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UMbRELLA: Evaluating the regulatory impacts of medical revalidation final report.

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Evaluating the regulatory impact of medical revalidation

February 2018

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List of abbreviations and acronyms

AOA	Annual Organisational Audit
CAMERA	Collaboration for the Advancement of Medical Education Research and Assessment
CCT	Certificate of Completion of Training
CHAT	Cultural Historical Activity Theory
CPD	Continuing Professional Development
DH PRP	Department of Health Policy Research Programme
EEA	European Economic Area
ELA	Employer Liaison Adviser
ELS	Employer Liaison Service
FTP	Fitness to Practise
GMC	General Medical Council
GMP	Good Medical Practice
GP	General Practice/General practitioner
ID	Identifier
IT	Information Technology
MARS	Medical Appraisal and Revalidation System
MSF	Multisource Feedback
NHS	National Health Service
NI	Northern Ireland
OR	Odds Ratio
PDP	Personal Development Plan
PMQ	Primary Medical Qualification
PO	Patient organisation
PPG	Patient Participation Group
PR	Patient representative
PPI	Patient and Public Involvement
QI(A)	Quality Improvement (activity)
RO	Responsible Officer
RQ	Research question
SASG	Staff and Associate Specialist Grade doctors
SEA	Significant Event Analysis
SI	Supporting Information
SOAR	Scottish Online Appraisal Resource
SoMEP	State of Medical Education and Practice in the UK
UK	United Kingdom
UMbRELLA	Uk Medical Revalidation Evaluation coLLaboration

Executive Summary

Background

Revalidation, launched in December 2012, signified a major shift in the regulation of medical practice in the United Kingdom (UK). All licensed doctors are now required to collect supporting information (SI) about their practice and to participate in annual appraisals, with the SI as the basis for a reflective discussion feeding into their Personal Development Plan (PDP). For the vast majority of doctors, the output of appraisal is shared with a Responsible Officer (RO), a role to which organisations employing or contracting with doctors are obliged to appoint a senior doctor. Most doctors have a 'prescribed connection' for the purposes of revalidation to such an organisation. ROs may make, usually every five years, one of three recommendations to the General Medical Council (GMC): that the doctor should be revalidated; that the doctor's revalidation should be deferred, either because there is insufficient evidence to recommend revalidation or because they are subject to on-going local processes; or the RO may notify the GMC that a doctor has not engaged with revalidation.

Between October 2014-2017, a collaboration of academics and revalidation implementers, called the UK Medical Revalidation Evaluation coLLAboration ([UMbRELLA](#)), was commissioned by the GMC to explore the impacts of revalidation during its first cycle of implementation.

Research questions

1. Is the GMC's objective of bringing all doctors into a governed system that evaluates their fitness to practise (FTP) on a regular basis being consistently achieved?
2. How is the requirement for all doctors to collect and reflect upon SI about their whole practice through appraisal being experienced by revalidation stakeholders?
3. Is engagement in revalidation promoting medical professionalism by increasing doctors' awareness and adoption of the principles and values set out in *Good Medical Practice*?
4. Are revalidation mechanisms facilitating the identification and remedy of potential concerns before they become safety issues or FTP referrals?
5. How do ROs fulfil their statutory function of advising the GMC about doctors' fitness to practise and what support do they have in this role?
6. Are patients being effectively and meaningfully engaged in revalidation processes?

Methods

To understand revalidation's impacts, we drew on Cultural Historical Activity Theory (CHAT) to frame our approach and structure our analysis, conceptualising revalidation as an activity system that is itself made up of many interconnecting subcomponent activities focused on supporting information, appraisal, and appraiser and RO decision-making.

We undertook an extensive three-year study across UK healthcare settings, sampling data from all registered and licensed doctors. We completed nine literature reviews, analysed GMC held data on nearly 281,000 doctors, completed eight surveys with over 85,000 participants. We recorded 44 appraisals, interviewed 156 doctors and patient representatives and reviewed 24 doctors' portfolios (Section [2.4](#)).

Key findings

Is the GMC's objective of bringing all doctors into a governed system that evaluates their fitness to practise on a regular basis being consistently achieved? (Section [3.1](#))

- Overall, most doctors have been brought into a governed system of medical revalidation.
- There are higher deferral rates in some groups, including female doctors, younger doctors and those from Black and Minority Ethnic (BME) backgrounds independent of where they obtained their primary medical qualification.
- Engagement in revalidation has generally been more straightforward for doctors working within existing governance structures, for example as an employee for one organisation.
- Medical revalidation has led to a rise in participation by UK doctors in annual appraisal.
- Outside existing governance structures, there are peripheral groups, including but not exclusively locums, where the ability to obtain an annual appraisal has been inconsistent.
- There are inconsistencies at the appraisal level for all doctors, where local and appraiser interpretations are central in shaping individual doctors' experience of the system.

How is the requirement for all doctors to collect and reflect upon supporting information about their whole practice through appraisal being experienced by revalidation stakeholders? (Section [3.2](#))

- Overall, doctors are able to collect the required SI.
- However, the ease with which doctors can collect some types of SI may vary according to their job role, setting or speciality.
- The requirement to submit SI across six defined categories during the five-year cycle has resulted in a strong focus within the appraisal process on the collection of SI.
- Doctors found patient and colleague feedback, and SEAs, most helpful in informing reflective discussions.
- Reflection on SI in appraisal is key for generating change, but reflection is often seen as just a product of appraisal, not necessarily translated into ongoing reflective practice.
- Expectations set locally, for example by employing organisations or individual appraisers, can influence doctors' experiences of SI collection and can go beyond the requirements set by the GMC for revalidation.

Is engagement in revalidation promoting medical professionalism by increasing doctors' awareness and adoption of the principles and values set out in Good Medical Practice? (Section [3.3](#))

- A significant minority of doctors reported changing an aspect of their clinical practice, professional behaviour or learning activities as a result of their most recent appraisal.
- Overwhelmingly these changes related to the focus or quantity of their continuing professional development (CPD) activities, though changes have occurred across the domains of *Good Medical Practice* (GMP).
- However, some doctors identified potentially negative impacts on practice or for professional autonomy.
- Revalidation, through appraisal, provides a means to document practice but may not necessarily improve professional practice.

- Ultimately, revalidation's ability to promote good professional practice is through the central role of high quality formative appraisal.

Are revalidation mechanisms facilitating the identification and remedy of potential concerns before they become safety issues or Fitness to Practise referrals? (Section [3.4](#))

- Many in the profession believe that the main aim of revalidation is to identify 'bad doctors', and that doctors' participation in appraisal will not achieve this aim.
- Since late 2012, fitness to practise referrals from employers have returned to pre-2009 levels, following spikes in such activity in the period leading up to revalidation's introduction. There is no statistical evidence, as yet, that referrals from employers have dropped as a result of the earlier identification and local remedy of concerns.
- Appraisal and appraisers can and do identify some concerns about doctors, particularly in relation to workplace and health issues, and many concerns identified through appraisal are addressed successfully within that process.

How do Responsible Officers fulfil their statutory function of advising the GMC about doctors' fitness to practise and what support do they have in this role? (Section [3.5](#))

- Responsible Officers' approaches to decision-making vary in terms of the information that they use and the extent to which they delegate or share decision-making responsibility.
- The size of the organisation in which they work, particularly the number of doctors connected to it, is a key factor in shaping Responsible Officers' approaches to decision-making.
- Some Responsible Officers do not feel that the three options available for revalidation recommendations (revalidate; deferral; and non-engagement) adequately cover all circumstances.
- The GMC's Employer Liaison Service plays a key and developing role in supporting Responsible Officers and acting as the point of contact between organisations and the medical regulator.

Are patients being effectively and meaningfully engaged in revalidation processes? (Section [3.6](#))

- Many of those involved in revalidation view patient and public involvement (PPI) positively, but there is confusion over its intended purpose and appropriate modes of delivery.
- Both doctors' and patients' engagement with patient feedback is inconsistent and at times problematic. A need for current patient feedback tools to be refined was repeatedly expressed from both patient and doctor perspectives.
- Patient complaints and compliments can have a negative or positive impact on performance. More formal ways of providing compliments is desirable.
- Lay representation in revalidation processes has increased since its implementation but activity varies across organisations. Existing lay representatives have identified key ways in which lay roles could be developed and supported.

Discussion

Exploring revalidation using our conceptual model, highlighted below, we found that the process of revalidation – doctors collecting and reflecting on supporting information as part of an annual appraisal cycle and ROs making recommendations periodically – has been widely implemented. However, the impact of revalidation and therefore understanding achievement of the proposed outcomes is less certain.

Our data reveals that a model built on NHS appraisal has been more successfully implemented in these organisational settings. There is more work to be done to ensure all doctors are fully supported in the activities of revalidation that they are engaged in. There may be opportunities to facilitate more flexibility in implementation between different groups of doctors such as those working overseas, part-time, or across different specialities. Further consideration is required to explore ways to facilitate doctors providing evidence of their full scope of practice; as many doctors undertake significant non-patient facing roles, including for example ROs as managers. There may be a need to better define where professional activity that impacts on patient care and safety begins and ends to assist RO recommendations. This might include defining ‘whole scope of practice’ as activities more directly related to patient care and safety not, as is currently the case, anything a doctor undertakes in any setting – in healthcare or outside. This could potentially be supported by additional recommendation categories that adequately cover all circumstances. For example, additional recommendation categories could facilitate ROs to differentiate between essentially ‘routine’ changes to revalidation dates, such as those resulting from changes in trainees’ Certificate of Completion of Training (CCT) dates or as a result of a period of parental leave, and those instances where doctors may not have collected adequate supporting information to enable an RO to confidently make a recommendation to revalidate but without any such extenuating circumstances. Possible evidence of differential outcomes between white and other ethnic groups and between UK and some non-UK trained doctors in deferral recommendations requires further exploration.

Doctors and patient organisations we spoke to remain confused about the purpose of revalidation and what it is therefore intending to achieve. Many doctors see appraisal as now focused on completing tasks to achieve documentary evidence of their adequate performance to maintain their licence. This has important implications for patients if in the future a recently revalidated doctor is found wanting; and for doctors, with appraisal moving to a more bureaucratic tick-box exercise where reflection is simply documented in line with requirements, but not translated into active reflective practice. The ‘tick-box’ idea has been reinforced by IT systems designed with dashboards and traffic light systems that require boxes to be literally ticked. There is now the risk that these systems are further driving the tick-box mentality through their design. Guidance varies throughout the system between the GMC, Royal Colleges, the four nations, ROs, lead appraisers and appraisers. This is of little concern for a developmental model but is much more significant if reliable regulatory assurance, in other words the need to demonstrate doctors’ achievement of a minimum standard, is the desired outcome.

Either way, central to the impact of the policy for the profession remains the success of appraisal and this is appraiser dependent. Appraisers are fundamental in supporting doctors through the dissonance, denial and self-affirmation which they may experience in appraisal – ultimately to bring

about positive change in behaviour or practice. This highlights that in terms of resource allocation, appraiser training should ensure mentoring/coaching techniques required to support appraisee personal and professional development. There may also be important opportunities to better link in CPD and quality improvement and therefore patient care.

Patient organisations we spoke to reported facing challenges to providing patient feedback, due to lack of information, inadequate instruments and fear of retribution. There is however much to celebrate as well including some examples of good practice in PPI across the UK, but there remains scope for developing more consistent, sustainable and meaningful engagement of patients in revalidation.

1 Introduction

Revalidation represents the most significant change to the regulation of medical practice in the United Kingdom since the Medical Act 1858.¹⁻³ This report sets out the major findings from a large-scale evaluation carried out in the first cycle of its implementation, commissioned by the General Medical Council (GMC), and conducted independently by the UK Medical Revalidation Evaluation coLLAboratiOn (UMbRELLA).

1.1 Introducing revalidation

Revalidation is a continued competency system, built on a relicensing model. Usually every five years, the GMC makes a decision about whether to maintain a doctor's licence to practise. Whilst doctors can simply be registered with the GMC, they may not practise in the UK without also holding a licence.

The GMC's revalidation decisions about most doctors are based on recommendations made by Responsible Officers (ROs), a role to which organisations employing or contracting with doctors (termed 'designated bodies') are obliged to appoint a senior doctor. Most doctors have a 'prescribed connection' to such an organisation for the purposes of revalidation. When compared to other relicensing schemes internationally,^{4,5} ROs are a unique feature of the UK revalidation process, acting as intermediaries between the medical profession within an organisational setting and the medical regulator. The approximately 600 ROs are either directly employed by an organisation or provide outsourced services.⁶ There are over 900 designated bodies in the UK and, whilst many ROs hold the role for a single organisation, some undertake RO work across multiple organisations.⁷ These designated bodies range from small organisations with just a few doctors connected to them, such as hospices, to Local Education and Training Boards or large acute hospital Trusts, with several thousand doctors.⁸ ROs' responsibilities are derived from primary legislation⁹ and detailed in subsequent statutory regulations.^{10,11} ROs' primary responsibility in relation to revalidation is to evaluate the fitness to practise of doctors with a prescribed connection to their organisation and periodically make a revalidation recommendation to the GMC about each doctor.¹² They may recommend that a doctor be revalidated or that their revalidation date should be deferred, either because they have insufficient evidence on which to recommend revalidation, or because the doctor is involved in an on-going local disciplinary process. ROs can also notify the GMC that a doctor has failed to engage in revalidation processes.¹³

ROs' recommendations should be based on information resulting from doctors' participation in an annual appraisal process and, in order to recommend revalidation, on the absence of any unaddressed concerns about their fitness to practise, determined from clinical governance information available to them.¹³ Doctors are required to collect supporting information (SI) about their practice across six categories and to participate in annual appraisals, with the SI as the basis for a reflective discussion feeding into their Personal Development Plan (PDP).

Doctors without a connection to an organisation may connect to a Suitable Person approved by the GMC to make revalidation recommendations, or revalidate via the GMC's annual return process, sending information directly to the regulator. For doctors in postgraduate speciality training, the

Annual Review of Competency Panel (ARCP) fulfils the appraisal and SI components, and their first revalidation date is typically aligned with their expected Certificate of Completion of Training (CCT) date.¹⁴

1.2 Contextualising revalidation

At 30th November 2017, there were 234,793 doctors subject to revalidation of whom 224,114 had a connection to a designated body or suitable person.¹⁵ Those without a connection include doctors working wholly overseas, doctors working in the UK in roles which do not involve direct patient contact, such as medico-legal work, as well as some doctors working in the UK and treating patients through their own private clinics or through locum work.¹⁶ By 30th November 2017, the GMC had approved revalidation recommendations for 184,101 doctors, whilst 42,561 doctors had had their revalidation date deferred due to there being insufficient evidence to support a recommendation to revalidate. There had been a further 1,636 deferrals due to the doctor's involvement in an on-going local process.¹⁵ In addition, 594 recommendations of non-engagement had been approved by the regulator by this point and the regulator had withdrawn the licences to practise of 3,840 doctors on the grounds that they had failed to engage with revalidation.¹⁵

Prior to revalidation's introduction in December 2012, doctors were not subject to oversight or intervention from the GMC, once qualified and registered, unless subject to Fitness to Practise (FTP) procedures following a complaint or referral.² Now doctors must participate in revalidation, and its constituent mechanisms, throughout their careers in order to retain their licence to practise. Developing and implementing such an intervention, encompassing nearly 235,000 doctors,¹² presents many challenges.

The need for revalidation, its aims, and format were all contested prior to its introduction,¹⁷ and debates as to its value have continued, focusing for example on whether revalidation is driving some doctors to leave practice.^{18,19} Other UK and international health professions' regulators are developing similar schemes,^{5,20-23} and comparable forms of continued assessment of professional competence, such as the Maintenance of Certification programme in the USA, have also been subject to debates about efficacy and value.^{24,25}

In trying to determine the evidence base for revalidation's impact, challenges arise because revalidation is not one singular activity, but rather several activities – SI, appraisal, RO recommendation-making – positioned as part of the regulatory process. Moreover, whilst revalidation is a professional regulatory intervention focused on monitoring individual doctors' fitness to practise and overseen by the GMC, revalidation relies on RO recommendations, annual appraisal and clinical governance information as core components. These components are largely owned and operated by other bodies, such as healthcare organisations²⁶ or the four devolved Departments of Health, whose policies and processes vary, for example in relation to appraisal delivery.²⁷⁻³⁰ The environment into which revalidation was launched has also seen changes, including most notably the creation of NHS England through the Health and Social Care Act 2012.³¹ There have also been developments specifically relating to the operation of revalidation, such as the production of revised guidance offered by the GMC,¹³ and by other organisations for specific groups of doctors.³²⁻³⁴

To date, little research has been undertaken to understand the impacts of revalidation, beyond small scale speciality specific surveys. For example, the Royal College of General Practitioners reported survey results showing that whilst two-thirds of General Practitioners (GPs) had not encountered any difficulties with appraisal or revalidation, the data also suggested some lack of clarity about the requirements, and concern about the time taken to undertake the process.³⁵ A study amongst GPs in Wales found mixed views about the impact of revalidation, again highlighting the time burden involved but also identifying an increase in reflection amongst some doctors.³⁶ In 2013-14, the Revalidation Support Team, commissioned the King's Fund and the University of Plymouth to undertake a small scale evaluation which involved surveying 3,500 doctors and interviews with patient representatives. They found that there was strong support for the system among ROs and appraisers but while doctors continued to value appraisals and continuing professional development (CPD), some felt that revalidation was not yet relevant to their needs.³⁷ There was also a call for patients and the public to have clearer and more empowered roles.³⁷ Other studies have considered the experiences and perspectives of military doctors,³⁸ doctors working in occupational medicine,³⁹ and ROs.^{6,40}

Notably, the GMC commissioned an independent, consultation-based review of revalidation led by Sir Keith Pearson, whilst our evaluative research was underway, to consider possible future modifications to revalidation.¹⁶

Here then, we seek to extend this existing but somewhat 'patchwork' knowledge base, by providing a wide-ranging evaluation of the implementation of revalidation and its impacts across the UK medical profession.

2 Study design and methods

Between January 2015 and October 2017, we conducted extensive mixed methods research ranging across the component parts of the revalidation system and encompassing the breadth of the UK medical profession. The research collaboration brought academic expertise in qualitative and quantitative research methodologies, from disciplinary backgrounds including medical education, medical sociology, health services research, and improvement science, together with the systems knowledge and procedural insights of clinicians and revalidation implementers from across the UK.

2.1 Aim

- To evaluate the regulatory impacts of medical revalidation as a complex intervention in UK healthcare

2.2 Research questions

In 2013, the Collaboration for the Advancement of Medical Education Research & Assessment (CAMERA), at the University of Plymouth, developed an evaluative framework to explore the impact of revalidation for the GMC.⁴¹ The framework was shaped around the principal regulatory aims for revalidation as identified by the GMC during that process. We developed research questions from these aims (Table 1) with a number of additional sub-questions for each (appendix A).

Table 1: Overarching research questions (RQs)

- 1) Is the GMC's objective of bringing all doctors into a governed system that evaluates their fitness to practise on a regular basis being consistently achieved?
- 2) How is the requirement for all doctors to collect and reflect upon supporting information (SI) about their whole practice through appraisal being experienced by revalidation stakeholders?
- 3) Is engagement in revalidation promoting medical professionalism by increasing doctors' awareness and adoption of the principles and values set out in *Good Medical Practice*?
- 4) Are revalidation mechanisms facilitating the identification and remedy of potential concerns before they become safety issues or FTP referrals?
- 5) How do ROs fulfil their statutory function of advising the GMC about doctors' fitness to practise and what support do they have in this role?
- 6) Are patients being effectively and meaningfully engaged in revalidation processes?

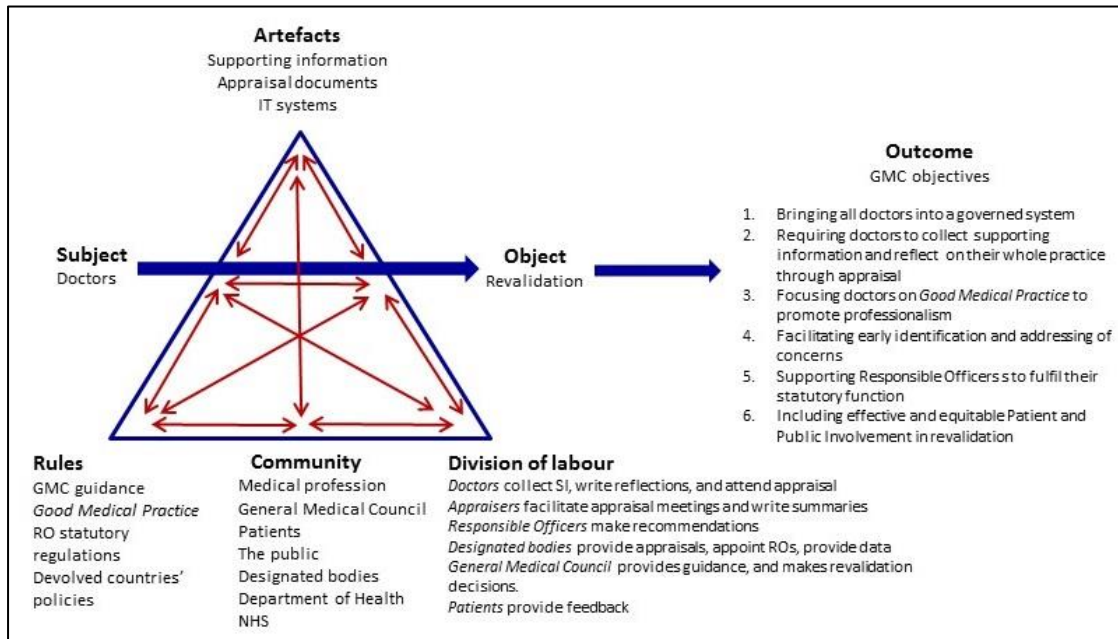
2.3 Conceptual framework

To understand revalidation's impacts, we drew on Cultural Historical Activity Theory (CHAT) to frame our approach and structure our analysis, conceptualising revalidation as an activity system that is itself made up of a number of interconnecting subcomponent activities – primarily supporting information, appraisal, and RO decision-making.

CHAT conceptualises the relationship between individuals and the environment as being mediated by artefacts (such as national guidance, IT systems) within a systemic culture. With the incorporation of socio-cultural activity and individual behaviour in one analytical approach, CHAT helped provide a nuanced understanding of the ways in which a range of participants are actually engaging with revalidation as part of a dynamic system, exploring for example, for any inconsistencies within interactions.⁴²

Figure 1 is a basic CHAT model showing the different elements of the activity with examples of expected content assigned to each element and the interactions between them indicated by red arrows. The dark blue arrow shows the doctor as one element of the system engaging with, and in turn being acted on by the other elements as the doctor moves towards the object – to be revalidated.

Figure 1: Revalidation as an activity system



Artefacts (such as IT systems) are mediational means, employed by the *subject* (doctors) to achieve the *object* (being revalidated). The *object* (revalidating) is the central issue to which activity is directed, which leads to an *outcome* as a consequence of the *activity*, the *outcomes* here being the GMC's six regulatory objectives for revalidation.⁴¹ The *community* comprises multiple individuals and/or sub-groups who share the same general object. The *division of labour* refers to both the horizontal division of tasks between the members of the *community* and to the vertical division of power and status. *Rules* refer to the explicit and implicit regulations, norms and conventions that constrain and empower actions and interactions that take place in the operationalisation of revalidation.

Through the work packages outlined in Table 2, we collected data to populate the different elements of the activity systems that make up revalidation. These were systematically analysed individually and relationally to address our research questions.

2.4 Sampling

Our sampling strategy was designed to include all the key stakeholders within the revalidation *community*: appraisees, appraisers, ROs, and patient representatives. We then operationalised our RQs into seven work packages of research activities, organised by methods, as summarised in Table 2.

The GMC is subject to the Public Sector Equality Duty set out in the Equality Act 2010,⁴³ and must therefore seek to ensure that its activities do not impact disproportionately on groups of registrants sharing protected characteristics. The GMC provided data on registrants' personal and professional characteristics, namely: sex, age, ethnicity, region of primary medical qualification (PMQ), prescribed connection, speciality and General Practice registration status, UK country, and whether or not the doctor held a licence to practise on 31st January 2017. Using GMC data on registration status and

prescribed connection to a designated body, we also created a new variable to show whether a doctor was a General Practitioner, on a Specialist register, in a postgraduate training programme, or none of these. We used these characteristics as variables in our statistical analyses conducted as part of work package 2 (Table 2).

Through our surveys, we collected data relating to personal and professional characteristics, namely: age, sex, national identity, ethnic group, religion, sexual orientation, disability, main job role, specialty group, healthcare setting, Royal College membership and full or part-time work status.

2.5 Reporting of findings

Quantitative data were analysed with Chi-squared tests and regression modelling. Chi-squared tests provide a measure of association between responses given to two survey questions. The strength of the association is indexed by 'Cramer's V ' (ranging from 0 to 1) where values above .20 indicate moderate associations and above .40 indicate strong associations. Regression modelling allowed multiple personal and professional characteristics to be taken into account whilst exploring the association of each one with a particular outcome variable, such as responses to survey questions or categories of revalidation decisions. Odds ratios (OR) are given to report the results of a logistic regression model where the odds of a particular outcome vary between the categories of a predictor variable. In reporting the results of such a model, the odds are expressed relative to the odds for a particular category called the 'reference category'.

For both tests, we regarded p values less than 0.001 as 'statistically significant' due to the large sample size.

Qualitative data from interviews and free text survey responses were thematically analysed using a template analysis approach.⁴⁴ In this report, we use quotations from participants to illustrate the major themes identified through this analysis, and to demonstrate the range of viewpoints on each issue.

2.6 Ethical approval

Ethical approval for this study was granted by the University of Plymouth Faculty of Health and Human Sciences & Peninsula Schools of Medicine and Dentistry Research Ethics Committee (application ref: 14/15-390; amendment ref: 14/15-443; addition 1: 15/16-554; addition 2: 16/17-755).

Table 2: Summary of work packages mapped to research questions (RQs) with sampling details

Work packages	Research questions and sub-questions addressed	Methods (with sampling and participant identifiers used throughout this report where appropriate)
1: Literature reviews	1c; 1d; 2a; 2b; 2c; 2d; 2e; 2f; 5b; 5d; 6a; 6e	<ul style="list-style-type: none"> • Understanding ROs recommendations for medical revalidation: an integrative narrative review of judgement and diagnostic decision-making • Patient and public involvement in medical regulation: a narrative synthesis • The impact of patient feedback on medical performance: a systematic review • Continuing Professional Development and its impact on medical performance: a systematic review of reviews • The impact of MSF on medical performance: a review of reviews • The impact of complaints on medical performance: a systematic review • The impact of Continuing Professional Development (CPD) on medical performance: a review of reviews • The impact of significant event analysis on medical performance: a systematic review • The impact of QI on medical performance: a review of reviews
2: Secondary analysis of existing datasets	1a; 1b; 1d; 4a; 4b	<ul style="list-style-type: none"> • Descriptive and inferential statistical analyses of five linked de-identified datasets held by the GMC (extracted 31st January 2017) relating to registrant characteristics, revalidation decisions, FTP enquiries & cases, licence withdrawals & licence relinquishments. Data related to nearly 281,000 individual doctors.
3: National and strategic surveys	1a; 1b; 1c; 1d; 2a; 2b; 2c; 2d; 2e; 2f; 3a; 3b; 4a 5a; 5b; 5c; 5d; 6a; 6d; 6e	<p>Descriptive and inferential statistical and qualitative analyses of:</p> <ul style="list-style-type: none"> • A survey of licensed doctors in 2015 about their experiences and perceptions of appraisal and revalidation (Responses: N=26,171; Participant IDs = SXXXXXXX) • A survey of ROs across the UK in 2015 in partnership with the DH PRP revalidation evaluation of revalidation's impact on organisations in England (Responses: N= 374; participant IDs = ROSXXX)⁶ • Focused surveys in 2016/17 of selected subgroups of doctors: <ul style="list-style-type: none"> ○ Doctors without a prescribed connection (Responses: N=557; Participant IDs = SXXXXXXX) ○ Doctors with a locum agency as their designated body (Responses: N=1,168; Participant IDs = SXXXXXXX) ○ Doctors with an independent provider as their designated body (Responses: N=944; Participant IDs = SXXXXXXX)

		<ul style="list-style-type: none"> ○ Doctors working as staff grades or associate specialists (Responses: N=3,448; Participant IDs = SXXXXXXX) • A survey of patient representative groups (N=19; participant IDs = POXX (patient organisation), PRXX (patient representative), or LRXX (lay representative)) • Additional questions included in the GMC National Trainee Survey 2016 (Responses; N=53,835)
4: Appraisal capture	1a; 1b; 1c; 1d; 2a; 2b; 2c; 2d; 2e; 2f; 2g; 3a; 3b; 6b; 6c	<ul style="list-style-type: none"> • Thematic analysis of audio recorded appraisals undertaken by consenting doctors (N=44)
5: Interviews with stakeholders	1a; 1b; 1c; 1d; 2a; 2b; 2c; 2d; 2e; 2f; 2g; 3a; 3b; 4a 5a; 5b; 5c; 5d; 6b; 6c; 6d	<p>Thematic analysis of semi-structured interviews conducted with:</p> <ul style="list-style-type: none"> • Appraisees (N=75; participant IDs = ROXXX) • Appraisers (N=41; participant IDs = AOXXX) • Lay representatives (N=20; participant IDs = LROX) • Employer Liaison Advisers (N=6; participant IDs = ELAXX) • ROs (N=9; participant IDs = R50XX)
6: Documentary analysis	2c; 2f; 2g; 5b 6b	<ul style="list-style-type: none"> • Template and Nguyen et al's⁶ model of reflection analyses of portfolio documentation from the MARS and SOARs systems in Wales and Scotland (N=19)
7: Appraisal documentation of doctors referred to FTP	4a;4b; 5a;5b;5c;5d	<ul style="list-style-type: none"> • Root cause analysis of prior appraisal documentation (up to 5 years) prior to referral to FTP procedures (N=5; participant IDs = RCA7XX)

3 Findings

3.1 Is the GMC's objective of bringing all doctors into a governed system that evaluates their fitness to practise on a regular basis being consistently achieved?

Key Findings:

Medical revalidation

- Overall, most doctors have been brought into a governed system of medical revalidation.
- There are higher deferral rates in some groups, including female doctors, younger doctors and those from BME backgrounds independent of where they obtained their primary medical qualification.
- Engagement in revalidation has generally been more straightforward for doctors working within existing governance structures, for example as an employee for one organisation.

Appraisal informing medical revalidation

- Medical revalidation has led to a rise in participation by UK doctors in annual appraisal.
- Outside existing governance structures, there are peripheral groups, including but not exclusively locums, where the ability to obtain an annual appraisal has been inconsistent.
- There are inconsistencies at the appraisal level for all doctors, where local and appraiser interpretations are central in shaping individual doctors' experience of the system.

3.1.1 All doctors in a governed revalidation system

By the end of January 2017, the GMC had made 216,514 revalidation decisions about 175,614 doctors in total. Of these decisions, 205,248 related to 166,084 doctors holding a licence to practise at 31st January 2017, from a total of 237,065 licence holders at that date. We focused our analyses of revalidation outcomes on those 166,084 doctors holding a licence at 31st January 2017 about whom revalidation decisions had been made. The personal and professional characteristics of the doctors included in these data and the variables used in our analyses are shown in Table 3.

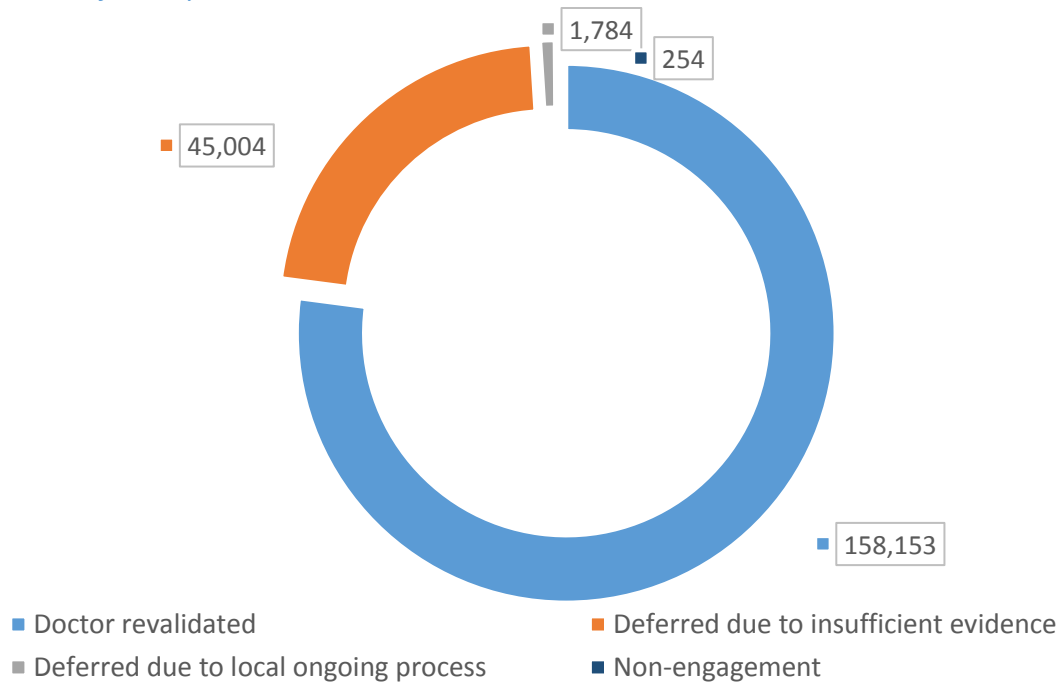
Table 3: The number and percentage of doctors holding a licence to practise at 31st January 2017 about whom revalidation decisions had been made by their protected and professional characteristics

Registrant characteristic	Level	N	%
Gender	Female	73,262	44.1
	Male	92,822	55.9
Age band*	Under 30	2,371	1.4
	30-39	46,210	28.2
	40-49	56,020	34.1
	50-59	41,978	25.6
	60-69	14,879	9.1
	70 and over	2,676	1.6
Ethnicity*	White	86,916	62.9
	Asian	39,171	28.4
	Black	5,297	3.8
	Mixed	2,830	2.0
	Other Ethnic Groups	3,884	2.8
PMQ region	UK	109,394	65.9
	EEA	13,404	8.1
	IMG	43,286	26.1
Dr Level	GP	57,901	34.9
	None	20,884	12.6
	Specialty	70,023	42.2
	Trainee	17,276	10.4
Prescribed connection	No	1,557	0.9
	Yes	164,527	99.1
Country (UK)*	England	137,652	84.1
	NI	4,556	2.8
	Scotland	14,250	8.7
	Wales	7,155	4.4

*Total N is less than 166,084 due to missing data.

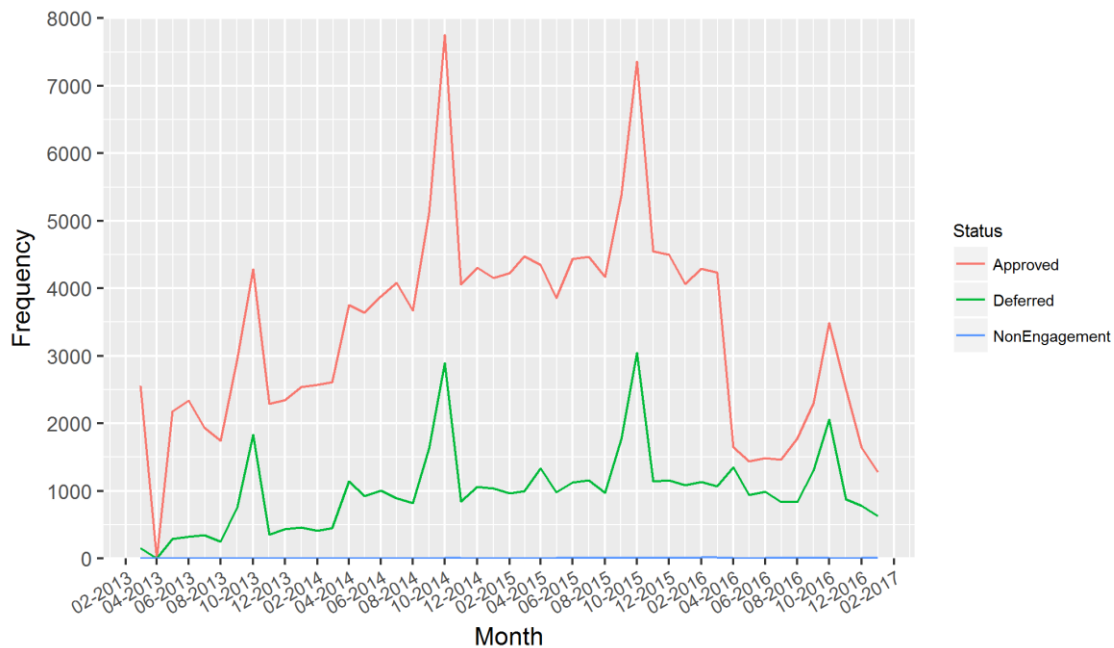
Figure 2 summarises the success of revalidation's implementation in terms of the numbers of GMC decisions in relation to doctors holding a licence at 31st January 2017. In addition to the data in Figure 2, another 285 non-engagement notifications had also been approved but these related to doctors no longer licensed to practise and so not included in this dataset or analysis. The GMC publish these data at regular intervals.⁴⁵

Figure 2: Recommendations completed between 3 December 2012 and 31 January 2017, for doctors licensed at end of January 2017



During the period up to 31st January 2017, the GMC had achieved their projected implementation targets of revalidating most doctors (not in training) by the end of the first cycle.⁴⁶ Figure 3 shows the large numbers of decisions about doctors who have been revalidated each month since revalidation's launch.

Figure 3: Time series plot of revalidation decisions per calendar month for doctors licensed at end of January 2017 (spikes in data related to the academic year and trainee decisions)



But while doctors have been brought into a governed system that evaluates their FTP on a regular basis broadly as planned, our participants' views on revalidation as a process and as an experience were mixed; some seeing it as a high-stakes process which could threaten their livelihood:

The threat of not practising medicine for failure to complete on time the revalidation process is somewhat strong and anxiety provoking. (S30315079, Consultant, Anaesthetics and Intensive Care, 2015 Dr survey)

Others felt that the general concept was good but had found the practicalities of participation presented challenging:

Revalidation process broadly a good idea but too much emphasis on form filling and getting through the process. (S09316691, Consultant, Radiology, 2015 Dr survey)

And some participants recalled finding out that they had been revalidated and having found this a relief and a form of positive feedback on their practice:

Yeah, you think that's great I've been rubberstamped, it's a boost to confidence really I think, you think I haven't got to worry about it for another four years now. (A0078, appraiser, interview).

3.1.2 Variation in revalidation outcomes

Variation in revalidation outcomes have been revealed by exploring the rates of approved deferral recommendations and non-engagement notifications.

When exploring all deferral decisions to the end of January 2017, we found that, after having taken other characteristics into account (see section 2.4), the odds of male doctors receiving a deferral decision are lower than those of female doctors (Male Odds Ratio (OR)ⁱ 0.83, Female* OR 1).ⁱⁱ Likewise, the odds of younger doctors are as much as double those of older doctors (aged under 30 OR 2.00; aged 30-39 OR 1.93; compared to aged 40-49). The odds of doctors aged over 70 (70+ OR 1.65) being deferred were also greater, whilst those in their fifties (50-59 OR 0.64) and sixties (60-69 OR 0.81) had slightly lower odds of being deferred, than those in the 40-49 year age group. We also found that trainees had greater odds of being deferred, than those on a specialist register, as did those doctors who are not on a GP or specialist register and not in speciality training (GP OR 0.83; None OR 1.83; Trainee OR 3.36).

But despite trainees being subject to revalidation we found, through the National Trainee Survey, that 81.1% (n=43,474) of trainees had not discussed revalidation with anyone in their last post.

ⁱ Odds Ratios (OR) are given to report the results of a logistic regression model where the odds of a particular outcome vary between the categories of a predictor variable. Here, the predictor variable is registrant sex and the categories are male and female. In reporting the results of such a model, the odds are expressed relative to the odds for a particular category called the 'reference category'. The reference category has an OR of 1.

ⁱⁱ Our logistic regression model produced a significant improvement compared to chance, in predicting doctors having one or more deferral ($X^2(19) = 14710.14, p < 0.001$)

We also found that BME doctors had greater odds of receiving a deferral decision (Asian or Asian British OR 1.11; Black or Black British OR 1.69; Mixed OR 1.26; Other OR 1.35 compared to White) as did those who qualified in a European Economic Area (EEA) country (EEA OR 1.60 compared to UK). However, the odds of international medical graduates (IMG) in receiving a deferral decision were no different to those who qualified in the UK (IMG OR 1.05 compared to UK). Doctors working in Northern Ireland (OR 0.83), Scotland (OR 0.80) and Wales (OR 0.75) had lower odds of being deferred than those working in England. These patterns are repeated if deferral reasons for insufficient evidence are considered separately.ⁱⁱⁱ

However, when a deferral is due to an ongoing process^{iv} there are fewer significant variations between groups with shared characteristics. Older doctors are at greatest risk of deferral for this reason with those in their sixties (60-69 OR 1.65) having higher odds of being deferred than doctors in the 40-49 age group.

Some groups of BME doctors have higher odds of being deferred due to an on-going process decision (Asian or Asian British OR 1.44; Black or Black British OR 1.80; compared with Whites). Doctors graduating in the EEA have greater odds of being deferred due to an ongoing local process (EEA OR 1.55 compared with UK).

3.1.3 All doctors in an appraisal system

Since the launch of revalidation, doctors are now overwhelmingly engaged in annual appraisal. In our survey sample, 90.3% (23,637/26,169) of participants stated that they had had a medical appraisal at some point in their career. Of those doctors, 94.5% (22,286/23,578) had done so within the previous 12 months and 98.9% (23,314/23,578) within the previous 24 months, comparable with Annual Organisational Audit (AOA) data in England,⁴⁷ and appraisal rates in Scotland⁴⁸ and Wales.⁴⁹

Regression analyses found no statistically significant differences in appraisal rates (either ever or within the last 12 months) based on sex, ethnicity, disability, full or part-time working hours, or between NHS versus independent doctors.

Table 4 shows appraisal rates in our sample for the previous 12 months for each of the four nations, and for doctors living outside of the UK.

Table 4: Appraisal rates for the previous 12 months from UK survey for each of the four nations and non-UK based doctors^v

Northern Ireland	Scotland	England	Wales	Other (Non-UK)
93.5	94.6	94.9	94.9	87.3

ⁱⁱⁱ Our logistic regression model produced a significant improvement compared to chance, in predicting doctors having one or more deferral due to insufficient evidence ($\chi^2 (19) = 15070.13, p < 0.001$).

^{iv} Our logistic regression model produced a significant improvement compared to chance in predicting doctors having one or more deferral due to an on-going local process ($\chi^2 (19) = 207.33, p < 0.001$).

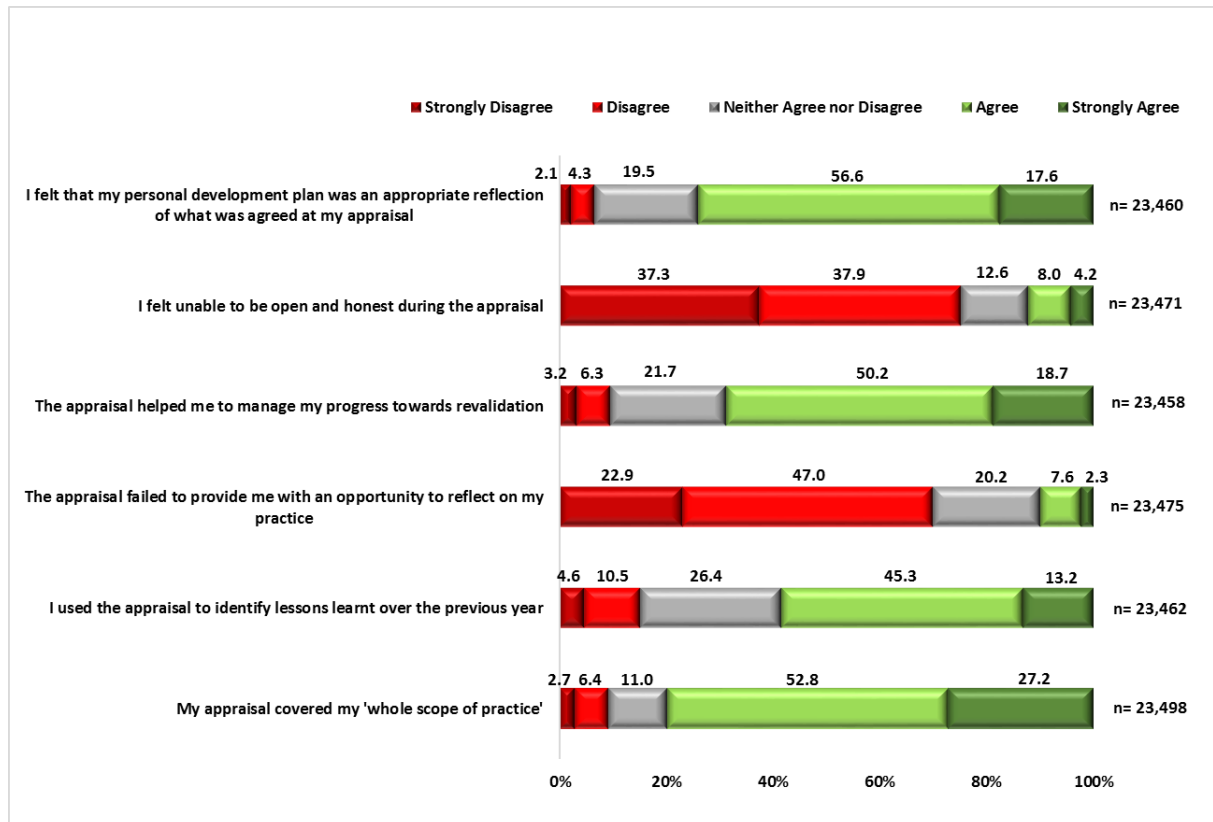
^v There was a relatively strong association between UK-four nations location or 'other' location and whether or not participants have ever had an appraisal, $\chi^2 (4) = 5688.2, p < .001$, Cramer's V = .47.

Such high overall annual appraisal rates are a testament to the impact of the implementation of revalidation. Some participants from groups with previously low appraisal rates commented positively on the extension of coverage prompted by revalidation:

It's [a] good thing [that's] happened which gives a formal platform for staff grade doctors, the most neglected but most hard working group of NHS [doctors] to discuss their concerns and gets addressed to some extent. (S3341467, Ophthalmology, 2015 Dr Survey)

Indeed, surveyed doctors' perceptions of their most recent appraisal were positive overall (Figure 4).

Figure 4: Participants' agreement with statements about their most recent appraisal



Many survey participants identified beneficial aspects of participation in appraisal, such as the opportunity to reflect on their work, discuss career development and set future objectives:

I found it highly relevant to my development as a clinician and allowed me to modify my job plan and CPD activity according to my needs. (S07323042, Consultant, Medicine, 2015 Dr survey)

Supportive, affirmative and valued - very important to ensuring I am keeping up to date - and having a colleague challenge my clinical thinking and professional values. (S63310348, GP partner/principal, General Practice, 2015 Dr Survey)

Participants' positive comments focused largely on the professional development elements of appraisal with an appreciation for the opportunity to engage in a reflective discussion.

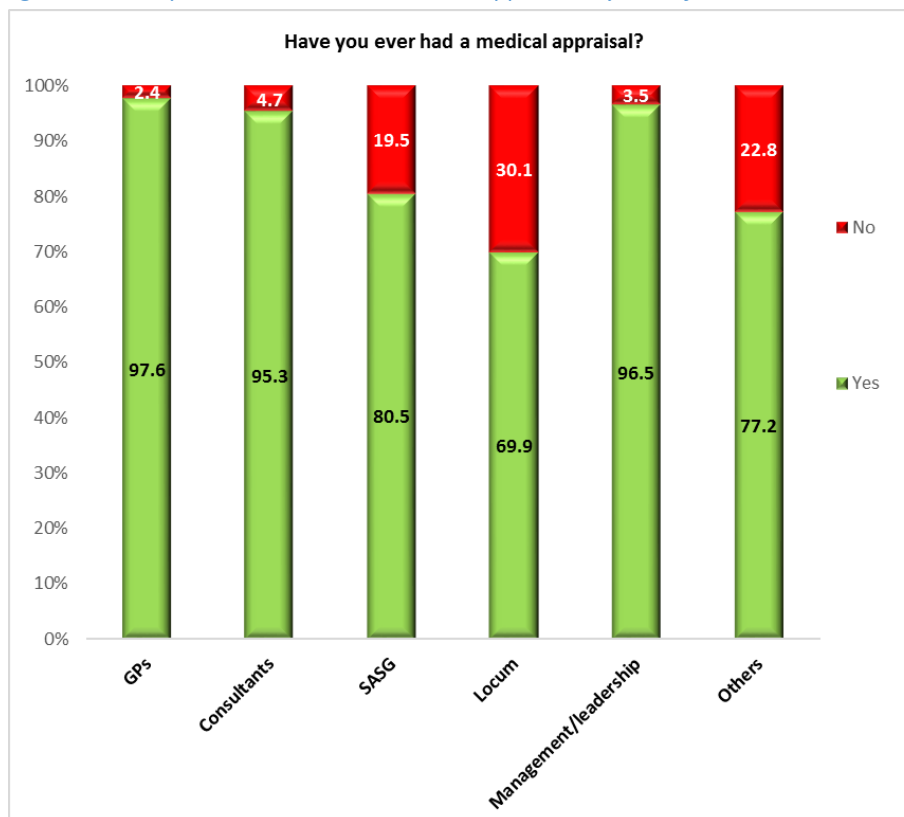
3.1.4 Inconsistencies in the appraisal system

While most doctors are participating in annual appraisal and many report potential benefits, we also found that participation in appraisal could be more challenging for some doctors in some groups. We identified factors which can influence appraisal experience.

3.1.4.1 Challenges for doctors working outside standard governance systems

We found a moderate association between a doctor's main-role and whether they had ever had an appraisal, $\chi^2(5) = 2206.5, p < .001$, Cramer's $V = .29$. Figure 5 shows locum participants were least likely (69.9%) and GP participants most likely (97.6%) to have ever had an appraisal.

Figure 5: Participants who have ever had an appraisal, by main job role



Doctors working as locums explained some of the difficulties they faced engaging in revalidation and appraisal particularly, for example:

Outside of the mainstream - finding a Responsible Officer willing to take me on was a nightmare process. 'Just' joining a locum agency was not as straightforward as it appears. (S77321721, Locum, Emergency medicine/maritime medicine, 2015 Dr survey)

However, while locums had the lowest appraisal rates, it is important to recognise that other groups working outside established governance systems (namely the NHS) have also experienced challenges in engaging in appraisal:

When considering revalidation, the GMC should take into account those doctors and specialities who are sitting outside the NHS (such as Universities, Research Institutes and Academia) as their needs and appraisal systems might differ substantially from those sitting within the NHS. (S77332950, Clinical academic, Medicine, 2015 Dr survey)

The direct costs of undertaking appraisal were mentioned by participants working in independent practice:

Another administrative burden that will have no effect on medical care. Expensive. We have to use private appraisers, private RO, private companies for 360...and the prices increase sharply each year. (S54323439, Consultant, Psychiatry, 2016/17 survey of independent doctors)

Moreover, whilst doctors working wholly outside the UK do not require a GMC licence, we received responses who practice both in the UK and elsewhere who were experiencing difficulties meeting the requirements for revalidation, such as collecting SI and arranging appraisals while abroad:

Arrangements for well qualified doctors who wish / need to work in several countries at the same time need to be made simpler. This group exists and the current system does not support them. This is bad for individuals and UK medicine. (S63294904, Management/leadership, Ophthalmology, 2015 Dr survey)

Therefore, whilst many doctors are participating in appraisal as required, there are some groups where the nature of their practice or the setting in which they work make engagement difficult or costly.

3.1.4.2 Challenges to participation for other groups

We found that, after having taken other characteristics in to account (see section [2.4](#) and [table 3](#)), the odds of our survey participants having had an appraisal in the last 12 months were lower if they were older (20-29 years OR 1.19; 30-39 years OR 0.94; 40-49 years 0.93; 60 – 69 years OR 0.53; 70 years and over OR 0.31; compared to 50-59 years) but were greater if they were a GP (consultant OR 0.49; SASG OR 0.42; locum OR 0.32; management/leadership OR 0.21, other OR 0.34; compared to GP) or had not taken a break of more than 3 months in the last 3 years (taken a break OR 0.24 compared to not having taken a break).

The odds of doctors without a prescribed connection having had an appraisal in the past year were nearly four times lower than those who were connected (prescribed connection OR 3.81 compared to no prescribed connection).

In our 2016 survey of doctors with no prescribed connection, we found that the majority were aged 30-49 (331/557 = 59.4%); white (306/557 = 54.9%); and male (322/557 = 60.5%). Importantly, the majority (300/513 = 58.48%) had taken a break of three months or more from practising in the UK during the preceding three years and of those, 61.0% (183/300) did so to work outside the UK. This profile contrasts with that of participants in our 2015 survey of licensed doctors, of whom only 15.7% (4002/25,492) took such a break, and of those just 28% (1,114/3,980) said it was to work abroad. From our data, it seems therefore that doctors with no prescribed connection are more likely to work outside the UK, and as noted above, this can mean participating in appraisal for revalidation is more difficult.

While some older groups (50-69 years as opposed to those under 50 years) accessed appraisal more readily the odds of those over 70 ever having had an appraisal were far lower than those of 50-69 year olds (20-29 years OR 0.05; 30-39 years OR 0.17; 40-49 years 0.50; 60 – 69 years OR 1.15; 70 years and over OR 0.30; compared to 50-59 years). Retirement or semi-retirement were mentioned frequently in cases such as doctors continuing to contribute medical expertise in roles involving medico-legal work or as crematorium medical referees.^{vi} Indeed, some participants stated that the introduction of revalidation had contributed to their decision to retire, or reported anecdotes of others who had made such decisions:

The Revalidation process is skewed towards younger and full-time doctors and has become very expensive for part-time doctors who are soon to retire. [...] I know of quite a few doctors who decide to retire completely instead of continuing to impart their valuable experience to other doctors and to fill in when there is a dire need. (S59294805, other role, Occupational Medicine, 2015 Dr survey)

Another group that experienced difficulties meeting appraisal requirements were women returning from maternity leave, some of whom felt that the appraisal process did not make sufficient allowances for this period of absence from work:

Having been on maternity leave for about 7 months of the last appraisal period I found it difficult to approach this year's appraisal as I might have liked. [...] it surprises me that there is no exemption for time away from work when it comes to appraisal. My mind and heart certainly was not on the appraisal system this time round as I am sure anyone can relate to - therefore I question whether this was a worthwhile exercise for me.... (S49342607, General Practice, 2015 Dr survey)

^{vi} Specific guidance has been developed by Public Health England and the Faculty of Public Health for doctors working as crematorium medical referees: Public Health England. Public Health England (PHE) and Faculty of Public Health (FPH) joint Revalidation Briefing #12: Guidance for Medical (Crematorium) Referees in preparation for completing professional annual appraisal. London, 2015.

Doctors in roles with little or no direct patient contact also identified concerns about participation:

Those of us in non-clinical, non-patient-facing roles have a very difficult time as the appraisal and revalidation process makes little provision for our scope of practice as revalidation is, by necessity, very clinically-focused. (S77326478, Other non-clinical role, Public Health, 2015 Dr survey)

Issues around scope of practice and the apparent clinical focus of appraisal was an issue that also arose in relation to the collection of supporting information for appraisal, as discussed in sections [3.2](#) and [3.6](#).

3.1.4.3 National inconsistencies

Across the four nations of the UK, there are policy variations that produce different *rules* for doctors. For instance, the *All Wales Appraisal Policy*²⁷ suggests ‘ideally, doctors will be able to choose their appraiser from a list of trained appraisers’, while the *NHS England Medical Appraisal Policy* states ‘the NHS England approach is for a doctor’s appraiser to be allocated by the relevant appraisal office’ although doctors have the option to appeal.²⁸ Doctors in Scotland are also allocated an appraiser.²⁹ Table 5 shows the percentages of doctors responding to our 2015 survey who chose their own appraiser by their location.

Table 5: Participants who chose their own appraiser, by UK nation and non-UK

Nation	Frequency/Total	Percent
Northern Ireland	249 / 524	47.5
Scotland	156 / 1,904	7.6
England	6,997 / 18,988	36.8
Wales	981 / 1,094	89.7
Other/Non-UK	158 / 913	17.3

Choice of appraiser was a factor which some participants to our survey identified as important in their experience of appraisal for revalidation:

I am unable to choose my appraiser, the venue, the date or time and now it seems the way I record my life. (S83317681, GP partner/principal, General Practice, 2015 Dr survey)

The question of agency within a process in which doctors are required to participate may be an important factor in shaping doctors’ perspectives on the process. In all, over a third of our 2015 survey participants chose their own appraiser (n=8,541/23,579 = 36.2%) and were able to select someone appropriate (yes 95.6% (8,162/8,536)).

As well as appraiser selection or allocation, there are inconsistencies in the approach to how often an appraiser should change in a revalidation cycle. Whilst GMC guidance does not make specific requirements but NHS England, the Wales Deanery, NHS Education for Scotland and the Department of Health in Northern Ireland, all recommend that doctors should have at least two different appraisers within each five-year cycle.^{27-30,50} For some appraisees, continuity was important as it facilitated a ‘feedback loop’ building with the same appraiser year on year:

This was the third year with the same appraiser, so continuity was helpful to both of us, as she has the history and is familiar with my work, and we could focus quickly down to the issues. (S48313457, Pharmaceutical physician, 2015 Dr survey)

In general it was "good". However it was from someone I have never met before and was another different face as per the last 4 years. (S61313650, Staff/speciality grade doctor, Multiple specialities, 2015 Dr survey)

3.1.4.4 Individual appraisers' influence

We found significant and moderate associations between participants' agreement with statements about their appraisal and agreement with statements about their appraiser. For example, there is a moderate association between agreement with the statements, 'My appraisal covered my whole scope of practice' and, 'My appraiser was well prepared for the appraisal', $\chi^2(16) = 2792.7, p < .001$, Cramer's $V = .30$; and a moderate association between the statement, 'The appraisal failed to provide me with an opportunity to reflect on my practice' and, 'My appraiser failed to review my progress against the previous year's personal development plan', $\chi^2(16) = 3181.3, p < .001$, Cramer's $V = .31$.

Many participating appraisees reported positive experiences about how their appraiser had made the appraisal meeting a positive and constructive event, for example:

Appraisal has been a most liberating and supporting experience, but only because of the open and honest relationship with my appraiser. (S76321027, Consultant, Surgery, 2015 Dr survey)

Other participants were less impressed by their appraiser's skills:

I'm not sure my appraiser entirely understands the reflection and development side of the appraisal. (S74314215, Consultant, Anaesthetics and Intensive Care, 2015 Dr survey)

We found specific issues around the appraiser-appraiser dynamic, such as whether their appraiser had been from the same or a different speciality, and the seniority of the appraiser relative to the appraiser. On the issue of speciality affiliation, there were views both for and against cross-speciality appraisals:

The appraiser was from a different speciality which was interesting and refreshing. However his skill set in challenging wasn't quite as strong as some of our really experienced appraisers in my own discipline. We started consultant appraisal in 1999 so we do have good people. (S68306087, Consultant, Anaesthetics and Intensive Care, 2015 Dr survey)

One of my previous appraisers was not a GP and had little understanding of what it involved. (S78309710, GP partner/principal, General Practice, 2015 Dr survey)

Seniority also arose as a concern for some participants who felt that their status as senior doctors either made finding an appropriately qualified appraiser difficult or suggested that more junior, less experienced colleagues would not make adequate appraisers:

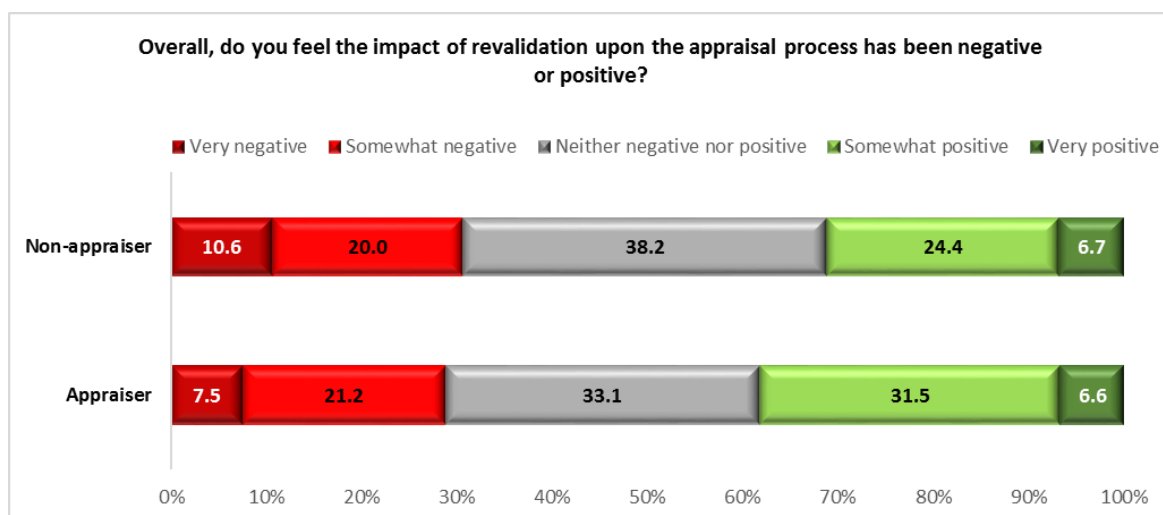
When a senior consultant it can be difficult in a DGH [District General Hospital] to 'select' an appraiser with sufficient 'experience and knowledge' to be a useful resource. (S68307539, Consultant, Anaesthetics and Intensive Care, 2015 Dr survey)

In my view, it is inappropriate that my appraiser is over twenty years less experienced than me. The process of selection of appraisers is flawed. (S3311488, Consultant, Paediatrics, 2015 Dr survey)

3.1.5 Revalidation's impact on appraisal

With the existence of NHS appraisal prior to revalidation, it was important to explore the impact of revalidation on appraisal. Some survey participants expressed concern about this. About a third (8,412/25,983 = 32.4%) believed that revalidation has had a positive impact on the appraisal process, with marginally fewer believing it has had a negative impact (7,870/25,983 = 30.3%) and the remainder believing its impact has been neither positive nor negative (9,701/25,983 = 37.3%). The difference in this spread of opinion between participants who were appraisers and those who were not was negligible ($\chi^2(4) = 134.6, p < .001, \text{Cramer's } V = .07$), as shown in Figure 6.

Figure 6: Appraiser and non-appraiser opinion about the impact of revalidation on the appraisal process



Amongst survey participants, 37.2% (7,235/19,435) reported having spent more time than they used to on activities that inform their appraisal. One fifth (3,850/19,435 = 19.8%) spent less time and 43% (8,350/19,435) reported no difference. Some doctors found that they spent more time usefully in discussion about their practice and reflecting on their work. For others, the time spent was a source of irritation:

It is unfortunate that it takes so much time and energy to gather evidence together for this appraisal. We need to find a better way forward for that part of the appraisal. (S322388, Associate Specialist, Paediatrics, 2015 Dr survey)

This points to the fact that doctors' participation in appraisal for revalidation requires more than simply attendance at the appraisal meeting itself. The collection of supporting information to inform the appraisal constitutes another activity within the revalidation process.

3.2 How is the requirement for all doctors to collect and reflect upon supporting information about their whole practice through appraisal being experienced by revalidation stakeholders?

Key Findings:

- Overall, doctors are collecting the required SI.
- However, the ease with which doctors can collect some types of SI may vary according to their job role, setting or speciality.
- The requirement to submit SI across six defined categories during the five-year cycle has resulted in a strong focus within the appraisal process on the collection of SI.
- Doctors found patient and colleague feedback, and SEAs, the most helpful in informing reflective discussions.
- Reflection on SI in appraisal is key for generating change, but reflection is often seen as just a product of appraisal, not necessarily translated into ongoing reflective practice.
- Expectations set locally, for example by employing organisations or individual appraisers, can influence doctors' experiences of SI collection and can go beyond the requirements set by the GMC for revalidation.

To revalidate successfully, doctors must submit SI across six categories as part of their appraisal portfolios during a five year cycle.⁴⁶ The frequency with which each type must be submitted varies, with some required annually and others less frequently as shown in Table 6.

Table 6: Supporting information categories and required frequencies

Supporting information type	Required frequency
Record of Continued Professional Development	Every year
Patient feedback	At least once per five years
Colleague feedback	At least once per five years
Significant event analysis	Significant events involving the doctor during a given appraisal period should be discussed
Evidence of quality improvement activity	At least once per five years, but dependent on the nature and scale of the activity.
Review of complaints and compliments	Should be discussed if any complaints have been received within a given appraisal period

It is individual doctors' responsibility to collect and submit the requisite SI, though some receive support with data collection from organisations in which they work.

3.2.1 Collecting supporting information

Our 2015 survey asked doctors which types of SI, and other documentation, they had submitted for their most recent appraisal. As expected, record of Continuing Professional Development (CPD) and the PDP, which is required annually alongside SI, were submitted most frequently whilst patient and colleague feedback, which is required once per five-year revalidation, were submitted by fewer doctors (Table 7).

Table 7: Percentage of participants submitting SI at their most recent appraisal

Types of SI	Frequency	Percent
Record of Continuing Professional Development (CPD)	23,131	98.2
Personal Development Plan (PDP)	22,561	95.7
Reflections on Continuing Professional Development (CPD)	21,051	89.3
Evidence of Quality Improvement activity	20,520	87.1
Review of complaints and compliments from patients	17,908	76.0
Significant Events Analysis	17,193	73.0
Letters (e.g. from patients, colleagues or students)	15,640	66.4
Feedback from colleagues	15,422	65.4
Other supporting information	15,151	64.3
Feedback from patients	13,604	57.7

Most doctors are successfully collecting SI to meet revalidation requirements. Behind these headline figures though, there are indications that SI collection differs for some groups of doctors.

Multivariate statistical analysis shows that, for example, the rate of submission of Significant Event Analysis (SEA) varied considerably according to age, location, main job role, speciality group, PMQ and the doctor's full or part-time status. The odds of GPs submitting SEA was much higher than the odds for consultants, SASG doctors, locums and those in other roles (consultant OR 0.25; SASG OR 0.16; locum OR 0.15; other OR 0.22: compared to GPs). Likewise, compared to general practice, those in secondary care specialities also had lower odds of having submitted SEA (for example, Obstetrics and Gynaecology OR 0.55; Anaesthetics and Intensive Care OR 0.36; Emergency Medicine OR 0.31; compared to GP). There were no statistically significant differences between submission rates for record of CPD based on sex, ethnicity, disability, region of PMQ, specialty group, healthcare setting, UK four nations, or NHS versus independent doctors.

For some doctors, the requirement to collect SI across specific categories had altered the focus of appraisal, with the assertion that it has become a rigid 'tick box exercise' occurring frequently in participants' comments:

...it's a positive experience for most. a unique experience to talk and reflect with a critical friend (colleague) however it's in danger of losing this most valuable part as it becomes a task oriented tick box exercise' (S60309061, Management/leadership role, General Practice, 2015 Dr survey)

Quality improvement activity such as audit is much harder to collect as a locum GP. Negotiating alternative QI activity with appraiser depends much on the personality traits of your appraiser. Some are much more rigid in their approach than others. (S38305679, Locum GP, General Practice, 2015 Dr survey)

Some doctors told us that their job role could impact upon their ability to collect patient feedback (discussed in Section [3.6.2](#)) and colleague feedback:

I have to rely on the goodwill of the practices who have got their own doctors' ones to do and I'm asking them a favour really [...] and it feels like a bit of an imposition to have to ask them. And the only times I've tried to do an MSF, well the last time I did one using locum work, one or two practices said 'we really can't comment, we don't know enough about you or your work' and so they declined, so I got a rather skewed group of people giving me feedback. (R0078, Locum GP, appraisee-appraiser, interview)

Here again, there is a suggestion that the requirement to collect a designated form of information has taken precedence over whether that information is genuinely representative of and relevant to the doctor's whole scope of practice.

3.2.1.1 E-portfolios and IT systems

Many doctors now use electronic systems to collate their SI and their written reflections and to collect some types of SI, such as colleague feedback. Some systems feed in organisational data. Other information must be uploaded by the doctor. Wales and Scotland have developed unified appraisal systems – the Medical Appraisal and Revalidation System (MARS) and the Scottish Online Appraisal Resource (SOAR) respectively. Elsewhere, a variety of systems are available, including the Medical Appraisal Guide form developed by NHS England.⁵¹

Our 2015 survey asked participants to rate the usefulness of their ePortfolio providers' guidance; although a higher proportion of doctors in Wales (56.5%) and Scotland (58.2%) than in Northern Ireland (44.8%) and England (42.2%) rated the guidance 'very' or 'extremely' useful, the statistical association between nation and overall rating was negligible.

Some participants commented that their e-Portfolio system made storing and triangulating their data easier:

... the system that we've got now in SOAR is incredibly helpful, it was updated last year to include recognition of trainers, the first two times you do it, it does seem to be a bit clunky but once you get used to it it's a very good way of doing it, so all your forms are now electronic, easily submit all your documents, and I like the way it's set out. Now they also have areas with reflection in it, as they do in your CPD diary and I find that particularly helpful. (R0001, Consultant, appraisee-appraiser, interview)

However, other participants indicated that these systems could be complex to use:

I should say that wherever I appraise, the system is different, and so you've got a system at [AA Trust], you've got a system at the [XX University Hospital] and in the private sector you've got different systems, and they all vary and the one at [AA Trust] is dire, so that's probably the least user-friendly of all of them and it can produce near emotional collapse when the individual is trying to fill it in... (A0043, appraiser, interview)

Some participants expressed frustration, for example, that their appraisal portfolio was incompatible with their Royal College CPD portfolio necessitating that the same information be uploaded twice for different assurance purposes. Others accepted that their own limited IT skills contributed to the process being problematic.

3.2.2 Variation in application of guidelines

GMC guidance on SI offers some examples of the types of information which doctors may submit under the six categories, however, these are limited and are examples not expectations.⁴⁶ In addition to the GMC's core guidance on SI, various other organisations, notably the medical Royal Colleges, also offer guidance to doctors about appraisal and SI.

We found that 74.3% (18,523/24,937) of our 2015 survey participants had used guidance about appraisal or revalidation issued by the GMC, with the most commonly used being *Supporting information for appraisal and revalidation* (62.6% of those using GMC guidance, 11,569/18,482). There were negligible to no differences in proportions of participants using GMC guidance across sex, age, main role, ethnicity, disability, UK four nations, specialty group, healthcare setting, region of PMQ, membership of a Royal College, prescribed connection, full or part time working hours or, NHS versus independent working.

However, despite the predominance of the GMC guidance and the fact that revalidation is a professional regulatory process, its reliance on appraisal means that for many doctors, whose appraisals take place within an organisational context, the SI expected from them is mediated by organisational or individual appraisers' expectations.

...he's told me I've got to get more colleagues cos I've got no patients, I think I could find fifteen colleagues if I had some patients, but I've got no patients, I've got to find twenty-five colleagues. (R0108, Other role, interview)

These expectations may extend the requirements set out in the GMC's own guidance. For doctors, it can be difficult to achieve clarity about what can or should be in their portfolio:

...the rules keep changing, they change the goalposts, they say you've got to have four items on your PDP and seventy-five percent has to be clinical, and I don't know how I was supposed to know that, how would you know that? (R0239, Salaried GP, appraisee, interview)

In this way, 'tacit rules' determined by individual appraisers or requirements set out by organisations, have introduced tensions into doctors' ability to fulfil revalidation requirements regarding SI. For the doctor, subject to the requirement to engage in this activity, such apparent discordance or lack of consensus over SI requirements can make the process harder and more frustrating.

3.2.3 Reflection

SI is intended to provide the basis for reflection, both in reflective writing included in the portfolio and through reflective discussion during the appraisal meeting.

Through analysis of survey free text and interview data, we found that some doctors saw themselves as being naturally or habitually reflective, a view which was particularly common amongst primary care participants. These doctors often commented that strengthened appraisal for revalidation had done little to affect their levels of reflection.

Others felt that collecting SI and appraisal had enabled them to 'learn' to reflect, and found that well-facilitated discussion in the appraisal meeting itself was the most important element:

Initially sceptical about reflection but I think it is useful and enhances CPD activities. (S66325471, Consultant, Radiology, 2015 Dr survey)

In discussing reflection, many doctors focused on the production of written reflective pieces for their appraisal portfolios, with some finding this process to be artificial and sceptical about its value:

Coming up with reflections all the time is time consuming and not very helpful when the effect of an activity is clear. (S24324459, GP partner/principal, General Practice, 2015 Dr survey)

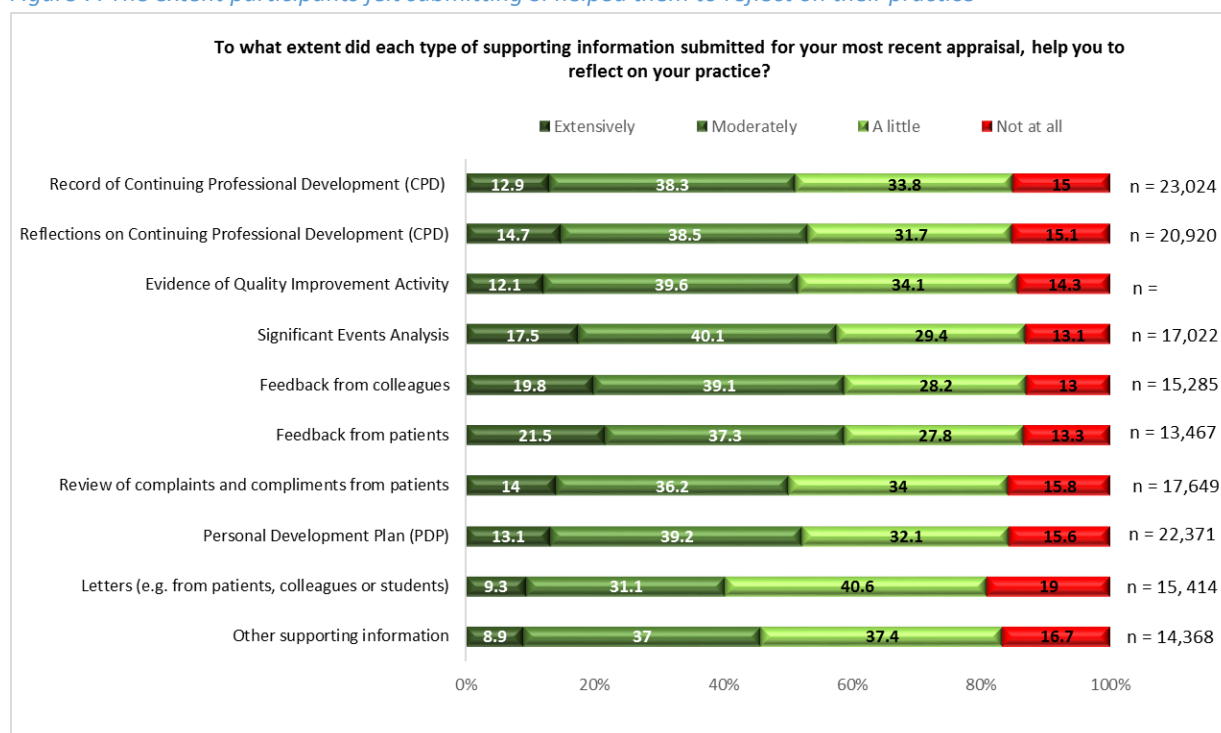
Some appraisees suggested the guidelines for reflection were too prescriptive, that appraisers were applying these guidelines too rigidly, or that they were being dictated to, to best frame the recording of their thoughts:

I've been aware that that's very much been an emphasis from all my recent appraisers is about reflection, reflection and more reflection, and in particular about documenting that reflection. So I'm sure appraisal has made us better at recording reflection but I wouldn't necessarily agree that's made us better at actually reflecting on our practice. (R0109, GP partner, appraisee, interview).

Reflection can and does happen in the appraisal meeting, prompted, at least in part, by the portfolio of SI. In-depth analysis of appraisal portfolios and appraisal summary forms provided an example in which a doctor had submitted a short SEA criticised for its lack of detail, but that following the appraisal discussion, the summary form described detailed reflection as having taken place.

Indeed, we found that many doctors were positive about the usefulness of various types of SI in helping them to reflect upon their practice as shown in Figure 7.

Figure 7: The extent participants felt submitting SI helped them to reflect on their practice



Whilst doctors' views on the usefulness of categories of SI for prompting reflection varied, we found that the appraisal meeting itself can be the driver for reflection. Many of our participants identified the appraisal meeting as having supported them to reflect.

Several interviewed doctors mentioned the significance of the appraisal meeting as a forum for discussion and reflection about all types of SI, but in particular significant events and complaints:

... it often triggers the thought process, and of course when you really need to reflect if someone's made a complaint or you've got an event that's happened, a significant event where somebody's died or a near miss situation, and you automatically reflect on that at the time. I don't think people always write it down as they go along, that's something that probably we should be doing, but it's often that piece of physical evidence that triggers the reflection to happen much of the time. (R0010, Consultant, appraisee-appraiser, interview)

And appraisers noted the value of encouraging a doctor to reflect on such events:

...certainly any areas where there have been patient interactions that haven't gone as well as they could have gone, and that could be something the doctor has offered in maybe a significant event analysis, I think can be really fruitful in terms of discussion and how could things have been done better, how could you have handled that better, what do you think the issues were, and so on, so I think that's really important.' (A0235, appraiser, interview)

For appraisal meetings to offer a space for useful and constructive reflection, it is important that they are facilitated by well-trained appraisers, and that the meeting format allows doctors time to discuss their practice freely and openly.

3.3 Is engagement in revalidation promoting medical professionalism by increasing doctors' awareness and adoption of the principles and values set out in *Good Medical Practice*?

Key Findings:

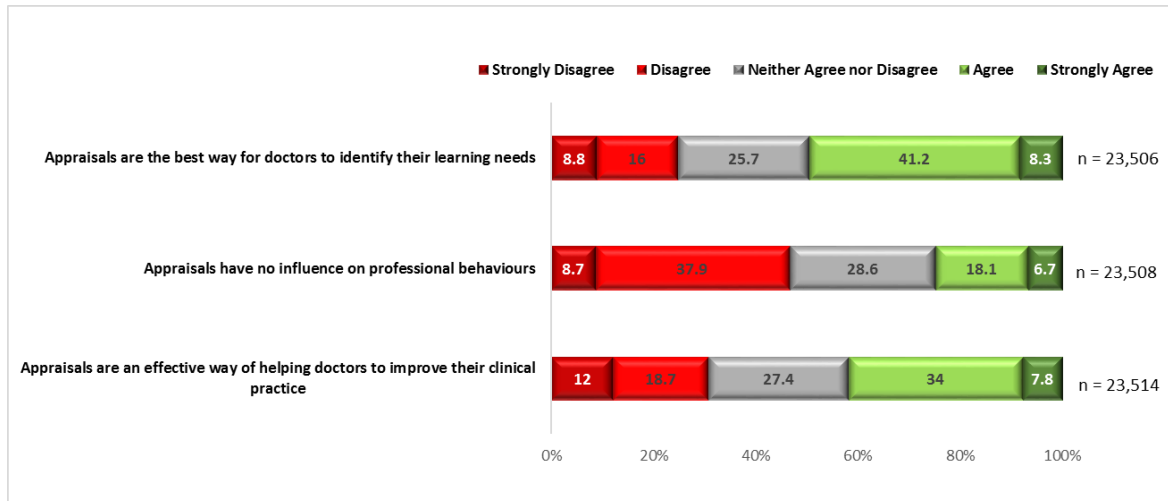
- A significant minority of doctors reported changing an aspect of their clinical practice, professional behaviour or learning activities as a result of their most recent appraisal.
- Overwhelmingly these changes related to the focus or quantity of their continuous professional development activities, though changes have occurred across the domains of *Good Medical Practice*.
- However, some doctors identified potentially negative impacts on practice or for professional autonomy.
- Revalidation, through appraisal, provides a means to document practice but may not necessarily improve professional practice.
- Ultimately, revalidation's ability to promote professional practice is through the central role of high quality formative appraisal.

Whilst there is no agreed definition of professionalism, (p.12)⁵² doctors holding a UK licence to practise are expected to practice in accordance with a code of conduct document produced by the GMC called *Good Medical Practice (GMP)*.⁵³ *GMP* is divided into four main domains: knowledge, skills and performance; safety and quality; communication, partnership and teamwork; and maintaining trust. We used this framework to explore our data to consider whether engagement in revalidation, through participation in annual appraisal and collecting and reflecting on SI, is impacting on professional practice. In our 2015 survey, doctors were asked to what extent they agreed or disagreed with the statement that 'revalidation will not improve the standards of doctors' practice.' In response, only 29.6% (7,687/25,971) disagreed, suggesting many remained unconvinced about revalidation's potential to prompt behaviour change, however we did find some evidence that doctor performance is evolving in some respects.

3.3.1 Revalidation activities, positive change and affirmation

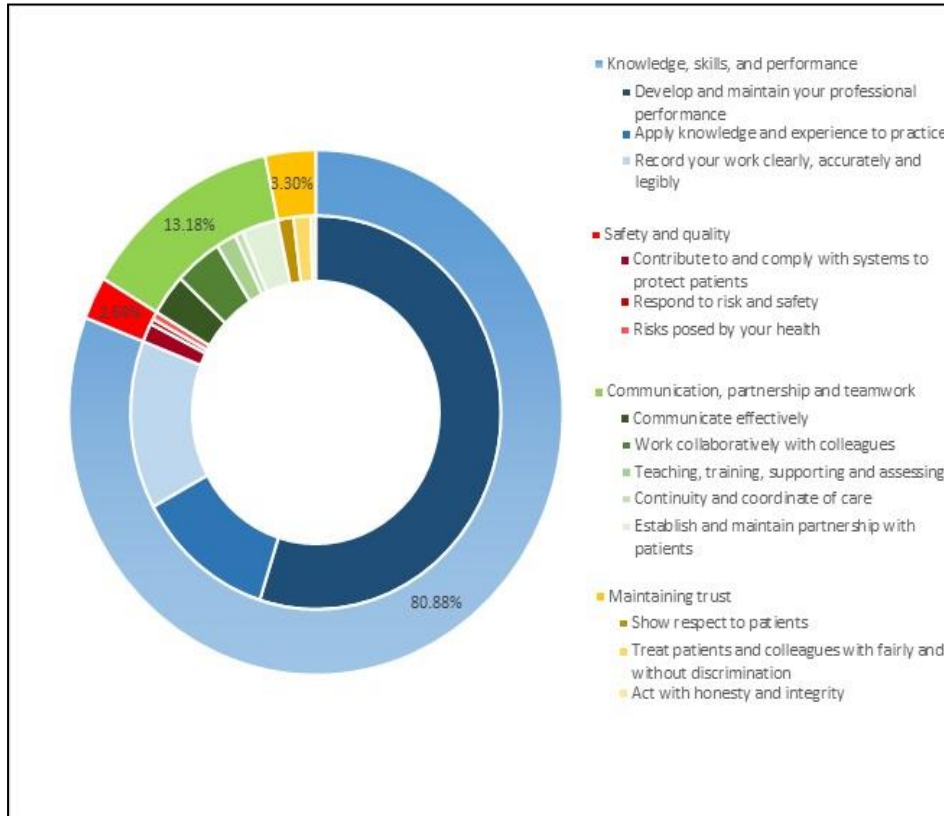
Figure 8 shows that doctors are divided about the role of appraisal in helping them to identify their learning needs, influencing their professional behaviours, or helping them to improve their clinical practice.

Figure 8: 2015 survey participants' agreement with statements about overall appraisal experience



In responses to our 2015 survey, 42.4% (9,982/23,547) of doctors stated that they had changed aspects of their clinical practice, professional behaviour or learning activities as a result of their most recent appraisal. There were no differences in the proportion of doctors reporting making a change based on sex, disability, region of PMQ, specialty group, healthcare setting, membership of a Royal College or Faculty, prescribed connection, full or part-time working hours or, NHS versus independent working. However, younger participants had higher odds of having made a change (20-29 OR 1.812; 30-39 OR 1.491; 40-49 OR 1.157; 60-69 OR 0.919; 70+ OR 0.745; compared to 50-59* OR 1); as did those of Black or Asian ethnicity (Black OR 2.346; Asian OR 1.649; Mixed OR 1.113; compared to White* OR 1). We mapped the free text explanations of changes made after appraisal to the domains, and subdomains, of *GMP* as shown in Figure 9.

Figure 9: Written survey responses mapped against GMP framework



This figure shows that 80.0% (6,837/8,453) of changes related to *GMP*'s first domain 'knowledge, skills and performance' and of those over half mapped to one sub-domain 'develop and maintain your professional performance'. Therefore, most changes made by our participants focused on changes to the CPD activities doctors are engaging in. Such changes to CPD activity could be important in leading to further changes in practice or behaviour, as through a review of 26 review articles, covering 868 studies, we found that most (n=22) identified that CPD resulted in a small-moderate change in the attitudes, knowledge, skills and/or behaviour of individual doctors. However, several factors influence its efficacy. To facilitate the greatest effect for participating physicians, CPD activities should encompass: multiple instructional techniques, exposures and media forms; interactive delivery; tailored/context-based information; and address outcomes perceived as important.

In some cases, participants did identify specific changes they had made following their appraisal, going beyond changes to CPD:

Started to use pulse oximeter more often. Strictly follow the NICE guidelines on feverish children. (S99317047, Locum GP, General Practice, 2015 Dr survey)

Changed my surgical technique slightly and was able to reduce blood loss. (S98351343, Consultant, Orthopaedics, 2015 Dr survey)

Participants described changes as having been prompted by various types of SI, including Quality Improvement Activity (QIA), SEA, and patient and colleague feedback:

Introduced changes following clinical audit by updating current care pathways. (S83333026, Consultant, Emergency medicine, 2015 Dr survey)

It was a small but significant change to a technical aspect of my practice, arising from discussion of an untoward incident. (S7316495, Consultant, Anaesthetics and intensive care, 2015 Dr survey)

MSF suggestive of need to subtly change the way post-take ward round carried out. (S83314453, Consultant, Surgery, 2015 Dr survey)

The data extracts above illustrate that the changes many doctors make are very specific and personal, decided as appropriate for their individual circumstances. This both reinforces the importance of tailored, useful feedback and facilitation in appraisal, but also demonstrates the difficulty of measuring composite impacts on quality/standards/practice arising from appraisal and revalidation.

The majority of participants (57.6%, n=13,565) to the 2015 survey reported that they had made no changes to their clinical practice, professional behaviour or learning activities as a result of their most recent appraisal. Analysis of their explanations revealed that the main reason given was that no necessary changes were identified (56%, n=6,503). Some participants described how for them appraisal was a positive way to affirm good practice; that their seniority or experience made no changes necessary; or that they had only recently completed training and so felt currently up to date.

When interviewing doctors, we rarely heard them mention *GMP* explicitly but some did believe that revalidation will, or is already, improving professional practice:

I think there's no question, I think it definitely has made a lot of doctors pull their socks [up] (R0061, GP, appraisee-appraiser, interview)

I think it's had a positive impact, certainly when it was first introduced there were a number of doctors who decided that they perhaps weren't able to reach the criteria for revalidation in occupational medicine and retired or left or went off and did extra training, so I have the feeling it probably increased the quality, or continues to increase the quality of physicians working in occupational medicine, I have no evidence for that, it's just a gut feeling. (R0165, Consultant, appraisee-appraiser, interview)

Many appraisers we interviewed also saw revalidation as positively contributing towards doctors' professional practice. They argued that appraisal encourages doctors to reflect on and consider their practice under a new scrutiny and that this provides new opportunities for bench marking; reducing the likelihood of doctors no longer being able to get away with poor practice or non-engagement. Though the impact was seen as positive, many appraisers also highlighted the need for a balance to be struck between improving standards and not over burdening doctors, for example:

I think doctors are now taking a lot more seriously than they used to because they know it's mandatory, but on the other hand they find it's an opportunity to look at their practice in more depth, so it's not just a cursory thing, just a box ticking exercise, because of the nature of the appraisal, which is much more in-depth and more comprehensive in scope, it's a great opportunity for doctors to improve, and if that happens then obviously better patient care should follow. (A0246, appraiser, interview)

The positive potential for revalidation to improve professional standards is recognised, but is typically predicated on the assumption that this will be delivered through a high-quality formative appraisal meeting, where doctors have the space to reflect upon their practice and the nature of their role more broadly. This positive potential is balanced by warnings of the possibility of damaging impacts, centring on concerns over the time burden that some see as associated with collating SI and the possibility that the regulatory aspect of appraisal for revalidation may be stressful for some doctors, distracting them from the developmental components.

3.3.2 Unintended consequences which may undermine professional practice

Some appraisees believed revalidation had had either a negative impact on professional practice or no impact at all. Some argued that those doctors in need of improvement may simply subvert the process by simulating engagement or 'gaming the system'.

...whether that actually makes them any better doctors at the end, certainly the ones that I can think with my medic and political hat on, probably haven't changed dramatically whatsoever, they simply present what they need to when they go to their appraisal and then carry on in their own sweet way anyway, so I don't think it achieves anything particularly, certainly in the locum area from my angle... (R0071, GP, appraisee, interview)

Others felt that by increasing oversight or performance management over doctors, revalidation alongside other changes such as the creation of NHS England,³¹ forms part of a wider trend towards decreased professional autonomy, one of the traditional markers of professionalism:

I think over the years it's become a little more pressured, a little more formulaic, and whether that was revalidation specifically or whether it's to do with the pressure many people feel on their time and also I feel there's a move away from professionalism towards performance management and targets and bean counting and a move to quality, so I think it's part of an ongoing process. (R0115, Consultant, appraisee-appraiser, interview)

Many doctors we interviewed felt that doctors are already highly professional in their practice and their approach to their work. Therefore, for the many doctors already practising to a high standard, the impact of revalidation may not be in any actual improvement to professional standards, but rather in making professionalism demonstrable through documentation.

Consequently, if the main impact is simply to document professional practice it might explain the significant concerns expressed about the time and resources required, with frequent statements in interviews and survey responses that it took doctors away from their patients. There was also a

belief that it had contributed to increased stress and anxiety within the profession, which then negatively affected doctors:

...we're losing GPs right, left and centre, anything that puts people off is a bit of a disaster at the moment, and I think we're in such a level of crisis that we've got to get back to real basics to see how we can encourage GPs to carry on, and I don't think revalidation in its current form is helping that, and I think it's still a bit of a barrier for some people so, I don't know who it's meant to be helping. I mean I think the annual appraisal is still a good idea, although most people haven't really got time to give it the amount of time it needs, but the actual revalidation side of things, I don't really know whether it's worth carrying on really. (A0015, appraiser, interview)

...Whereas with the introduction of revalidation then more people became either more anxious or more cynical about it and said here we are, this is now getting more stressful and more prescriptive and more imposed on us and it's becoming less useful for the individual person but more for the administration [...]. (R0180, GP, appraisee-appraiser, interview)

We therefore found mixed evidence on whether participation in revalidation and its related activities is encouraging awareness and adoption of the principles set out in *GMP*. There remain concerns over the unintended consequences resulting from the implementation of revalidation which may impact negatively in this regard. It is clear, though, that many doctors have been prompted to make changes as a result of their appraisal and the SI informing it, and that many of these changes have centred on their CPD activities and keeping up to date. Importantly, where changes have occurred, these resulted from useful SI and a high-quality, formative appraisal meeting focused on professional development.

3.4 Are revalidation mechanisms facilitating the identification and remedy of potential concerns before they become safety issues or FTP referrals?

Key findings:

- Many in the profession believe that the main aim of revalidation is to identify ‘bad doctors’, and that doctors’ participation in appraisal will not achieve this aim.
- Since late 2012, fitness to practise referrals from employers have returned to pre-2009 levels, following spikes in such activity in the period leading up to revalidation’s introduction. There is no statistical evidence, as yet, that referrals from employers have dropped as a result of the earlier identification and local remedy of concerns.
- Appraisal and appraisers can and do identify some concerns about doctors, particularly in relation to workplace and health issues, and many concerns identified through appraisal are addressed successfully within that process.

Here, we consider whether revalidation has impacted upon referrals to the GMC’s fitness to practise (FTP) procedures and, more specifically, whether revalidation mechanisms are facilitating the identification and the remedy of potential concerns before they become safety issues or reach the level at which referral into FTP procedures would be appropriate.

We focused on two main levels of enquiry. First, we looked at the referral behaviour of ROs, and how they fulfil their responsibility to monitor doctors’ FTP. Secondly, we looked at appraisal (and the SI which informs it) as the main mechanism around which doctors’ engagement with the revalidation process centres, and which serves as a major source of information for ROs.

3.4.1 Design and purpose

Overall, we found some scepticism about the ability of revalidation to identify potential concerns about doctors. In our 2015 survey of doctors, 46.1% (11,963/25,968) of participants agreed or agreed strongly that ‘revalidation will fail to identify doctors in difficulty at an earlier stage’, whilst 22.9% (5,954/25,968) disagreed or disagreed strongly, and 31.0% (8051/25,968) neither agreed nor disagreed.

Many in the profession are convinced that identifying ‘bad’ doctors is a core aim of revalidation, particularly focusing on the idea that the process is intended to stop the ‘next Shipman’:

I do not think it provides any protection for the public from future Harold Shipmans. I think Shipman would have ticked all the boxes and sailed through the process so from that perspective it is not fit for purpose. (S83323167, Consultant, Psychiatry, 2015 Dr survey)

The idea that revalidation aims to identify criminality or other deliberate wrong-doing then feeds doubt that revalidation based around doctors’ participation in annual appraisal can effectively achieve this aim. Many participants expressed the view that a doctor intent on doing so would be

able to conceal misconduct, poor performance or ill-health from their appraiser, and therefore from the system:

...I think the people who are the real sharks and cowboys out there, they're going to work the toolkit, work appraisal, they can give the spiel, they know what to say to tick the buttons, they know how to talk round their colleague, they're going to choose a colleague who doesn't challenge them to be their appraiser, and they're going to get a nice clean record. (R0025, GP Partner, appraisee, interview)

However, other participants – particularly amongst appraisers – looked beyond appraisal and cited wider systems and processes in place to identify potential concerns about doctors:

Well I think revalidation is a judgemental process as it tends to allow you to continue to practice based on some clinical governance issues and your ability to complete your appraisal. I'm not entirely confident that it would necessarily pick up underperforming doctors, although I think the clinical governance should feed into that, it's probably maybe better than appraisal to detect these people... (A0021, appraiser, interview)

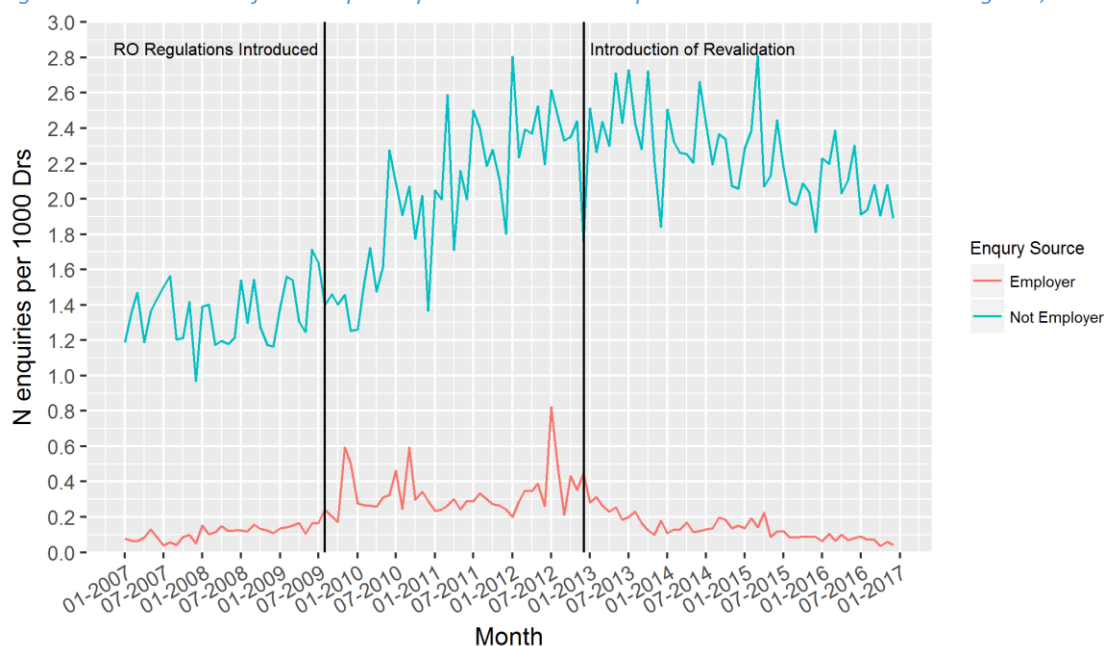
This perspective was less common though than the view that revalidation, centring on appraisal, would fail to reliably identify potential concerns.

3.4.2 Revalidation and fitness to practise referrals

3.4.2.1 Overall trends

Statistical analysis of the GMC's FTP data showed that the frequency of FTP enquiries per 1000 doctors entering the GMC's system as a result of referrals from employers increased between 2009 and 2012 – with some noticeable spikes in activity - before subsequently decreasing again to pre-2009 levels. Whilst we have selected the date markers in Figure 10, and could have chosen others, the data points to increased referral activity in the years immediately preceding December 2012, when the imminent introduction of revalidation was subject to much attention. Moreover, the trend in enquiries from other sources, such as members of the public, is somewhat different, pointing to specific factors influencing employer referral behaviour.

Figure 10: Time series of FTP enquiries per calendar month per 1000 doctors on the GMC register, 2007-2017



Whilst referrals from employers have returned to the levels seen before 2009 and the pre-revalidation implementation period, we found no evidence that, as yet, referral rates from employers have dropped significantly since revalidation as doctors in difficulty are identified and remediated earlier. There has been an overall fall in referrals to FTP from all sources (such as the public) since revalidation was launched, though there is no evidence of a causal relationship and wider changes to FTP procedures have also occurred during this period.⁵⁴

3.4.2.2 Responsible Officers and FTP referrals

In our 2015 survey of ROs, run collaboratively with a DH PRP funded study,⁶ a majority of responding ROs (62.7%, n = 170) reported that the prevalence of cases of concern about doctors had remained about the same since the introduction of revalidation, although 15.8% (n = 94) reported that the numbers of such cases had increased. Around half (47.6%, n = 169) reported that there had been changes in their organisation's arrangements for managing cases of concern since revalidation's introduction.

Our interviews with ROs and members of the GMC's Employer Liaison Service (ELS) shed more light on how ROs are meeting their FTP responsibilities. We report more findings concerning ROs' revalidation decision-making processes in section [3.5](#).

Specifically exploring impacts on FTP referrals, ROs particularly commented on the importance of the ELS as a designated point of contact with the regulator. The ELS was seen to offer an opportunity to discuss potential referrals with a GMC representative to help establish if a case merited referral or not:

...I think it's important that we identify doctors who are at risk of either health problems or competency problems, and we do our best to manage that within the framework that we have in [organisation name]. When we think that it's a GMC issue we'll often talk about that

internally first and then we will discuss it with our GMC liaison officer... (R5001, Responsible Officer, Scotland, 2000+ connected doctors, interview)

One participant noted that their experience of dealing with the GMC before the creation of the ELS was very different:

And I had a very significant problem in 2011, before we had workplace liaison, and I found the most frustrating thing about that process was the difficulty with getting straight answers from the GMC. [...] Now I just pick up the phone and talk to [ELA name] and say how do you think I should handle this, and he'll say I'd better talk to my boss about this and get back to you, and we work it out together, made an absolutely huge difference. (R5014, Responsible Officer, England, c.300 connected doctors, interview)

The ELS has clearly had an important impact on the way in which ROs work and has provided support to them in deciding what issues to refer to the regulator. But there are potentially other explanations for changing patterns in referrals or for changes in approaches to managing concerns locally. One RO noted that recruitment and retention issues in primary care may be driving a stronger focus on remediation, rather than this change in emphasis being a consequence of revalidation:

I think because of the GP workforce crisis and the perception that general practice needs a little bit more support, more effort has gone into remediation than we used to put in, there didn't use to be very much helpful remediation across the system, but I think it's grown significantly. Whether that's due to the process of revalidation I'm not so sure, I think there are other forces at play that have led that element. (R5013, Responsible Officer, England, 2000+ connected doctors, interview)

This highlights the complexities of identifying the causal factors behind trends in data at a time of major changes and pressures in UK healthcare.

3.4.2.3 Associations between revalidation outcomes and FTP referrals

Using logistic regression analyses, we found that doctors with a past FTP enquiry from any source had higher odds of receiving a non-engagement revalidation decision than doctors with no past FTP enquiries (at least one previous enquiry from non-employer source that was closed at triage, OR 1.70; at least one previous enquiry from non-employer source that was opened for investigation, OR 2.33; at least one previous enquiry from an employer source that was closed at triage, OR 4.59; at least one previous enquiry from an employer source that was opened for investigation, OR 4.48).^{vii}

In our interviews with ROs, the idea that past FTP concerns might impact upon an RO's approach to making a revalidation decision about them was acknowledged:

^{vii} The model produced a significant improvement compared to chance, in predicting doctors having one or more non-engagement decisions, $X^2(5) = 204.07$, $p < 0.001$.

...so if a doctor's had a FTP issue, and we've had some people like that, and they go through their conditions, and it's quite a tough climb to get back from that, and I have a lot of admiration for doctors that do that, they come back, they build up their skill set or they deal with their addiction or whatever they have to do, and then we give them six months to a year after all of that to make sure they're back to the way their peers would be, so we give them time to build up their CPD and then get a proper appraisal [...] we'll then give them six months to a year so then we'll defer them for them to then become an autonomous practitioner again. (R5001, Responsible Officer, Scotland, 2000+ connected doctors, interview)

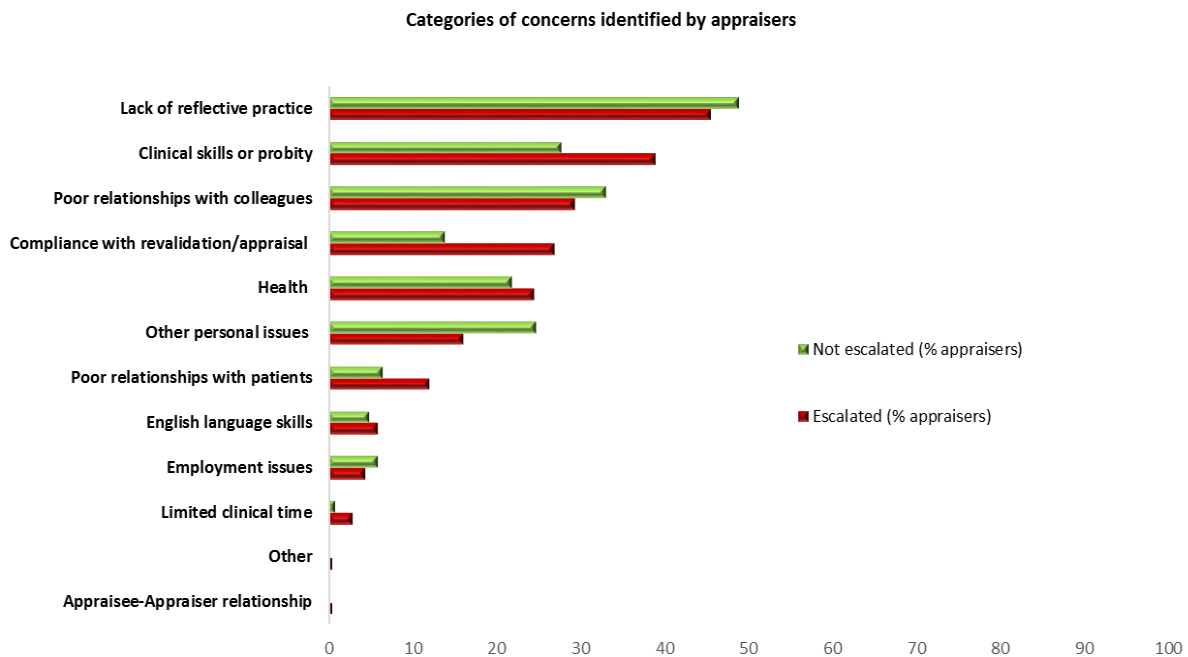
Within our quantitative and qualitative data there is evidence about emergent associations between FTP referrals and revalidation recommendations and outcome decisions. For instance, the odds of a doctor receiving an approved revalidation decision as opposed to a deferral due to insufficient evidence were higher when the decision was preceded by at least one enquiry from a non-employer source (at least one enquiry from a non-employer source that was closed at triage, OR 1.52; at least one enquiry from a non-employer source that was opened for investigation, OR 1.29). The odds of being approved as opposed to deferred due to insufficient evidence were lower when the doctor had a previous enquiry from an employer which was opened for investigation (OR 0.53). However, the precise nature of these relationships requires further longitudinal analysis beyond the first regulatory cycle.

3.4.3 Appraisal and the identification of concerns

Our 2015 doctor survey received 4,454 responses from appraisers who had appraised 30,536 doctors between April 2014-March 2015. Of these appraisers, 10.4% (412/3,944) had formally escalated a concern about at least one of their appraisees to an appraisal lead or to the RO. In all, these appraisers had identified these concerns about 1.7% (528/30,536) of the doctors they had appraised. Just under a quarter of the responding appraisers (887/3,944 = 22.5%) had identified concerns which they did not escalate, most of which (759/883 = 86%) were resolved within the appraisal process itself. These concerns were identified about 5.2% (1,592/30,536) of the doctors appraised by responding appraisers.

We asked appraisers to describe the nature of the concerns they had identified. Figure 11 combines appraisers' selections from a multiple-choice list of concern categories and categories identified from coding their free text responses.

Figure 11: Types of concern identified by appraisers



Overall, the same categories were present in concerns that appraisers had escalated out of appraisal and those that they had not. We do not, as yet, know how or why appraisers determine the threshold for escalating a concern about a doctor. Notably, these data show that appraisal can be a space where doctors discuss their workplace issues, health, and other personal matters.

However, some participants expressed reservations about whether appraisers or appraisal more widely could work to resolve potential issues, especially if focused on workplace issues, other than by promoting change by the individual concerned:

I can look and see whether this person is doing their work properly, or appears to be doing their work properly, but if they bring concerns to me where do I take those concerns, and what if their concerns are about their bosses, and I don't know where you take those concerns and what you do with them. And I would say that appraisal probably gives people the opportunity to air their disquiet and unhappiness about the organisation and the organisation structure that they work in, but there's no mechanism for us [appraisers] to change that. (RCA701, Consultant, interview)

There was generally more confidence amongst participants that appraisal might identify work stress or potential burnout rather than instances of misconduct or poor clinical performance:

...it's an opportunity if a doctor wants to talk about their stresses, yes one could help them with that and therefore, then prevent their stress then causing harm to a patient later on, but from the point of view of downright dodgy doctor, I think they could easily yeah, not be picked up. (A0015, appraiser, interview)

Finally, there was also some concern amongst participants that focusing on the identification of potential concerns could affect the degree of openness with which doctors engage in the appraisal process:

And we're supposed when we start the appraisal to give the appraisee the warning you know, that I do have a duty to report to the GMC if I have any concerns about your performance, but I have to say I actually actively don't do that [...] because if you start ratcheting up the intensity of your inquisitorial performance then it just becomes very, very confrontational and people will not say what they would like to say. (A0027, appraiser, interview)

Our data show that doctors do raise concerns within appraisal meetings, and that appraisers identify concerns in some cases. The potential concerns identified may be about the individual appraisee, about a colleague or about organisational practices.

3.5 How do ROs fulfil their statutory function of advising the GMC about doctors' fitness to practise and what support do they have in this role?

Key findings:

- Responsible Officers' approaches to decision-making vary in terms of the information that they use and the extent to which they delegate or share decision-making responsibility.
- The size of the organisation in which they work, particularly the number of doctors connected to it, is a key factor in shaping Responsible Officers' approaches to decision-making.
- Some Responsible Officers do not feel that the three options available for revalidation recommendations (revalidate; deferral; and non-engagement) adequately cover all circumstances.
- The GMC's Employer Liaison Service plays a key and developing role in supporting Responsible Officers and acting as the point of contact between organisations and the medical regulator.

ROs make recommendations to the GMC about each doctor's revalidation, typically every five years. In addition to making these recommendations, ROs must also monitor doctors' on-going FTP and advise the GMC about any FTP concerns as they arise (as discussed in section 3.4), irrespective of the doctor's revalidation date. Moreover, the absence of any unaddressed FTP concerns is a major factor informing the RO's revalidation recommendation about a doctor.

3.5.1 RO decision-making

Overall, ROs who responded to our 2015 survey,⁶ found the GMC's guidance *The GMC protocol for making revalidation recommendations: Guidance for Responsible Officers and Suitable Persons*¹³ 'quite useful' (213/374 = 57.0%) or 'very useful' (148/374 = 39.6%). ROs' comments in interviews were also broadly positive about the guidance provided by the GMC:

These decisions are not always completely black and white, but there are some fairly clear guidance around it, and where it's slightly grey I always seek advice. (R5008, Responsible Officer, England, 1000+ connected doctors, interview)

One 'grey area' identified was in relation to doctors who working outside, or partly outside the UK, and what type of recommendation should be made in such cases:

So it's one of the challenges, and looking at the three available categories for the revalidation decision, I'm struggling to see where does it fit more neatly, or whether the GMC will need a special guidance issued for those particular group of doctors. (R5004, Responsible Officer, Wales, 500+ connected doctors, interviews)

Our interviews with ROs also revealed some other concerns about the limitations of the three available recommendation options, in particular around deferral. One participant expressed the view

that the system had been developed based on traditional models of NHS working, and full-time permanent employment or contracts, and that this created some issues when dealing with the increasing numbers of doctors working across multiple organisations and not as direct employees consistently under one RO's gaze:

I think we need a more sophisticated way of looking about deferrals, I don't think it's an absolute pass / fail; my gravest worry is locums... and now we have UK trained agency locums, international doctors who are NHS but very little NHS experience, we have a mixed portfolio of work staff, or workforce, which is quite different I think to what people envisaged when appraisal and revalidation were set up, it was all NHS staff coming into an NHS process, but increasingly they're not NHS staff, or don't have sufficient NHS experience, and I think that's the challenge, and I suspect we're going to move to a much more open workforce market, whether we like it or not. (R5006, Responsible Officer, Northern Ireland, interview)

Issues around when to potentially defer decisions or provide notifications of non-engagement were also raised by other participants as areas where the guidance available could be clarified or expanded, or even where the system may need to be adapted:

I think we need to make it more seamless, and particular if a non-engagement is made we need to make the process less bureaucratic and more crispy when it comes to what additional information is absolutely required to support a non-engagement.... (R5004, Responsible Officer, Wales, 500+ connected doctors, interviews)

Our findings suggest that there may sometimes be a lack of clarity about when and how a deferral recommendation or notification of non-engagement should be made. GMC ELAs offered some insights into the extent to which RO decision-making is inconsistent, particularly around the use of deferral recommendations:

...it's all about hawks and doves. So of my forty odd ROs you have some who are very tough and they're intentionally tough 'cos their argument is if you give doctors a bit of leeway then that culture will develop in the organisation and you'll be forever chasing people for appraisal dates, documentation, so that's why I think the flexibility bit that we've built into our guidance is really important, it depends on the style of leadership and being RO that that RO wants to develop in that organisation. (ELA004, Employee Liaison Adviser, interview)

It is therefore clear that, whilst most ROs find the guidance available useful, this is not universal and there can be some variation in decision-making styles.

3.5.1.1 *Decision-making mechanisms*

In addition, the mechanisms by which individual ROs make revalidation recommendations can be different. In our 2015 RO survey,⁶ 88.1% (311/353) of ROs personally reviewed the case documentation, such as appraisal summaries, 41.4% (146/352) discussed the case with someone else, 25.5% (90/353) reported that they confirm recommendations made by someone else and 22.4% (79/353) discussed the case in a formal group. These approaches could be used in combination, and ROs also cited other approaches to deciding revalidation recommendations

including triangulating information from different sources, one to one meetings with doctors, and discussions with their ELA.

3.5.2 Organisational context

Interviews with ROs demonstrated the various ways in which ROs reach revalidation recommendations and show how this is linked to organisational size and type. One RO, from an NHS secondary care organisation in England with around 1000 connected doctors, described sharing the decision-making process with a panel which includes both medical and non-medical colleagues:

The [revalidation] panel has on it the trust's lead appraiser, who's an anaesthetist, and he also screens the latest appraisal document of the doctor, which is very helpful because that means we've got a manager and a doctor doing it, and the panel also has on it head of the HR department which runs the revalidation mechanism, the chief medical officer, occasionally the deputy chief medical officer, and myself. (R5012, Responsible Officer, England, 1000+ connected doctors, interview)

In large organisations, ROs cannot have personal knowledge of all the doctors connected to them but are at the apex of an institutional hierarchy and flow of information which informs a recommendation, reliant on organisational systems and other staff to provide them with the requisite information:

...mostly they're just names on the screen, out of 3,500 that's the way it is. So this back office preparation; our administrator gets them to check the appraisals, checks our main data sources for anything else that might be happening that we haven't heard about, and we have a checklist where they fill in the latest information; complaints, no complaints, poor performances, complaints years ago, closed no further issue, all bullet point things like that, and that's all prepared. (R5007, Responsible Officer, NHS primary care, England, 3000+ connected doctors, 2015 RO survey)

Other ROs, usually in smaller organisations, expressed that they did see the task of making revalidation recommendations as an individual responsibility or that personal knowledge was important in informing decisions:

I review each appraisal personally and when revalidation decisions are made, I review my checklist for each appraisal and check any items which are unclear or borderline. (ROS123, Mental health foundation trust, 51-100 doctors connected, 2015 RO survey)

How ROs fulfil their statutory function of advising the GMC about doctors' fitness to practise is, therefore, often shaped by the organisation in which they work, both because of the differing number of revalidation recommendations that they have to make, but also because of the differing resources and supporting structures in place around them.

3.5.3 Employer Liaison Service

As noted in section [3.4.2.2](#), the GMC's ELAs have become the key point of contact between ROs and the medical regulator, and they support ROs' with advice about revalidation as well as about

potential FTP referrals. We found that the ELS plays an important role in supporting ROs to interpret guidance about revalidation processes and recommendations, in particular around the non-engagement and deferral routes:

...if an RO has an apprehension that a doctor's heading down a non-engagement route the RO should be in touch with, and discussing this with, the ELA at a very early stage. And the reason I'm saying that's what we think should happen is cos that doesn't always happen unfortunately [...] so we're constantly refreshing this guidance with ROs that it's really important to let us know, just apart from anything else there's quite a bit that the GMC can do to support the RO in terms of taking forward how they manage that situation. (ELA005, Employer Liaison Adviser, interview)

I think what has made a massive difference to this whole thing is the change in approach from GMC with regard to the employment liaison officers, which really have made a very significant difference to one's ability to engage with GMC and sort out the problems before you're faced with a difficult revalidation decision, and I think that's been hugely beneficial innovation by the GMC. (R5014, Responsible Officer, England, c.300 connected doctors, interview)

One ELA suggested that the proportion of their work concerned specifically with revalidation had decreased recently as the process has become more embedded and ROs more familiar with requirements:

...at the beginning it was probably about 60%, 70% of my interaction with ROs and their colleagues. Now it's probably, I think in the last six months it's really dropped and it's probably about 30%, 40%. (ELA002, Employer Liaison Adviser, interview)

The ELS has clearly changed how organisations interact with the medical regulator, and in the case of ROs' work in making revalidation recommendations and FTP referrals this has been welcomed as a source of support and clarity around GMC processes and expectations.

3.6 Are patients being effectively and meaningfully engaged in revalidation processes?

Key Findings:

- Many of those involved in revalidation view patient and public involvement (PPI) positively, but there is confusion over its intended purpose and appropriate modes of delivery.
- Both doctors' and patients' engagement with patient feedback is inconsistent and at times problematic. A need for current patient feedback tools to be refined was repeatedly expressed from both patient and doctor perspectives.
- Patient complaints and compliments can have a negative or positive impact on performance. More formal ways of providing compliments is desirable.
- Lay Representation in revalidation processes has increased since its implementation but activity varies across organisations. Existing lay representatives have identified key ways in which lay roles could be developed and supported.

3.6.1 Patient and Public Involvement in revalidation

Our research demonstrates that patient and public involvement (PPI) is considered important. For example, in our survey of patient organisations 77% of participants agreed that PPI in revalidation was valuable (11.1%, n=2/18 agree, 66.7%, n=12/18 strongly agree). However, 64% (n=11/17) of participants felt patients were either not aware of revalidation or did not understand its aims and purpose. Of our survey participants, 70% (n=12/17) also considered the statement 'patients understand how they can be involved in revalidation' to be untrue. Remaining participants felt 'unable to say'.

Few patients or members of the public in our practice know anything about revalidation yet.
(PRO01, 2015 PPI survey)

Following this, evidence collected from three systematic reviews, our patient representative survey, and interviews with lay representatives indicated a lack of awareness and understanding regarding the purpose of revalidation, and the role of PPI within it. Our evaluation addresses three central ways in which patients are engaged with revalidation processes: the provision of patient feedback; the submission of compliments and complaints; and lay representation.

3.6.2 Patient feedback

Our systematic review exploring the impact of patient feedback concluded that it can have a measurable impact on medical performance. However, a number of factors influence its assimilation, acceptance and subsequent use. To be effective, patient feedback tools should: be regarded as credible by all those involved; contain narrative comments; and involve facilitated

reflective discussions where emotional reactions can be transformed into specific behavioural change or educational tasks.

A culture that supports patient feedback engagement is also essential for its effective use. Despite this, the evidence we reviewed suggests engagement with patient feedback for revalidation purposes is inconsistent, and at times problematic.

A need for existing tools and processes to be refined due to perceived inadequacy was repeatedly expressed from both patient and doctor perspectives. For example, when responding to the question ‘Can you describe the difficulties you had collecting patient data, and any solutions you identified?’, participants in our 2015 doctor survey (n=2,744) provided responses in which they identified challenges, with some possible solutions suggested by 16.5% (454/2,744) of participants (Table 8).

Table 8: Difficulties doctors described when collecting patient feedback with possible solutions

Difficulties in collecting patient feedback data	Potential solutions
<ul style="list-style-type: none"> · Patient health status/assumed capacity · Lack of patient engagement · Limited patient contact due to speciality, role or setting · Issues of sensitivity requesting feedback · Administrative errors (lost forms, loss of patient contact) · Resource constraints (limited support and costs incurred) differing perceptions of the intended purpose of patient feedback · Tool complexity · Restrictive rule applications, to ensure ‘valid’ responses, with an emphasis on technical validity over fitness for use e.g. patient and/or doctor engagement/reflection · Use of a generic ‘one-size-fits-all’ approach that fails to acknowledge local contexts. 	<ul style="list-style-type: none"> · Provision of additional support for doctors e.g. self-administration · Encouragement of on-site completion · Increased help from others e.g. greater non-clinical staff engagement, better administrative support, online reminders, and assistance with form completion · Closing the ‘feedback loop’ through the provision of information demonstrating changes made following patient feedback · Internal reporting of findings to help enhance patient understanding, commitment and motivation.

In particular, those in specialities with: limited patient contact, such as radiology, pharmaceutical medicine; contact with patients on a short-term basis only, such as anaesthetics; and those working with particularly vulnerable patient groups, as in psychiatry or palliative medicine, found it harder to collect patient feedback:

... we’ve struggled, certainly in the hospital, in the hospice setting you’ve got a bit more of a captive population so it can be a bit easier to get them or relatives, but in the hospital it’s quite tricky because people are much more unwell, yeah with some specialities if you have a big clinic you can just get them all from the clinic and that will be your lot, but we don’t have that type of patient... (A0064, appraiser, interview)

However, patient (and colleague) feedback when obtained were highly rated overall in terms of usefulness by doctors. There is some contradiction of this finding elsewhere in our data where the usefulness of patient feedback in its current form was described as being limited, with suggestions that patient questionnaires tend to result in generally positive feedback and therefore offer scant content to drive reflection or change:

'Patient feedback is always overwhelmingly positive and is a waste of time.' (S00313703, GP partner/principal, General Practice, 2015 Dr survey)

Others though, could identify opportunities to reflect from patient feedback:

I mean on the whole it's excellent and patients write gorgeous things, but there's always one or two that don't say I'm, like this year three patients out of the twenty ticked that they would have liked to have been more involved in the discussion, that was interesting, I'm thinking oh so you think you get it right for everybody but you're not, so yeah I do find that helpful. (R0008, Consultant, appraisee-appraiser, interview)

In our survey of patient organisations, over half of participants (n=10/18) also considered existing patient feedback tools to be inadequate.

It is important that the mechanisms for patient feedback are tailored to the patients' needs rather than the doctor's needs (PR013, PPI survey)

Barriers to engaging with patient feedback from a patient perspective included: a fear of repercussion, lack of accessible information regarding the intended purpose, use, and outcome; perceived bias in patient selection; and current unavailability of questionnaires and other more accessible tools in different formats/languages. For example, patient organisational representatives commented:

Patients may not provide honest feedback because they may be afraid of negative consequences (PO003, PPI survey)

The current GMC questionnaire is limited in the way it fails to provide assistance to patients in clarifying the intentions of the questions (PO005, PPI survey)

The process is not rigorous enough since doctors can pick their "easy" patients to give fairly undifferentiated feedback (PR007, PPI survey)

There need to be other ways of giving feedback which do not rely on questionnaires, especially for patients who may not have English as a first language or who have literacy issues (PO012, PPI survey)

Lay representatives interviewed suggested there is some way to go in overcoming the challenges:

It's [revalidation] supposed to portray that to the patient a greater confidence in their safety and security and so on. I think the majority of patients have not got a clue about whether the doctor has been revalidated, his shortcomings or what experience he has" (LR016, Lay representative, interview).

I'm not necessarily sure that it's as public as it might be. (LR010, Lay representative, interview)

3.6.3 Compliments and complaints

The impact of complaints and compliments is complex. Our systematic review exploring the impact of complaints and compliments on medical performance indicated they can have both positive and negative effects. While complaints may unintentionally lead to defensive practice or avoidance behaviour, our review concluded they also have the potential to become a valuable learning resource if used sensitively in the appropriate setting.

Efforts to address issues of fear and stigmatisation arising from complaints for both doctors and patients would therefore be beneficial. The importance of a centralised and efficient data collection method whose purpose and processes are made clear to those involved, particularly the difference between complaints and patient feedback may be helpful, if complaints are to become a valued learning resource.

Finally, the evidence reviewed suggests formal and recognised systems for recording patient compliments should be encouraged to counter the negative or punitive connotations often associated with complaints.

3.6.4 Lay Representation

Lay representation has increased since the implementation of revalidation. Lay representatives we interviewed considered their role as being to act as an independent voice rather than as a champion for patients or doctors in particular, providing a different contribution to that of a patient providing patient feedback:

About revalidation, it's not about a medical condition, it's all about a system and I think therefore we bring as a group of lay people just a different independent view of how the system is being organised and run, which within the doctors' world they don't necessarily see from a broader aspect. (LR011, Lay representative, interview)

I bring to it a lay person point of view, in that I can be an honest broker. I don't come with any baggage in terms of the profession....It's the public interest I would say, in a sense to encompass what is best for the doctor, the profession, and patient safety. (LR002, Lay representative, interview)

Lay representatives provided examples of how their work had impacted on: practice e.g. facilitating reflection; improving resources; systems, e.g. embedding PPI in organisational structures; changing cultural attitudes; individual doctors' experiences e.g. providing personal support and; lay representatives themselves e.g. public service; facilitating public awareness. For example, lay representatives commented:

It's about the constructive challenge and the devil's advocate role in that... I guess I've managed to influence the risk assessment to some extent, and I have to say that in the time I've been there, there has been a change in the way that people take patients' comments on board, which is good. (LR010, Lay representative, interview)

We're there to look at it from the lay person on the street; if I was to explain what was happening to a member of the public, would they feel that it was a reasonable course of action we were taking, would they feel that we were representing their interests in the best way. (LR014, Lay representative, interview)

The role itself hasn't changed much, except to say that I think the contribution of lay members is now pretty well embedded and accepted. (LR012, Lay representative, interview)

I know that sometimes some of the complaints raised by the patient or their family are vexatious, that they're not justified, or that they're misunderstood...I don't feel that I should be seen to represent one particular side, I'm there as a member of the panel and can speak out if I feel that either side is at blame, or at fault, or unreasonable. (LR016, Lay representative, interview)

Although considered important, the activity of lay representation appeared highly variable. The most frequently identified role for lay representation related revalidation committee board membership. Further cited opportunities included: responding to Patient Participation Group (PPG) queries; lay representative involvement of the Higher Level Responsible Officer's quality Advisory Group; and appraisal quality assurance.

Patient representative and organisation survey participants also hoped to provide future PPI opportunities (42%, n=8/19) including: raising general patient awareness; having discussions with doctors in the first instance to find out how they are engaging with revalidation; offering places on the Leading Together programme for lay people and healthcare professions to jointly learn and explore PPI in revalidation; involve lay representatives in rigorous checks on how feedback tools are validated and applied; and, involve patient/public reps in training appraisers.

Five key solutions were identified to try to address self-reported inconsistencies associated with PPI in revalidation:

- i) Similar levels and types of induction from organisations or centrally if more appropriate/organisation is too small.

It's a bit of a challenge because different organisations work very differently with their lay group and some are more developed than others and have different ways of working – so I think the issue of finding common ground where you can all work together [is important] (LR001, Lay representative, interview)

- ii) Ongoing provision of training and skills development (regionally).

It's a funny sort of status really, where you are not really employed...they give you a set amount of training but it's a loose arrangement really. (LR006, Lay representative, interview)

- iii) Facilitation of social networks, collaborative working and information sharing.

I think it would be useful to have a pack that new people coming in could use with some check sheets and that sort of thing, and I've done that sort of thing, come up with materials and stuff. But we don't see, to have a forum for people who are doing the role to get together to put anything that people, to pull good practice together, a regional group of lay people who perhaps meet one or twice a year. (LR008, Lay representative, interview)

- iv) Appreciation and discussion about the personal challenges and problem solving around conflicts arising from lack of familiarity with systems and jargon.

The only concern I have is the existence of medical jargon, terminology is just very defeating sometimes, but providing you can cope with that it's a very fulfilling role. (LR012, Lay representative, interview)

- v) Negotiation and support for positive working relationships between both lay and non-lay colleagues including the positive management and promotion of complementary insider/outsider identities.

I think slight fear and suspicion and "what do we know about anything?"...it was very hard to establish ourselves at the beginning, and then we had to thoroughly explain ourselves and then I think over time people actually value our input. (LR003, Lay representative, interview)

3.6.5 Embedding PPI within revalidation

Data collected from our multiple data sources highlights a need for further development of PPI opportunities across revalidation including patient feedback, appraisal, lay representation and complaints/compliments. Enhanced PPI engagement requires a shift in the nature of PPI from a purely *contractual* to a *collegiate* relationship between the medical profession, patients and the public.

However, in order to become embedded, efforts should be made to improve both doctors' and patients' awareness and understanding of the intended aims and purpose of revalidation; their roles within this process; and the opportunities available to them. Our research highlights some tangible approaches to embedding PPI within revalidation. These include: fostering greater familiarisation of revalidation within public and patient communities; improving existing tools and processes so they are aligned with responder (patients) and end user (doctors and appraisers) expectations/desires; ensuring safety and anonymity within existing systems; developing positive and constructive use of complaints and compliments; allaying doctors' fears that patients do not have capacity to provide feedback that is useful or meaningful; aligning lay representation and feedback roles to assist in understanding systems and process and; modelling examples of good practice.

These potential solutions directly address some of the challenges set out by the Pearson Review,¹⁶ and wider public interests:

So, we need to make sure our [PPI] role is properly marketed to the people at a wider level. I think that people's faith in the NHS is being undermined at the moment politically, and by some of the experiences that people are having personally, and I think they need to be sure

and confident that the safeguards to protect their interests – as well as their doctors’ interests – are in balance and in place, and I’ll continue to press for that, making sure that the role [of PPI] is widely understood and widely appreciated. (LR012, Lay representative, interview)

4 Discussion

Our three year evaluation within the first cycle of revalidation has revealed that the process of revalidation has been implemented mostly in line with projections.⁵⁵ Doctors holding a licence to practise with the GMC have on the whole linked to designated bodies, have an RO or Suitable Person in place and have had a recommendation made about them in line with allocated dates between 2012-17.⁸ The success of the implementation of the process of revalidation has led to the large majority of doctors now undertaking annual appraisal in numbers unseen before its launch. Appraisal was introduced in the NHS for GPs and consultants in the early 2000s,⁵⁶ yet appraisal rates remained low, and negligible for other doctors. In 2010-11, overall rates in England were only 63%; then 76% by 2012-13,⁵⁷ 83.8% in 2014-15 and then 88.2% in 2015-16.⁵⁸ This compared with 90% appraisal rates in Scotland by 2013-14 and 92% by 2015-16;⁵⁹ and rates in Wales reaching 85%-97% in 2015-16 depending on Health Board.⁴⁹ Engaging in annual appraisal has led to a significant minority of doctors stating that they have changed their clinical practice, professional behaviour or learning activities.

Before revalidation was formally launched there was a peak of doctors referred to FTP procedures. This might imply that revalidation was a catalyst for newly created ROs to act in response to longer term performance concerns for a small but important cohort of doctors. Referral rates from ROs to FTP are now back to pre-revalidation levels; although any direct relationship to revalidation is unclear and wider changes to FTP procedures may also have impacted on referral patterns. Appraisal as the core activity of revalidation might also be good at identifying some performance issues such as stress and workload concerns. Lastly, lay engagement in revalidation is becoming established in pockets around the country with evidence that PPI in regulation can facilitate quality improvement, enable professional development and support clinician professionalism.

Overall, the vast majority of doctors (as *subjects* in our CHAT model of revalidation) are now within a governed system undertaking the core *activity* of revalidation; which involves the collection of and reflection on supporting information as part of an annual appraisal cycle.⁶⁰ This, in most cases, has led to revalidation decisions as scheduled (hence achieving the *object*). However, it is harder to evidence that by achieving its primary *object*, revalidation is driving its desired *outcomes* ([Figure 1](#))

We often conceptualise revalidation as one system. However, revalidation is being played out through a very complex multitude of systems, involving diverse *subjects* undertaking different activities that have been shaped even in a relatively short period of time by local and national, implicit and explicit *rules*. Further still, different members of the *community* then interpret these rules differently and take different approaches to who is responsible for what elements (*division of labour*). In each case, experience of the systems has also been shaped by *community* members’ interactions with portfolios, feedback tools, guidance, IT systems (*artefacts*) and so understanding

the impact of revalidation is far more nuanced than simply the fact that doctors have completed the first cycle in large numbers.

In order to frame these nuances, we discuss our findings through the lens of our conceptual framework,^{42,61} that helps to separate out any inconsistencies in the system(s) that are important for policy and *Taking Revalidation Forward*.^{16,62}

Subjects: Doctors (as *subjects*) are a heterogeneous group working across organisations,⁶³ within and outside the NHS, and indeed the UK. Their roles vary from procedural based specialities, like surgery and anaesthetics, through diverse medical specialities, generalists, managers, researchers, trade unionists, and even Members of Parliament. However, revalidation as a group of activities was primarily developed for doctors as employees, idealised as working full time in the NHS.⁶⁴ This was understandable in order to achieve a policy launch in the face of protracted opposition.^{17,65} It is therefore perhaps unsurprising that outside of established governance systems, such as NHS Trusts and GP practices, revalidation is yet to be fully embedded. Sub-groups of doctors, for example locums, those in private practice, and those working partly overseas, struggle more to engage with appraisal. We also identified other groups, such as older doctors and including those in semi-retirement, with concerns that the additional challenges they face engaging in revalidation might be leading to an exacerbation of the workforce crisis,¹⁶ especially in primary care.^{18,66} Other examples include doctors with portfolio careers, spending at least some of their time away from direct patient care, who find evidencing their whole scope of practice more challenging. As others have noted, there may be opportunities to facilitate more flexibility between these different groups of doctors, including for example ROs as managers.⁴⁰

Outcomes: Supporting the heterogeneity of the profession to complete the process is important, but it falls short of establishing more accurately if revalidation is achieving its desired *outcomes*. Part of the challenge of evidencing this from our data is the lack of clarity over the purpose of revalidation that remains within many parts of the *community*. Many doctors and, as importantly, patients remain unclear about what revalidation is designed to achieve. Many in the profession believe that the main aim of revalidation is to identify ‘bad doctors’ and can be failed, as ultimately successful involvement in revalidation *activities* is linked to a judgement about FTP. In part, this may be reinforced because traditionally assessment *of* learning and assessment *for* learning (in this context, analogous to fitness to practise and promoting professionalism) are kept somewhat apart. As Cees van der Vleuten, a leading expert in medical education, puts it:

*...the assurance of lifelong learning is the prime aim for which a regulator should strive. So the issue here is to develop assessment strategies that help learning. The next purpose for the regulator is to guarantee patient safety by safeguarding the public from incompetent individuals in the workforce. These two purposes should be separated, even firewalled, and treated differently in developing an assessment strategy.*⁶⁷

One unintended consequence of this confusion may explain why we found that reflection has become a ‘product’ of appraisal. Doctors actively engaging in reflective practice is at the core of promoting professionalism.⁶⁸ Whilst reflection is generally assumed to play a role in supporting

learning and development, the precise relationship is poorly evidenced,⁶⁸ and the theoretical/philosophical basis for the extensive use of written reflection in medical education has been challenged.⁶⁹ Though reflection and reflective practice have been placed at the heart of the appraisal process and enshrined in the GMC's guidance on appraisal for revalidation,⁴⁶ our findings suggest that the dual forms of reflection in which doctors are required to engage – written reflections and verbally in the appraisal meeting – evoke quite different responses. Written reflection is often seen as burdensome, tokenistic, and lacking value.⁷⁰ This scientific-bureaucratic approach, of having to record an activity to prove it happened,^{71,72} may explain why many doctors we surveyed and interviewed felt that mandated reflection for appraisal may not drive any actual increase in professionalism, but rather simply make professionalism more demonstrable. Others have identified the risks of such regulatory 'transparency',⁷³ exposing doctors to possible legal challenge,⁷⁴ and the threat of counter-reactions such as anxiety, avoidance and gaming, with professionals ultimately concealing any adverse evidence.⁷⁵

The lack of a 'firewall', providing a clear dividing line between revalidation *outcomes*, may also help to explain the dominance of the 'tick-box' rebuttal of revalidation;⁷⁵⁻⁷⁷ as doctors and patients complete activities primarily to document them. A revalidation policy that supports appraisal engagement, but minimises direct interference in actual appraisal processes, may ultimately support revalidation's ability to promote professionalism through a high quality formative approach.^{64,68} The alternative route of further strengthening current revalidation activities, fundamentally appraisal, in order to reliably identify poor performance is not supported by our data, or the wider literature.^{57,78-80} While appraisal seems to identify important issues such as stress and burnout in some instances, our participants are sceptical about appraisals' ability to identify wider performance issues. Arguing for such a link may be counterproductive as, if the public are wrongly reassured that revalidation can achieve improved safety⁸¹ but this subsequently proves to be unfounded, the potential developmental benefits of appraisal for revalidation may also be lost.

Division of labour: While appraisal is not the only revalidation activity, for the medical profession it is often their only experience of revalidation policy in practice. Indeed we found, in associated research, that organisations, while acknowledging the positive impact of revalidation on appraisal systems, often denied that wider clinical governance systems have changed dramatically due to the launch of revalidation.⁸² There was, though, a recognition that systems around appraisal had tightened, for example making sure that information collected centrally in organisations was being fed into appraisal.⁸² Information flow into and out of appraisal is fundamental as we found that despite the regulations,¹⁰ ROs sometimes delegate the responsibility of revalidation recommendations to others and rely on second-hand knowledge, perhaps understandably with sometimes thousands of doctors connected to them. However, in many instances concerns around mainly health and stress are being resolved locally by appraisers, appraisal leads and ROs. Furthermore, the creation of the ELS has played an important part in aiding ROs to make appropriate decisions about the potential for concerns to be resolved locally or whether an FTP referral is appropriate.

Fundamentally though the activities of revalidation through appraisal fall to all doctors as appraisees. As others have reported,³⁶ we found that doctors worry about the time burden involved

in the activities of revalidation. These activities focus around collecting and reflecting on SI. Despite some integration of systems, such as some organisations buying in online portfolios, mostly it still falls to individual doctors to collect their own data.

Alongside the appraisee, the appraiser is the other central member of the appraisal *community* to whom a significant *division of labour* has been allotted.^{64,83} Understandably, the role of the appraiser is linked to perceptions about appraisal and indeed revalidation. If doctors' experiences of their appraiser are positive then their views of appraisal correlate. We have found that the appraiser is fundamental in supporting doctors through dissonance, denial and self-affirmation in appraisal – ultimately to bring about positive change in behaviour or practice.^{68,84-87} However perhaps understandably linked to the need to drive functional implementation in the first cycle, we have found so far that changes in behaviour and practice overwhelmingly relate to the focus or quantity of doctors' CPD activities only. This is an important start, which could present significant opportunities to better link CPD to Quality Improvement, and therefore patient care.⁸⁸ It also further highlights that in terms of resource allocation, appraiser training needs should be prioritised to ensure appraisers are equipped with the mentoring/coaching techniques required to support appraisees' personal and professional development.⁸⁹ However, expecting appraisers to consistently evaluate doctors' fitness to practise, based on appraisal, is unlikely to be reliable.⁹⁰

Rules: In terms of considering revalidation policy in practice, we have found important differences in the ways that *rules* – as written in policy or GMC guidance – have been played out in the workplace. ROs have been given guidance around how to make revalidation recommendations but we have found notable differences in outcomes, including deferrals regardless of reason (insufficient evidence or subject to an ongoing process) and non-engagement. Deferrals as an outcome are described as an opportunity to 'provide [ROs] with more time in which to submit a revalidation recommendation' (p36).⁹¹ They are described as a 'neutral act',⁹² but whether it is delivered, experienced or perceived as such has been questioned.¹⁶

We found for example that female and also younger doctors are over-represented in deferral decisions. While these two variables are independent in our statistical modelling, they are still likely explained by the large number of doctors in training in the dataset. Doctors in postgraduate speciality training are predominately younger and female; and trainees have their revalidation date reset in line with their Certificate of Completion of Training (CCT) date. This often requires a realignment by their RO using deferral as the mechanism.⁹¹ Many female doctors may also take breaks from practice for maternity leave and have their revalidation date deferred to allow further time to collect the requisite SI. Different terminology might allow ROs to differentiate between 'routine' changes to revalidation dates, such as those resulting from changes in trainees' CCT dates or as a result of a period of parental leave, and those instances where doctors may not have collected adequate supporting information to enable an RO to confidently make a recommendation to revalidate and those instances where doctors may not have collected adequate supporting information to enable an RO to confidently make a recommendation to revalidate but without any such extenuating circumstances.

We also found that BME doctors and EEA-qualified doctors are over-represented in deferral decisions. Issues around differential outcomes including attainment,⁹³⁻⁹⁷ are well recognised but our analysis must be treated with some caution. As summarised in Section 2.4, we were unable to link data such as a doctor's job role or prescribed connection to each outcome. This may be important as we know that doctors in some roles have higher rates of deferral. For example in 2015, doctors connected to locum agencies had a deferral rate of 36% compared to an average of 16% for doctors connected to other types of (non-trainee) designated bodies.¹⁶

There are also explicit differences between the *rules* about how appraisers are selected across the four nations as well as local expectations about how data for and from appraisal are shared and managed. The four nations have different *rules* about how an appraiser should be chosen.⁹⁸⁻¹⁰¹ This is potentially an important difference considering the centrality of the appraiser. We also found evidence that local organisations are making active links between performance management systems, including job plans, and appraisal. There are arguments to be made for and against these links but the current inconsistency across the systems could be detrimental. We found that appraisers vary in how they conduct appraisals and that this would seem linked to the appraisers' beliefs about what the purpose of appraisal is, again raising the central importance of this issue. While a few appraisers were pleased that appraisal has been strengthened through the regulatory link, as they felt that some doctors now take the process more seriously, we found evidence that many experienced appraisers are concerned about the standardisation: efficiency; calculability; predictability; and control through technology of appraisal after its explicit link to revalidation.¹⁰² Many appraisers are keen to preserve the educational potential which they see threatened by its link to a regulatory process.

Artefacts: Lastly, artefacts are important in supporting or in some cases hindering the implementation of the policy in practice. There is evidence that revalidation has systematised a previously more personal process. The focus on ensuring participation in the system and compliance with the requirements for strengthened appraisal has driven a focus on whether doctors have achieved SI across the six codified categories. This focus has had the unintended consequence that the collection of the 'correct' or 'enough' SI has often been privileged over the subsequent use of the SI as the basis for a facilitated reflective discussion. For many doctors, this focus on collecting designated types of SI (with the prescription of what forms the SI should take often extended beyond GMC guidance by organisations and/or individual appraisers, or nuanced by Royal Colleges³²) has again embedded criticisms of appraisal being a 'tick box' exercise. The use of IT systems, MARS and SOAR in Scotland and Wales but also commercial providers in England and Northern Ireland, have inevitably shaped this. The wider literature tells us that it is not the production of 'data' that brings about change; it is the long term facilitation of feedback that matters.^{68,103} In this regard, appraisers would appear to play a crucial role in the process, and the relationship between the appraisee and appraiser is critically important.¹⁰⁴⁻¹⁰⁶ This relationship – as with any therapeutic relationship – is central, and indeed independently significant of other supportive factors.¹⁰⁷ Recognising the significance of the appraisee-appraiser dynamic and nurturing the development of positive relationships within the process could encourage doctors to feel more positive and engaged with the process, which is again an important element in driving behaviour change.^{104,107,108}

One specific *artefact* we examined was patient feedback, which was contested by doctors and patient organisations. Doctors are keen to receive feedback from patients and patients are equally keen to provide it. Patient organisations we spoke to reported challenges in providing feedback though due to a lack of information, inadequate instruments and in some cases a fear of negative consequences. Patient feedback tools and their administration have defined how many patients are asked for feedback and how often it is completed and there is concern that the tools themselves restrict patients by using questions and language that do not necessarily facilitate what patients really want to say. The PPI workstream in the GMC's response to the Pearson report seeks to understand this area further.¹⁶ There is much to celebrate as well including some examples of good practice in PPI across the UK, but there remains scope for developing more consistent, sustainable and meaningful engagement of patients in revalidation.

It must be noted that many of the supportive structures around revalidation have been very successful. We found for example that doctors, including in their roles as ROs, appraisers and appraisees, use guidance from the GMC; although as others have found,¹⁰⁹ there is more to be done to provide further clarity over supporting information quantity and quality. However, doctors also seek guidance from their Royal Colleges which is not always consistent with GMC guidance. This raises questions about the role of Royal Colleges but it might also represent an opportunity to develop more specific guidance for specialities where different roles and their particular challenges are acknowledged and addressed. In a less standardised model focused more on personal development, variation of approach at a local, speciality (e.g. surgeons gathering more skills based data),¹¹⁰ or health settings level would not be contrary to developing policy further. Only if minimum standard requirement decisions are required as part of a quality assurance process would this potentially prove more challenging as standardisation would then be key.

This was an extensive study exploring the impact of revalidation, including one of the largest ever surveys of the medical profession. We were especially interested in the impact of appraisal and revalidation on equality and diversity and so sampled as widely as we could. However, as with similar studies, for the survey and interviews we spoke only to those who were willing to speak to us. This is therefore a self-selected sample. However, our main survey population represented that of the profession in terms of professional and protected characteristics and we got a range of views from both them and our interviewees. Doctors we spoke to at interview as appraisees, were also often appraisers. However, we did not find significant differences in opinions in our large survey between appraiser and appraiser participants' views and perceptions so this should not undermine the findings.

In conclusion, revalidation has been launched into a complex network of healthcare systems to a heterogeneous group of professionals. The history of the policy is important as it was developed on top of existing structures (NHS appraisal). Revalidation has also been implemented into an evolving landscape in both individual and organisational regulation, with changes including the emergent and sometimes contested role of regulators in professional development. There remains a risk that while regulatory initiatives like revalidation could support individual learning and organisational improvement, information held generated by such processes might also be used to apportion blame

when things go wrong.^{74,111,112} Such use would be potentially antithetical to supporting learning, and the risk or perceived risk that this may happen could have unintended consequences in the form of reduced engagement or openness.

This evaluation, undertaken within the first implementation cycle of a significant policy change, has unsurprisingly revealed that there are still opportunities to ensure all doctors and patients are fully supported, and able to benefit from, their engagement in the activities of revalidation.

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6 Appendices

Appendix A: UMBRELLA research questions and sub-questions

1) Is the GMC's objective of bringing all doctors into a governed system that evaluates their fitness to practise on a regular basis being consistently achieved?

1a) Is appraisal taking place for all doctors and all doctors similarly?

1b) If not, why not?

1c) How are GMC guidelines on appraisal applied in practice and how can this guidance and/or its application be improved?

1d) How do doctors experience appraisal and does this vary according to job role, setting, or protected characteristics?

2) How is the requirement for all doctors to collect and reflect upon supporting information (SI) about their whole practice through appraisal being experienced by revalidation stakeholders?

2a) How are GMC guidelines on SI applied in practice?

2b) Can doctors collect each type of SI and does this vary according to job role, setting, or protected characteristics?

2c) What additional SI do doctors bring to appraisal?

2d) Is the quality of SI evolving over time?

2e) Which type of SI is impacting on practice?

2f) Has collecting SI & appraisal changed doctors' levels of reflection?

2g) Are doctors reflecting on SI in appraisal?

3) Is engagement in revalidation promoting medical professionalism by increasing doctors' awareness and adoption of the principles and values set out in *Good Medical Practice*?

3a) Is the revalidation process increasing the awareness and adoption of the values and principles of *Good Medical Practice*?

3b) Is the revalidation process increasing levels of professionalism?

4) Are revalidation mechanisms facilitating the identification and remedy of potential concerns before they become safety issues or FTP referrals?

4a) Does revalidation facilitate the identification and addressing of potential concerns earlier & before they become safety issues or FTP referrals and does this vary according to job role, setting, or protected characteristics?

4b) What impact, if any, has revalidation had on FTP referrals?

5) How do ROs fulfil their statutory function of advising the GMC about doctors' fitness to practise and what support do they have in this role?

5a) How is revalidation supporting ROs to fulfil their statutory function of advising the GMC about FTP of doctors?

5b) How do RO's make judgements?

5c) How is the RO protocol being applied in practice and how can it be improved?

5d) Do the RO regulations shape RO behaviour?

6) Are patients being effectively and meaningfully engaged in revalidation processes?

6a) What opportunities currently exist for involving patients and the public in revalidation processes?

6b) How far, and in what ways, do doctors reflect and act upon patient feedback in revalidation?

6c) How effective are existing patient feedback systems in i) helping doctors to reflect and improve their practice, and ii) informing decision making processes in revalidation?

6d) How accessible are current patient feedback tools for a range of patients, including those across the protected characteristics, and what are patients' views in relation to their actual and potential roles in revalidation?

6e) What potential opportunities are there for strengthening patient and the public involvement in revalidation, and how might they be implemented more widely in future?