Implementing medical revalidation

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Implementing medical revalidation: organisational changes and impacts

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Executive Summary ................................................................................................................................. 1

1 Introduction ........................................................................................................................................ 3

2 Methods ........................................................................................................................................... 3

3 Coverage and representativeness of the data collected ................................................................. 6

4 Individual, organisational and external resources for revalidation .............................................. 8
  4.1 The position and role of the RO within their DB ................................................................. 9
  4.2 Staff and IT resources available for revalidation ............................................................ 10
  4.3 Training and support for ROs .............................................................................................. 13

5 Organisational systems for managing medical performance ...................................................... 16
  5.1 Comparison of organisational systems for managing medical performance ........... 17
  5.2 Changes in performance management systems due to the introduction of revalidation ... 21
    5.2.1 Appraisal ......................................................................................................................... 22
    5.2.2 Continuing Professional Development (CPD) ............................................................. 23
    5.2.3 Complaints management ............................................................................................. 24
    5.2.4 Quality improvement ..................................................................................................... 25
    5.2.5 Significant Events / SUIs ............................................................................................ 26
    5.2.6 Doctors causing concern .............................................................................................. 27
    5.2.7 Fitness to practise .......................................................................................................... 30

6 How revalidation recommendations to the GMC are made ......................................................... 33
  6.1 Use of information from other performance management systems in revalidation .... 33
  6.2 Decision making processes and structures for making revalidation recommendations ..... 36
  6.3 Positive recommendations but with some residual concerns ............................................ 38
  6.4 Deferral due to an on-going local investigation or disciplinary process ....................... 39
  6.5 Deferral due to insufficient supporting information ......................................................... 40
  6.6 Recommendation of non-engagement ................................................................................. 40
  6.7 Issues related to making revalidation recommendations .................................................. 42
    6.7.1 GMC support systems .................................................................................................... 42
    6.7.2 Doctors who are remote from the RO ........................................................................ 43
    6.7.3 Quality and quality assurance of appraisal and revalidation .................................... 43

7 The implementation and impact of revalidation ............................................................................ 45
  7.1 Factors affecting the implementation of revalidation ......................................................... 45
  7.2 Impact of revalidation on the RO ....................................................................................... 50
  7.3 Impact of revalidation on systems for managing medical performance ............................ 52
  7.4 Impact of revalidation on clinical practice ......................................................................... 54
Executive Summary

The introduction of medical revalidation in 2012, after over a decade of policy development and debate, is perhaps the most important change to the way that medical professionals are regulated in the United Kingdom for many years. Put simply, it requires all doctors to demonstrate on a regular basis that they are up to date and fit to practise in their chosen field, and able to provide a good level of care. Doctors are required to have an annual appraisal, and to provide a portfolio of supporting information about their practice. Organisations which employ doctors are required to have a designated senior medical professional who takes statutory responsibility for making revalidation recommendations to the General Medical Council. For both doctors and organisations, medical revalidation involves important changes to the way that medical performance is managed and assured.

The implementation of medical revalidation has required healthcare organisations which employ doctors (termed “designated bodies”) to introduce or revise their processes for managing and reporting on medical performance. Each designated body has a “Responsible Officer” who is the person responsible under the legislation for implementing medical revalidation and, in particular, for making recommendations about the revalidation of individual doctors to the General Medical Council.

We conducted an online survey of all Responsible Officers (ROs) in the UK between 26th June 2015 and 20th September 2015. We wanted to map how revalidation has actually been implemented by designated bodies (DBs), and how it has interacted with other organisational systems for managing medical performance. A total of 595 survey invitations were issued in late June 2015 to all individuals across the UK who were ROs at that time. 374 out of 595 ROs (response rate 63%) completed the whole survey. Small designated bodies with less than 20 doctors were under-represented, so additional analyses of these organisations were conducted.

Responsible Officers believe that revalidation has driven improvements in the use and sharing of information about medical performance within many organisations. This has been principally focused on appraisal as the mechanism whereby information is brought together, considered and used to inform revalidation recommendations. 85% of respondents to the survey perceived that the appraisal system in their designated body had changed; mostly for the better. Improvements in other systems for managing medical performance (continuing professional development/CPD, complaints, quality improvement, significant events/serious untoward incidents, doctors causing concern and fitness to practise) have also occurred, but have been less widespread. Almost half of respondents’ designated bodies are reported to have improved their systems in relation to doctors causing concern, and almost 40% are reported to have improved CPD.

Information sharing between organisations and the General Medical Council about doctor performance also seems to have improved, with the GMC’s Employer Liaison Service in particular providing better, earlier and more timely access to advice. Over 93% of respondents had contacted ELS advisors, and over 70% of these had found this very useful. It is not clear however that revalidation has driven a similar improvement in information sharing between organisations.
Respondents commonly reported difficulties in obtaining performance information about doctors such as locums, who work across more than one DB or about doctors when they move from one DB to another.

The design of revalidation is best suited to larger organisations with a substantial pre-existing clinical governance infrastructure. Smaller designated bodies in particular may find revalidation onerous and a strain on their resources and capabilities. Many ROs have added revalidation to their existing leadership responsibilities without having sufficient additional hours allocated to this activity by their organisation.

Very few Responsible Officers want to see a reversal of policy on medical revalidation, but many think it could be made more effective and efficient, and there are some clear and consistent messages about how that might be achieved. Moving from a “one size fits all” single model of revalidation to allow some legitimate and appropriate variation in the way the policy is applied seems to have widespread support. This might mean differences in the way it works with organisations with many or few employed doctors; with organisations where there is a close or more distant relationship with employed doctors; with doctors in different fields or specialties due to the clinical content and nature of their work; and perhaps most controversially with individual doctors according to their past and current performance track record.

It is very difficult to answer the question of what impact medical revalidation has had or will have on clinical practice and the quality of medical care. There are some early indications from this survey, and we are exploring impact both qualitatively and quantitatively in our ongoing research programme. It seems likely that the impact so far is mostly focused on identifying and remediating poor performance, and there is more to be done to ensure that revalidation has benefits and impact for doctors who perform well already.

The General Medical Council has recently commissioned Sir Keith Pearson, Chair of the GMC’s Revalidation Advisory Board, to lead a review of revalidation, and we hope our report and future research will be useful to his review.
1 Introduction

The implementation of medical revalidation has required healthcare organisations which employ doctors to introduce some new processes for dealing with issues of medical performance and to consider how these relate to some existing processes. Revalidation requires every licensed doctor to collect, report and reflect on information about various aspects of their performance. Healthcare organisations must, through a nominated Responsible Officer (RO), make informed decisions about whether to recommend to the General Medical Council that a doctor be revalidated, and thus allowed to continue to practise. This presumes the existence of a number of organisational systems for managing medical performance, such as clinical audit/quality improvement, continuing professional development (CPD), incident reporting and investigation and complaints management. Furthermore, those systems also need to be fit for purpose. One of the potential impacts of the introduction of revalidation is that it would lead to changes in these systems for managing medical performance, and in the way they are used in healthcare organisations.

We conducted a survey of all ROs in the UK between 26th June 2015 and 20th September 2015. We wanted to map how revalidation has actually been implemented by designated bodies (DBs), and how it has interacted with other organisational systems for managing medical performance. The survey also aimed to capture the views of ROs about the implementation of revalidation, including their views of the key factors affecting implementation and impact and their suggestions for improving the process. The survey also explored how revalidation might have influenced the management of instances of suboptimal medical performance, or doctors about whom there are concerns. This report focuses on revalidation in England, as per the scope of the research commissioned by the Department of Health. Additional UK-wide analyses and comparisons with England will be reported separately.

2 Methods

The survey was designed to complement the Annual Organisational Audit (AOA) (and previously Organisational Readiness Self-Assessment - ORSA) surveys of designated bodies in England conducted by NHS England and the Department of Health1. Data already collected through AOA (such as the number of doctors connected with a DB; number of doctors having an appraisal in the last 12 months, etc) was not duplicated. Instead, we linked our survey data with AOA and ORSA data.

The survey was conducted online using Qualtrics Research Suite survey builder. This helped us to personalise the survey with the name of the RO’s DB, and to allow for different questions to be presented, depending on the answers given to previous questions.

We were very conscious that DBs constitute a wide range of organisations. While many doctors are connected with NHS organisations, there are also DBs in the independent sector, the voluntary sector, academia, the armed forces and other public sector bodies. The services that different DBs

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1 See https://www.england.nhs.uk/revalidation/qa/ for further information
provide include secondary care, primary care, mental healthcare, community healthcare, palliative care, occupational health and public health. There is also wide variation in the number of doctors connected with different DBs. In order to gather comparable data across all DBs, we endeavoured to phrase questions in ways that would be relevant to all DBs, irrespective of their particular organisational structures, processes and the different terminologies that might be in use.

We were also conscious of wanting to reflect in our survey the diversity and heterogeneity of systems for managing medical performance in DBs, while not asking respondents to answer questions which might not seem relevant to their DB. We decided to structure the survey so that each section would correspond to a particular performance management system, with very similar questions in each section, so that different systems could be compared.

We decided not to ask for exact numeric information about parameters such as rates of participation or coverage where this would require respondents to refer to information systems and collate data especially for the survey, greatly increasing the time required to complete the survey, and likely lowering response rates accordingly. Instead we asked ROs to provide estimates within quite broad bands (such as 0-20%, 21-40%, etc), which we judged to be feasible and to have acceptable reliability. Where questions referred to a time period, this was either “the year April 2014-March 2015”, to facilitate comparability with data collected by other surveys; or “since the introduction of revalidation”.

A significant proportion of ROs are responsible for multiple DBs (see below). So as to avoid survey overload, we surveyed each of these ROs only once. We asked them primarily about the DB with the greatest number of doctors connected to it, because this would be most likely to produce rich data. We included a single additional question asking whether their other DBs differed from this one, and if so, how.

Drafts of the survey were piloted sequentially with different ROs. Pilot participants were identified mainly via personal contacts of the researchers, although recruitment was also sought through some events that ROs were attending. Potential pilot participants were emailed an information sheet. Although we had hoped to observe some ROs completing the draft survey online, this did not prove feasible. All piloting took the form of a 15-20 minute semi-structured telephone interviews after the RO had typically been asked to skim through either an online version or a Word version of the survey. As preparation for later interviews, ROs were asked to focus on particular sections or questions which had either been revised following feedback from earlier interviews, or had not been much covered previously. Interviews covered:

- General comments about the survey
- Relevance. In particular, whether there were any sections or questions which did not really apply to ROs
- Whether selected sections were meaningful
- Whether the similarly worded questions for each section/system made sense in relation to all of the systems
- Suggestions for improving the wording of questions
- Whether the length of the survey would preclude them from completing it, or preclude them from providing comments in response to free text questions
Whether any other ROs might react differently to the survey, and in what ways.

The pilot included a total of 12 ROs, based in England, Scotland, Wales and Northern Ireland, and in relation to DBs of various sizes and types, and from various sectors.

The survey was designed to shed light on how revalidation might interact with other systems for managing medical performance, drawing on stakeholder interviews and a rapid realist review of the literature, conducted as part of our wider research project. Relevant ideas are outlined at the start of sections 4, 5 and 6.

The final survey covered four key areas of interest:

1. Individual, organisational and external resources for revalidation:
   - How the RO is situated within their DB
   - Staff and IT resources available for revalidation
   - Training and support for ROs
2. Organisational systems for managing medical performance:
   - Appraisal;
   - CPD;
   - Complaints;
   - Quality improvement;
   - Significant events/ serious untoward incidents (SUIs);
   - Doctors causing concern;
   - Fitness to practise (FTP);
3. How revalidation recommendations to the GMC are made
   - Decision making processes and structures
   - Positive recommendations with some residual concerns
   - Deferral due to lack of information
   - Deferral due to an on-going local process
   - Recommendations of non-engagement
4. The implementation and impact of revalidation
   - Factors affecting the implementation of revalidation
   - Impact of revalidation on the RO
   - Impact of revalidation on systems for managing medical performance
   - Impact of revalidation on clinical practice
   - Changes to improve the way revalidation works

Survey questions are listed in Appendix 1.

Prior to issuing the survey invitations we emailed ROs to provide information about the research and the survey, and to encourage their engagement. We emailed periodic reminders to non-respondents, each of which produced an increase in response without increasing opt out rates.

We analysed numeric and Likert scale data from survey respondents using frequency tables and cross-tabulations, identifying statistically significant differences through Chi-square tests. We conducted thematic analyses of free text comments. Themes were identified inductively in relation
to each question and then compared across questions in order to identify common, cross-cutting themes. Where a large number of respondents had provided comments with regard to a particular question, we counted the number of responses within each theme in order to give a sense of how common each theme was. Where relevant, we also categorised comments as positive or negative and calculated the balance of positive and negative comments, in order to indicate the direction of views with regard to particular issues of interest.

3 Coverage and representativeness of the data collected

A total of 595 survey invitations were issued in late June 2015 to ROs across the UK. ROs in Scotland, Wales and Northern Ireland were included because this involved little additional workload, due to the generous support of Scottish and Welsh colleagues in the UMbRELLA research team. Our analysis of free text comments includes those of all respondents, but the statistics relate only to England, unless stated otherwise or marked with †.

374 ROs (response rate 63%) from across the UK completed the whole survey by the closing date in mid-September 2015, with a further 9 ROs answering more than half of the questions. A small number of survey responses were made by deputy ROs or others on behalf of their RO. 335 ROs from England responded. This is a comparatively high response rate, and likely reflects engagement with revalidation among ROs, and interest in the subject and findings from the survey.

The response rate did not differ significantly between the countries of the UK, nor between the different regions within England. Neither did the response rate differ between DBs who self-assessed their organisation as exhibiting various types of good practice in AOA 2013/14, and those who did not regard their organisation to be exhibiting good practice at that time. Similarly, there was no statistically significant difference between respondent DBs and non-responding DBs in the percentage of connected doctors having had an appraisal in the last year. These figures do not provide any reasons to doubt the survey’s representativeness with regard to geographical coverage and quality of revalidation systems.

There was however a lower response rate (just under 50%) from ROs responsible for designated bodies with less than 20 doctors connected to them.

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1 See http://www.umbrella-revalidation.org.uk/ for more information about the UMbRELLA research project commissioned by the General Medical Council.
Table 1). There was already some in-built bias towards larger designated bodies because we surveyed the largest DB when an RO was responsible for more than one. This means that we need to be careful when attempting to generalise our findings to all DBs, by checking whether there are differential effects for small DBs.
Table 1: Comparison of response rates between small designated bodies and other designated bodies†

<table>
<thead>
<tr>
<th>Small number (0-19) of doctors connected to the DB</th>
<th>No</th>
<th>%</th>
<th>Yes</th>
<th>%</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>97</td>
<td>27%</td>
<td>261</td>
<td>73%</td>
<td>358</td>
</tr>
<tr>
<td>Yes</td>
<td>111</td>
<td>51%</td>
<td>109</td>
<td>50%</td>
<td>220</td>
</tr>
</tbody>
</table>

The response rate was also higher for ROs of NHS and other public sector DBs compared with ROs of DBs not in the public sector. Further analysis suggests that differential response was not actually due to the nature of the DB’s sector, but simply reflected lower response rates among ROs of small DBs, which are under-represented among public sector organisations.

Response rates were also relatively low for ROs responsible for locum agencies (8 out of 24 responded, 33%) and for DBs specifically identified as hospices in the AOA dataset (2 out of 10 responded, 20%)†.

Qualitative data suggests that lower response rates among ROs of small DBs may reflect lower engagement and lower satisfaction with revalidation (regarding revalidation as bureaucratic, onerous and time consuming, for little gain). This needs to be borne in mind when interpreting the survey results. It is also important to note that while a substantial proportion of ROs (38%) are responsible for small DBs, these DBs account for less than 1% of all doctors with prescribed connections.

4 Individual, organisational and external resources for revalidation

As a general principle, we would expect the resources available for revalidation to be important in determining the nature and impact of revalidation. At an individual level, the roles that the RO has in the DB – particularly their seniority and reach – could affect the ease with which the RO is able to implement revalidation (for example to access organisational resources) and link it with other organisational systems. Having too many roles however might dilute the RO’s focus on revalidation or produce overload. How familiar the RO is with the organisation could also affect their ability to design revalidation systems to suit the organisation, and to navigate any organisational politics. The number of DBs for which a person is the RO for could also be a factor – giving the RO a wider range of experience, but also potentially limiting their time input and reducing their familiarity with the individual organisations and the doctors within them. Levels of familiarity could also be affected by

†UK-wide data; excludes 17 DBs for which the number of connected doctors was not known.
the number of doctors connected with the DB and whether the RO is internal or external to the organisations or workplaces within which those doctors work. For example, ROs in NHS England Area Teams revalidate large numbers of GPs and are not part of the GP practices within which those GPs work. Small organisations may also contract out the RO function to an external person. In our survey we asked ROs to indicate which other roles they perform in the organisation, and for how many years they had worked in or with the DB.

At an organisational level, the development, management and support of revalidation systems and processes require resources of time and expertise: leadership from the RO, clinical expertise and administrative expertise. These resources need to be commensurate with the size of the task. Appropriate computerised information systems to support revalidation might also reduce the administrative burden and provide opportunities to integrate revalidation with other organisational systems. We asked ROs to say how much of their time is formally allocated to their role as RO, and approximately how much of their working week is actually used for their RO activities. We also asked ROs to estimate how much other clinical and administrative staff time is used to manage and coordinate the revalidation process. ROs were also asked to name the computerised information system available to them to support the revalidation process, if any was available.

While experience as a senior clinician will be valuable to an RO, there are specific requirements of the role which require particular knowledge and expertise. Training and support for ROs is therefore important, and various external sources of training and support are available that ROs might access. These resources are likely helpful in different ways and to different extents, perhaps depending on the individual RO and their organisational context. We asked ROs how useful they had found different guidance documents to be, and what training they had undertaken. We also asked ROs to provide comments about training and support for ROs.

In the following sections of this report we describe our findings with regard to the resources available for revalidation.

4.1 The position and role of the RO within their DB

A high proportion of ROs are in very senior, board level roles in their designated bodies. 65% of survey respondents were the Medical Director (MD) of their DB, in addition to being the RO. A further 26 (7%) were an Associate or Deputy Medical Director, and 24 were consultants (7%). 67 ROs (19%) had a variety of other roles, including 7 CEOs/Deputy CEOs, 6 Postgraduate Deans and 5 GPs.

On average, respondents had been working in or with their DB for 10.6 years, but time in the organisation varied widely. Over half of ROs had been with their organisation for 8 years or more; over a quarter for 3 years or less. ROs of small organisations had only worked there for about 7 years on average compared with an average of about 12 years for ROs in larger organisations.
As might be expected, having worked longer in the DB is associated with having greater knowledge about the systems for managing medical performance in the organisation – correlations with self-assessed levels of knowledge about appraisal, CPD and complaints systems are statistically significant (p=0.01).

About 15% of ROs are responsible for multiple DBs, with almost 5% being responsible for three or more. Of the 48 survey respondents who confirmed they were managing multiple DBs, most (38 out of 48, 79%) thought that revalidation worked similarly in the different designated bodies†. Where comments were made about revalidation working differently, these mostly referred to the size of the designated body, or the number of doctors connected with it. Levels of resources and infrastructure differences were also mentioned.

4.2 **Staff and IT resources available for revalidation**

Comments made by ROs about the resources available for revalidation indicate that there is a lot of variation in how well or poorly DBs are resourced. Almost half of ROs have no specifically allocated
time for revalidation in their job plan or work programme, and on average an RO spends about 2 hours more per week working on revalidation than the time they have allocated, rising to 4 hours for over a quarter of ROs [See Table 2]. This may not sound much, but respondents’ comments indicate that the time demands of revalidation are a concern for a significant proportion of ROs - 58 highlighted time issues in their comments.

“the revalidation process was conceived and launched many years ago without any significant regard or involvement of those who would have to implement it. That is the role of RO often fell to medical directors, who already had a full timetable.”

The need to attend training events and RO network meetings was mentioned as being a time consuming activity that it was difficult to find cover for, especially in small DBs. Such time demands, the need for additional working hours and training, and sometimes new IT systems, were regarded as contributing to making revalidation a costly undertaking.

Table 2 Length of time spent on RO role and revalidation (hours per week)

<table>
<thead>
<tr>
<th></th>
<th>Average time spent on RO activities</th>
<th>Time formally allocated RO activities</th>
<th>Administrative or managerial staff time used on revalidation</th>
<th>Medical or clinical staff time used on revalidation</th>
<th>Excess of RO actual time over allocated time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>5.3</td>
<td>3.4</td>
<td>23.7</td>
<td>5.1</td>
<td>2.0</td>
</tr>
<tr>
<td>Median</td>
<td>4.0</td>
<td>0.3</td>
<td>8.0</td>
<td>2.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Lower quartile</td>
<td>2.0</td>
<td>0.0</td>
<td>1.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Upper quartile</td>
<td>6.0</td>
<td>4.0</td>
<td>30.0</td>
<td>5.0</td>
<td>4.0</td>
</tr>
</tbody>
</table>

Significant amounts of administrative time are being used to support revalidation. Where specific Human Resource department (HR), administrative and support roles for revalidation do not exist, other staff have to take on the extra work to ensure implementation and smooth running. There were a number of comments noting that the success of the process relied on the good will of administrative departments and resource sharing, with personnel being borrowed as and when needed. For those ROs who said they were under resourced, lack of administrative support was commonly cited. There were also instances of dedicated HR and administrative resources having been made available on the introduction of revalidation, but then subsequently removed as part of cost savings, causing problems for the revalidation process.

“It is just one of the tasks that need to be incorporated into an individual’s job. It has to be prioritised alongside all their other work. Gapped admin posts have been a constraint on the implementation of revalidation”

Conversely, HR and administrative support featured in comments as being crucial to the smooth running of revalidation and successful implementation. Where extra resources had been provided for this, revalidation was described as having a positive effect on resources generally, and needs of the DB as met.
It was common for those who identified their resources as adequate to qualify this statement with an acknowledgement that this was only the case because they had very few doctors, which meant the demands of revalidation were relatively small.

“\textit{We are very small and therefore could not justify more resources}”

Computerised appraisal and revalidation management systems of various sorts are now commonly used to support revalidation processes. Overall, 67% of responding ROs had access to a computerised information system. Such systems administer core processes including: matching of an appraiser with an individual doctor, monitoring usage statistics and information regarding quantity, type and volume of attachments, managing planned appraisal dates and completion of appraisal, and managing the sign-off process. Appraisal and revalidation support systems can also provide management reports including, for example, data relating to participation in patient and colleague feedback, or information regarding any doctors undergoing investigation, conditions or undertakings on their practice\textsuperscript{4}.

Some organisations use manual systems for processing appraisal and revalidation information, such as the Medical Appraisal Guide Model Appraisal Form (“MAG form” - a pdf form designed for the doctor and the appraiser to agree and sign-off the outputs of appraisal), or the Responsible Officer Dashboard (a spreadsheet pro forma providing the responsible officer with a means of maintaining a list of doctors for whom they have responsibility). Only 38% of ROs for small DBs had computerised revalidation systems however, compared with 80% of those responsible for larger DBs (see Table 3).

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|}
\hline
\textbf{Access to a computerised information system to support the revalidation process} & \textbf{No} & \textbf{%} & \textbf{Yes} & \textbf{\%} \\
\hline
Small number (0-19) of doctors connected to the DB & Yes & 65 & 62% & 40 & 38% \\
No & 47 & 20% & 188 & 80% \\
\hline
\end{tabular}
\caption{Table 3 Access to a computerised information system to support the revalidation process}
\end{table}

Where small DBs did have a computerised system, they were more likely to be classed as bespoke or “other” (45% of systems) than the computerised systems of larger DBs (26% of their systems were classed as bespoke or “other”). Larger organisations were more likely to have commercial systems,  

\textsuperscript{4}Information Management for Medical Revalidation in England’, NHS Revalidation Support Team, March 2012, pp. 19, 22, 23.
particularly Premier IT (PreP) and Allocate/Zircadian, which have functionality such as linking with the GMC revalidation system (GMC Connect) and supporting quality assurance processes. RMS Equiniti was the most common commercial system among small DBs. NHS England has procured a national Revalidation Management System, and expects all NHS England ROs to be using it for their doctors by March 2016⁵.

4.3 Training and support for ROs

Various documents intended to support and guide ROs have been published by different bodies, including the Department of Health, NHS England, the GMC and Royal Colleges. In the survey we asked ROs how useful they had found some of the most high profile documents. We also asked about the usefulness of formal support mechanisms such as Employer Liaison Advisers (ELAs) and informal sources of support, such as other ROs and Level 2 responsible officers (L2ROs), also commonly known as Higher Level Responsible Officer (HROs). Our findings are presented in Table 4.

Table 4 Usefulness of different sources of advice and guidance

<table>
<thead>
<tr>
<th>Source of Advice and Guidance</th>
<th>Never used it</th>
<th>%</th>
<th>Not at all useful</th>
<th>%</th>
<th>Not very useful</th>
<th>%</th>
<th>Quite useful</th>
<th>%</th>
<th>Very useful</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible Officers regulations 2010</td>
<td>8</td>
<td>2%</td>
<td>5</td>
<td>2%</td>
<td>40</td>
<td>12%</td>
<td>197</td>
<td>58%</td>
<td>90</td>
<td>27%</td>
</tr>
<tr>
<td>GMC protocol for making revalidation recommendations</td>
<td>6</td>
<td>2%</td>
<td>0</td>
<td>0%</td>
<td>9</td>
<td>3%</td>
<td>192</td>
<td>57%</td>
<td>132</td>
<td>39%</td>
</tr>
<tr>
<td>Effective governance to support medical revalidation / A handbook</td>
<td>64</td>
<td>19%</td>
<td>5</td>
<td>2%</td>
<td>53</td>
<td>16%</td>
<td>188</td>
<td>55%</td>
<td>30</td>
<td>9%</td>
</tr>
<tr>
<td>Guidance documents from Royal Colleges or specialty associations</td>
<td>49</td>
<td>15%</td>
<td>20</td>
<td>6%</td>
<td>109</td>
<td>32%</td>
<td>141</td>
<td>42%</td>
<td>20</td>
<td>6%</td>
</tr>
<tr>
<td>Advice from a higher level responsible officer</td>
<td>102</td>
<td>30%</td>
<td>8</td>
<td>2%</td>
<td>46</td>
<td>14%</td>
<td>129</td>
<td>38%</td>
<td>54</td>
<td>16%</td>
</tr>
<tr>
<td>Advice from other responsible officers</td>
<td>40</td>
<td>12%</td>
<td>2</td>
<td>1%</td>
<td>23</td>
<td>7%</td>
<td>183</td>
<td>54%</td>
<td>91</td>
<td>27%</td>
</tr>
<tr>
<td>Advice from your GMC Employer Liaison Adviser</td>
<td>23</td>
<td>7%</td>
<td>0</td>
<td>0%</td>
<td>14</td>
<td>4%</td>
<td>78</td>
<td>23%</td>
<td>222</td>
<td>66%</td>
</tr>
<tr>
<td>Other sources of support or guidance on revalidation</td>
<td>39</td>
<td>36%</td>
<td>0</td>
<td>0%</td>
<td>8</td>
<td>7%</td>
<td>18</td>
<td>16%</td>
<td>45</td>
<td>41%</td>
</tr>
</tbody>
</table>

⁵ NHSE Medical Appraisal Policy, Version 2.0, April 2015, p.20
Each of the sources of support we asked about had been used by over two thirds of ROs. All of the sources had been found to be at least “quite useful” by over half of ROs. GMC Employer Liaison Advisers were found to be the most useful - over 90% of ROs had sought advice from an ELA, and this was rated as very useful by over 70%. The GMC protocol for making revalidation recommendations had been used by virtually all ROs, and found very useful by nearly 40% of them.

Other responsible officers were also a useful source of advice for many ROs, whether on a one-to-one basis or via RO network meetings. Other sources of support or guidance mentioned by ROs included NCAS/medico-legal advice, RO/RST training, the NHS England revalidation team and the GMC website.

ROs of small designated bodies did however find a number of sources of advice and guidance somewhat less useful than did ROs in larger organisations. The greatest difference was with regard to ELAs, but these were still found very useful by 56% of ROs in small DBs (compared with 77% of ROs in larger DBs).

We also asked ROs whether they had accessed training provision of various types (see Table 5)

<table>
<thead>
<tr>
<th>Table 5 Training that ROs have undertaken</th>
<th>Responsible Officers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Nationally agreed introductory training programme</td>
<td>325</td>
</tr>
<tr>
<td>E-learning package</td>
<td>140</td>
</tr>
<tr>
<td>Attendance at responsible officer network meetings</td>
<td>332</td>
</tr>
<tr>
<td>Other training</td>
<td>65</td>
</tr>
</tbody>
</table>

After their introductory training, it would appear that many ROs rely on RO network meetings for on-going training and support. A wide variety of other training opportunities had however been accessed by some ROs. These other training opportunities included NHS England training and refresher training (10 mentions), NCAS/medico-legal training (7 mentions) and the GMC RO reference group (6 mentions). Some Deans mentioned the Conference of Postgraduate Medical Deans (COPMed) and English deans meetings.

The vast majority of respondents who commented on training said that it was good quality or met RO training needs. The RO networks were identified as useful, especially for benchmarking, networking and learning from others. It was commonly noted however that these would be improved if the help they offered was more practical and example/case orientated. In addition, the usefulness of network meetings was sometimes said to be variable, due to the wide range of attendees. ROs at network meetings had a range of interests and areas of practice. Participants also varied with regard to their experience and competence levels.
“I have been attending the RO network since I started as a deputy revalidation lead in 2009 (originally RO training) and have found the events very useful to have discussions with colleagues and to hear national updates in a timely and directive manner.”

“RO network meetings of variable quality - some really not useful at all and resent requirement to go to 3 out of 4 annually”

The ELAs were identified as being very useful, often filling in the gaps that courses missed and providing more tailored support to problems as they arose. Other training sources identified frequently as particularly useful were NHS England’s E-learning and introduction packages. These were referenced even by those outside of the NHS. MIAD (a private organisation which provides e-learning and classroom based training for the health sector and specifically offers training for appraisers and ROs with regard to revalidation) was also identified as very useful by some ROs.

“Basic training good. GMC Employer Liaison Officer extremely helpful and useful.”

Training was felt to be very much directed towards the NHS. It was suggested that broadening the training to make it more relevant to ROs working outside of the NHS (such as in charities, universities, private medical clinics, pharmaceutical companies, public health settings) or in a commercial setting would be helpful. RO Conferences, both regional and national, which had been held in previous years (Ahead of the Curve, NHS England Annual National Conference for Responsible Officers June 2014; The Annual Responsible Officer Conference (North) December 2014) were also noted to be valuable learning spaces.

Though useful, training courses and indeed the networks were identified as time consuming, especially by ROs who were responsible only for a small number of doctors. These ROs felt that the benefits of attendance were outweighed by the time required and the cost to the organisation of providing cover. For some ROs, attendance was also hampered by location.

“Disproportionate time spent for those of us who are ROs for few doctors. Our problems are very different from large trust ROs or GPs’ ROs, and we would almost always need to seek advice from ELAs if a significant issue arises. Training and others’ experiences are not a substitute for personal experience.”

Some comments indicated that additional networks have been set up to help support ROs whose needs may not be met by regional RO network meetings organised by NHS England. Networks/meetings focusing on small DBs and on the independent sector were mentioned by some ROs.

Improvements suggested by ROs include a clearer and more readily accessible list of events and training available. Announcing the date of meetings further in advance, with fewer date/time changes would help ROs to fit training into their schedules. Running sessions on more than one occasion would also increase their accessibility.
5 Organisational systems for managing medical performance

There are many organisational systems for managing medical performance. In this research we are interested in the relationship between revalidation and these other systems. In the survey we asked questions about appraisal, continuing professional development (CPD), complaints, quality improvement, significant events/serious untoward incidents (SUIs), doctors causing concern, and fitness to practise (FTP). Where possible, we asked similar questions about each of the systems in order to be able to compare them.

Revalidation was developed on the basis that these other systems for managing medical performance would support the revalidation system by providing relevant information about a doctor’s performance. The extent to which this happens, and the usefulness of the information provided, may be influenced by the state of these other systems. They require resources such as organisational commitment, time and engagement if they are to function well. To indicate the extent to which these systems were embedded in the DB, we asked whether there was a formal, written policy for them, and how often information from the system was reported to the board or governing body of the DB. Answers to these questions should be a useful indicator of the importance the organisation attaches to the particular system.

The extent of RO knowledge about these other systems will also likely affect whether and how revalidation makes use of information from other systems. We therefore asked ROs how much knowledge they have about how each of these systems operates with regard to doctors with a prescribed connection to the DB.

The introduction of revalidation might potentially have an indirect effect on doctor performance via these other systems. This might happen in two ways. Firstly, more doctors might participate more fully in the other systems, perhaps because information about their participation is sought and assessed as part of revalidation (for example, information about participation in CPD). We asked ROs to estimate the proportion of doctors connected with their DB who participate in each system in accordance with the policy. For DBs where there is no policy, we asked about the proportion of doctors participating “properly” in each system.

Secondly, the introduction of revalidation might influence how other systems operate. Most obviously for example, appraisal is integral to the revalidation system, and appraisal for revalidation must meet certain requirements (be conducted annually, consider a doctor portfolio containing specific items, etc.). Appraisal may therefore have changed in order to comply with these requirements. Other systems may have changed too. We asked ROs to say whether the arrangements for each system have changed due to the introduction of revalidation. If arrangements have changed then we asked the RO to describe the nature and impact of the changes.

The extent to which these indirect influence pathways actually produce changes in doctor performance will also depend on the extent to which each of the other systems impacts on doctor behaviour. In the survey we therefore asked how the RO perceives that doctor participation in each system had changed clinical practice in the last year.
In addition to producing changes in the performance of doctors, revalidation may also influence how doctors who are performing poorly are identified, and hence the number of cases identified, and also the actions that are taken in such cases. This is quite a complex area, so our survey aimed to describe the broad patterns. We asked questions about the information sources used in bringing cases of doctors causing concern to light, and in Fitness to Practise referrals. We asked whether the number of cases of doctors causing concern had risen or decreased since the introduction of revalidation, and similarly for the number of FTP cases. We also asked what actions were taken in cases of doctors causing concern.

In the following sections of the report we present the findings of our survey with regard to other systems for managing medical performance. In the first section we make comparisons between the different systems, then in subsequent sections we present more detailed information about how ROs perceive the introduction of revalidation has changed other performance management systems.

5.1 Comparison of organisational systems for managing medical performance

Survey respondents’ self-assessments of their level of knowledge about the various systems for managing medical performance in their DB are reported in [See Table 6 ]

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>A little</th>
<th>Some</th>
<th>A lot</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td><strong>Appraisals</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td><strong>CPD</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>0%</td>
<td>5</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Complaints</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0%</td>
<td>6</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Quality Improvement</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>0%</td>
<td>7</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Significant event/SUI</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systems operate**</td>
<td>2</td>
<td>1%</td>
<td>5</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Doctors causing concern</strong></td>
<td>0</td>
<td>0%</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Fitness to Practise</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0%</td>
<td>4</td>
<td>1%</td>
</tr>
</tbody>
</table>

Many ROs felt they possessed a lot of knowledge about the operation of organisational systems for managing medical performance. Unsurprisingly given the central role of appraisal in revalidation, almost all the respondents felt they knew a lot about appraisal systems. Levels of knowledge about systems most closely associated with addressing performance issues (Fitness to Practise, doctors causing concern, and complaints) were also high. The results suggest that ROs tend to have less knowledge of quality improvement and CPD systems, which are more oriented to development and improvement.
ROs in small DBs said they had somewhat lower levels of knowledge about how these organisational systems operate, particularly with regard to doctors causing concern and Fitness to Practise. In smaller organisations, cases of doctors causing concern and Fitness to Practise referrals are likely to be relatively infrequent, so ROs may lack some practical experience of the operation of these systems. Having said this however, over 80% of ROs in small DBs still say that they know a lot about these two systems.

Figures from our survey regarding the extent to which DBs have written policies in relation to various performance management systems are given in [See Table 7].

Table 7 Existence of written policies on different aspects of performance

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Appraisal</td>
<td>334</td>
<td>96%</td>
<td>8</td>
</tr>
<tr>
<td>CPD</td>
<td>197</td>
<td>58%</td>
<td>113</td>
</tr>
<tr>
<td>Complaints</td>
<td>325</td>
<td>97%</td>
<td>4</td>
</tr>
<tr>
<td>Quality improvement</td>
<td>207</td>
<td>62%</td>
<td>104</td>
</tr>
<tr>
<td>Significant events/SU1s</td>
<td>313</td>
<td>94%</td>
<td>13</td>
</tr>
<tr>
<td>Doctors causing concern</td>
<td>293</td>
<td>88%</td>
<td>31</td>
</tr>
<tr>
<td>Fitness to practise</td>
<td>217</td>
<td>65%</td>
<td>103</td>
</tr>
</tbody>
</table>

As might be expected ROs appear to have good knowledge about the existence or otherwise of organisational policies on various systems for managing medical performance. There were however slightly lower (not statistically significant) levels of knowledge among ROs regarding the existence of CPD and quality improvement policies.

The proportion of DBs having written policies regarding organisational systems followed a similar pattern to the extent of RO knowledge about those systems. The proportion of DBs having a written policy was lowest for CPD and quality improvement, and highest for appraisal. Smaller DBs are somewhat less likely to have written policies than other DBs.

For those DBs with written policies we asked ROs to estimate approximately what proportion of doctors connected to the DB were participating in accordance with the policy. These figures are reported in Table 8.
The extent of doctor participation in accordance with policy again followed a similar pattern to that for RO knowledge of organisational systems, and for the existence of written policies (Figure 2). The proportion of doctors undertaking their CPD plan tended to be lower than the proportion participating in other systems. The proportion of doctors participating in quality improvement was the next lowest, while the proportion of doctors having an appraisal was the highest.

Figure 2: Comparison of knowledge of systems with presence of policy and % of doctors who are in line with the policy

| Table 8 Extent of doctor participation in accordance with policy in 2014/15 |
|---------------------------------|----------|----------|----------|----------|----------|----------|
|                                 | 0-20%    | 21-40%   | 41-60%   | 61-80%   | 81-100%  | Don’t know |
|                                 | N  | %   | N  | %   | N  | %   | N  | %   | N  | %   |
| Doctors having an appraisal     | 6  | 2%  | 2  | 1%  | 8  | 2%  | 21 | 6%  | 298| 88% | 5 | 2%  |
| Doctors undertaking their CPD plan | 2  | 1%  | 1  | 0%  | 13 | 4%  | 61 | 18% | 196| 59% | 62| 19% |
| Complaints responded to         | 0  | 0%  | 2  | 1%  | 8  | 3%  | 34 | 11% | 225| 70% | 54| 17% |
| Doctors participating in quality improvement | 5  | 2%  | 10 | 5%  | 3  | 2%  | 29 | 14% | 134| 65% | 25| 12% |
| Significant events/SUIs responded to | 3  | 1%  | 2  | 1%  | 3  | 1%  | 29 | 9%  | 241| 78% | 30| 10% |
For ROs whose DBs do not have written policies we asked a similar question about the proportion of doctors participating "properly". These figures are not included in the tables above. The distribution was broadly similar, but generally with slightly lower proportions reported to be participating.

RO responses to the survey question about how frequently various aspects of doctor performance are reported to the board or governing body are reported in Table 9.

Table 9 Frequency of reporting information about various aspects of performance to the board or governing body

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Annually</th>
<th>Quarterly</th>
<th>Monthly</th>
<th>More often than monthly</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Appraisals</td>
<td>10</td>
<td>3%</td>
<td>214</td>
<td>62%</td>
<td>68</td>
<td>20%</td>
</tr>
<tr>
<td>Participation in CPD</td>
<td>157</td>
<td>47%</td>
<td>119</td>
<td>36%</td>
<td>19</td>
<td>6%</td>
</tr>
<tr>
<td>Responses to complaints</td>
<td>10</td>
<td>3%</td>
<td>47</td>
<td>14%</td>
<td>105</td>
<td>32%</td>
</tr>
<tr>
<td>Participation in quality improvement</td>
<td>103</td>
<td>31%</td>
<td>96</td>
<td>29%</td>
<td>46</td>
<td>14%</td>
</tr>
<tr>
<td>Responses to significant events/SUIs</td>
<td>11</td>
<td>3%</td>
<td>42</td>
<td>13%</td>
<td>63</td>
<td>19%</td>
</tr>
</tbody>
</table>

There are again some similarities in the pattern of responses to this question when compared with responses to previous questions. Doctor participation in CPD and in Quality Improvement are reported to the board less frequently than responses to complaints and to significant events. Completion of appraisals information is typically only reported to the board annually, however.

Survey responses regarding the impact on clinical practice of the various systems for managing medical performance are tabulated in Table 10.

Table 10 Impact on clinical practice in 2014-15 of systems for managing medical performance

<table>
<thead>
<tr>
<th></th>
<th>A lot worse</th>
<th>A little worse</th>
<th>No change</th>
<th>A little better</th>
<th>A lot better</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Appraisal</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>74</td>
</tr>
<tr>
<td>Participation in CPD</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>0%</td>
<td>99</td>
</tr>
<tr>
<td>Responses to complaints</td>
<td>1</td>
<td>0%</td>
<td>2</td>
<td>1%</td>
<td>88</td>
</tr>
<tr>
<td>Participation in quality improvement</td>
<td>0</td>
<td>0%</td>
<td>3</td>
<td>1%</td>
<td>61</td>
</tr>
<tr>
<td>Responses to significant events/SUIs</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>0%</td>
<td>76</td>
</tr>
<tr>
<td>Actions taken in cases of doctors causing concern</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>95</td>
</tr>
</tbody>
</table>
ROs responding to the survey felt that all systems for improving doctor performance had a broadly positive impact on clinical practice in 2014-15. 65% or more of ROs believed each system had made practice at least a little better, and about 20% of ROs believed that each system had made practice a lot better. The differences in perceived effectiveness are not particularly large, with each system having similar impacts. Participation in quality improvement was however regarded as the most effective system overall, along with responses to significant events. Participation in CPD was felt to be the least effective, while views about the effectiveness of actions taken in cases of doctors causing concern are the most polarised.

5.2 Changes in performance management systems due to the introduction of revalidation

We asked ROs directly whether they thought the introduction of revalidation had brought about changes in systems for managing medical performance. RO responses are tabulated in Table 11.

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Appraisal</td>
<td>49</td>
<td>15%</td>
</tr>
<tr>
<td>CPD</td>
<td>192</td>
<td>61%</td>
</tr>
<tr>
<td>Complaints</td>
<td>231</td>
<td>72%</td>
</tr>
<tr>
<td>Quality improvement</td>
<td>190</td>
<td>62%</td>
</tr>
<tr>
<td>Significant events/SUIs</td>
<td>218</td>
<td>72%</td>
</tr>
<tr>
<td>Doctors causing concern</td>
<td>168</td>
<td>53%</td>
</tr>
<tr>
<td>Fitness to Practise</td>
<td>203</td>
<td>67%</td>
</tr>
</tbody>
</table>

A high proportion (85%) of ROs perceived that their DB’s appraisal systems had changed due to the introduction of revalidation. The proportion of DBs whose other performance management systems had changed due to revalidation was much lower, but not insubstantial. Almost half of systems for dealing with cases of doctors causing concern were felt to have changed. Change had occurred least for complaints management systems, but even here, over a quarter were perceived to have changed.

Comments provided by ROs indicated that the vast majority of changes to other performance management systems resulting from the introduction of revalidation were regarded positively by ROs (see Table 12).

---

6 Don’t knows have been excluded from this table
Table 12: RO views about the desirability of the changes to performance management systems resulting from the introduction of revalidation

<table>
<thead>
<tr>
<th></th>
<th>Positive N</th>
<th>%</th>
<th>Neutral/Mixed N</th>
<th>%</th>
<th>Negative N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPD</td>
<td>105</td>
<td>89%</td>
<td>13</td>
<td>11%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Complaints</td>
<td>70</td>
<td>91%</td>
<td>4</td>
<td>5%</td>
<td>3</td>
<td>4%</td>
</tr>
<tr>
<td>Quality improvement</td>
<td>99</td>
<td>93%</td>
<td>5</td>
<td>5%</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>Significant events/SUIs</td>
<td>62</td>
<td>84%</td>
<td>10</td>
<td>14%</td>
<td>2</td>
<td>3%</td>
</tr>
<tr>
<td>Doctors causing concern</td>
<td>124</td>
<td>89%</td>
<td>10</td>
<td>7%</td>
<td>6</td>
<td>4%</td>
</tr>
<tr>
<td>Fitness to Practise</td>
<td>78</td>
<td>83%</td>
<td>16</td>
<td>17%</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

Some types of change were mentioned quite frequently in relation to many or all of the performance management systems: increased formalisation; greater doctor engagement and participation; improved record keeping and monitoring; better alignment between appraisal and other systems; greater doctor awareness of the importance of that aspect of performance; and increased robustness and quality of the system.

RO perceptions of the nature of the changes that revalidation has brought to each of the systems for managing medical performance are presented in the following sub-sections.

### 5.2.1 Appraisal

The most prominent change to be perceived by RO survey respondents was the increased formalisation and robustness of the appraisal system. Revalidation was identified as having necessitated organisations to ensure proper policies and systems are in place for the conduct of appraisals. A streamlining and standardisation was commonly said to have taken place. In some instances an element of this was moving to online or electronic appraisal systems.

“Increased rigour and discipline”

“more systematic, thorough, complete, to GMC standards”

Where revalidation had brought changes, many ROs felt that the quality of appraisals had increased – they were more robust, i.e., entailed more comprehensive and in-depth consideration of a doctor’s performance. With the advent of revalidation, better quality assurance systems with more frequent checks on quality had been put in place in some organisations. Part of this increase in quality was suggested to be as a result of appraisers being used from outside a DB, and appraisers being better trained. Properly trained appraisers were also stated to be easier for ROs to identify, with lists being provided.

---

7 Excludes a relatively small number of comments that could not be coded
Doctors who did not complete or properly engage in appraisal were said by ROs who perceived revalidation impacts to be easier to chase and if necessary to reprimand. Appraisal rates were also commonly described as having increased, especially in those organisations where they had previously been poor. Appraisals were also described as being conducted in a more timely and frequent manner.

“The appraisal process is much more robust with the introduction of revalidation. The quality is continuously checked and improvements made as a result of findings. Our compliance rate has improved significantly.”

Some organisations had been prompted to provide a dedicated revalidation team or administrative/HR teams to support appraisal, or to make arrangements for general HR or administrative staff to provide some help. This represented an increase in resources to administer appraisal systems.

Some ROs described revalidation as providing them with more power and authority to ensure policy expectations and GMC requirements for appraisal were met. Revalidation could be used as a negotiating tool, and also as a threat to encourage doctors to undertake actions that ROs felt were needed.

‘Sanctions for not completing appraisal now enforced (loss of pay progression, no CEA award support, threat of disciplinary action)’.

Negative comments given by ROs related to the duplication of appraisal activities for doctors working in organisations where little clinical work was undertaken. Doctors working in this type of organisation could have to continue completing the appraisals required by their organisation as well as their appraisals for revalidation purposes. A few ROs also stated that revalidation had increased doctors’ levels of anxiety with regard to appraisal.

### 5.2.2 Continuing Professional Development (CPD)

ROs who perceived change typically saw that making evidence of CPD a mandatory part of revalidation, to be evidenced through annual appraisal, had improved the standard and frequency of CPD undertaken. Doctors were believed to be more aware of CPD, and more engaged in it. It was also felt that CPD was more likely to be appropriate for the needs of both individual doctors and the organisations they work in. CPD was now felt to be more aligned with genuine development needs identified through appraisal, and more in line with professional requirements, such as those outlined in the GMC’s guidance, “Good Medical Practice”.

“The linking between CPD plans and the annual Medical Appraisal process has increased the emphasis individual doctors put on CPD”

“For more rigour in ensuring adequate time and quality of CPD”

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Once again the process was understood to have become more formalised, helped by better record keeping and better means to track doctors’ CPD, thus ensuring that it is undertaken.

“Prior to my arrival, all CPD was ‘signed off’ as appropriate by a non-medical member of staff. As RO, I now sign off all CPD requests, ensuring that CPD is appropriate to both the individuals’ as well as the organisations overall needs”

Some organisations were felt to be more supportive of doctor development, and in some more in-house training was taking place. It was also suggested that CPD having to be formally considered as part of appraisal and revalidation had given doctors more power to access funding and time away from work.

“Revalidation and the appraisal CPD plan are often cited as justification for funds to undertake CPD."

A negative however was that it was felt by a few that CPD arrangements for revalidation did not work for doctors in training given the requirements already set in place for them.

5.2.3 Complaints management

Some ROs asserted that they were now better informed of complaints within their organisations, and attributed this to the improvement and formalisation of the complaints process in response to revalidation. Examples were given of organisations that had improved what were previously poor systems and processes for managing complaints.

Survey answers highlighted instances where revalidation had brought about better data management and use. Complaints could be uploaded to appraisal or portfolio files, or to a central logging system that the RO, appraiser and doctor all had access to. This information was often viewed directly by the RO and/or Medical Director.

“We have a system that ensures that any complaint activity is not only fed back to the Dr involved - but also to their appraisal. It is part of a corporate information sheet which has to be discussed at appraisal”

“As an RO, I now ask questions about complaints and how they were investigated / resolved that previously I may not have had any knowledge of.”

The wider accessibility of complaints data and its use in appraisal was also suggested to have resulted in improved reflection from doctors who had to discuss these events with their appraiser and give responses.

A few respondents noted that as they already had good, robust complaints management systems in place, revalidation had produced little or no impact on these systems. A handful of comments suggested that revalidation had impacted negatively on complaints responses, for example because the formalisation of the process had involved centralisation, reducing responsiveness.
5.2.4 Quality improvement

For ROs who perceived revalidation to have had an impact on quality improvement, this impact was described in many of the comments as a formalisation and systemisation of quality improvement arrangements. Doctors now had to provide and record demonstrable engagement and specific examples, replacing the previous often anecdotal nature of this reporting. Expectations were described as having risen and guidance having become clearer and firmer. The introduction of revalidation had produced large changes in organisations where quality improvement activities had not previously been a requirement.

“Any QI activity has to be demonstrable and documented as opposed to anecdotal.”

The incorporation of quality improvement into revalidation, to be evidenced through appraisal, was also viewed by some ROs as having contributed to quality improvement being given more importance and becoming more focused.

“Annual appraisal is a powerful reminder to medical staff about importance of engaging within Quality Improvement activities”

“Learning from audits/inspections and process improvement initiatives typically leads to excellent reflection - and very clear Corrective Actions and Plans. These activities are given high weighting in ‘evidence review’”

Quality improvement was also said by some ROs to now be part of and better integrated into curricula with an increasing number of trainees partaking in related activities.

“Now part of all curricula, with national working group established at Academy of Medical Royal Colleges. Increasing numbers of trainees engaging with quality improvement projects.”

“The requirement for participation in QI is now becoming embedded in most postgraduate curricula, and subject to review at ARCP. This is not yet universal, but is spreading rapidly, and will be monitored through ARCP.”

Negative perceptions of the impact of revalidation on quality improvement were a small minority of the comments. These highlighted a possible tick box attitude to quality improvement activities, due to the summative nature of revalidation. While doctors were identified as now taking part and being more involved in formal audits, this might not necessarily be oriented towards improving practice, and instead be undertaken as a defensive strategy:

“My problem with quality improvement for revalidation is that it has driven doctors towards simply auditing and justifying their own practice. Innovation enquiry and enterprise has been driven out by regulation and risk management.”

Several ROs also noted that revalidation had enabled them to have clinical audits conducted and enforced which had previously not been possible.
5.2.5 Significant Events / SUIs

For those ROs who perceived change in the way that significant events or SUIs were managed, the introduction of revalidation was generally felt to have brought about formalisation and made existing systems more robust and rigorous, or to have forced organisation that had no systems in place to implement them.

“There is a formal process to follow now, whereas prior to revalidation there was no one process, and the doctors involved were sometimes not taken to task in the same way as they are now.”

There were examples of greater adherence to policy at both organisational and individual levels. More reliable and consistent reporting was described and a better communication of incidents across organisations and within them. Learning was said to be shared more often across departments and organisations, and closer working and information sharing with nurses was described.

“Revalidation led us to link medical involvement in SUIs to our corporate info sheet so that it is more visible. I have also taken on a larger responsibility for the overall running of the SUI system as a result of being an RO”

ROs comments indicated that many regarded reporting and reflecting on SUIs to be an important part of appraisal and revalidation. This focus on SUIs, together with the formalisation of SUI processes were believed by some ROs to have resulted in doctors becoming more accountable for their actions in relation to SUIs. SUIs were seen as good opportunities for triggering CPD that was particularly useful for the individual in question.

“More challenge to individual clinicians to manage and accept responsibility and learn from”

The balance of comments was that where revalidation had impacted on SUI systems, this had been positive: in some of those DBs it had increased doctor engagement in responding to SUIs, and in some others it had helped to develop a ‘no blame’ culture. On the other hand, it was also felt that revalidation might have led to more defensive practice in some cases. A few ROs noted that some clinicians had stopped undertaking some procedures because of worry that things might go wrong and potentially threaten their revalidation.

“Doctors are becoming more engaged, but also potentially a little bit more defensive.”

The need for SUIs to be discussed carefully and sensitively in appraisal was emphasised by some ROs, in order to encourage self-reporting, enable doctors to feel able to ask for help and prevent defensive practice.

“Need to be very cautious as it is imperative not to discourage self-reporting of incidents. If individual thought they would be penalised as a result they would not report. Message needs to be that appropriate reaction to and reporting of a SE is a ‘plus point’ for revalidation. However this would be very difficult message to get across convincingly.”
5.2.6 Doctors causing concern

Most early concerns about a doctor’s practice should be addressed through a variety of organisational processes long prior to revalidation. In our survey we asked ROs what actions had been taken in relation to cases of doctors causing concern that had come to light in 2014-15. Table 13 shows the frequency with which different actions were taken.

Table 13 Actions taken with regard to doctors causing concern during 2014-15

<table>
<thead>
<tr>
<th>Designated Bodies</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formal local investigation</td>
<td>250</td>
<td>80%</td>
</tr>
<tr>
<td>Advice sought from GMC Employer Liaison Adviser</td>
<td>236</td>
<td>75%</td>
</tr>
<tr>
<td>Referral to the Occupational Health department</td>
<td>190</td>
<td>61%</td>
</tr>
<tr>
<td>Restrictions placed on areas of expertise</td>
<td>174</td>
<td>55%</td>
</tr>
<tr>
<td>Formal Local disciplinary action</td>
<td>163</td>
<td>52%</td>
</tr>
<tr>
<td>Referral to the National Clinical Assessment Service</td>
<td>150</td>
<td>48%</td>
</tr>
<tr>
<td>Fitness to Practice referral to the GMC</td>
<td>146</td>
<td>47%</td>
</tr>
<tr>
<td>Other actions</td>
<td>78</td>
<td>25%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>11</td>
<td>4%</td>
</tr>
</tbody>
</table>

At least one formal local investigation had taken place in 80% of DBs where cases of doctors causing concern had come to light in 2014-15. Advice from GMC Employer Liaison Advisers had also been sought by many DBs. A wide variety of actions may be used – none of the potential actions we asked about had been used infrequently. The most frequently cited action that we had not listed was low level remediation activity by managers, such as informal advice, reviews of work and agreements of new behavioural standards for the doctor. External agencies were also called on, including involving the police, NHS Protect Counter Fraud Investigations, and external review by a Royal College or other organisation. Some doctors were subject to disciplinary sanctions up to and including dismissal. Others were informally excluded: the prospect of disciplinary action was used to encourage them to retire or to leave the organisation.

As for other systems for managing medical performance, the introduction of revalidation was commonly mentioned by ROs as having brought about more formalised processes in relation to doctors causing concern.

“It is more formalised and we have a remediation policy with more support. We have implemented coaching for doctors for example. We have 9 trained consultant coaches who coach other consultants as part of a local remediation process. This has in my view "saved" careers as well as help doctors improve their skills and so healthcare delivery. I believe we are the first hospital to implement such a service and we have recently submitted an article on this to "Coaching Today".”
Many responses indicate that multi-faceted approaches have been designed and employed. These deploy a variety of measures to meet the specifics of the situations ROs encounter in their Designated Bodies. The need to bring about culture change was also touched upon by a few ROs. The sorts of values that might be desirable are illustrated in one RO’s approach to the issue of doctors causing concern:

“1. Less tolerance of doctors not fit to practice; 2. Better understanding of what ‘good’ looks like; 3. Colleagues know that raising concerns is part of their duty as a doctor, even about colleagues”

A number of comments indicated the revalidation had caused organisations to review and clarify their policies for dealing with doctors causing concern. There were also examples of other, related local policies being developed too, including local policies on remediation, Maintaining High Professional Standard (MHPS), clinical behaviour and codes of conduct.

“Because [our organisation] does not employ doctors, there was no formal response to doctors causing concern before revalidation. This and all the organisational structure supporting revalidation has had to be set up de novo.”

The introduction of revalidation has also changed the relationship between some DBs and the GMC’s Employer Liaison Service (ELS). Some comments indicated that ROs are contacting the GMC, via the ELs, at an earlier stage of concern than they would have done previously.

“Early discussion with GMC ELA is most helpful - not possible before”

“It is a far more robust process now. The linkage with the ELA has helped communication with the GMC.”

The attitude to the ELAs’ role in this regard was overwhelmingly positive, and often ROs cited the ELAs as helping to make the process of dealing with doctors causing concern more ‘robust’ at a local level. One RO went so far as to suggest that it had changed their entire working relationship with the GMC.

There were several examples of communication having improved as a result of revalidation. Some improvements were in formal processes. For example:

“The RO and MD meet with the GMC on a regular basis to discuss doctors causing concern.”

In addition there was an indication that informal process of reporting and raising concerns about doctors had improved in some DBs:

“I think perhaps people are more likely to raise concerns about colleagues now than before”

One RO stated that there had been more discussion with other employing bodies, but some other ROs had encountered problems with the Medical Practice Information Transfer (MPIT) system⁹. The voluntary nature of the RO’s responsibility to push information about doctors causing concern forward to new employers was also mentioned as an issue.

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⁹ See https://www.england.nhs.uk/revalidation/ro/info-docs/mpit-form/ for further information
“RO to RO transfer of information remains patchy and at times late.”

Some ROs suggested that although the introduction of revalidation may have been a factor, the changes to how doctors causing concern were managed were more to do with other changes. For example:

“Yes, but more as a result of regulatory oversight of education, and QA of education, than as a result of revalidation... We now have very well developed processes for the performance support and management of what were commonly termed ‘doctors in difficulty’.”

“Change of MD more important than RV itself”

Data gathered elsewhere in our survey indicates that ROs do not believe revalidation itself has made much difference to enabling concerns to be identified earlier. Comments suggested that, as per guidance, the five-yearly revalidation recommendation is not an appropriate tool for dealing with concerns. Prompt action is important in such cases.

“The key requirement in regard to concerns is that the must be acted on in a timely and effective manner by those responsible. If action is only taken at the time of revalidation then the system has failed.”

“Concerns must be identified investigated and managed appropriately when they arise” [emphasis added]

“To realise that there are concerns about a doctor only at the point of revalidation is a failure. Concerns must be identified investigated and managed appropriately when they arise, this is the message of the regulations”

Annual appraisals might contribute to raising concerns about a doctor, but issues would more likely be picked up through other means in between appraisals, such as complaints and significant events/SUIs.

“Appraisal is still very rarely the means of identifying concerns - in only 1 case has appraisal been the primary source of a concern (though on some occasions appraisal information has echoed concerns already 'live' from another [source])”

“Appraisal is an annual process, revalidation every 5 years. That means most concerns surface and must be responded to outside these processes”

Summary statistics from our survey regarding the information sources that had been used in bringing cases of doctors causing concern to light in 2014-15 are given in Table 14.
Table 14: Information Sources identifying doctors causing concern in 2014-15

<table>
<thead>
<tr>
<th>Information Source</th>
<th>Designated Bodies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Appraisal</td>
<td>144</td>
</tr>
<tr>
<td>CPD</td>
<td>39</td>
</tr>
<tr>
<td>Complaints</td>
<td>250</td>
</tr>
<tr>
<td>Quality improvement</td>
<td>77</td>
</tr>
<tr>
<td>Significant events/SUIs</td>
<td>218</td>
</tr>
<tr>
<td>Whistleblowing</td>
<td>147</td>
</tr>
<tr>
<td>Other sources</td>
<td>142</td>
</tr>
</tbody>
</table>

These figures relate to organisations rather than to individual cases of doctors causing concern, so they are not straightforward to interpret. They do however give a rough indication of the relative extent to which different systems for managing medical performance are likely to play a role in giving rise to concerns about doctors. Complaints and SUIs are likely to be the most frequent sources of concerns, with CPD and Quality Improvement relatively infrequent sources. Appraisal would appear to be a not infrequent source of information that at least helps to bring cases of doctors causing concern to light.

The most commonly mentioned of the “other sources” of information about doctors causing concern was other members of staff internal to the organisation (n = 35). There were 20 mentions of the GMC providing information\(^\text{10}\). The criminal justice system, primarily the Police, but also fraud cases, was mentioned 18 times.

The role of revalidation in bringing cases of doctors causing concern to light would appear to be relatively small. However, excluding don’t knows, 34% of ROs responding to our survey said that there have been more cases of doctors causing concern since the introduction of revalidation. 63% felt that the number of cases has been about the same, while only 3% felt there had been fewer cases. It is not clear from our data what might underlie this perceived increase in cases.

5.2.7 Fitness to practise

Table 15 shows the information sources which ROs said had been instrumental in at least one fitness to practise (FTP) referral from their DB during 2014-15.

\(^{10}\) Although the survey comments do not specify this, these instances may have been the GMC informing ROs of FTP complaints that were not sufficiently serious by themselves to threaten a doctor’s registration. In these cases the GMC asks the RO if there is any other information that might indicate a pattern of behaviour. See [http://www.gmc-uk.org/concerns/making_a_complaint/referrals.asp](http://www.gmc-uk.org/concerns/making_a_complaint/referrals.asp)
The pattern of information sources is very similar to that of those used in identifying doctors causing concern (Table 14). Some similarity is to be expected, as cases of doctors causing concern may lead on to FTP referrals. The slightly flatter distribution for FTP referrals would be consistent with FTP referrals tending to arise when information from more than one system indicates issues. Almost half of RO respondents said that other sources of information had been used in FTP referrals. These were largely external sources of information. Investigatory or regulatory/governance bodies such as the police, coroner, NHS Protect, CQC, GMC or Controlled Drugs Accountable officers (CDAOs), were prominent. Information might also come from Royal Colleges, NHS Employers or other healthcare organisations (e.g. NHS Trusts, CCGs), or through RO to RO communication. Sources mentioned that were internal to the DB included Occupational Health departments and the educational records of employees.

Figure 3: Comparison of information sources used to identify doctors causing concern and in making fitness to practise referrals
About a third of respondents indicated that there had been changes in fitness to practise arrangements due to the introduction of revalidation. These appear to be similar to the changes in arrangements for managing cases of doctors causing concern, with ELAs, formalisation and better communication prominent in RO comments.

ELAs are regarded very favourably and their advice about how issues can be managed locally may have prevented some doctors from being referred to the GMC. ELAs have also helped some ROs to be clearer about the thresholds for referral.

"Through the relationship with my ELA I am able to have very useful conversations that inform action. So far none have needed to be referred for formal FtP"

"We have far more cases coming forward and they are exceedingly complex. We have forged a close relationship with our ELA who provides us with an excellent service"

Some ROs say that revalidation has prompted some DBs to make their FtP processes ‘more organised and standardised’ as one RO described it. In some organisations formal policies have been introduced or updated. Professional Standards Monitoring Groups to oversee some of the processes have also been established. Revalidation has also provided access to forums where FtP systems can be discussed:

“We discuss our approaches [to FTP arrangements] at the regional MD monthly meetings and the RO networks”

Comments suggest the value to ROs of having a variety of communication channels for information sharing and advice - upwards towards the GMC through the ELAs, downwards into the running of designated bodies, and horizontally through RO networks.

Further comments centred on how ROs felt that the FtP referral thresholds had been lowered since the introduction of revalidation. Excluding don’t knows, 26% of ROs responding to our survey said that there have been more FTP referrals since the introduction of revalidation. 71% felt that the number of cases has been about the same, while only 3% felt there had been fewer cases. Issues regarding referral thresholds are discussed further below.

Some ROs also expressed a concern that FTP processes are overly lengthy and bureaucratic, interfering with revalidation schedules among other things:

“This slow delivery of justice is unhelpful to the NHS”
6 How revalidation recommendations to the GMC are made

Revalidation recommendations should be supported by information about a doctor’s performance drawn from other systems for managing medical performance. We therefore asked ROs about the proportion of revalidation recommendations which used information about doctor performance drawn from each of these other systems. We also asked ROs to comment on how such information is used in revalidation.

Decision making processes and structures with regard to making revalidation recommendations are likely to vary between different organisations, particularly bearing in mind the wide range in the number of doctors connected with a DB, and whether the RO is internal or external to the organisation within which a doctor works. We aimed to identify broad patterns as a basis for more detailed exploration later in the research. ROs were also asked to provide a brief description of the arrangements and what determines the process followed for a particular doctor.

There was one further, very specific question we asked, about whether the RO communicates their revalidation recommendation to the doctor concerned, and if so, whether this is before or after the recommendation is made. This was to investigate the extent to which this aspect of the GMC protocol on making revalidation recommendations was being followed, as informal prior intelligence suggested that practice was variable.

We also asked for free text descriptive information regarding instances where making revalidation recommendations that might not be straightforward:

- Positive recommendations where the RO nevertheless had some concerns about the doctor, but they were judged not sufficient to warrant deferral.
- Deferring a recommendation due to lack of information
- Deferring a recommendation due to an ongoing local process
- Recommendations of non-engagement in revalidation

In the sections below we present our findings with regard to how revalidation recommendations are made. First we cover decision making processes and structures, then the instances where making revalidation recommendations may not be straightforward.

6.1 Use of information from other performance management systems in revalidation

Table 16 presents statistics regarding the proportion of revalidation recommendations in which information about CPD, complaints, quality improvement or SUIs is used. Don’t knows are excluded from the table.
Table 16: Proportion of revalidation recommendations made using different types of information

<table>
<thead>
<tr>
<th></th>
<th>0-20%</th>
<th>21-40%</th>
<th>41-60%</th>
<th>61-80%</th>
<th>81-100%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N %</td>
<td>N %</td>
<td>N %</td>
<td>N %</td>
<td>N %</td>
</tr>
<tr>
<td>CPD</td>
<td>18</td>
<td>6%</td>
<td>5</td>
<td>2%</td>
<td>288</td>
</tr>
<tr>
<td>Complaints</td>
<td>36</td>
<td>12%</td>
<td>11</td>
<td>4%</td>
<td>237</td>
</tr>
<tr>
<td>Quality improvement</td>
<td>28</td>
<td>9%</td>
<td>10</td>
<td>4%</td>
<td>242</td>
</tr>
<tr>
<td>Significant events/SUIs</td>
<td>46</td>
<td>15%</td>
<td>13</td>
<td>4%</td>
<td>226</td>
</tr>
</tbody>
</table>

Information drawn from other systems for managing medical performance would appear to be used in making quite a high proportion of revalidation recommendations. Information about CPD is used the most, which is consistent with CPD being considered in every appraisal. Information about complaints and SUIs is used less, which is consistent with some doctors not receiving complaints or being involved in SUIs. It is difficult however from these figures to estimate the proportion of revalidation recommendations that do not make use of information from other systems, or to say whether there is differential use of information from the different systems.

Explanatory comments made by ROs indicated that on the whole CPD was seen as an important factor in determining the revalidation recommendation. Many ROs noted that if a doctor had not undertaken enough high quality CPD, or didn't have a good enough CPD plan, then they would not revalidate them. “No evidence, no revalidation” was the sentiment of a number of comments. CPD information was passed on by the appraiser or through formal records (appraisal portfolios, organisational record keeping of doctors activities i.e. not based on self-reporting alone) for many. Some noted that while the CPD information was not used explicitly, appraisal reports were, and so as CPD is discussed in appraisal it impacts on revalidation recommendations indirectly through this.

“We require all doctors to record participation in CPD activities within their e-appraisal record. This information is reviewed for all doctors prior to revalidation. CPD information is checked for quality, appropriateness and confirmation that College requirements have been met.”

“No information about CPD was used directly in terms of making revalidation decision, but it was implicit in as much as CPD discussion had to take place in the appraisal process, and this latter was used in revalidation decision”

The significance of CPD for revalidation decisions however was seen to vary across specialities. For example, an RO might feel that experience and clinical practice are more significant for the improvement of clinical surgical skills than a course. A minority of ROs felt that CPD was not a sensitive measure of overall performance or that it should not be taken into consideration in revalidation decisions.

“It does not seem to be a very sensitive discriminator of overall performance”

Complaints information was acknowledged as a crucial part of appraisal and a form of evidence required for and contributing to revalidation decisions. Some ROs indicated that complaints serious enough to affect a revalidation decision would be picked up outside of appraisal.
information about complaints can be more difficult with regard to doctors who work for an organisation other than the designated body. This would make it easier for such doctors to not self-report accurately in appraisal if they were so inclined.

Although a small number of ROs mentioned complaints data being triangulated both within appraisal and more between appraisal and the complaints system, the value of looking at complaints other than those brought specifically to appraisal was felt to be limited. It is difficult to use complaints to make inferences about the overall quality of a doctor’s professional practice because complaints are only tracked if a specific doctor is named, are eclectic in their content and recording, and often rely on self-reporting.

“Complaints against medics (and other staff) are of varying quality and it is often difficult to draw conclusions from them concerning the quality of a professional’s practice.”

The most important aspect of complaints being raised in appraisal, and how complaints against doctors were noted as being judged by responsible officers, was not the content of the complaint nor the organisation’s response, but instead the doctor’s personal response, in particular their ability to reflect and to improve their practice.

“We just check how many, not the quality of the response....which is in any case heavily altered at corporate level and so not a fair judgement on the doctor. It is more how the complaints are reflected on in the appraisal that counts”

There was no indication in the comments provided by ROs that when making revalidation recommendations they looked beyond the quality improvement activity that had been considered in appraisals. Rather, ROs regarded quality improvement information as an integral and mandatory part of appraisal, which should be reflected on by doctors in appraisal.

Self-reporting of significant events/SUIs in appraisal was expected. Reflection on SUIs was seen as crucial. As with complaints, the most important aspect of an SUI in regards to assessing a doctor was how that doctor learned from the incident. A small number of ROs suggested that how a doctor reviews their practice in response to SUIs is a good indicator of their overall practice.

Some ROs noted that not all doctors report SUIs in appraisal. Furthermore, it can be difficult for ROs to access information about SUIs held by other organisations where a doctor has been working.

“Again this information is often not available for contracted doctors revalidated under separate DBs. As long as the process focuses on support of the doctor and dissemination of learning without finger pointing this is effective although some loss of confidence is inevitable. I have observed restrictions and changes in practice put in place after SUIs can improve audited clinical practice.”

The problem of reliance on the self-reporting of SUIs was said to be most acute in regards to doctors who either do not work for the DB or who work across multiple sites, particularly if these sites are situated both inside and outside of the NHS. It was suggested that this may be less of a problem for ROs in smaller organisations, as it is easier for them to be aware of any SUIs and other events that occur in their organisation.
If concerns about a doctor were on-going when a revalidation recommendation was due, then a deferral recommendation might be made, in order to allow time for the concerns to be investigated fully. Concerns by themselves would not automatically constitute a reason for withholding a positive revalidation recommendation, as revalidation relates to “Fitness to Practise” rather than a higher standard of “fitness for purpose”, i.e., standards expected of the post.

“We look at fitness to purpose and the GMC has [an] interest in Fitness to Practise. There is a gulf between them.”

“Actually this is very difficult because of the limited options. A Yes / No button is unable to describe doctors with local action plans, or in whom there are concerns. I have a few doctors who are cause for concern but who have been revalidated because they are fit to practise. I don’t know the answer to this because I would not want to flag them up to the GMC as being a ‘problem’ if this is a local, probably temporary situation which can be managed.”

Concerns might however form part of a bigger picture, and as such contribute to the revalidation recommendation.

“I think it [concerns] is an important part of the decision making process when considering a recommendation”.

6.2 Decision making processes and structures for making revalidation recommendations

We asked ROs to indicate the processes that they usually follow in order to determine their revalidation recommendations. Their responses are summarised in Table 17.

<table>
<thead>
<tr>
<th>Process</th>
<th>Responsible Officers</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviewing the case documentation</td>
<td></td>
<td>279</td>
<td>88%</td>
</tr>
<tr>
<td>Discussing the case with someone else</td>
<td></td>
<td>129</td>
<td>41%</td>
</tr>
<tr>
<td>Confirming a recommendation made by someone else</td>
<td></td>
<td>82</td>
<td>26%</td>
</tr>
<tr>
<td>Discussing the case in a formal group</td>
<td></td>
<td>69</td>
<td>22%</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>31</td>
<td>10%</td>
</tr>
</tbody>
</table>

A high proportion of ROs usually arrive at their revalidation recommendations by reviewing the case documentation. Various additional means of arriving at recommendations may be employed. Comments made by ROs indicate that there is no uniform pattern to this - different DBs/ROs have different arrangements, and different processes may be used for individual cases depending on their
nature. Some organisations seek consistency by having a single multi-stage process that involves several potential steps. Whether these steps are followed depends on the severity or complexity of the issues relevant to the recommendation. The elements of the process may be carried out by various actors, such as Deputy ROs, Deputy Medical Directors, Line managers, and Appraisal leads.

In addition to the options offered in the survey, RO responses suggest that having read the appraisal documentation it may be quite common for the RO to discuss the situation with the doctor concerned. There may also sometimes be discussions with others in the workplace such as the doctor’s line manager, or with others in the revalidation system, such as the appraiser.

Once a revalidation recommendation has been determined, GMC guidance is that the RO should inform the doctor of the recommendation prior to sending it to GMC. However, less than a third of ROs who responded to our survey said that they do this (see Table 18).

Table 18 Are your revalidation recommendations to the GMC communicated to the doctor concerned?

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes - after making the recommendation</td>
<td>165</td>
<td>53%</td>
</tr>
<tr>
<td>No</td>
<td>47</td>
<td>15%</td>
</tr>
<tr>
<td>Yes - before making the recommendation</td>
<td>102</td>
<td>33%</td>
</tr>
</tbody>
</table>

The proportions of ROs who had encountered various situations where making a recommendation was not straightforward is given in Table 19.

Table 19: ROs who have made revalidation recommendations that are not straightforward

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Positive recommendation but with concerns</td>
<td>227</td>
<td>72%</td>
</tr>
<tr>
<td>Deferral because of ongoing local process</td>
<td>173</td>
<td>55%</td>
</tr>
<tr>
<td>Deferral based on insufficient information</td>
<td>68</td>
<td>22%</td>
</tr>
<tr>
<td>Non-Engagement</td>
<td>228</td>
<td>73%</td>
</tr>
</tbody>
</table>

None of these situations would appear to be very rare (a quarter or more of ROs have encountered them), except perhaps in small DBs. Deferral based on insufficient information may even be quite common. We asked ROs who had encountered these situations to describe the circumstances that pertained, and what types of action they had taken.
6.3 Positive recommendations but with some residual concerns

28% of ROs had made at least one positive recommendation of revalidation while still having residual concerns about the doctor. Some commented:

“The definition of concern is broad and ill-defined. I have concerns about several of my colleagues but nothing objective and little in writing. This is not a robust enough evidence trail for action or not giving a recommendation that is positive”

“Issues that were below the threshold for formal investigation and insufficient to warrant a deferral - e.g. minor behavioural issues, issues related to the age of the individual but where competency was not shown to be materially flawed.”

Some ROs expressed the view that the quality of the evidence that doctors make available in appraisal is not always a good guide to their performance as doctors. Some good doctors do not produce good portfolios, and conversely some doctors about whom ROs have concerns are adept at producing high quality information for their appraisals.

‘More often than not the concern relates to the quality of the evidence in the Doctors portfolio rather than the Doctor per se. Some Doctors whom I have some concern about produce excellent portfolios’.

“Minor behavioural concerns that were addressed at the time but subsequently have escalated again. In some doctors they tick all the boxes and can evidence everything that they need to - as an RO you can only really act on the evidence before you and not the “gut reaction.””

Some ROs may take precautionary actions in such situations to improve the doctor’s practice or to look out for potential poor practice in future, such as adding training requirements to the doctor’s personal development plan, or instituting on-going forms of monitoring the individual, where the concerns are ‘banked’ or ‘noted’ on the local records of the organisation.

Some ROs were of the view that the revalidation criteria are not well suited to some doctors, such as those who practice medicine in non-clinical areas, or who have no patient contact. Others raised concerns about the criteria not being applied reliably, suggesting that there might be variation between DBs, or that appraisals are not all conducted with the same level of rigour.

The means by which ROs came to a decision on these more marginal cases seemed once more to be a mixture of internal and external process to a DB. For example, some would liaise with Royal Colleges:

“Subject to judicial mediation. Subsequent externally facilitated mediation, Invited College Review.”

Equally some ROs indicated they would approach the ELA for advice on this matter:

“After discussion with the Employer Liaison Adviser it was agreed that there is not enough concern to warrant a deferral.”

It was also common for ROs to talk to the Clinical Director or another RO before choosing an action,
“Low level behavioural/performance issues which myself and the Associate Medical Director discuss prior to making a recommendation.”

Typically the RO would only approach an ELA when things had reached a ‘serious' point that moved beyond their local procedures:

“These cases are always discussed in great length by the RO and his team. If necessary, further advice from the GMC ELA is sought.”

Deferral might be used in such cases to allow more time for investigation or for the doctor to address perceived issues.

“There are always a few doctors where I and my team spend time discussing the evidence because of some concerns. In some instances we have asked the doctor to participate in specific educational or improvement activity. We probably now are more inclined to defer if [in] doubt, after an experience where we had a positive recommendation and the CQC subsequently visited the practice where the doctor worked and discovered very unsafe practice”

6.4 Deferral due to an on-going local investigation or disciplinary process

Almost half of respondents had requested deferral of a recommendation because of an on-going local process. The majority of comments respondents made about deferral requests related to doctors being under internal investigation or disciplinary action, including concerns about employed doctors that were being handled under the national Maintaining High Professional Standards (MHPS) framework. The RO often needed additional time to establish the outcome of a local investigation. For example:

“A doctor under investigation for capability and conduct. Deferred until the outcome was likely to be known. In some cases that investigation might lead to a GMC referral in any case.”

Other reasons for deferral included the doctor being subject to an ongoing GMC investigation; being under NCAS referral; or being under formal remediation. A number of respondents mentioned that they contacted their assigned ELA to seek advice on deferral. For example:

“By the RO protocol a request for deferral must be made if an internal disciplinary process is ongoing, but there are not fitness to practise concerns above the GMC threshold. ELA advice was sought.”

6.5 Deferral due to insufficient supporting information

A variety of issues were identified by ROs that had caused the deferral of a revalidation recommendation due to insufficient evidence. This was primarily a lack of either quality or quantity of supporting information. Patient, colleague or multi-source feedback was most frequently highlighted as being problematic by survey respondents. Lack of evidence of CPD was not indicated as frequently.

Respondents indicated various underlying reasons that might lead to a deferral on the grounds of insufficient evidence. Ill health was mentioned most frequently, followed by maternity leave and a doctor being new to the role, having moved from another designated body or from outside the UK. The issue of a lack of information from previous roles might be more likely to occur with regard to doctors on short-term contracts or working as locums.

A few ROs indicated that deferrals may also occur because the doctor has chosen to prioritise their clinical work, or has a very high workload, and has not found the time to complete their documentation. A number of ROs said that when they make a deferral, the necessary actions to address the lack of supporting information are incorporated into the doctor’s personal development plan in order to help ensure that the changes are made. In one instance this included a highly structured programme that required the doctor to meet weekly targets.

Some deferrals were attributed to shortcomings in GMC guidance about supporting information for appraisal and revalidation. The doctors concerned had not fully understood this guidance. Other comments also highlighted that some clinicians do not have a good understanding of revalidation processes and requirements.

“A proportion of deferrals are due to inadequate supporting information on QI. The guidance from GMC is however confusing and weak. There should be an annual requirement for something, with the 5 year requirement being a full range of activities.”

“There is a lack of understanding about requirements for revalidation and any recommendation other than to relicense. Many doctors think they will lose their licence to practise if I recommend deferral. I most often defer due to lack of QI information which they did not realise they had to undertake...”

6.6 Recommendation of non-engagement

About a quarter of respondents had made at least one recommendation of non-engagement. This lack of engagement in the revalidation process ranged from portfolios not providing sufficient evidence to reach the minimum standard required, to refusing to take part in an appraisal meeting, to in some cases refusing to participate in any aspect of revalidation. Most comments did not explain why some doctors refused or were unable to comply, although three responses cited ill health as a

contributory factor. One of these doctors subsequently had their licence removed; in the other two instances the issues underlying non-engagement were resolved:

“Non-participation in the appraisal process, which we discovered, on close inspection, to be due to ill-health. Now being resolved.”

“One doctor had conduct and health issues. He is now engaging fully with the process”

In some cases, a recommendation of non-engagement appears to be a powerful tool to secure engagement; as one RO commented:

“A doctor was 'not engaging' - after a referral to the GMC he complied remarkably quickly!”

Several free text responses highlighted the issue of non-compliance in revalidation by long-serving or senior doctors, particularly those nearing retirement, for whom not being revalidated would make little difference to their career path. For example,

“[one doctor] ...chose a route of non-engagement upon impending retirement to express displeasure with the GMC and Revalidation in general!”

Rather than outright protest, however, comments typically indicated that the non-engagement of senior doctors might occur because the process does not accord with their views about what constitutes a professional, believing that the extent of their experience should be sufficient; for example:

“Senior doctors who do not believe the processes apply to them - expect revalidation on past reputation”

In one case, a doctor nearing retirement age was apparently under the impression that she had no need to be revalidated.

“An elderly doctor who was in a very specific role in an unusual PH setting. She did not fully understand the significance of retaining her licence to practise (despite many communications on our part) and had thought she could just retire.”

The RO made a failure to engage recommendation, in full discussion with an ELA, and shortly thereafter the doctor made an application to voluntarily relinquish her licence, which the GMC accepted.

Three instances were cited where doctors had continued to practise, despite having a non-engagement recommendation. In some cases, further investigation and action by the GMC following a recommendation of non-engagement may take considerable time. From the perspective of the RO making the recommendation this can appear as though the doctor is being incorrectly allowed to continue to practise. Such doctors may subsequently ‘slip under the radar’ when moving between designated bodies. For example, two of the respondents explained:

“A doctor who has not had an appraisal for several years and refuses to do so. Despite many warnings he refused. A referral to the GMC for non-engagement led to the doctor requesting a
different RO. To my knowledge this doctor has still not had an appraisal but continues to work in the private sector.”

“This was in my previous role as RO to [Designated Body X]. A doctor refused to record or take part in any CPD. After much and lengthy discussion and encouragement I had, in the end, to say that he was not engaging. I note that nothing appears to have happened and he continues to practice.”

6.7 Issues related to making revalidation recommendations

We asked ROs to provide general comments about the processes of making revalidation recommendations to the General Medical Council. Three themes came through strongly in the comments: GMC support systems; the difficulties of obtaining information about doctors who are somewhat remote from the RO; and the quality of the process and assuring its quality. These themes are described the following sub-sections.

6.7.1 GMC support systems

Mixed views were expressed about support from the GMC, with roughly equal numbers of positive (9) and negative (7) comments. For example one respondent commented how such external support helped improve standards and reduce costs when introducing revalidation within his/her organisation:

“The system for making recommendations through GMC Connect works well and has been well designed to facilitate the work of the RO”

On the other hand, the GMC Connect system was also said not to be ‘user-friendly’ by a small number of ROs. Individual respondents also suggested areas where advice and guidance might be improved.

“More definitive guidance on QIA [Quality Improvement Activity] requirements”

“The training and RO networks could do with giving more worked examples of difficult cases. The workload involved in making the recommendations is large and I currently don't have the confidence to delegate this to anyone else (probably quite rightly). I get the impression that in the difficult cases the GMC Liaison Advisers don't really want to be hassled with giving advice. Someone supportive to chat with would be helpful.”

The GMC role in addressing difficult cases was a wider theme across the survey. A number of ROs would like to see a more rapid and coordinated service from GMC with regard to addressing doctor non-engagement and FTP issues.

“There is sometimes problem linking different arms of the GMC, revalidation team (non-engagement) and fitness to practice team. End up doing same reports for both!”
“FTP concerns are managed slowly by the GMC and often only taken after a trust MHPS process”

6.7.2  Doctors who are remote from the RO

If the RO has little or no opportunity to interact with a doctor or others in their place of work, then this can make it difficult to resolve any problems related to the revalidation of that doctor. Such doctors include locums, who may only work in one particular organisation for a short period of time; doctors whose workplace is not that of the RO; and doctors who work both in the UK and outside it. Where doctors are geographically distant from the RO, then there is less personal contact, and if they work in another organisation then there can be difficulties in tracking performance data. There is evidence however, of some ROs taking a proactive approach to try to improve the communication of information between ROs:

“...Locums remain a problem area but I have developed good links with the ROs of the agencies we use. Also I have discussed individual doctors’ performance with other ROs if the doctor has moved or is part of a training rotation.”

Another respondent raised concerns over limited company doctors registering with locum agencies to be revalidated, and not being subject to rigorous revalidation processes:

“One of my main concerns is the way that Limited Company doctors make connections to designated bodies - usually agencies. [...] This group of doctors can be revalidated directly with the GMC but choose to follow an inappropriate process with agencies which the agencies continue to foster. As you can imagine this is a huge irritation and I am strongly of the opinion that the regs either need to be changed or enforced more actively.”

One RO from a government agency highlighted difficulties in obtaining relevant information about medical performance in relation to connected doctors that the agency does not employ directly:

“...We cannot easily be assured that, in 152 [organisations], there are adequate policies and practices in place to... provide the RO with the ‘clinical’ governance intelligence in sufficient detail that he requires....”

The respondent did add however that his/her agency is working to develop a 'concordat' with these organisations to improve continuity of practice and communication, but also noted that “they have no obligation to agree!”

6.7.3  Quality and quality assurance of appraisal and revalidation

Some participants emphasised the importance of effective quality assurance for the appraisal and revalidation process. The need to have clear systems to collate data, written policies, and interdepartmental support from colleagues at all levels, was a common theme, particularly with
regard to large DBs, or situations where the DB is remote from the doctors being revalidated. For example:

“Needs to be well supported by a team of medical managers who know what is involved and who are proactively dealing with issues not ducking them in the hope I will action through re-laid action recommendations.”

“I work across a multi-centre organisation, and often have never met my doctors even making recommendations. [There is a] High reliance on local processes adherence to policy and trusting colleagues.”

“It is straightforward in the majority of cases especially when the doctor is know[n] personally. More difficult if there are ongoing issues and also there need to be clear processes for the RO to obtain appropriate confirmatory evidence from clinical leads who do know the doctor personally.”

Other participants doubted whether effective quality assurance systems were in place in all DBs. Concern over ensuring continuity, quality and integrity within the appraisal process were raised by a number of respondents. There can be variability in both what the appraisee brings to an appraisal meeting, and in how that meeting is conducted by the appraiser.

“… One must have a lot of trust in the validity of the appraisal process, and I know that appraisal is very variable (not from my own connected doctors but from my own Trust). I know of appraisals which are done on the telephone for 10 minutes and appraisals which take 4 hours, and portfolios which take days to compile and reflect compared with portfolios which are just lists of conferences and meetings attended.”

Nine respondents went so far as to question the revalidation model and its value. Their perception was that revalidation has done little to improve clinical standards and patient safety, and as currently constituted, does not represent value for money.

“…huge and expensive industry, which will be self-serving and we’ll be stuck with it for ever. To improve governance processes in the organisations would have had a much better effect…”

“It’s an enormous bureaucratic process that I am not totally convinced improves the clinical practice .It may reassure the public and cover the GMC but not sure it helps deal with doctors in trouble.”

“Been very expensive in time and money with no gain. Total waste of resource for my Practice and I think for the Medical Profession in the UK but I will follow it as it is the law of the land.”
7 The implementation and impact of revalidation

It is important to understand the variety of factors affecting the implementation of revalidation and the variety of impacts that have resulted. So as not to constrain answers we asked ROs to describe factors helping or hindering the implementation of revalidation, plus three areas of impact: on the RO and their role; on appraisal and other systems for managing quality; and on clinical practice. Similarly, we aimed to tap into RO insights through an open ended question asking for suggestions of changes that might improve the way revalidation works. The following sections present our results with regard to implementation, the three areas of impact, and suggestions for improvement.

7.1 Factors affecting the implementation of revalidation

Respondents described a variety of factors that had affected the implementation of revalidation. The themes we identified in what ROs told us, and the number of ROs whose comments constituted each theme are listed in
There are several factors that appear to help the implementation of revalidation if they are present and hinder it if they are absent. These factors might be potential priority areas for action in order to ensure they are present to a sufficient extent, as they can both reduce problems and support good practice. The problem areas most often mentioned are lack of resources (especially financial resources); issue with, or lack of IT support systems; lack of a good internal support team and interdepartmental working; the time consuming nature of revalidation; and lack of doctor engagement in, and understanding of revalidation.

Having a good internal support team and interdepartmental working would appear to be important to the successful implementation of revalidation, and is present in a significant proportion of DBs.

“...I was helped by a group of enthusiastic consultants, HR and education and training...”

“Company very proactive and supportive. Doctors and appraisers trained in house which helps engagement.”

Conversely however, a lack of support or communication at board level or between departments when implementing revalidation had been experienced by a number of ROs. For example:

“Lack of access to experienced staff in HR and Governance with background of working with medical staff”

“There was no infrastructure at all and it has been my job to create it, including the policies. The company has only very infrequent board meetings so it has been a challenge getting policies approved by the board. I have created a lot of policies that are waiting board approval to go into effect.”
<table>
<thead>
<tr>
<th>Helping factors</th>
<th>N</th>
<th>Hindering factors</th>
<th>N</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having a good internal support team/interdepartmental working (inc Board)</td>
<td>86</td>
<td>Lack of a good internal support team/interdepartmental working (inc Board)</td>
<td>25</td>
<td>111</td>
</tr>
<tr>
<td>Good IT systems</td>
<td>22</td>
<td>Issues with/lack of IT systems</td>
<td>28</td>
<td>50</td>
</tr>
<tr>
<td>Having adequate resources</td>
<td>11</td>
<td>Lack of resources (especially financial)</td>
<td>32</td>
<td>43</td>
</tr>
<tr>
<td>Good pre-existing governance system</td>
<td>25</td>
<td>Poor/lack of pre-existing governance system</td>
<td>3</td>
<td>28</td>
</tr>
<tr>
<td>Small DB makes it easy to know about the doctors in the organisation</td>
<td>18</td>
<td>Small DB not suited to this model of revalidation</td>
<td>tbc</td>
<td>tbc</td>
</tr>
<tr>
<td>Doctor engagement/understanding</td>
<td>5</td>
<td>Lack of doctor engagement/understanding</td>
<td>18</td>
<td>23</td>
</tr>
<tr>
<td>Requires little time</td>
<td>0</td>
<td>Time consuming</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>GMC support/guidance</td>
<td>14</td>
<td>Lack of GMC support/guidance</td>
<td>5</td>
<td>19</td>
</tr>
<tr>
<td>ELA support/guidance</td>
<td>14</td>
<td>Lack of ELA support/guidance</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>Other external support/guidance (e.g. Royal Colleges)</td>
<td>11</td>
<td>Lack of other external support/guidance</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>RO Networks support</td>
<td>12</td>
<td>RO Networks poor value</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Revalidation system is simple</td>
<td>0</td>
<td>Revalidation system is bureaucratic/complicated</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Developing internal policy documents</td>
<td>10</td>
<td>Lack of internal policy documents</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>No groups of staff difficult to revalidate</td>
<td>0</td>
<td>Issues with revalidating new starters/leavers and temp staff (e.g. locums, overseas doctors)</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>NHS England support/guidance</td>
<td>7</td>
<td>Lack of NHS England support/guidance</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Effective appraisal system already in place</td>
<td>7</td>
<td>Issues establishing an effective appraisal system</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Training events (inc NHS and RO training)</td>
<td>6</td>
<td>Lack of training events</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Revalidation being a legal/necessary requirement</td>
<td>4</td>
<td>Revalidation not perceived to be mandatory</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Appraisers easy to find</td>
<td>0</td>
<td>Problems sourcing appraisers</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Data collation/communication straightforward</td>
<td>0</td>
<td>Issues with data collation/communication</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Having separate MD and RO roles</td>
<td>3</td>
<td>One person being both RO and MD</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Revalidation system accommodates different circumstances</td>
<td>0</td>
<td>System too rigid (e.g. ‘one size fits all’)</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Good timing of the introduction of revalidation</td>
<td>0</td>
<td>Bad timing of the introduction of revalidation (coincided with other major reorganisations)</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Registering as a DB straightforward</td>
<td>0</td>
<td>Problems with registering as a DB</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td>248</td>
<td><strong>Total:</strong></td>
<td>183</td>
<td>431</td>
</tr>
</tbody>
</table>

The support team might be drawn from staff supporting pre-existing clinical governance systems. If these systems were effective and well organised, then this made it easier for revalidation to be implemented. Similarly, if there were good appraisal systems already in existence, then revalidation

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13 ROs could make multiple comments
could build on these rather than having to start from scratch or attempt to address deficiencies. A lack of such pre-existing systems was seldom mentioned as a problem.

“Excellent pre-existing clinical governance systems were an enormous help, with competent, experienced staff.”

“We always had a robust process of Appraisal before revalidation, so no major factors to mention”

Having an appropriate electronic system to deal with revalidation data collection and processing featured in over 10% of the comments made by ROs, with a roughly equal split of positive and negative experiences. For example:

“High quality admin support and implementation of revalidation support software has been invaluable”

Although IT support systems are more common in larger DBs (see Table 3), ROs from large organisations participants sometimes lacked access to a comprehensive revalidation IT system that could enable data to be shared easily, both internally and externally. This could potentially be problematic. For example, one DB with hundreds of doctors connected to it, commented:

“Lack of a system to tie up revalidation and appraisal and complaints, litigation and investigation. A lot depends upon organisational memory - mine and the appraisal lead and revalidation assistant.”

Acquiring such an IT system might require a disproportionately large investment for a small DB, which the organisation could not justify:

“The lack of a central IT system to record all RO matters including appraisal and revalidation outcomes. For a non-NHS organisation with <10 doctors there is no way I can make a business case for an IT system so all the record-keeping has to be done by me and manually.”

Other comments made by ROs mentioned a lack of resources, particularly financial resources, but without giving specific details. In a similar vein, other respondents drew attention to the time consuming nature of revalidation and the increase in bureaucracy that has occurred since its introduction.

“Endless bureaucracy makes the whole business [of revalidation] hell”

“Only obstacles are resources; time, energy and costs. I also do not get the impression that the revalidation process was considered in sufficient detail before the launch. Questions are often responded to by saying that there is no answer, but that it will get ‘figured out’. This uncertainty leads to time, funds and energy losses. I would have liked to see that the introduction was, and current process is, smoother - more business-like, clearer processes and policies, perhaps with more legal input and support.”
The resources required to support revalidation might be a particular problem for non-NHS organisations. Revalidation was believed to be designed primarily with NHS organisations in mind, so implementation required more work for non-NHS DBs.

“the fact that revalidation was designed for the NHS - understandably - and we have had to adapt/mirror with no precedents to refer to. Our whole system, procedures and processes have been from base zero”

A significant number of ROs from small DBs commented that the revalidation system was a poor fit for their organisation. An advantage of having few prescribed connections is that the RO can “know all the doctors personally,” which facilitated implementation and made ROs more aware of any potential issues relating to career development or patient safety. But the current revalidation system doesn’t seem to take this into account. These ROs felt that the revalidation system had been designed around larger organisations, such as NHS hospitals. Small organisations might have a limited infrastructure in terms of people, time and money, so the resources required for implementation represented a relatively large additional overhead, which could be regarded as a burden.

“I believe that for a small DB the processes that revalidation requires seems disproportionate, and this seems to be lost with a one size fits all approach.”

“The main issue is the increased demand on resources on small organisations. This demand is not proportionate and so the process has caused some unhappiness among the team. It is viewed as unnecessary and bureaucratic. One excellent doctor has retired early because of it.”

A lack of doctor engagement was highlighted as something that could be problematic. Several respondents cited ‘doctor culture’ as being at odds with the concept of revalidation, with one RO stating, “they simply do not believe in it”. Another RO suggested that there might be differences of culture among some doctors from outside the UK, who she encountered particularly in relation to short term contracts.

“A lack of individual ownership by doctors is significant hinder”

“Healing with a largely foreign trained workforce who have a different cultural history on appraisal and revalidation.”

Other reasons for a lack of doctor engagement cited by respondents concerned poor time management or workload pressures, and a lack of understanding among doctors of what they needed to do for appraisal and revalidation; for example:

“The tendency of all doctors to be too busy and to do regulatory functions last-minute.”

“Lack of knowledge of requirements for appraisal and revalidation by appraisee doctors.”

In some cases it would appear that lack of engagement may be due to doctors perceiving revalidation to be a superficial exercise over which they have little say:
“Wayward doctors reluctant to embrace the process remain a challenge. Many doctors argue passionately and with some justification that revalidation is a paper exercise with very little real benefit.”

There were a small number of ROs who cited existing doctor engagement as a helping factor. A few others said that the introduction of revalidation had engendered engagement over time.

There were numerous comments about various forms of support and guidance – mostly developed by external organisations, such as the GMC, NHS England and Royal Colleges. The comments were almost all positive, saying that this support had aided the implementation of revalidation.

“Good national guidance and ongoing support from NHS England and GMC have helped.”

RO Networks had provided ROs with opportunities to share knowledge, to benchmark standards for revalidation processes and to discuss improvement to appraisal and revalidation systems.

“The key impact has been my training and development in the role of Responsible Officer - the whole process has improved our governance arrangements and helped with information sharing with other ROs.”

Small numbers of ROs highlighted other factors. Revalidation being mandatory and the RO being personally responsible had given an organisational impetus to improve systems and quality assurance; as one respondent commented.

“RO formal responsibility has helped focus the mind of all staff and the board on quality.”

One respondent reported the issues experienced over finding suitable external appraisers after the introduction of revalidation:

“Prior to revalidation it seemed easier to find willing external appraisers from local trusts. About a year after revalidation was implemented, appraisers we’d used before started telling us their trusts had told them they could no longer do appraisals for anyone outside their trust. This has limited the pool of appraisers, as NHS trusts are by far the biggest employers. We continue to find it challenging to source appraisers.”

### 7.2 Impact of revalidation on the RO

A large majority of ROs who responded to the survey provided comments explaining how revalidation had affected their role, with only a small minority saying there had been little or no impact on them from the introduction of revalidation. Most prominent among the changes was an increase in workload and responsibility. For some ROs this additional responsibility had enabled them to achieve more for the organisation and had facilitated personal and professional development. The extent of the workload, and some conflicts between the roles of RO and MD, had prompted these roles to be undertaken by different individuals in some DBs. These themes are illustrated in more detail in the following paragraphs.
Over a quarter of the comments highlighted an increase in workload, sometimes a great increase. This had created an extra pressure on their time and hence on other aspects of their role that were not directly related to revalidation. The additional time they now spent on revalidation related work had however given some ROs a greater understanding of the work and issues experienced by doctors in their organisation.

“It has been significant extra work for me… I feel I have a closer link to the doctor network and knowledge of their medical activities”

“Time consuming but a better sense of assurance about what 1200 doctors are doing every day.”

“Me - much busier. Much more knowledge of more consultants work pressures. Much improved appraisal standards”

Other ROs also commented that the revalidation system had enhanced their role, enabling them to be more effective in providing clinical governance, addressing doctor performance issues and improving service quality.

“...has added to my usual workload but on the positive side, has given me a framework with which to identify problems and act upon them.”

“More work! But actually makes the job easier sometimes as now there is a formal process to tackle problems compared to before - i.e., some teeth!”

“It has undoubtedly increased my workload, but it allows me a clear justification for the quality work that must be delivered with reference to healthcare professionals”

“I now have a much stronger grip on the performance and conduct of doctors, and have been able to use the needs of appraisal and revalidation to bring about a number of quality improvements that have benefitted the whole organisation.”

Furthermore, some responses indicated that the demands of being an RO, together with the new opportunities and support mechanisms brought through revalidation, had facilitated individual ROs to develop their own professional skills:

“As it affects me personally, more transparency about my own performance; I’ve done more CPD; I’ve sought evidence about my outcomes; ensured mandatory training done, etc. As RO I have to report to the Board on revalidation so more Board contact. Case management investigation seems a bigger part of life now.”

“I have developed increased resilience. I have learned a lot from other ROs … and the non-London-centric view has been very refreshing. I have realised that we need to harness the leadership skills of several layers of medical management to get the job done because it is so massive one person can’t do everything”

Although they now had more contact with doctors and could take more effective action, several ROs also highlighted that the nature of their relationship with colleagues had changed. The fact that the
RO could potentially determine their future as a doctor through revalidation had resulted in some doctors having lower levels of trust and openness with their RO.

“[there is] some slightly greater engagement with doctors but I think they all now associate the Medical Director with being a policeman/headmaster/oppressor.”

“I became RO after revalidation was introduced. It gives the MD a lot of (unwelcome) power.”

“Doctors feel they are more dependent on me, as they think their professional fate is in my hands (slightly wrong perception).”

The increase in workload, along with the distancing of the RO from other doctors in the organisation had prompted some DBs to separate the RO and Medical Director roles. There might however be further implications of this for both roles, which would need to be thought through.

“I am uncomfortable with the idea that the MD is not the RO although I am aware that many organisations have this and, to be honest it would be impossible in a larger Trust. Further thought needs to be given to the statutory roles and how this fits into a modern Board structure.”

“I have to stay close to the MD function too to be up to speed with governance activity and available information about my doctors”

“The process of administering the regulations, assuring the board, and providing an appraisal and revalidation system for [hundreds of] doctors takes a great deal of my time, it is not in fact compatible with also being the Joint Medical Director (as I was) and a practising clinician. Therefore the role has been refocused to allow me to, with a clinical job, undertake the RO role.”

7.3 Impact of revalidation on systems for managing medical performance

The most commonly referred to impact of revalidation on other organisational systems for managing medical performance, expressed by 169 respondents (55% of those commenting), was that it had led to improvements in the quality of appraisals, and in systems for the quality assurance of appraisals. 80 comments (26%) indicated that revalidation had also prompted changes to that had made wider clinical governance systems more formalised, which had in turn increased levels of compliance among doctors. Comments also indicated however that there had been little or no such impact in a significant proportion of DBs [65, 21% of ROs making comments], and a few ROs drew attention to other factors which might have been more influential than revalidation in bringing about certain changes. These themes are described in more detail in the following paragraphs.

Many respondents reported that since the introduction of revalidation the quality of appraisals had been enhanced, and that more doctors were having appraisals and more regularly. There had been improvements in the organisational infrastructure for appraisals on account of revalidation, including improvements in quality assurance systems.
“Improvement in the quality of appraisal, together with ensuring that every doctors gets an Appraisal, which was not previously the case”

“It has supported the embedding of a much more robust appraisal process in terms of having trained appraisers, clear information to be included/discussed, robust monitoring of appraisals.”

“the appraisal system is now much more professional. Annual appraisals are now of revalidation standard.”

A number of ROs also said that revalidation had prompted organisations to introduce greater formalisation of wider clinical governance systems. In some DBs this had resulted in doctors getting more actively involved in various systems for improving quality, with positive outcomes.

“[Revalidation has] formalised processes ... raised the profile of quality and performance monitoring.”

“very helpful in engaging doctors with quality improvement that is relevant to the service, rather than a personal interest”

Some comments suggested that revalidation had led managers and performance systems to focus more on the clinical aspects of services and the role that doctors play in producing quality. This rebalancing of focus to put clinical quality more on a par with financial and efficiency concerns was welcomed. One comment also highlighted how appraisal had reconnected some doctors with senior doctors, and hence with the profession and their own development as clinicians.

“There systems [are] now more robust and clinically focussed rather than business focussed.”

“It has introduced an appraisal focused on each doctor's personal development, and reflection on the quality of their work - rather than on simply the attainment of business objectives. For those physicians who report into a non-medic, this may be the only interaction of this type they have with a senior medic in [the organisation]. The feedback we have had has been that this has been very rewarding i.e. the opportunity to reflect on strengths, development and learnings in the past year from their practice with a senior medical colleague.”

A significant proportion of ROs who made comments expressed the view that revalidation had produced little or no impact on systems for managing quality. Some indicated that this was because their organisation already had efficient appraisal and internal governance systems that predated revalidation (see above)

“The doctors have been engaging in annual appraisal for several years so this did not change.”

Some ROs drew attention to other factors which they believed had produced change in systems for managing medical performance, either alongside, or rather than revalidation.

“Very little [is due to revalidation] it’s the culture that mainly drives it.”

“[Revalidation] has strengthened position of appraisal but withholding pay threshold progression had more impact.”
The agenda on Quality has been influenced by other factors as well as Revalidation - mainly the national focus following the Francis report, the regulator HFEA’s focus on quality etc.

7.4 Impact of revalidation on clinical practice

In addition to asking ROs to comment on the impact of revalidation on themselves and on performance management systems, we also asked them to comment on how revalidation might have impacted on clinical practice. The number of comments which related to particular types of impact is detailed in Table 21, which also indicates the frequency of positive and negative comments concerning each type of impact.

Table 21: Positive and negative impacts of revalidation on clinical practice

<table>
<thead>
<tr>
<th>Positive</th>
<th>N</th>
<th>Negative or neutral</th>
<th>N</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical practice / standards / quality improved</td>
<td>41</td>
<td>Little or no impact on clinical practice</td>
<td>99</td>
<td>140</td>
</tr>
<tr>
<td>Greater doctor sense of responsibility/reflection toward own practice; greater engagement in CPD/Personal Development Plan</td>
<td>37</td>
<td>Little or no impact on doctor reflection and development; or changes would have happened anyway</td>
<td>7</td>
<td>44</td>
</tr>
<tr>
<td>Improved appraisal quality</td>
<td>10</td>
<td>Appraisal quality unchanged or worse</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Formalised dealing with concerns / greater scrutiny</td>
<td>9</td>
<td>No impact on dealing with concerns</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>RO has greater assurance of doctor competence/FTP</td>
<td>7</td>
<td>No impact on assurance of doctor competence</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Reduced workload/more time with patients</td>
<td>0</td>
<td>Increased workload/less time with patients</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Underperforming doctors resigned/removed</td>
<td>5</td>
<td>No action against underperforming doctors</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Audit formalised</td>
<td>4</td>
<td>Audit remains informal</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Created a more supportive environment</td>
<td>2</td>
<td>Created a blame culture / less supportive of doctors</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Created a culture where poor performance is not acceptable</td>
<td>2</td>
<td>Culture where poor performance is acceptable</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>An individual approach to revalidation is appropriate</td>
<td>0</td>
<td>Need to have a team approach to revalidation</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>118</strong></td>
<td><strong>Negative or neutral</strong></td>
<td><strong>113</strong></td>
<td><strong>231</strong></td>
</tr>
</tbody>
</table>

Depending on how wide a definition of clinical practice is used, then roughly between 15% and 40% of survey respondents indicated positive impacts of revalidation on clinical practice. The lower figure would exclude impacts which might be considered less directly to be about patient care, such

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14 One comment could indicate more than one type of impact. All were counted.
as better and more formalised governance processes, which have been highlighted elsewhere in this report.

“50% of our doctors who responded to our questionnaire on appraisal report that it has a positive impact on patient care. This is because of the improved systems we have put in and that in turn is because of revalidation. I think that is fantastic, and all praise to the team for that.”

A number of comments expressed impact in terms of revalidation having promoted greater personal engagement of doctors in improving the quality of services and of their own practice.

“Enhanced focus of individual doctors on importance of quality governance agenda, reflection on practice and responsibility to keep up to date with practice. Has helped doctors to see their personal responsibility rather than over reliance on trust systems”

A few responses indicated that clinical practice had been improved through the resignation or retirement of doctors who may not have been up to date.

“It has improved clinical practice and has led to several doctors voluntarily leaving employment and medicine - good in many ways.”

“It has also meant that some doctors coming to the end of their working life have chosen to retire and take voluntary erasure rather than participate. This has probably improved quality”

A sizeable proportion of ROs felt that revalidation had made little or no direct impact on clinical practice. Some ROs suggested that it was better appraisal, rather than revalidation per se, that was the key factor in improving clinical practice. Some acknowledged that the introduction of revalidation may have prompted improvements in appraisal, but others felt that appraisals in their organisation were already of a good quality, and that the benefits arising from revalidation were not commensurate with the extra workload it had necessitated.

“I think ‘revalidation’ is a bit of a red herring, since it is rigorous annual professional appraisal that is the potential ‘game changer’”

“annual appraisals happened before revalidation and were sufficient to impact upon clinical practice. Revalidation for this small organisation has been bureaucratic and unwieldy”

Very few outright negative impacts on clinical practice were mentioned, and these by only a handful of respondents. These concerned the bureaucracy of revalidation increasing doctor workload or taking time away from direct patient contact, the creation of more of a blame culture, and focusing overly on the individual doctor rather than on the team.

7.5 Changes to improve the way revalidation works

Respondents made a wide variety of suggestions for improving revalidation. The rationales that were provided for these suggestions indicated however that there was some commonality regarding the issues that ROs are seeking to address, and what they would like to achieve through their
suggestions. The overall sense was of ROs wanting to make revalidation more fit for purpose – in assessing doctors’ performance and supporting doctors to improve their performance, taking greater account of the nature of the professional field or specialty, the performance of the individual doctor, and of the organisational context. Overall, this might be summarised as securing consistency in revalidation processes, while allowing for legitimate and appropriate differentiation in how they are applied.

While there were a number of concerns that might need to be addressed, many ROs did see revalidation producing some value. As one respondent said even after detailing considerable criticisms of revalidation:

“That said, I really like the shift towards transparency and the conversations (formal and informal) between medical colleagues that ‘Revalidation stimulates’.”

Many ROs expressed concern that there was too much variability in the quality of appraisal, both with regard to the inputs of supporting information and with regard to the conduct of sessions. This could affect the quality of the information on which recommendations were made and the personal development plans of appraisees.

Some respondents suggested that introducing formal tests into revalidation might provide a means of assessing doctors’ performance that would be more valid and reliable, and might also produce comparable information about doctors.

“Formal tests of competence starting with a written exam every 5 years. I know exams do not test behaviour or the application of knowledge particularly well but if a doctor doesn’t have the knowledge in the first place s/he certainly cannot apply it!”

Not every RO would agree with this however. Another respondent doubted that testing doctors’ knowledge would provide useful information to improve practice.

“There is little evidence to suggest that lack of knowledge or skills is a large problem. Generally it is poor behaviours and we need a much more robust method of identifying and addressing those types of issue.”

Aside from the actual measures of doctor performance, a larger number of respondents drew attention to the quality and quantity of resources to support revalidation. Improving the quality of appraisal was seen as key by some respondents. Suggestions included better training for appraisers and a more extensive and consistent system for quality assurance.

“It is appraisal that is the much more important component, and that training is needed for appraisers to support generation of a high quality appraisal, and a PDP focused on identifying the real development need and followed by action to be taken to meet this in the interest of improved health outcome. The quality of appraisers, their training and assurance is therefore key. [...] Revalidation as a concept should therefore major on the quality of appraisal; having a high quality appraisal should generate an (almost) automatic recommendation for revalidation, in the absence of concerns arising from other sources.”
“[Revalidation would be improved by] a national system for quality assuring appraisal outputs.”

In order to address the mismatch between the resources available in small DBs and the requirements of the revalidation system, one respondent suggested providing financial incentives, another that the system should be changed to make it less onerous for small DBs.

“It is still excessively burdensome and very time-consuming. Small organisations without economies of scale struggle to implement systems. There is no acknowledgement of how expensive it is. If it is to be successful a lot of the resources should be government funded or at least there should be some tax rebate for compliance awarded to companies. It is really hard to get a board to implement all processes with no carrot. Revalidation for institutions is all stick I’m afraid.”

“A 2 tier system would be less onerous for small organisations where the issues are often very different - and once the structures are in place it is more knowing where to get advice in order to ensure consistent decisions made when there are concerns, rather than needing frequent network meetings.”

“There are risks in imposing too complex a system on small organisations designed to harness creative and innovative energies that could flow into and support larger "delivery end" organisations such as NHS trusts. There is also a risk that the “systematisation” of best practice could paradoxically reduce individual responsibility and "professionalism" - an unintended consequence (as TS Eliot put it: “Man tries to create systems so perfect that nobody has to be good any more”).

Some other ROs had concerns generally about revalidation becoming a burdensome, over-complicated, bureaucratic system that could alienate doctors and do little to strengthen clinical governance and improve clinical practice.

“[Revalidation] needs to avoid becoming another beast to be fed.”

“Make it simple - avoid overcomplicating the issue and consuming more time and resources we don’t have. Don’t turn it into a cottage industry…”

“We need to ensure that doctors are supported and that the pendulum does not swing too far in the direction of an authoritarian or even dystopian future with austere processes and disenfranchised and disillusioned workforce.”

Several respondents commented that there is too much emphasis on what they felt was superficial monitoring.

“I think there is an over emphasis on completing 5 successful appraisals in the 5 year cycle. We are constantly reminded at RO networks that poor performance should be picked up in the wider governance systems and not at appraisal and yet there is a fixation on reporting appraisals completed data. I think the result of this is that individuals and organisation put resources into counting numbers rather than good governance systems.”
A few ROs blamed NHS England for what they saw as the bureaucratic nature of the revalidation system and its emphasis on performance management rather than improvement. They suggested that revalidation should become the responsibility of an independent organisation.

“Revalidation should be administered by an independent organisation, not NHS England. It should not be used to punish doctors, it is not a performance management tool and it should not assume that doctors are guilty until proven innocent.”

“Reduce the supervisory bureaucracy over the ROs by NHS England. This has been completely excessive.”

A significant number of respondents mentioned the need for better sharing of knowledge and information across organisational boundaries. This included the collation of data relating to doctors causing concern or sharing ideas for best practice and shared training. Some felt that information sharing could be improved through specifying common standards, or through setting up a national IT system.

“Communication of revalidation and appraisal history with supporting intelligence re: complaints, claims, SIs and remediation/capability between ROs needs to be standardised.”

“The variety of ways that appraisal is captured can be problematic and standardisation would be helpful (although difficult to agree). Finding out who a doctor is working for across their whole scope of practice is based upon self-declaration. If employers were made to declare which doctors undertook work for them and this was on GMC Connect then it would be easier to contact all employers to get the information necessary to support revalidation. This could be achieved by having a system where Designated Bodies could link to a RO stating they had employed the doctor and whether they had any concerns or not.”

“The IT systems should have been uniform - in my view it is a scandal that there is not unified appraisal documentation on line for NHS doctors”

“A national IT and appraisal system for the NHS that would allow data to flow regardless of the Trust and which could also flow into the private sector. Some hope!”

One respondent suggested that there should be greater flexibility within the RO role to set revalidation dates. This could be particularly helpful in relation to doctors who are considering retirement.

“I personally suggest a new category of time-limited provisional or probationary revalidation for those who have on-going issues which may or may not be resolved. ROs should have the power to vary RV dates for doctors. This would be especially helpful for those approaching retirement. I believe that some doctors retire rather than face revalidation. Adjusting their date by a year or two - whilst maintaining standards - might retain some good doctors in NHS service for some valuable time. Doctors are now in short supply: a factor encouraging retirement by an arbitrarily set RV date could be mitigated. ROs should have the power to re-instate licences rapidly. Many recently retired doctors receive unexpected work opportunities which they wish to take up but have relinquished their licence. The current re-instatement process is a palaver.”
Another suggested that there should be a group approach to revalidation which would suit certain clinical environments and assess practice in teams not by individuals:

“Most of our clinical practice is delivered by non-doctors (optometrists mainly), and doctors are nearly always involved in teams, e.g. in theatre. I would much rather have a process which looked carefully at team outcomes and system delivery rather than have a formal process which picks out one member of the team (the doctor) for unusual attention.”

8 Limitations of the research

The survey had various limitations which should be borne in mind when considering the findings. Although the response rate was relatively high for an online survey, and respondents appeared to be largely similar to non-respondents in various respects, it is possible that non-respondents may differ systematically in some way. We plan to distribute an Executive Summary of this report to all ROs, which will offer non-respondents an opportunity to identify any elements of the report that they disagree with.

We know that ROs from small DBs are under-represented in this survey. We have taken care to compare the responses of ROs from small DBs with those from other DBs, and are confident that we have identified the most important differences, which we have reported.

The relatively small number of respondents (limited by the number of ROs) and the range of areas of interest means that we are only able to give indicative results in terms of statistical significance. We have conducted multiple tests, which increases the risk of us incorrectly identifying differences or effects where there are in fact none. With this in mind we have endeavoured to triangulate quantitative and qualitative data where possible.

The qualitative data also had some limitations. Although ROs provided lots of free text comments, some did not describe issues in much detail, so we could not provide as much in-depth analysis as we would ideally have liked. Where there was sufficient data we calculated the frequencies with which different categories of comment were made in response to a question. This gave us some broad indications of how prevalent particular views/issues were, but we cannot be very specific about the proportions of ROs holding these. The 2016 survey can provide scope for producing more specific figures for those issues where this is deemed important to know.

The survey covered only a selection of systems for managing medical performance in order to keep the length of the survey manageable. We prioritised systems most closely related to revalidation – appraisal, plus CPD, quality improvement activity, significant events/SUIs and complaints, which should be included in appraisal portfolios and reviewed during the appraisal. We also asked about systems for dealing with doctors causing concern and FTP referrals, which we know can be closely related to those for making revalidation recommendations and involve liaison with the GMC. We did not ask questions about systems for obtaining feedback from colleagues and patients, which only needs to be provided once in every 5 year revalidation cycle, and is being considered in detail in the UMBRELLA research project. We also did not cover job planning, occupational health, whistle blowing and risk management and litigation. We will investigate these in upcoming case studies.
The survey did not include higher level responsible officers (HROs), who make revalidation recommendations regarding responsible officers, nor suitable persons, who can make revalidation recommendations regarding doctors who do not have a connection to a designated body. We intend to interview some HROs later in our research.

The responses given by a limited number of ROs to some questions suggest that they may have found these questions difficult to understand. This has limited our ability to analyse whether and how, when they are making revalidation recommendations, ROs use information over and above that considered in appraisal. Such information could be gathered in the 2016 RO survey.

Some of the questions did not provide very detailed information, such as those questions about revalidation decision making structures and processes. For this first survey, we wanted to get a broad idea about such areas of revalidation where very little previous research has been conducted. Having obtained some information we will be in a better position to ask more specific questions in the 2016 RO survey.

Finally, we need to remember that the survey provides information about RO perceptions. The extent to which these are useful depends partly on the representativeness of the respondents (see above) and on how insightful their perspectives are. ROs would be expected to have a good overview of revalidation and of other systems for managing medical performance, and in the survey they certainly claim to have good levels of knowledge. Their perspectives may however be different from those of other stakeholders. We will seek comments of other stakeholders when disseminating our report.

9 Discussion

The findings section highlights a great number of issues and themes that potentially might be of interest. In this discussion section we focus on those themes that we found in ROs responses across a number of different questions, or that seem to us to be particularly important, and that fit together into a coherent picture. This triangulation of themes from different questions provides greater confidence that these themes genuinely represent what ROs are saying. The discussion considers potential implications of these themes for revalidation going forward and what action might be appropriate.

The key themes relate to two broad areas:

- The impact of revalidation: on systems for managing medical performance, on improving clinical practice, on addressing poor performance, and on the roles of ROs and Medical Directors.
- The nature of the current revalidation model: its focus, the resources needed to administer it, and its suitability for different sizes and types of designated bodies and organisational or clinical contexts.

ROs believe that revalidation has had a substantial impact on appraisal. This is not surprising given the emphasis on appraisal in the revalidation system, and the responsibility placed on ROs to ensure that the appraisal system is fit for purpose. Appraisal is seen particularly as enabling doctors to
reflect – an important aspect of the GMC’s Good Medical Practice guidance\textsuperscript{8}. This focus on reflection in appraisal is seen as appropriate by ROs. The data indicates that there may be less of a focus in revalidation at present on the general improvement of clinical practice through systems such as CPD and quality improvement, than there is on addressing performance issues. The thrust of many RO suggestions for improvement was to try to make revalidation work better for doctors who are already performing well.

The degree to which appraisal may contribute to identifying doctors who are performing poorly is uncertain, but many ROs would assert that the task of identifying and addressing poor performance by doctors should not rely overly on appraisal, where doctors may to some extent censor the information that is discussed. It does, and needs to, draw on data from other performance management systems, together with other sources of intelligence. Other performance management systems (CPD, complaints, quality improvement, significant event/SUIs, doctors causing concern, fitness to practise) were perceived to have improved by over a quarter of respondents in each case. This rose to almost half of respondents feeling that systems for doctors causing concern had improved. These ROs felt that these systems were now better organised and more robust. A sizeable proportion of ROs also felt that more cases of doctors causing concern had come to light since the implementation of revalidation, and also that there had been more fitness to practise referrals.

This is consistent with systems being more robust, but might also be due to ROs becoming more risk averse, with lower thresholds for raising concerns or taking action. Attitudes to risk might influence whether to give a positive recommendation with residual concerns or whether to defer pending further investigation. Some ROs take the view that if there is currently little evidence then there is no reason not to give a positive recommendation; others that further information should be gathered in order to make a more informed decision. Some ROs expressed concern about the long time it could take for FTP cases to be investigated by the GMC and for action to be taken.

Managing the information about the performance of doctors required by revalidation when they move between organisations can be problematic, and this may be particularly pertinent in relation to locum doctors who work for short time periods in numerous different organisations, and for doctors who move jobs frequently or have a portfolio career.

In its current format, revalidation is intended to be a ‘single model’ process for doctors engaging with it. However, the implementation and operation of revalidation has varied considerably between different DBs. There are variations in resources, RO roles and decision making processes. We do not know how this may affect the reliability and validity of RO recommendations. The current system does not appear to be well suited to the numerous designated bodies which have only a small number of doctors connected to them. Concerns over a ‘one size fits all’ approach more geared towards larger organisations and consequently overly resource intensive and bureaucratic for small DBs, were expressed by some ROs. Possible improvements might therefore: reduce the bureaucracy and resources required for small DBs to engage fully in revalidation by simplifying the model of revalidation for small DBs; increase the resources available to small DBs; or take the RO function out of small DBs and into a larger infrastructure. A number of DBs have engaged external ROs, who typically serve multiple DBs, and the Suitable Person role also provides an option, but the ROs of most small DBs remain internal staff. GP practices provide another perspective on this, as they have
an external RO based in an NHS England local office or regional team. The survey provides only limited information about primary care, but it appears there may be some issues associated with the substantial organisational distance between the RO and the doctors, and the sheer number of connected doctors connected with these ROs in NHS England. Looking across both small and large DBs, a key challenge would appear to be balancing economies of scale in revalidation systems and administration against the RO having a good knowledge of the doctors and organisations they cover, and effective means to influence policy and practice in those organisations. Consideration might be given to this, bearing in mind the proportion of doctors affected (less than 1% connected with small DBs, but many GPs) and the costs of different options for change that might be developed.

ROs expressed largely positive views about the provision of support and guidance, and in particular about the advice from ELAs. A substantial minority of ROs would also appear to perceive that revalidation is producing improvements in clinical practice. Many ROs however, including ROs not based in small DBs, felt that revalidation was not delivering sufficient benefits yet to warrant the investment of time and resources involved. The vast majority were not calling for revalidation to be dismantled, but they would like to see revalidation systems and associated monitoring made less bureaucratic and time consuming. It remains a possibility that the full benefits of revalidation may accrue over a longer time period than the 3½ years it has so far been in operation, but we did not pick up any particular sense of this in the survey responses.

Revalidation has brought into being the RO role, filled by a senior doctor, with concomitant responsibilities, powers and opportunities. In some DBs this seems to be changing doctor relationships: between the RO and the doctors to be revalidated by the RO; between the RO and the Medical Director, where these roles are separate; and between the RO and senior managers in the DB. External relationships have also changed. RO to RO relationships have been established, supported by RO network meetings, adding another dynamic; and ROs have closer links with the GMC, facilitated in part by ELAs.

10 Ideas for further research

There are various opportunities for further research that we can use to develop our initial analyses presented here and to conduct new analyses. These include:

- More detailed, in-depth analyses of the 2015 RO survey data, including more work on subgroup analyses and associations between data items in the survey
- Linking the survey data with other datasets (such as the Annual Organisational Audit, GMC datasets, CQC ratings, National Staff Survey data, Hospital Episodes Statistics)
- Conducting analyses across this data and data collected by the UMbRELLA research project, which will be, for example, interviewing some ROs
- Collecting additional data through the case studies or the RO survey in 2016.
- Research outside of this project

In the rest of this section we set out some further research which might be conducted, focusing particularly on investigations related to the issues and themes from the Discussion section above.
The UMbRELLA project is conducting various investigations of the content, process and outcomes of appraisal, through interviews with appraisers and appraises and recorded appraisal interactions. This may shed further light on whether and how appraisal may be enabling doctors to be more reflective and whether such reflection leads to changes improvement in individual clinical practice, and whether it also produces wider service improvement.

The degree to which appraisal and revalidation may contribute to identifying doctors who are performing poorly is uncertain. The UMbRELLA census survey data from appraisers on identification of concerns in appraisal may shed some light on this. The perception among some ROs that since the implementation of revalidation there has been a rise in the numbers of doctors causing concern and of FTP referrals might be tested by analysing GMC data. More generally, it is not clear quite how performance information from appraisal and other systems is brought together by ROs and used to inform their revalidation recommendations. This is being investigated further in our case studies, and the 2016 RO survey might include some more specific questions with regard to organisational processes and structures. Workpackage 3 (WP3) of our study, which focuses on the management of suboptimal medical performance, should also shed further light on what influences RO decision-making and how reliable that decision making is, which could be further tested in the 2016 RO survey.

Another challenge that research might address is how to share and transfer data between organisations in a sector with a mobile workforce and lots of doctors with portfolio careers who work across multiple organisations. We hope to explore revalidation in locum agencies in some of our case studies.

We know that ROs of small DBs have different experiences to those in other DBs. There may be scope for additional analyses of the 2015 RO survey data to identify further patterns related to organisational characteristics such as type and size. For example, it is possible that positive changes to systems for managing medical performance may not be distributed evenly across different types and sizes of organisations. Have organisations used revalidation as an opportunity to improve all of their performance management systems, or have there been smaller improvements spread across a wider number of organisations? Has there been a levelling up, whereby organisations which previously had poor clinical governance systems have brought their systems up to standard? Or has the gap between high performers and low performers widened, because high performers had a better existing infrastructure with which to implement revalidation?

What constitutes a small DB in relation to revalidation is complex. We have used under 20 doctors in the statistical analyses presented in this report. There are indications however that size is implicated differently with regard to different aspects of revalidation. For example, the data suggests that not having access to a computerised information system to support revalidation is particularly common among DBs with fewer than 8 doctors; and commissioning an external QA review by 2014 was particularly rare among DBs with fewer than 14 doctors. Further research might increase our understanding of the implications of DB size for revalidation, and inform decision making about potential changes in support for small DBs, or to the model of revalidation for small DBs. In our case studies we will have opportunities to investigate some of the issues related to revalidation arrangements for organisations with not many doctors, the RO being external to the DB and the RO being responsible for multiple DBs or organisations. Further research might perhaps also...
investigate the support for small DBs that is already available and how useful it has been – for example, there was a small DB conference in February 2015, and a small DB group was set up following this.

As there are fewer very large DBs than small DBs, it is harder to identify statistical relationships pertaining to large DBs, and we have not prioritised this in our 2015 RO survey analysis. We will be investigating some large DBs in our case studies.

Further research might also be carried out to explore how the RO role is performed differently by different individuals, particularly in relation to the extent to which the role is seen as managerial or directive by doctors in the DB. The case studies and UMbRELLA HRO interviews may shed some light on how ROs may perform their roles differently. The implications of this for revalidation processes and impacts might be investigated in the 2016 RO survey.

The implications of joint or separate RO and Medical Director roles may also merit further research. There is scope for further analysis of the 2015 RO survey data to look at this, and possibly also in the case studies. There may also be scope for more detailed analysis of our 2015 RO survey data in order to investigate how the availability of staff and IT resources and RO workload affect revalidation and RO perspectives on it. We hope to investigate HRO perspectives on ROs and their workload via interviews with HROs - some related to our case studies and some independent of them.

11 Conclusions

As we noted at the outset of this report, the development of medical revalidation is probably the most important change to the way that doctors are regulated in the United Kingdom in recent years. The policy was developed by the Department of Health and the General Medical Council over a period of more than a decade – influenced by a number of high profile cases of performance failure and subject to several rounds of extensive consultation – before finally being implemented from late 2012. It is a substantial investment of resources – the Department of Health’s business case in 2012 put the likely costs in England at £97 million pa.

This report provides some important insights into medical how revalidation has been implemented in organisations, the impact of revalidation on organisational systems for managing medical performance and the developing role of the Responsible Officer in overseeing and assuring medical performance. Responsible Officers have been absolutely central to the implementation of revalidation, and their views and perspectives on the process and its impacts are particularly valuable.

Overall, we find that medical revalidation has so far had some important impacts on the way that medical performance is managed and assured – in particular strengthening oversight within organisations (especially those which did not have robust systems in place before) and improving liaison with and communication with the General Medical Council. It has helped to integrate often
diverse sources of information within organisations, and has given the Responsible Officer the authority and scope to bring together information on performance and to act upon it.

However there are concerns about the consistency of medical revalidation – with some suggestion that it varies across and within organisations – and about its coverage, particularly of doctors who do not work predominately in one organisation, but who move between organisations and have portfolio careers. The transfer of information about medical performance between organisations seems problematic. The revalidation model seems to suit large organisations with the capacity to put systems in place, but work less well for smaller organisations who employ only a few doctors. The extent to which the Responsible Officer can exercise effective oversight reduces as the “organisational distance” to the doctor increases.

Very few Responsible Officers want to see a reversal of policy on medical revalidation, but many think it could be made more effective and efficient, and there are some clear and consistent messages about how that might be achieved. Moving from a “one size fits all” single model of revalidation to allow some legitimate and appropriate variation in the way the policy is applied seems to have widespread support. This might mean differences in the way it works with organisations with many or few employed doctors; with organisations where there is a close or more distant relationship with employed doctors; with doctors in different fields or specialties due to the clinical content and nature of their work; and perhaps most controversially with individual doctors according to their past and current performance track record.

It is very difficult to answer the question of what impact medical revalidation has had or will have on clinical practice and the quality of medical care. There are some early indications from this survey, and we are exploring impact both qualitatively and quantitatively in our ongoing research programme. It seems likely that the impact so far is mostly focused on identifying and remediating poor performance, and there is more to be done to ensure that revalidation has benefits and impact for doctors who perform well already.

The General Medical Council has recently commissioned Sir Keith Pearson, Chair of the GMC’s Revalidation Advisory Board, to lead a review of revalidation, and we hope our report and future research will be useful to his review. The review will draw on evidence of the operation and impact of revalidation since it was launched in December 2012 and look forward to how it can be improved. The aim will be to produce recommendations for changes during 2017. Sir Keith’s report, which will include recommendations to the GMC, will be produced by the end of this year and will be published.
Appendix 1: Survey questions – UK-wide survey of responsible officers, 2015

1. About you

Q1.1 What are your job roles in relation to [DB name]? Please tick all that apply

- Responsible Officer
- Medical Director
- Associate/Deputy MD
- Other role (please state) ____________________
- I do not have any role in relation to [DB name]

Q1.2 For how long in total have you worked in/with [DB name], whether as responsible officer or in other roles?

___ years

2. Resources for revalidation

Q2.1 How much of your working week is formally allocated to your role as a responsible officer for [DB name]? Put 0 if you have no allocated time

___ hours per week

Q2.2 On average, approximately how much of your working week is actually used for your role as a responsible officer for [DB name]?

___ hours per week

Q2.3 On average, approximately how much staff time apart from yours is used to manage and coordinate the revalidation process for doctors connected with [DB name]? Do not include time spent on managing, coordinating or conducting appraisals Put 0 if no other staff time is used

Administrative or managerial staff time: ___ hours per week

Medical or clinical staff time: ___ hours per week

Q2.4 Do you have access to a computerised information system to support the revalidation process for doctors connected with [DB name]? Do not count GMC Connect

- Yes (please specify) ____________________
Q2.5 Do you have any comments about the resources in [DB name] available for revalidation?

3. Training and support

Q3.1 How useful have you found the following sources of support or guidance on revalidation?

<table>
<thead>
<tr>
<th>Source</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>The GMC protocol for making revalidation recommendations</td>
<td>Never used it</td>
</tr>
<tr>
<td>Effective governance to support medical revalidation</td>
<td>Not at all useful</td>
</tr>
<tr>
<td>Guidance documents from Royal Colleges or specialty associations</td>
<td>Not very useful</td>
</tr>
<tr>
<td>Advice from a higher level responsible officer</td>
<td>Quite useful</td>
</tr>
<tr>
<td>Advice from other responsible officers</td>
<td>Very useful</td>
</tr>
<tr>
<td>Advice from your GMC Employer Liaison Adviser</td>
<td></td>
</tr>
<tr>
<td>Other sources of support or guidance (please state)</td>
<td></td>
</tr>
</tbody>
</table>

Q3.2 What training have you undertaken for the role of responsible officer? Please tick all that apply

- Nationally agreed introductory training programme (England-wide, Scotland-wide, Wales-wide or Northern Ireland-wide)
- E-learning package
- Attendance at responsible officer network meetings
- Other training (please give details) ____________________
- None

Q3.3 Do you have any comments about training and support for responsible officers?

4. Knowledge about systems

Q4.1 How much knowledge do you have about how the following systems operate for the doctors connected with [DB name]?

<table>
<thead>
<tr>
<th>System</th>
<th>Knowledge Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appraisal</td>
<td>None</td>
</tr>
<tr>
<td>Continuing Professional</td>
<td>A little</td>
</tr>
<tr>
<td>Development</td>
<td>Some</td>
</tr>
<tr>
<td>Complaints</td>
<td>A lot</td>
</tr>
<tr>
<td>Quality improvement</td>
<td></td>
</tr>
<tr>
<td>Significant events/SUIs</td>
<td></td>
</tr>
<tr>
<td>Doctors causing concern</td>
<td></td>
</tr>
<tr>
<td>Fitness to Practise</td>
<td></td>
</tr>
</tbody>
</table>

5. Appraisal
Q5.1 Does [DB name] have a written policy on appraisal? The policy may be standalone, or part of a wider policy

- Yes
- No
- Don't know

Q5.2 Approximately what proportion of doctors connected with [DB name] had an appraisal in the year April 2014-March 2015?

- 0-20%
- 21-40%
- 41-60%
- 61-80%
- 81-100%
- Don't know

Q5.3 How often was information about the completion of appraisals reported to the board or governing body of [DB name] in the year April 2014-March 2015? Either as a separate report or as part of a larger report

- Never
- Annually
- Quarterly
- Monthly
- More often than monthly
- Don't know

Q6.5 How do you think appraisal of doctors has changed clinical practice in the year April 2014-March 2015?

- A lot worse
- A little worse
- No change
- A little better
- A lot better
- Don't know

Q6.6 Have the arrangements for appraisal in [DB name] changed due to the introduction of revalidation?

- Yes Please give details about the nature and impact of the changes ____________________
- No
- Don't know
Q7.1 4. Appraisal

Q7.2 Do you have any comments about how information from appraisal is used in revalidation?

Q8.1 5. Continuing Professional Development (CPD)

Q8.2 Does [DB name] have a written policy on CPD? The policy may be standalone, or part of a wider policy

- Yes
- No
- Don’t know

Q8.3 Approximately what proportion of doctors connected with [DB name] have an agreed CPD plan?

- 0-20%
- 21-40%
- 41-60%
- 61-80%
- 81-100%
- Don’t know

Q8.4 Approximately what proportion of doctors connected with [DB name] have undertaken their planned CPD in the year April 2014-March 2015?

- 0-20%
- 21-40%
- 41-60%
- 61-80%
- 81-100%
- Don't know

Q8.5 How often was information about doctor participation in CPD reported to the board or governing body of [DB name] in the year April 2014-March 2015? Either as a separate report or as part of a larger report

- Never
- Annually
- Quarterly
- Monthly
- More often than monthly
- Don’t know
Q8.6 How do you think doctor participation in CPD has changed clinical practice in the year April 2014-March 2015?

- A lot worse
- A little worse
- No change
- A little better
- A lot better
- Don't know

Q8.7 Have the arrangements for CPD in [DB name] changed due to the introduction of revalidation?

- Yes Please give details about the nature and impact of the changes ____________________
- No
- Don't know

Q9.1 5. Continuing Professional Development (CPD)

Q9.2 In approximately what proportion of revalidation recommendations to the GMC regarding doctors connected with [DB name] is information about participation in CPD used?

- 0-20%
- 21-40%
- 41-60%
- 61-80%
- 81-100%
- Don't know

Q9.3 Do you have any comments about how information about CPD is used in revalidation?

Q10.1 6. Complaints

Q10.2 Does [DB name] have a written policy on responding to complaints? The policy may be standalone, or part of a wider policy

- Yes
- No
- Don't know
Q10.3 Approximately what proportion of complaints were responded to in accordance with the policy in the year April 2014-March 2015?

- 0-20%
- 21-40%
- 41-60%
- 61-80%
- 81-100%
- Don't know

Q10.4 Approximately what proportion of complaints were responded to properly in the year April 2014-March 2015?

- 0-20%
- 21-40%
- 41-60%
- 61-80%
- 81-100%
- Don't know

Q10.5 How often was information about responses to complaints reported to the board or governing body of [DB name] in the year April 2014-March 2015? Either as a separate report or as part of a larger report

- Never
- Annually
- Quarterly
- Monthly
- More often than monthly
- Don't know

Q10.6 How do you think responses to complaints have changed clinical practice in the year April 2014-March 2015?

- A lot worse
- A little worse
- No change
- A little better
- A lot better
- Don't know

Q10.7 Have the arrangements for responding to complaints in [DB name] changed due to the introduction of revalidation?

- Yes Please give details about the nature and impact of the changes ____________________
- No
- Don't know
Q11.1 6. Complaints

Q11.2 In approximately what proportion of revalidation recommendations to the GMC regarding doctors connected with [DB name] is information about responses to complaints used?

- 0-20%
- 21-40%
- 41-60%
- 61-80%
- 81-100%
- Don't know

Q11.3 Do you have any comments about how information about complaints is used in revalidation?

Q12.1 7. Quality improvement

Q12.2 Does [DB name] have a written policy on quality improvement? The policy may be standalone, or part of a wider policy

- Yes
- No
- Don't know

Q12.3 Approximately what proportion of doctors connected with [DB name] participated in quality improvement in accordance with the policy in the year April 2014-March 2015?

- 0-20%
- 21-40%
- 41-60%
- 61-80%
- 81-100%
- Don't know

Q12.4 Approximately what proportion of doctors connected with [DB name] participated in quality improvement properly in the year April 2014-March 2015?

- 0-20%
- 21-40%
- 41-60%
- 61-80%
- 81-100%
Q12.5 How often was information about doctor participation in quality improvement reported to the board or governing body of [DB name] in the year April 2014-March 2015? Either as a separate report or as part of a larger report

- Never
- Annually
- Quarterly
- Monthly
- More often than monthly
- Don't know

Q12.6 How do you think doctor participation in quality improvement has changed clinical practice in the year April 2014-March 2015?

- A lot worse
- A little worse
- No change
- A little better
- A lot better
- Don't know

Q12.7 Have the arrangements for quality improvement in [DB name] changed due to the introduction of revalidation?

- Yes
  Please give details about the nature and impact of the changes ____________________
- No
- Don't know

Q13.1 7. Quality improvement

Q13.2 In approximately what proportion of revalidation recommendations to the GMC regarding doctors connected with [DB name] is information about participation in quality improvement used?

- 0-20%
- 21-40%
- 41-60%
- 61-80%
- 81-100%
- Don't know
Q13.3 Do you have any comments about how information about quality improvement is used in revalidation?

Q14.1 8. Significant events or serious untoward incidents (SUIs)

Q14.2 Does [DB name] have a written policy on responding to significant events/SUIs? The policy may be standalone, or part of a wider policy

- Yes
- No
- Don't know

Q14.3 Approximately what proportion of significant events/SUIs were responded to in accordance with the policy in the year April 2014-March 2015?

- 0-20%
- 21-40%
- 41-60%
- 61-80%
- 80-100%
- Don't know

Q14.4 Approximately what proportion of significant events/SUIs were responded to properly in the year April 2014-March 2015?

- 0-20%
- 21-40%
- 41-60%
- 61-80%
- 80-100%
- Don't know

Q14.5 How often was information about responses to significant events/SUIs reported to the board or governing body of [DB name] in the year April 2014-March 2015? Either as a separate report or as part of a larger report

- Never
- Annually
- Quarterly
- Monthly
- More often than monthly
- Don't know
Q14.6 How do you think responses to significant events/SUIs have changed clinical practice in the year April 2014-March 2015?

- A lot worse
- A little worse
- No change
- A little better
- A lot better
- Don’t know

Q14.7 Have the arrangements for responding to significant events/SUIs in [DB name] changed due to the introduction of revalidation?

- Yes
  Please give details about the nature and impact of the changes ____________________
- No
- Don’t know

Q15.1 8. Significant events or serious untoward incidents (SUIs)

Q15.2 In approximately what proportion of revalidation recommendations to the GMC regarding doctors connected with [DB name] is information about responses to significant events/SUIs used?

- 0-20%
- 21-40%
- 41-60%
- 61-80%
- 81-100%
- Don't know

Q15.3 Do you have any comments about how information about significant events/SUIs is used in revalidation?

Q16.1 9. Doctors causing concern

Q16.2 Does [DB name] have a written policy on doctors causing concern? The policy may be standalone, or part of a wider policy

- Yes
- No
- Don’t know
Q16.3 Which of the following information sources were used in bringing cases of doctors causing concern to light in the year April 2014-March 2015? Tick all that apply

- Appraisal
- CPD
- Complaints
- Quality improvement
- Significant events/SUIs
- Whistleblowing
- Other sources (please state) ____________________
- Don't know

Q16.4 Which of the following actions were taken in these cases of doctors causing concern? Tick all that apply

- Formal local investigation
- Required to undertake further training
- Restrictions placed on areas of practice
- Referral to the Occupational Health department
- Formal local disciplinary action
- Advice sought from GMC Employer Liaison Adviser
- Referral to the National Clinical Assessment Service (NCAS)
- Fitness to Practise referral to the GMC
- Other actions (please state) ____________________
- Don't know

Q16.5 How do you think responses to actions taken in cases of doctors causing concern have changed clinical practice in the year April 2014-March 2015?

- A lot worse
- A little worse
- Unchanged
- A little better
- A lot better
- Don't know

Q16.6 How has the number of cases of doctors causing concern changed since the introduction of revalidation?

- There have been more cases since the introduction of revalidation
• There have been about the same number of cases
• There have been fewer cases since the introduction of revalidation
• Don't know

Q16.7 Have the arrangements for managing cases of doctors causing concern in [DB name] changed due to the introduction of revalidation?

• Yes
  Please give details about the nature and impact of the changes ____________________
• No
• Don't know

Q17.1 9. Doctors causing concern

Q17.2 Do you have any comments about how information about doctors causing concern is used in revalidation?

Q18.1 10. Fitness to practise

Q18.2 Does [DB name] have a written policy on making fitness to practise referrals to the GMC? The policy may be standalone, or part of a wider policy

• Yes
• No
• Don't know

Q18.3 Was information from the following sources instrumental in any fitness to practise referrals made in the year April 2014-March 2015? Tick all that apply

• Appraisal
• CPD
• Complaints
• Quality improvement
• Significant events/SUIs
• Whistleblowing
• Other sources (please state) ____________________
• Don't know
Q18.4 How has the number of fitness to practise referrals made to GMC changed since the introduction of revalidation?

- There have been more referrals since the introduction of revalidation
- There have been about the same number of referrals
- There have been fewer referrals since the introduction of revalidation
- Don't know

Q18.5 Have fitness to practise arrangements in [DB name] changed due to the introduction of revalidation?

- Yes
  Please give details about the nature and impact of the changes
- No
- Don't know

Q19.1 11. Making revalidation recommendations

Q19.2 How do you usually arrive at your revalidation recommendations to the GMC? Tick all that apply

- Reviewing the case documentation
- Discussing the case with someone else
- Discussing the case in a formal group
- Confirming a recommendation made by someone else
- Other (please state) ____________________
- I have not yet made any recommendations

Q19.3 Please give brief details about the arrangements for arriving at revalidation recommendations. What determines the process that is followed for a particular doctor?

Q19.4 Are your revalidation recommendations to the GMC communicated to the doctor concerned?

- Yes - before making the recommendation
- Yes - after making the recommendation
- No
Q19.5 Have there been any cases since the introduction of revalidation where you made a positive revalidation recommendation to the GMC, though you had some residual concerns about the doctor which were not sufficient to warrant deferral of the recommendation?

- No
- Yes

Please describe the circumstances in which this has happened, and what types of action you have taken _________________

Q19.6 Have there been any cases since the introduction of revalidation where you made a request to the GMC to defer making a revalidation recommendation on the basis of insufficient information?

- No
- Yes

Please describe the circumstances in which this has happened, and what types of action you have taken _________________

Q19.7 Have there been any cases since the introduction of revalidation where you made a request to the GMC to defer making a revalidation recommendation because of an ongoing local process?

- No
- Yes

Please describe the circumstances in which this has happened, and what types of action you have taken _________________

Q19.8 Have there been any cases since the introduction of revalidation where you made a recommendation of non-engagement in revalidation to the GMC?

- No
- Yes

Please describe the circumstances in which this has happened, and what types of action you have taken _________________

Q19.9 Do you have any further comments about making revalidation recommendations?
Q20.1 12. Implementation and impact of revalidation

Q20.2 What factors have helped or hindered the implementation of revalidation in [DB name]? Please explain briefly

Q20.3 What impact has the introduction of revalidation had on you and your role with regard to [DB name]?

Q20.4 What impact has the introduction of revalidation had on appraisal and other systems for managing quality in [DB name]?

Q20.5 What impact has the introduction of revalidation had on clinical practice in [DB name]?

Q20.6 What changes do you think might improve the way revalidation works?

Q21.1 Comparing [DB name] with other designated bodies

Q21.2 Are there any significant differences in the way in which revalidation works in the other designated bodies for which you are the responsible officer?

- No
- Not applicable - I am not the responsible officer for any other designated bodies
- Yes (please give details) ____________________

Q22.1 Final comments

Q22.2 Do you think [DB name] would be interested in being involved in the next phase of this research?
Q22.3 Would you like a copy of your responses to this survey to be emailed to you as evidence of your participation? Only tick "Yes" if you are happy for your responses to be emailed to ${m://Email1}. If you would like your responses emailed to a different email address, please email alan.boyd@mbs.ac.uk to arrange this

- Yes
- No

Q22.4 Please use this box to make any additional comments about revalidation, or about this survey.