidance/good_medical_practice.asp

Methodology

A qualitative method was adopted for this study to allow participants to explore their responses to how doctors are kept up to date and fit to practise. A deliberative approach was chosen. This approach allows greater opportunity to reflect on the issues being discussed than is possible using other methods, such as shorter qualitative approaches or, indeed, quantitative methodologies.

Four workshops were conducted in London, Bristol, Birmingham and Sheffield, with around 40 participants in each.

Location	Date
London	14 th January 2011
Bristol	28 th January 2011
Birmingham	4 th February 2011
Sheffield	11 th February 2011

Recruitment

Participants were recruited on-street by experienced Ipsos MORI recruiters. The profile of each event was chosen to be broadly reflective of the socio-demographic profile of the local population. Each group also contained a representative proportion of those with long-term conditions and recent experience of using health services.

Event structure

Participants arrived at the start of the day without prior knowledge or information about the revalidation policy. This approach allowed us to elicit participants' uninformed views at the beginning of the research, allowing us to explore what people expect from doctors, how people absorbed the information and which information influences their opinions.

Upon arrival at an event, participants were split into 5 separate discussion groups, of around 8-9 people each. Participants were divided into groups broadly according to age.

Each event lasted for 6 hours, allowing participants enough time to express their views about the following issues:

- What people want from doctors and what gives them confidence in doctors;
- What they know about current procedures that ensure doctors are up to date and fit to practise, how they think doctors should be regulated;
- An explanation on the current model of assessing fitness to practise, with participant reactions and case studies on specific doctors;
- An introduction to the proposed revalidation process, reactions to the policy, and how revalidation may influence the confidence participants have in doctors.

Information about the current approach to doctors' appraisals and the revalidation policy itself was presented in person by representatives from the RST.

The discussion guide used at each event can be found in the appendix to this report.

Case studies

There were four distinct case studies, each presenting a different type of doctor and a different scenario.

1. GP Locum
2. Hospital doctor
3. GP in a small practice
4. Hospital specialist with private practice

The case studies were designed to provide illustrative examples of the varying levels of oversight applied to doctors. This helped to provoke participants into comparing different approaches and their views on the pros and cons of each, what they felt could be done differently or better, and what aspects within each scenario increased or decreased confidence in doctors. Each case study also included examples of how revalidation would change the level of oversight. The full case studies can be found in the appendix at the end of this report.

Interpretation of qualitative data

Unlike quantitative surveys, qualitative research is not designed to provide statistically reliable data on what participants as a whole are thinking. It is illustrative rather than statistically reliable.

Qualitative research is intended to shed light on why people have particular views and how these views relate to the experiences of the participants concerned. The deliberative forum used here enables people to participate in an informal and interactive discussion and to allow time for the complex issues to be outlined and addressed in some detail. It also enables researchers to test the strength of people's opinions. This approach, in other words, facilitates deeper insight into attitudes compared to the more "top of the mind" responses elicited by quantitative studies. It is important to bear in mind that we are dealing with perceptions rather than facts, although to participants these perceptions are facts.

Anonymous verbatim comments made by participants during the discussions have been included throughout this report, attributed by location and age range. These should not be interpreted as defining the views of all participants but have been selected to provide insight into a particular issue or topic.

The report also incorporates "word clouds" to visually represent the frequency and strength of responses to certain issues or information.

Please note that one structured closed question was asked of all participants at the end of each event. Each participant was asked the extent to which they agreed or disagreed with the following statement: *The process proposed would give me more confidence in doctors.* Results can be found in the "Revalidation" chapter of this report.

Report structure

This report follows the same outline as the deliberative events themselves. First, it explores the extent to which people currently have confidence in doctors and why, before moving on to examine what systems and structures people believe exist to ensure doctors are up to date. Next, the report details participants' responses and reactions to the current situation and the reasons why revalidation is being introduced. Finally, participants' views on the revalidation policy itself are outlined.

Confidence in doctors

Confidence in doctors

This chapter outlines what people want from their doctors. It explores the spontaneous associations people have with the profession, what makes them think this way and what gives them confidence (or not) in their doctors.

Perceptions of doctors

The public have high levels of confidence in doctors. The Ipsos MORI Veracity Index² regularly shows that doctors are the most trusted profession. The findings from the revalidation deliberative events reflect this perception.

Participants were initially asked what words and ideas they associate with ‘doctors’. The word cloud below (figure 1) presents the responses participants gave.

Figure 1: The words participants associate with doctors



As this word cloud demonstrates, participants are largely highly positive about their doctors, highlighting the good things doctors do. It seems likely that these positive associations are closely linked to the trust the public have in doctors.

² Trust in Professions 2011: <http://www.ipsos-mori.com/researchpublications/researcharchive/2818/Doctors-are-most-trusted-profession-politicians-least-trusted.aspx>

When asked what words and phrases they associate with doctors, participants stress four key themes:

- **Knowledge** – doctors are strongly associated with expertise and technical competence, gained through working for their qualifications.
- **Professionalism** – doctors are regarded as highly professional, well-trained and seen to abide by a strict code of confidentiality and discretion.
- **Communication** – people see communication skills as central to a doctor's role, though they find that some doctors are better at this than others. People stress various aspects of communication, stressing the importance of listening, a good bedside manner and being sympathetic.
- **Busy** – participants believe doctors are very busy and they are acutely aware that being a doctor can be a demanding and stressful career.

While most participants are positive about their doctor, there are others who suggest that doctors can seem unsympathetic to their patients. Participants feel doctors can sometimes seem dismissive of patients' concerns, failing to engage with patients during appointments and appearing unsupportive to some. That said, even this negative perception is typically linked to participants acknowledging that this may be due to doctors being very busy and that it can be a stressful profession.

What people want from their doctor

When discussing what would make them confident in their doctor, participants' responses emphasised three key themes, as the language depicted in the word cloud below (figure 2) indicates:

- *Communication*: both the doctor's ability to listen and explain.
- *Familiarity*: the relationship participants feel they share with their doctor – the sense of sharing knowledge.
- *Availability*: both seeing and feeling they have enough time with doctors.

These three themes are explored in more detail below.

Figure 2: What people expect from their doctor



When asked about what people want from their doctor, almost all participants stress their need for doctors and healthcare to be *easily available and accessible*. They want to be being able to see a doctor when they want. Beyond this, the most common theme among all participants is the emphasis they place on the importance of *soft skills*, such as listening, empathy and familiarity, to giving them confidence in their doctor. It is noteworthy that participants tend to focus on the importance of such soft skills at the expense of technical expertise. They assume doctors are *technically competent*, trusting them to possess the knowledge and expertise that qualify them for the job. Though discussions were dominated by themes such as empathy, communication, being personable, participants' confidence is backed up by an underlying faith in a doctor's technical ability and qualifications.

I have an assumption that a doctor will be qualified – I just assume that. Tied in to that is a compassionate and sympathetic attitude

Sheffield, 50-60

Communication

Participants need for doctors to have a compassionate and sympathetic attitude is clear. They stress that this can be demonstrated by doctors through their communication skills. For example, participants often explain how a doctor's mannerisms and attitude are important in instilling confidence in them. Participants are confident in doctors who demonstrate that they care and who make the patient feel at ease by being friendly and personable. This includes

being engaging, eye contact, and facing the patient during appointments rather than a computer screen.

It's their attitude; whether they make you feel comfortable, relaxed, whether they're sincere with you

London, 30-40

In particular, almost all participants have confidence in doctors who listen to them and demonstrate that they have understood the patient's perspective by responding to their problems with clear explanations and appropriate treatment options. Without this sense of engagement, confidence is undermined. For example, writing a prescription, without discussion with a patient, can result in a sense that they have not been listened to or that their problem has not been dealt with in sufficient detail.

If you feel that the doctor has heard what you have said then you feel good about the visit, and have more confidence in both the doctor and the treatment. If the doctor just offers you standard things and just one thing, it isn't personal

Bristol, 18-30

Specifically, there is a common feeling that patients' confidence in their doctor is enhanced by being informed about what treatment involves and by doctors providing explanations that can be easily understood, without using too much technical language. The use of jargon can distance patients from their doctor. The doctors that patients have most confidence in are those that avoid using highly technical terminology, put things in layman's terms that can be easily understood, thus offering advice simply and effectively.

I like my doctor to share their knowledge and not blind me with jargon. I think good doctors can do that, they can share their knowledge, they're not pretentious. I think bad ones can't do that, they just make you feel anxious

London, 40-50

Another common theme emphasised by many participants is that patients want to feel like they are not being talked down to by their doctor but, rather, consulted as an equal. The sense of being able to consult closely with a doctor, to feel that they have some input into their own care, is central to a patient's ability to have confidence in their doctor and the treatment provided.

Doctors shouldn't talk over you or past you, but talk to you as a person

Birmingham, 60+

Familiarity

Many participants stress how their confidence in a doctor is increased if their doctor is familiar with their conditions and medical history. Similarly, others also suggest confidence is supported by patients having some degree of familiarity with their doctor. It is important to a patient's confidence in a doctor that they feel they know one another well, that a doctor knows the patient's medical history, and that there is a personal – but still professional – relationship between the two. The rotation of doctors and the lack of continuity this creates often makes participants unhappy. It undermines the confidence in the patient-doctor relationship. Participants have more confidence in doctors that they know well and with whom they have a shared history and experience.

You want to find some kind of common ground; not be observed and treated like a thing. The personal touch is very important

Bristol, 18-30

I sought out and registered with a true 'family doctor' – for myself and my two daughters who are doctors - to get the idealised patient-doctor relationship we all wanted but didn't feel we had

London, 30-50

Availability

Almost all participants want to have more time with their doctor during appointments. Patients want to feel that a doctor is not rushing through an appointment and that they are being afforded the appropriate care and attention. A sense of giving patients the time they want is transmitted by doctors through body language and engagement with their patients. Participants frequently emphasise that they do not want to feel their doctor is rushing through an appointment as fast as possible. They want to feel that their care is being taken seriously.

I do want their time. I don't want them to be rushing. I need them to make me feel that they're not going to be rushing

London, 40-50

However, all patients are aware of how acutely busy doctors are. There is widespread awareness that doctors have many patients to see and that their time is necessarily limited. This sense of doctors being overworked is central to the sympathy that patients have with

doctors and tempers any frustration that they are not always afforded the time and attention that they would prefer. There is a sense among some participants that they do not always get the most appropriate treatment and that the prime reason for this is the time pressures and workload faced by almost all doctors.

Doctors are under pressure and overworked – they're nice people but you only have 2 minutes with them

Bristol, 30-40

They're too stretched. They give you a pill and send you out the door

Bristol, 30-40

A focus on GPs

When asked about doctors, participants tend to focus on GPs rather than discussing other types of doctor, for example hospital doctors. Participants tend to have less experience of hospital doctors or of locums, for example, and so find it more difficult to spontaneously discuss these sorts of doctors without a great deal of prompting. Expectations of GPs and specialists do differ. Therefore, many of the perceptions outlined in this report are typically filtered through the prism of what people think of their own GP. However, there is considerable overlap on the key themes when direct comparisons are made between different types of doctor.

Hospital doctors

When asked specifically about their confidence in hospital doctors, many participants suggest that they have more *specialised knowledge*, assuming it is one focussed on a specific area, and therefore more expert and technical than a GP's. Conversely, participants imagine GPs have a more general overall knowledge of medical conditions, wider in range than a specialist's. The specialised knowledge of hospital doctors both increased expectations of these doctors and, in some cases, increased confidence in them.

I'd give less leeway to a doctor who was a specialist or in a hospital setting. I'd expect more expert knowledge. With general practitioners, it's a wider range of knowledge

Bristol, 18-30

You think differently of hospital doctors – you expect more in hospital, higher qualifications

Birmingham, 25-50

GPs

When discussing GPs, participants generally place more emphasis on the importance of *soft skills* in contrast to when discussing hospital doctors. People are confident in a GP with whom they have a personal relationship and rapport. Indeed, this closeness is expected of their GP by many participants. On the other hand, they are confident in the specific technical skills and medical expertise that they expect from a surgeon in a hospital, for example, without demanding the same level of empathy.

I have a rapport with my GP. In hospital, you are just a name and number, they see you as a symptom. They lack bedside manner. You don't get same respect in hospital

Birmingham, 25-50

With my surgeon I didn't care about how sympathetic he was, I cared about how steady his hand was

Sheffield, 50-60

In reference to a GP's more generalised knowledge, participants also emphasise the positive impact on patient confidence of a doctor's readiness to research into their condition. Some participants, though not all, appreciate it when their GP admits that they are not sure about something and need to consult further with colleagues or refer to other sources of information.

The willingness to look up what's wrong with you inspires confidence – it doesn't matter if they don't know about it, as long as they're willing to check

Sheffield, 50-60

GPs don't know about specialisms. If he's out of his depth he'll refer you to a specialist. It's about knowing your limits

Bristol, 60+

Similarly, most are happy to be referred on to specialists if needed. Seeing GPs as the first point of call, on the 'front line' of medical care and treatment, patients expect to be referred when necessary.

GPs need to be able to filter between what they need to do themselves and when they need to refer on. Identify medical problems and refer on

Birmingham 60+

However, this should not be seen to be an open invitation to referral. Although patients do not expect their doctors to have infinite knowledge, and want their doctors to be open minded, there are limits to how far they will tolerate this without it affecting their confidence in a doctor. Continual referral or consultation with other information sources can affect patients' faith in a doctor's capability and qualifications. As we have seen, the public assume a certain level of technical expertise and knowledge from doctors but this can be undermined if not regularly demonstrated.

My partner won't go the GP anymore. He kept going and all the doctor did was Google it, so he refuses to go now. He can't trust them, if they've been through years of study and then they have to Google it

Sheffield, 20-30

Understanding of current levels of oversight and regulation

Understanding of current levels of oversight and regulation

This chapter reports on participants' awareness of how a doctor's fitness to practise is currently assessed. It also details the expectations patients have of how to ensure the things that give them confidence in doctors are in place.

Knowledge of current practices

Although participants often focus on their experience and expectations of doctors' soft skills, they do want reassurance on doctors' medical competence. They assume that there is a system in place to ensure that doctors are up to date and fit to practise, although they are not able to say exactly what this system involves.

Participants do not have much awareness of what procedures currently exist to ensure doctors are up to date. However, they *do* assume that procedures are in place to identify a doctor's fitness to practise. Yet there is also a sense of a lack of transparency to these processes. That is, there is a feeling that there is insufficient information available to the public. Few know where they might find out about how the medical profession ensures doctors are up to date and caring for patients appropriately.

Is there any sort of corrective action procedure?

London, 50-60

Does it currently happen? I imagine it all does, but it's not transparent enough. We don't know it happens, and we wouldn't know who to go to, to complain

Bristol, 40-50

Participants are broadly aware of the concept of appraisal systems and professional development. Many of those in work have direct experience of this from their own careers. However, their knowledge of how this applies, or might apply, to doctors is very limited. Drawing on either their own experience, or awareness of systems in other sectors, such as for police, pilots and teachers, they assume a system of review is in place. That is, doctors will be subject to a system of continued professional development, just like other professions in positions of responsibility.

We expect uniform standards of service from the police – so why not doctors?

London, 30-50

I suspect there is some kind of continual professional development. Architects have to clock a certain number of hours training and demonstrate that they are keeping up with new trends. I think it's widespread in a lot of professions. I would presume doctors do this

Bristol, 18-30

It should be like Ofsted for schools - there should be something like this in the medical profession

Birmingham, 25-50

What does oversight look like?

Participants are willing to speculate on what the system may look like, drawing either from their own experience of appraisal systems or knowledge of medical authorities. Knowledge of healthcare structures is patchy, many mention the Department of Health and some suggest Primary Care Trusts (PCTs), far fewer reference the General Medical Council (GMC), for example.

While knowledge is low of specific oversight processes, many participants feel that their experiences as patients *imply* that some monitoring and development procedures must exist at the moment. For example, some suggest that new developments in medicine must be introduced to doctors in a systematic manner. Alternatively, others are aware of a complaints system and of doctors being struck off. The vague awareness of instances like these leads participants to assume that there is a system of appraisal and oversight in place. They further assume that such a system will be consistent and comprehensive.

Doctors are struck off if they make bad mistakes. If a doctor makes errors and kills patients they are struck off the list

Bristol, 60+

There must be – for example with micro-surgery, people must be trained in it otherwise it wouldn't be done. So there has to be re-training going on

Sheffield, 50-60

What should be happening?

Continuous learning and development throughout doctors' careers is highly valued by patients. The assumption that this already happens is an important factor underpinning people's confidence in doctors. Participants particularly want their doctors to be up to date in their medical knowledge and assume there is continual and compulsory training of doctors.

They should constantly upgrade. There are lots of new things coming out all the time, so doctors should update themselves

London, 30-40

For any medical professional there should be continual training. It should be compulsory. It should be the government that rules to make sure that this is done

Birmingham, 60+

Overall, participants think any system of professional development should have three key elements; doctors, patients and an independent body.

- **Doctors:** People recognise doctors themselves should be involved, particularly to provide feedback on clinical aspects of a doctor's work and to mentor junior doctors.
- **Patients:** Patients want their opinions to be heard and are especially keen for the profession to monitor patient satisfaction with the services doctors provide to them.
- **A third party:** An independent body should exist to review the overall process, ensure compulsory training, or feedback on non-clinical aspects of the health service.

To provide patients with confidence in doctors, any system of oversight should be a combination of these different perspectives.

It should be a range of people: The Department of Health, other doctors and patients as well. Patients can feed back on peers. Senior doctors can appraise medics and the Department of Health can appraise administration and management. This is how it should be.

London, 18-30

The ideal approach to inspire confidence in docs? Peer assessment, refresher training, patient feedback

Bristol, 18-30

Patient feedback

While recognising that other factors are important, patient feedback is seen as vital – participants want to know that patients have a voice. In particular, participants feel that there should be opportunities to easily feedback, complain and comment on their doctors. They feel the use of patient feedback will ensure objectivity, and provide a valuable critique of the soft skills that are considered so important.

Doctors should attend groups like these, with patients directly feeding back to doctors

Bristol, 18-30

There has to be a lay person to assess personality skills – from our point of view, not their [doctors'] point of view

Sheffield, 50-60

Participants also see the ability to log complaints against a doctor as particularly important. Participants want to know there is an independent body they can complain to, and moreover have clearer instructions on how to make a complaint.

I think it keeps the doctors on their toes if they know that we can complain to a public body

London, 40-50

Independent oversight

Importantly, most participants want to ensure the entire process of ensuring doctors are fit to practise is independent and objective. This can be achieved through some kind of external body overseeing doctors' appraisals and development, and ensuring patient feedback is used. There is a concern that close professional or personal relationships between those being checked and those doing the checking could result in a lack of the objectivity required to honestly assess a doctor's performance and behaviour.

Being appraised by another doctor may be difficult, they are their peers so it could be biased

Sheffield, 20-30s

It should be objective. It could work if the practice manager appraises the doctors and then there is an independent person they go to; someone to review the managers'

appraisals. So doctors are appraised by managers and then the practice is reviewed by an independent body

Sheffield, 20-30s

There are mixed views on which authority should provide oversight. Most suggest the Department of Health, while the few who are aware of it suggest that the GMC should be included. However, many question the impartiality of such organisations, especially those organisations that are closest to doctors and may have a vested interest in doctors' reputation. Therefore, some argue for an organisation that is separate from the medical profession and propose an entirely new body. Though participants tend to be unclear about what or who this body may be, they recognise that medical expertise would be necessary in this role.

Department of Health should be doing it. Someone needs to oversee it and see that the right people get the right information

Sheffield, 20-30

I think it should be a separate body, not the GMC – they're too in with the doctors, they are doctors. It's like the police investigating the police, it looks a bit insidious?

London, 40-50

A burden on doctors?

As we have seen, participants perceive doctors to be very busy. Therefore, it is generally felt that any process for ensuring doctors are up to date should not overburden doctors with too much paperwork. Recognising that doctors are already stretched, participants are concerned that any system of oversight may take up too much of their time, or more importantly sacrifice time they could be spending with patients. Participants feel a balance therefore needs to be struck between confidence that doctors are being overseen and managed correctly, while not overburdening them with extra work that detracts from the care and treatment provided to patients.

You don't want them all going out and leaving the practice, it's a time burden and will have a knock-on effect on the patients. This would involve lots of paperwork, you don't want them to stop being doctors

Birmingham, 25-50

The frequency with which participants believe training and oversight should be taking place varies. Participants want doctors to be up to date and checked regularly, but recognise that there is a trade-off between achieving this and time taken away from patients. Most agreed it should be assessed around every 2-5 years.

I think they should be examined every 3 years or so about general medicine, to make sure they keep up to date

Bristol, 18-30

2 years: If you make it shorter than 2 years you're increasing the burden, longer is too long – it's difficult to set a time limit

Sheffield, 50-60

Some, though not all, believe that the results of any process of oversight should be available to the public in some form. Patients not only want to know that doctors are being overseen, but in some cases want some kind of visible proof that their doctor is qualified and up to date. This could take the form of a certificate on display in the doctor's surgery, or an easily accessible and searchable database of doctors with a record of their qualifications and appraisal outcomes.

I would like to see a certificate on the wall so you can look at that certificate and see that they've been qualified

Birmingham, 50-60

In hospitals you can go online and rate your doctors – you can choose hospitals according to specialty. There should be more of this on GPs – a star rating which you can access online

Bristol, 30-40

The case for change

The case for change

This chapter explores participants' reactions to the reasons why revalidation is being introduced. It begins by outlining how the current processes were presented to participants, before moving on to look at their immediate responses and, finally, looking at how participants reacted to the case study examples.

Presenting the case for change

Dr Nick Lyons and Dr Chris Hewitt from the RST presented the "case for change" at each of the events, outlining the current system of ensuring that doctors are up to date and fit to practise. Their presentations explained the following:

- The GMC keeps register of licensed doctors;
- There is ongoing continuing professional development per year for licensed doctors, although this is not mandatory;
- The GMC is the regulatory authority and is able to remove a doctor's registration in cases where the doctor is shown to have serious performance issues
- Annual appraisals exist and are undertaken by many doctors, though these are not compulsory for all doctors nor is there a consistent format for these.

Immediate reactions

Reacting to the "case for change", participants are surprised that there is currently no mandatory process to ensure doctors are up to date, despite varying degrees of coverage around the country. The voluntary nature of the current system is what participants comment on immediately, to which they express surprise, shock or worry. The word cloud below (figure 3) shows the language participants use in their immediate reactions to the case for change.

Figure3: responses to the case for change



Reactions vary in strength, from simply being puzzled but accepting to being shocked. Almost all assumed or expected that something was in place to manage this.

Generally, younger participants tend to be most surprised or alarmed. Older participants are more trusting of doctors' abilities and so tend to be less surprised and more accepting of the information. This is the only significant distinction between participants that can be identified from these deliberative events. Having in place some system for checking that doctors are fit to perform their duties is simply felt to be common sense. The lack of such a system acts to potentially undermine the confidence some have in their doctor.

That's scary, that makes me really not want to go to the doctor

Sheffield 18-25

It's good that there are some appraisals. It's very vague though – needs to be compulsory – it's absurd that it's not

Bristol, 30-40

People are most concerned by the voluntary nature of the current processes. They feel that any system must be consistently applied, as it is in many other professions. Furthermore, it becomes particularly apparent at this stage that there is a sense among many people that doctors see themselves as above "normal" standards. Through doctors avoiding the obligations that many feel should be central to their professional standard, participants' confidence is undermined.

Doctors feel they're superior to appraisals – they're too good for it. High arrogance level

Bristol, 30-40

Doctors can get by by doing “the bare minimum” of their profession and still have no consequences

Bristol, 18-30

However, the fact that some form of appraisal system, albeit inconsistently applied, is in place, is a reassurance to some participants. While not compulsory for all doctors, at least there is a process allowing for doctors being appraised sometimes. However, in some cases participants would have liked to have known that this was happening, with this knowledge serving to increase their confidence in doctors.

Half of the things you think should be happening are happening. You do feel a bit more reassured that these things are in place

Birmingham, 50-60

While glad that there is some system, applying this more consistently is of paramount importance to participants. As the word cloud of figure 3 shows, the most common reaction to the case for change was surprise that the existing systems of oversight are voluntary. The lack of consistency – regardless of status, specialism or location – worries participants, suggesting to them that there is no way of discerning whether their own doctor is subject to oversight or not.

It's good that there is a system – but it's too bitty; depending on area. The NHS standards should be the same across the board and this is why it's criticised; because there's no consistency

Bristol, 30-40

Training and appraisals

When critiquing the current situation, participants focus on two key aspects that they feel are lacking and need to be improved: the lack of ongoing training and the lack of consistency in appraisals.

As discussed earlier, people feel that continuous, career-long training is vital to a doctor's role and to them having confidence in doctors. It is essential that doctors attend training, with participants offering the following issues as examples:

- Training on new drugs;

- Training in new or alternative techniques for tackling illness and disease, such as the holistic approaches to medicine and counselling;
- Training in new skills such as keyhole surgery;
- Training in breakthroughs in medical science; and
- Training in dealing with contemporary social problems like the use of 'legal highs' and teenage drinking.

I thought it would be mandatory for them to do training every year. I was very surprised to find that out it wasn't

Sheffield, 30-40

I just think he needs to go to these training sessions. That needs to be in place that you have to go

London, 40-50

Similarly, participants generally agree that a system of appraisal whereby doctors are regularly assessed for their knowledge of new treatments and drugs is important to their having confidence in a doctor. Most accept that someone with clinical knowledge would be best placed to do this, and thus agree that doctors need to be involved in the appraisal of other doctors. They would prefer a group of doctors doing this rather than an immediate colleague who may be too close to the doctor being appraised.

I think it comes back to examining again. He needs to go to a board every so often and be appraised with more than one person. Not one doctor telling him how good or how bad he is but several doctors

Bristol, 60+

The system, not the doctor

Exploring the case studies in detail, participants are concerned that the system is failing doctors, rather than the other way around. People acknowledge that doctors are extremely busy, that some are isolated and lack a support network, or opportunity to develop in their career. Participants consequently feel that doctors need more support to keep up to date, and develop in their careers, than they currently get.

In particular, this perception is highlighted by the case study about the GP locum. While the case study does not suggest that this is a 'bad' GP, participants express concern that he may not be able to keep up to date and lacks a support network that could provide advice and

assistance. Indeed, many feel that, with the right structure in place around him, they would have more confidence in the locum.

With regular training he can become a very good doctor because he has all the skills. But he's being let down by the system because there is no regular training that is built into his career path

London, 40-50

Participants contrast the locum with the case study of the hospital specialist. The latter is seen to have far greater support and a much more organised and tightly managed environment. In this way, the system is in place to allow the hospital specialist to make the most of their abilities.

I'm not surprised that there's more structure in a hospital – GPs/locum GP is harder to manage; this makes sense that it's more rigid. Hospitals are more business-like – you have management teams

Bristol, 30-40

It's very organised, consistent. A clear plan, if they follow this we'd have the ideal situation. There's a proper plan, a proper career path. It's how you'd love your organisation to be

London, 40-50

Mixing private and NHS work

The case study about the hospital specialist who also works in a private practice highlights participants' concerns about the split between private and public healthcare. There is some suspicion of the extent to which a private organisation would employ the same standards as the NHS. Participants are therefore concerned about a lack of consistency between the NHS and the private sector or for doctors working across multiple organisations.

If the NHS has standards, the private sector should have exactly the same standards – it doesn't become a different job in the private sector

Sheffield, 50-60

They should be more regulated in private practice because it's easier for them to slip under the radar. They work for a single institution which is not accountable to any

other institution. At least in the NHS you will eventually be picked up on the radar and someone will swoop on you

London, 40-50

However, participants question how the desired consistency would be enforced, and are sceptical about the amount of communication that would take place between public and private organisations. Particularly they fear that the NHS would be reluctant to ask questions about a doctor's activities within a private setting, and vice versa.

I'm surprised that there's no communication with the NHS hospital. This is the most frightening of the lot. There's no regular feedback.

London, 40-50

Indeed, the case study of the hospital doctor with a private practice (case study 4, see Appendix) allows participants to reiterate their central concern – that an appraisal system should be consistently applied to all doctors, regardless of professional status, area of specialism or geographical location.

This shows why appraisals need to be compulsory whether they're in the private sector or not. Early on she was very, very good. I think she sounds as though she's over extended herself. It doesn't seem right that you should be able to do that much.

Birmingham, 60+

Revalidation

Revalidation

This chapter outlines participants' reactions to the proposed revalidation policy – immediate reactions, consideration of the pros and cons, and a sense of how the policy might be developed over time.

Presenting revalidation

As with the “case for change”, Dr Nick Lyons and Dr Chris Hewitt from the RST presented the revalidation policy itself at each of the events, explaining how things will be different under the new system and what patients can expect from it. Their presentations included the following:

- The introduction of compulsory annual appraisals;
- An explanation of the role of the Responsible Officer;
- The use of patient feedback;
- A reiteration of revalidation being driven by the need to ensure patients can be confident in doctors.

Immediate reactions

Importantly, understanding the proposed revalidation concept is straightforward for most participants. Those in work, in particular, are familiar with appraisal systems from their own professional lives. This makes them particularly positive about the introduction of the process.

I'd love to see it implemented... it would be a dream

Bristol, 18-30

In responding to the presentation about the proposed policy, it is apparent that most participants are happy that revalidation is being introduced. They approve of the way it covers many of the areas they had previously highlighted as being desirable, such as continuous professional development and mandatory appraisals. Indeed, some express surprise that the proposed system is as thorough as it is. That is, participants feel

revalidation will be rigorous and demanding of doctors, meeting their expectations of what could or should be happening already.

As discussed in previous chapters, participants want a compulsory system of oversight that is applied consistently to all doctors. They want it to include regular appraisals, mandatory training, feedback from patients, and feedback from other clinicians. They want it to take place with a frequency that will not overburden the doctor but at the same time ensure thoroughness. Finally, participants want any system to be independently monitored by someone unconnected to the doctor in question.

I'm quite pleased, I feel that my mind has been put at rest about quite a lot of issues

Birmingham, 50-60

It's a good thing. I'm surprised that they would go that far. It seems like they've gone further than I would expect them to go. They seem to be being a lot more investigative of the doctors than I would expect

Birmingham, 40-60

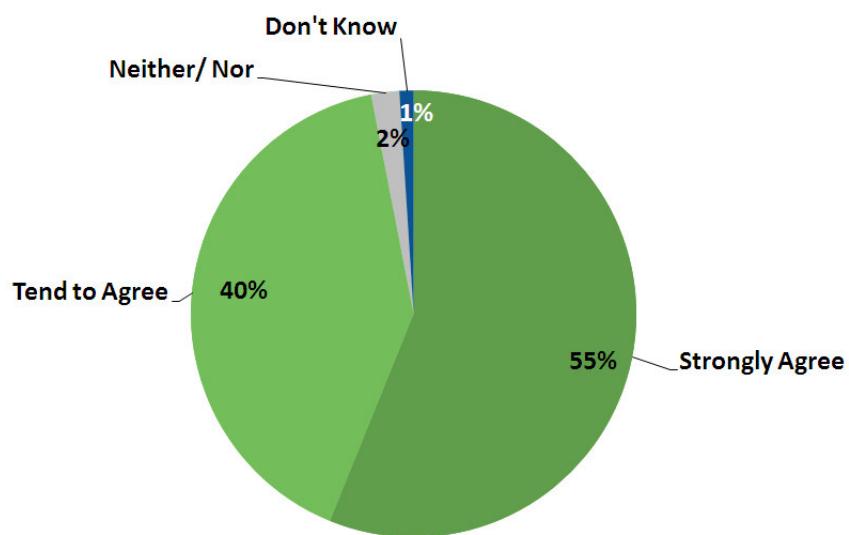
Near universal approval

Despite some disquiet over the current lack of any compulsory and consistent system to appraise doctors, the proposed introduction of revalidation is almost universally welcomed. When asked, nineteen in twenty participants (95%) agree that the proposed system would give them more confidence in doctors³. Though the *strength* of agreement varies across the country, the proportion of participants who express some form of agreement barely changes from city to city.

³ At the end of the session participants were asked the following question: 'To what extent do you agree or disagree with the following statement? *The process proposed would give me more confidence in doctors'*

Figure 4: revalidation increases confidence in doctors⁴

Revalidation will improve my confidence in doctors



'To what extent do you agree or disagree with the following statement? The process proposed would give me more confidence in doctors'.
Base: Total 137 (Birmingham 26, Sheffield 38, Bristol 37, London 36)



Benefits of revalidation

Participants find it easy to identify the benefits they expect revalidation to provide. They are especially pleased that it will incorporate patient feedback which, as we have seen, is important to people feeling that they have a voice in the process.

At the end of surgery, just do a little feedback form. Anonymously. So it will ask you how you've been treated in your hospital stay

Birmingham, 60+

Revalidation is seen as progressive move by most. They feel it will provide patients with reassurance that doctors are subject to proper oversight, something they had, as we have

⁴ Please note that the sample of participants asked this question is not nationally representative in demographic terms. Furthermore, they have been exposed to a great deal of debate and information about the proposed revalidation policy. Therefore, the findings outlined in Figure 4 are not easily generalised to the wider public in England.

seen, expected to be in place already. Furthermore, participants stress that revalidation should be a supportive process that enables doctors “to be better doctors”, offering them encouragement and support, rather than a bureaucratic barrier preventing doctors from treating patients. They want it to act as an incentive for doctors to be better at their jobs, and an opportunity to improve their work, rather than a system of “finger pointing” and punishment.

It's a step in the right direction so long as it doesn't become burdensome as regards paperwork

Birmingham, 40-60

Maybe there should be more carrot. The only appraisals I ever felt got me anywhere at work were the ones where I walked out feeling reasonably good about myself at the end. The carrot doesn't have to be money, maybe just recognition. Or top people saying “well done.” I think that goes a long way

London, 30-50

For most, revalidation is felt to be a positive process of encouraging doctors and improving the care they provide to patients, rather than trying to “weed out” those who are failing. Participants generally feel revalidation should be about enabling the development of doctors rather than judging doctors.

Appraisals need to be mandatory, but should not feel like a chore. Should be encouraged [and] feel like you are a better doctor coming out of it

Bristol 18-30

When exploring the changes revalidation will make to the case study doctors, most participants suggest that the new system will benefit non-hospital doctors the most. As discussed above, there exists a perception that it is easier for hospital ‘specialists’ to be up to date as their range of expertise is more tightly confined and they work within defined teams and in a more managed environment. Participants focus on how the new system will be of particular benefit to the locum, who most feel is a good enough doctor but who is simply being let down by a lack of support and structure.

And this would help the [locum] to get a full time post as he has more evidence of his good practice

Sheffield, 50-60

Concerns

Despite the generally positive reception revalidation receives, participants still voice some concerns about the proposed revalidation policy. Reflecting the suggestions that revalidation ought to be a positive and supportive process, participants want to achieve a balance between rigour and time treating patients. They want it to be an approach that is comprehensive enough to support doctors and ensures they are keeping up to date without imposing a bureaucratic system of regulation that detracts from time spent treating patients. This balance between time and workload is central to people's concerns about the implementation of revalidation. People are particularly concerned by comparisons to Ofsted inspections, which many feel are overly bureaucratic and take time away from teachers being able to teach.

I found that generally in teaching we were drowning in paperwork. The appraisals were time consuming. It's changed over the last few years and has become even more so. I know that teachers now view each other's lessons and an awful lot of time is taken up with that

Bristol, 50-60

Other issues that participants express concern about include the cost of introducing revalidation and ensuring the independence necessary to make it work properly. People are aware that budgets are tight in these times of austerity and want to know where the money for revalidation will come from. They fear that the cost of introducing revalidation will have a knock-on effect of reducing budgets elsewhere in the NHS, possibly affecting care in other areas. They see revalidation as, potentially, an expensive process in financial terms as well as detracting from the time doctors spend treating patients.

Is revalidation coming out of the NHS budget?

Birmingham, 50-60

As long as there are funds and the appraisals are carried out to say they need the training and then there is money to fund the training.

Sheffield, 30-40

The question of how independent a system of doctors appraising doctors can possibly be also concerns patients. While acknowledging the expertise required to effectively appraise such a specialist profession, they are keen to ensure that any appraisal system avoid any

conflict of interest, with colleagues appraising one another. To this end, they stress the importance of the Responsible Officer being truly impartial.

I still think it needs to be slightly more detached. If its two local doctors who play golf together it's not going to work. There has to be some detachment

London, 40-50

Finally, while seeing revalidation as a positive process of encouraging and improving doctors' performance and abilities, participants still want to know that, should problems be identified, there will be consequences for 'poor performers'. Participants are unclear as to how this will be managed. While applauding the introduction of revalidation, they are concerned that it may still not provide the strong and, most importantly, swift action against failing doctors that patients demand.

Is it not possible that a Responsible Officer within an organisation would not want to criticise a doctor within his own organisation?

Sheffield, 50-60

Next steps

Participants see revalidation as an improvement on the current situation, and are keen to look ahead and to see how it will be implemented. Participants have two key queries; when will they see it and how will they know about it? They wish to see revalidation introduced as soon as possible, and furthermore, they also want information about doctors who have been through revalidation to be publicly available, allowing them to be assured of a doctor's fitness and confident in their diagnosis.

When will it start? Will it make a difference to when I go to see the doctor?

London, 40-60

If this was available I would like to be able to see the information on my doctors

London, 40-60

Finally, they suggest that the public would benefit from knowing more about revalidation. They have no wish to be subject to an overload of technical information. However, they suggest that greater awareness of this system will improve people's confidence in doctors.

Considering this seems quite important, I'm surprised I haven't seen anything about it in the media

Sheffield, 30-40

It increases confidence if it's well publicised

Bristol, 18-30

Implications

Implications

Public confidence in revalidation

The findings outlined in this report indicate that the participants do have confidence in doctors and that revalidation will only serve to improve this. The implications of the findings can be summarised in three themes, concerning the *design of the revalidation process*, the *implementation of the process* and *public communication about revalidation*. These themes and implications are explored in this chapter.

The design of revalidation processes

The proposed system of revalidation is almost universally approved of by participants, and most of the elements they would want to see are included. Overall then, the public are likely to react positively to the proposed processes. However, there are a number of aspects about which participants expressed some concern.

As discussed, participants value soft skills, as well as clinical expertise. Communication skills, familiarity and availability are all important to participants. Therefore, *revalidation processes need to assure the public of all doctors' skills, not just clinical knowledge*.

Participants recognise that the process may raise issues of poor performance, but did not see in the information presented at the events how performance issues would be managed. *Clear processes for managing the outcomes of revalidation need to be outlined and communicated*.

The importance of the doctor having time with patients is frequently raised as a vital part of providing confidence. Conversely, participants are concerned that the revalidation process might be time-consuming for doctors and detract from time spent treating patients. Therefore, *the processes need to be demonstrated to the public as being efficient and not creating significant time pressures or bureaucratic burden. Evaluation of this will, therefore, need to be established*.

Participants are concerned about a lack of consistency between NHS and private sector processes and infrastructure, as well as for doctors working across multiple organisations. *So revalidation processes must assure or improve quality of practice regardless of the work environment or organisation*.

There are concerns about the independence of appraisers. Participants question whether they may have a vested interest in doctors being deemed fit to practise. *An assurance of impartiality must be an important part of the revalidation process.*

Participants are also concerned about the cost of revalidation and that these might put pressure on already stretched NHS budgets. Therefore, *there is a need to evaluate the costs and explain how revalidation is funded.*

Implementation

Participants are surprised that, once qualified, there is no system in place to ensure that doctors remained up to date. *The sense of urgency that revalidation is required should be met with action. The timetable for implementation should not be interrupted. A plan for public information that these processes are being implemented would provide reassurance.*

Post implementation, participants are interested in knowing the value of the process. That is, whether or not doctors' performance, and the care patients receive, has improved. *This will require effective evaluation and communication to the public.*

Communication

It is clear that a communication strategy is required. It will need to consider the public information and communication for the connected but different purposes of revalidation that the deliberative events identified.

- a) revalidation as a mechanism to improve public confidence by supporting doctors to improve the quality of their medical care,
- b) revalidation as a mechanism to identify and manage poorly performing doctors,
- c) revalidation to generate information to assist the public in making choices about doctors,

While all the recommendations suggest a need for clear public communication, *any communication about revalidation must be careful not to undermine the existing high levels of trust and confidence in doctors.* For example, it would be concerning if communication about the introduction of revalidation highlights its absence. Having discovered that no comprehensive revalidation process is yet in place the *public want to be assured they will be in place for all doctors and when.* Most but not all grasped the concept and need for revalidation without trouble, recognising parallels in other professions. This suggests *the*

public will be receptive to information about revalidation, when presented in ways they can relate to in other professions.

When participants think about “doctors” they more readily think about GPs. In communication about revalidation, *it needs to be made clear that the processes apply equally to doctors in all settings of practice, whether general practice, hospital specialists or private sector.*

As always the language used in communicating with the public is very important. Revalidation needs to be positioned with care. ‘*Regulation*’ has negative connotations, being associated with the extra burdens on doctors participants are keen to avoid, whereas ‘*quality improvement*’ does not. Further work may be needed to determine how best to communicate this.

The public grasped the many complexities and contradictions with ease. These include the following examples:

- that the process needs to be comprehensive and yet not time consuming
- that doctors need more time for patients yet they must have time for revalidation processes
- that revalidation must be about the individual yet doctors performance is influenced by the team and the work environment
- that confidence comes from the doctor knowing the ‘answer’ and yet confidence is also about the doctor admitting s/he doesn’t know everything
- that 50 hours per year for keeping up to date is less than 1 per week, therefore not much and yet the processes must not add time pressure for the doctors
- that appraisal is a good process for assessment and yet it could be undertaken by a ‘mate’ or someone with a vested interest
- that patients input to the process is important and yet the doctor might only show positive feedback

This indicates that the public can manage the inherent complexities and potential contradictions, so these contradictions should be recognised and taken into consideration when planning public communication about revalidation.

Appendix

Appendix

Discussion guide

Aims	Activities	Stimulus required	Timing
	<p>1. Welcome and introduction</p> <p>Ipsos MORI Chair to introduce staff and their roles, explain the format of the day and that we will be discussing doctors, what people feel about them and what gives people confidence in them, among other things. Each topic will be introduced in more detail as we go along.</p> <p>Introduce King's Fund and RST</p>		10.00-10.15
To obtain spontaneous views of what people want from their doctors. To find out what inspires trust and confidence.	<p>2. What do people want from their doctors?</p> <p><u>In groups</u></p> <p>Participants to introduce themselves to one another – short ice breaker at the discretion of the moderator.</p> <p>NOTE: Please note the language used here by participants – what words or phrases do they naturally use when discussing these issues?</p> <p>FACILITATOR TO INTRODUCE BRIEF BRAINSTORM (USING FLIPCHART) ABOUT PEOPLE'S ASSOCIATIONS WITH DOCTORS.</p> <p>When you think of a doctor, what are the first words that spring to mind? What makes you say that? What attributes do you expect or need a doctor to have?</p> <ul style="list-style-type: none">○ Is this different for different types of doctor? E.g. hospital doctor compared to a GP, surgeons compared to medical doctors, private vs NHS, etc. <p>What do you want from a doctor? What do you expect from a doctor caring for you or a family member?</p> <ul style="list-style-type: none">○ PROBE on knowledgeable, personable, skilled, informed about your case and medical history, reassuring, organised, etc.○ To what extent do you feel doctors provide what you want? What makes you say that?○ Again, how does this differ depending on type of doctor? Hospital doctor compared to a GP, private vs NHS, etc		10.15-10.45

	<ul style="list-style-type: none"> ○ What distinguishes the best doctors? What are they especially good at? <p>How important is it to you that you have <u>confidence</u> in doctors?</p> <ul style="list-style-type: none"> ○ PROBE on past experiences and examples <p>To what extent do you have confidence in doctors? Probe fully for reasons why and prompt on differences between doctors</p> <p>Which are the 5 most important factors in giving you confidence in doctors? And what 5 things would mean you wouldn't have confidence in a doctor?</p> <p>FACILITATOR TO USE FLIPCHART TO RECORD WHAT FACTORS ARE MOST IMPORTANT</p> <p><u>Plenary</u></p> <p>Participant from each group to explain to the rest of the room how their group reached their 5 factors.</p> <p>General reactions from other groups – what do they agree with, what don't they agree with and why?</p>		
To gain an understanding of participants' current range of knowledge.	<p>3. How do people think this happens now?</p> <p>Ipsos MORI Chair: Now that we know what is important to you we are now interested in discussing how you think the medical profession ensures that this happens. In this session we want to find out from you both how you think they do this and if there is anything else you think should be done.</p> <p>In groups</p> <p>Reiterate the 5 factors which are most important.</p> <p>Any changes based on plenary discussion with other groups?</p> <p>How do you think the medical profession tries to ensure this happens? Probe fully</p> <p>Prompt on:</p> <ul style="list-style-type: none"> • Training • Appraisals • Regulation • Professional bodies • Patient feedback 		10.45-11.15

	<ul style="list-style-type: none"> • Local oversight • Feedback from peers • Employers <p>How does this compare to how other professions go about this? Probe fully and ask for examples</p> <p>How <i>well</i> do you think the medical profession currently does this? Probe fully</p> <p>What system of appraisal or professional development do you think doctors currently have?</p> <ul style="list-style-type: none"> ○ Who do you think is involved? PROBE on other doctors, outside specialists, professional bodies? ○ What specific steps do you think are involved? PROBE on whether or not there is a structured process of professional development ○ What role do you think patients have in this? ○ What examples of this happening have you heard about? ○ What do you think <u>should</u> be happening? <p>Who should be responsible for ensuring each of these important factors actually happens in practice?</p> <ul style="list-style-type: none"> ○ PROBE on doctors themselves, other doctors, Department of Health, patients, professional bodies (e.g. BMA, GMC), etc ○ What do you believe are the advantages and disadvantages of each of these different groups taking responsibility? ○ To what extent does this differ depending on the type of doctor? Doctors in training, surgeons, GPs, private, NHS, etc <p>Do you know who is <u>currently responsible</u> for ensuring each of these actually happens in practice?</p> <p>EXERCISE TO DESIGN APPROACH: Please summarise our discussions by designing a process which would give you confidence in doctors. Please design a system that is not costly or impractical to implement but at the same time gives you the confidence you need.</p> <p><u>Plenary</u> Groups will take turns to explain their ideas to the rest of the room, focussing on outlining their preferred approach.</p> <p>Participants will be probed as to whether they agree with each of the groups' ideas.</p>	
--	--	--

	Tea and coffee break (Ipsos MORI, RST and King's Fund to confer on any potential changes or amends needed in light of first hour of event)		11.15-11.30
To ensure participants are aware of the current situation. To explain the need to achieve consistency across the profession. To push participants towards realistic trade-offs between the factors that they view as important. How do they prioritise these factors?	<p>4. Case for change</p> <p>Ipsos MORI chair to explain the purpose of the event and why we are here.</p> <p>Representative from the RST – “the NHS Revalidation Support Team set up by the Department of Health to take this forward” – to explain that many of the factors participants think are important are laid out in by the GMC (brief discussion of what factors raised already are covered by this and what is not – THIS WILL NEED TO BE FLEXIBLE BASED ON PREVIOUS DISCUSSION ON THE DAY)</p> <p>However, although the standards are there, the assurance that all doctors always comply is not.</p> <p>Presentation of statistics explaining the extent to which this happens now, e.g. the number of doctors who currently undergo an annual appraisal.</p> <p>In groups</p> <p>What do you think about this? What are your immediate reactions to the current situation?</p> <p>To what extent is this similar/different to what you thought was currently happening?</p> <p>How near/far away is this from what you want/expect to be happening? How does this compare to what you suggested earlier?</p> <p>Does anything you have heard just now surprise you? What exactly? Why?</p> <p>How does this information affect the 5 attributes which are the most important in ensuring your confidence in doctors?</p> <ul style="list-style-type: none"> ○ Why has this / has this not affected your opinion? ○ Has your view on the most important factors shifted? How so? 	Detailed information on the scale of regulation at the moment – who does what and how often.	11.30-12.00
Find out how participants react to scenarios and how they apply	<p>5. Case studies</p> <p>Introduce this section – we are going to discuss a number of different scenarios. We would like you to think about oversight of the doctor in each scenario – what could or should be done to ensure that you have confidence in the doctor?</p>	Case studies	12.00-12.45

the knowledge gained in the previous section	<p>Present case studies of doctors with different levels of professional engagement in several contexts.</p> <p>In groups</p> <p>FOR EACH SCENARIO – MODERATORS TO RECORD THE ORDER IN WHICH SCENARIOS ARE DISCUSSED (randomise order for each group)</p> <p>Initial reactions?</p> <p>How common do you think this scenario is? What makes you say that?</p> <p>How confident are you in this doctor? Would you be happy to be seen by them?</p> <ul style="list-style-type: none"> ○ What stands out as being particularly good about the doctor in this scenario? ○ What is less good? ○ What makes you say that? <p>What about the way the doctor could be overseen in this scenario?</p> <ul style="list-style-type: none"> ○ How would you want and expect the doctor to be overseen and regulated in these circumstances? Why? ○ What could be done better? ○ What would give you confidence that this doctor would treat patients properly and well? 		
	Lunch break		12.45 – 1.45
Would the new system give people more confidence in their doctors?	<p>6. Would this give people more confidence in doctors?</p> <p>Plenary</p> <p>Representative from RST to explain proposed revalidation policy to participants</p> <p>Allow for short clarification / Q and A with participants at this stage.</p> <p>Ipsos MORI to present case studies which show how the new system will alter the processes in the context of previous case studies.</p> <p>In groups</p> <p>Initial reactions?</p> <p>Postives? Negatives?</p>		1.45 – 2.30

	<p>To what extent does this provide the answer/s to our discussions from earlier?</p> <p>Is there anything missing? Is there anything there you weren't expecting?</p> <p>Overall, what impact would the new arrangements have on your confidence in doctors?</p> <ul style="list-style-type: none"> <input type="radio"/> What makes you say that? PROBE on reasons for increased confidence (or not) <input type="radio"/> To what extent does this differ depending on the various scenarios we discussed earlier? <input type="radio"/> What other circumstances would affect this? <p>Thinking back to our earlier discussion, we agreed that the 5 most important factors in ensuring you were confident in a doctor were – LIST FACTORS</p> <p>Does the new system address the factors that are important in giving you confidence?</p> <ul style="list-style-type: none"> <input type="radio"/> Which factors? <input type="radio"/> Some more than others? <p>When thinking about the new system, which aspects give you the <u>most/least confidence</u> that this approach will ensure doctors are fit to practise? Which aspects are <u>most important</u> to you?</p> <ul style="list-style-type: none"> <input type="radio"/> What makes you say that? <p>How important is it for you to know that this sort of system is in place?</p> <ul style="list-style-type: none"> <input type="radio"/> Why? <input type="radio"/> How useful is this information to patients? <p>What sort of involvement would you like in how this system would work? What makes you say that?</p>	
Explain proposed system of revalidation and explore participants' reactions.	<p>7. What would happen in the new system?</p> <p><u>In groups</u></p> <p>Explore reactions to new case studies.</p> <p>FOR EACH SCENARIO</p> <p>What do you think of this? What are your immediate reactions?</p> <ul style="list-style-type: none"> <input type="radio"/> What do you think are the positive things in this case study? <input type="radio"/> And the negative things? 	<p>Present future arrangements as amends to previous case studies / scenarios.</p> <p>2.30 – 3.00</p>

	<p>To what extent does the new approach address the important areas of concern from this scenario?</p> <p>What effect does it have on your confidence in the doctor? Why do you say that?</p> <p>Is there anything that the new approach would fail to address?</p> <ul style="list-style-type: none"> o What is this? o Why is this a concern? 		
	Coffee break (optional)		3.00-3.15
	<p>8. Next steps</p> <p>In groups</p> <p>What are you overall reactions to everything you have seen today?</p> <p>What have you learnt?</p> <p>Thinking about when this is introduced how much would you like to know about it?</p> <p>How should the public be made aware of it?</p> <p>How would you like to find out about your own doctor?</p>		3.15-3.45
Thanks and close	<p>9. Summary</p> <p>Brief summary</p> <p>Plenary</p> <p>Q&A session with representative of RST team</p> <p>Participants to ask general questions</p> <p>Thank and close</p>		3.45-4.00

Case studies

Case Study 1: GP Locum

CURRENT SITUATION

Dr Davies qualified as a doctor in 2001 at Bristol medical school. He hoped to join a large GP practice and eventually become a partner but so far he has not been able to do so. As a result, he has been working as a locum in a large number of GP practices ie he has been filling in when a partner has been on maternity leave and then moving on when he or she has returned. Sometimes he has done stints as a doctor aboard a cruise ship when GP locum work has not been available.

His performance is not formally appraised by each practice at the end of each 'tour of duty'. On cruise ships and other temporary placements such as out of hours work he typically works alone. He attends some seminars and conferences as part of continuing professional development, but these rarely go into detail about day to day clinical issues.

His frequent moves have made it hard for him to engage in the policies in place in the different practices he works in designed to improve the quality of care they offer. The partners in the practices he works have been usually too busy to give advice when he has encountered difficult patients or difficult cases.

Like all doctors he has available to him large amounts of information on new clinical developments such as new guidelines for detecting dementia or the harmful impact of drugs that were once thought to be safe and effective. But whether he looks out for and absorbs this information is largely down to him.

Case Study 1: GP Locum

AFTER REVALIDATION IS INTRODUCED

The proposed arrangements will make major changes to Dr Davies career development. He will be required to maintain a full portfolio describing what clinical he has done, just the same as a GP in full time practice. He will be required to present such evidence at an annual appraisal, the results of which will in due course be used when he is due for revalidation. The appraiser will be looking for the same attributes of a good doctor as would be expected of a GP in full time employment or contract.

However other arrangements will be different: in particular the solution to his lack of peer support may take various forms, including ad hoc professional groups or organisations for others working in a similar way Or, if he works regularly for one or two employers (GP practice or out of hours organisation) these will be charged with taking some responsibility for ensuring, for example, that any complaint about his conduct is discussed with him. Such arrangements will be worked out on a local basis. In addition special arrangements may have to be worked out to enable Dr Davies to collect the views of his peers and of patients on his standard of practice.[NB there remain a number of areas where the Royal College of General Practitioners is working out how to enable locums to demonstrate their fitness to practice]

Case Study 2: Hospital Doctor

CURRENT SITUATION

Dr Young currently works at a large hospital in London after qualifying as a doctor in 2005 at Newcastle medical school. She has been attached to different specialties in a number of hospitals as part of her post-graduate training and has decided she would like to specialise in cardiovascular conditions such as heart disease and stroke. She now works in a large department in which the consultants are committed to ensuring that junior staff have a clear job plan and learning objectives as she gathers experience on the wards or in the consulting room. She keeps a personal record of her clinical work, including in particular details of difficult cases and the lessons learned from them.

The department holds regular meetings at which difficult cases are discussed and key measures of the performance of the whole team (which will include specialist nurses and other skills) are presented. These are based on regular audits of their own work which shows how successful they are in saving the lives of those admitted through the A&E department as emergencies. The audit allows them to check if they are improving from one year to the next and how well they are doing compared to other hospitals.

Each year she undergoes an appraisal of her performance with a senior member of the team. Unless things have gone badly wrong, the main focus of the appraisal is to discuss the next steps in her career as a heart specialist and what additional training she may need. It also offers the opportunity to discuss more personal issues, such as how well she gets on with other members of the specialist team, which might affect the performance of the team as a whole.

Case Study 2: Hospital Doctor

AFTER REVALIDATION IS INTRODUCED

The new arrangements will not make a great deal of difference to Dr Young as most of the elements of the new system are in place in her trust.

The appraisal itself may be more formally structured to ensure it is completely in line with GMC guidance; for example, it would include additional elements eg a 360 degree view of her performance from medical, nursing and other colleagues as well as patient feedback.

The senior team member with whom she has her appraisal will in future communicate the results to the trust's responsible officer for onward transmission to the GMC, which, if the appraisal is satisfactory will renew her registration.

Case Study 3: GP in small practice

CURRENT SITUATION

Dr Smith qualified as a doctor from Birmingham medical school in 1975. He joined his present practice soon after that, became a partner five years later and has remained in the same surgery ever since.

He attends some conferences and seminars as part of his continuing professional development but these tend to focus on issues such as the latest public health campaigns or important new policy developments. They rarely concern the clinical issues he has to deal with on a day to day basis such as how to recognise the symptoms of colorectal cancer, which are difficult to detect.

Compared to doctors in other practices in the city he refers a large number of his patients to hospital and a high proportion of his patients are admitted as emergency admissions eg diabetic collapses. But he has not been required to demonstrate to any other doctor that his high rate of referral is justified nor that some at least of the emergency admissions could have been prevented if his care had been of a higher standard.

Dr Smith is very popular with his patients. His manner is calm and reassuring and his patients always feel he has enough time for them. They usually leave a consultation with a prescription or a referral to a hospital specialist. Many of his patients are elderly or recent immigrants and are not inclined to question his judgement. He scores highly on the regular monitoring of patient views that each practice must organise.

Case Study 3: GP in small practice

AFTER REVALIDATION IS INTRODUCED

The new arrangements will make a major change to Dr Smith's professional life. . He will be subject to annual appraisal by another GP (trained for this role) At each appraisal he will be required to prepare a portfolio describing the range of his professional activities eg whether he engages in out of hours work as well as general practice or carries out research.

For revalidation he will also have to present the results of a feedback survey from professional colleagues including practice nurses or administrative staff and from patients, the results of at least one audit of a specific improvement activity and a number of significant event audits. He will be required to set out a development plan for his practice and for himself as an individual and keep a log of his learning activities.

Case Study 4: Hospital specialist with private practice

CURRENT SITUATION

Ms Clark graduated from Cardiff medical school in 1990. After her postgraduate experience in a number of specialties, she decided to train to be a surgeon. She did well and achieved consultant grade as a general surgeon when she was 34 in a large provincial, non-teaching hospital.

In her early years as a consultant she found she was drawn to treating patients who had suffered serious injuries and who retained scars as a result as well as children with inherited birth defects.

The development of these skills meant that opportunities for work in private practice opened up. Over time she has extended her practice to a number of other privately owned surgical facilities.

By this time the NHS had begun to introduce annual appraisals but these were conducted in an informal way and the senior doctors conducting them were not familiar with her area of expertise. She has not been put under any pressure to ensure, through systematic audit, that the results she obtained were comparable to those achieved in other hospitals.

In her private work she is not required to undergo annual appraisal or to carry out any clinical audit of her work. One private hospital operator did however monitor patients' views of her work: this feedback suggested that her performance was of an uneven standard. This finding was not however communicated to the NHS hospital where she worked and no regular feedback from patients was available within her NHS hospital.

Case Study 4: Hospital specialist with private practice

AFTER REVALIDATION IS INTRODUCED

The new arrangements will make a major difference to the conduct of Ms Clark's professional life. Her appraiser will be someone working within her specialty or one closely linked to it - in her case from another hospital trust. The appraisal will take in the whole scope of her practice ie include both NHS and private work. This will require her to prepare a record of all her clinical work, present evidence of audit activity and the views of her professional colleagues and patients on her performance.

The results of the appraisal will be forwarded to the trust's medical director (who will probably be the responsible officer) who will decide if local action is required to remedy any weaknesses in Ms Clark's practice or whether he/she can recommend revalidation.

To prepare for her appraisal, she will have to present a portfolio of evidence relating to the scope her practice, her personal development plan, CPD activities, feedback from colleagues and patients and any complaints or compliments. She will also have to present, at minimum, information on the outcomes of her care (where suitable measures are available), audits of some aspects of her clinical practice, and reports of involvement in 'review of practice' meeting with colleagues.