Interim Report

January 2016

The Uk Medical Revalidation coLLAboration (UMbRELLA) involves:

Collaborators: Dr Julian Archer, Dr Niall Cameron, Ms Katie Laugharne, Professor Martin Marshall, Dr Sam Regan de Bere, Professor Kieran Walshe, Mr Steven Wilson, and Dr Richard Wright.

Research Team: Mr Alan Boyd, Dr Marie Bryce, Dr Charlotte Hillier, Ms Sarah Holmes, Dr Stephanie Howarth, Dr Mirza Lalani, Miss Rebecca Pitt, Mr Martin Roberts, Dr Abigail Tazzyman, Dr John Tredinnick-Rowe, Dr Judy Wakeling, Dr Daniel Zahra, Dr Elizabeth Gabe-Thomas, and Mr Sebastian Stevens.

Funded by the General Medical Council

The views expressed in this report are those of the authors and do not necessarily reflect those of the General Medical Council.

Acknowledgements: The research team would like to thank all those who have taken the time to complete our survey questionnaires and those who are participating in further research activities into understanding appraisal more closely.

Table of Contents

Table of Tables

Table of Figures

Table of Abbreviations and Acronyms

CAMERA	Collaboration for the Advancement of Medical Education Research and Assessment
CHAT	Cultural Historical Activity Theory
EEA	European Economic Area
ELA	Employer Liaison Adviser
ELS	Employer Liaison Service
FtP	Fitness to Practise
GMC	General Medical Council
IMG	International Medical Graduate
MARS	Medical Appraisal and Revalidation System
PDP	Personal Development Plan
PMQ	Primary Medical Qualification
PPI	Patient and Public Involvement
PU PSMD	Plymouth University Peninsula Schools of Medicine and Dentistry
QI	Quality Improvement
RO	Responsible Officer
SEA	Significant Event Analysis
SI	Supporting Information
SOAR	Scottish Online Appraisal Resource
UID	Unique Identifier
UMbRELLA	Uk Medical Revalidation Evaluation coLLAboration

Executive Summary

Introduction

This report presents emerging findings from the UMbRELLA study into the regulatory impacts of revalidation. Medical revalidation is a major policy initiative. Understanding the impact and consequences – both intended and unintended – of its implementation during the first years will inform future developments impacting on all doctors licensed to practise in the UK. Furthermore, with comparable schemes being introduced or considered for other healthcare professionals in the UK and internationally, the findings from this extensive research study offer insights relevant to a range of stakeholders.

Study design

The UMbRELLA study consists of seven work packages, organised by research methods, designed to collect and analyse both quantitative and qualitative data covering revalidation's component activities. This report primarily contains findings from three surveys: a survey of doctors licensed to practise[1]; a survey of Responsible Officers (ROs) from across the UK and a survey of patient and public representatives.

Emerging Findings

26,171 doctors of 156,610 invitees completed our survey providing a response rate of 16.7%. A detailed analysis comparing the proportions in each subgroup between the population and the survey respondents, has shown that the characteristics of the survey respondents are representative of the population as a whole. The survey of Responsible Officers received 374 complete responses. 41 patient and public representatives from national, regional and local organisations and employers responded to the patient and public involvement survey.

Key findings from initial descriptive analyses are summarised and mapped to UMbRELLA's core research questions.

[1] The survey was not distributed to doctors in postgraduate specialty training.

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?

The vast majority of doctors licensed to practise by the GMC are engaged in annual appraisal processes, which constitute doctors' primary point of contact with the governed system of revalidation. 90.3% (23,637/26,171) of respondents stated that they had had a medical appraisal at some point in their career. However, there was some variation in participation rates, with lower appraisal rates for respondents in non-consultant posts in secondary care (e.g. trust grade doctors 63.9% (593/928), and resident medical officers 60.0% (168/280) or working as locums (602/861 = 69.9%) outside primary care). Participation rates were also lower for those in non-clinical practice groups (such as public health doctors (602/808 = 74.5%). There was an important minority of responding doctors licensed to practise in the UK but with no known UK location – the GMC does not hold details of a UK address or designated body. These responding doctors appear to have had a different experience of revalidation processes with much lower rates of participation in appraisal (931/2120 = 43.9%).

Whilst most of the responding doctors were participating in appraisal and therefore the governed system of revalidation, views about these processes were mixed. For example, responding doctors who had had an appraisal within the twelve months prior to the survey were positive overall about that individual appraisal experience. However, less than half of respondents agreed that appraisal is an effective way to help improve clinical practice (9,833/23,514 = 41.8%). Responding doctors were divided in their opinions about the impact of revalidation on appraisal with less than a third believing that revalidation has had a somewhat or very positive impact on appraisal (8,412/25,983 = 32.3%).

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?

A majority of responding doctors used guidance documents about supporting information, appraisal and revalidation produced by the GMC (18,523/24,937 = 74.3%) and reported finding them useful. However, nearly a quarter (5,699/24,937 = 22.7%) reported that although they were aware of such guidance produced by the GMC, they had not made use

of it. Respondents also used guidance from a range of other organisations, such as employers and professional bodies.

Rates of submission varied for different types of supporting information, as might be expected as they are required at different intervals within a revalidation 'cycle'. However, there were also variations in submission rates between subgroups – for instance respondents in some specialties, namely pathology and public health, had lower rates of patient feedback submission (118/574 = 20.6% & 92/364 = 25.3% respectively) than for example GP's (3,766/7,453 = 50.5%). Respondents in anaesthetics (689/1,263 = 55.6%), psychiatry (556/1,123 = 49.5%) and emergency medicine (281/627 = 44.8%) were more likely to report some degree of difficulty in collecting patient feedback. A third (4,445/13,537 = 32.8%) of respondents distributed their patient feedback forms personally, contrary to GMC guidance. Some of the responding doctors had concerns about the ability of certain patient groups to give feedback, such as those in intensive care, patients with poor English language skills or where older patients may not be familiar with online feedback tools. Where patient feedback was submitted, a majority of responding doctors found it to be the most helpful type of supporting information in supporting reflection on their practice; 37.3% (5,029/13,467) found patient feedback moderately helpful and 21.5% (2,901/13,467) found it extensively helpful.

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

The majority of responding doctors (13,565/23,547 = 57.6%) stated that they had not made any changes to their clinical practice, professional behaviour or learning activities as a result of their most recent appraisal compared to 42.4% (9,982/13,565) who reported having made such changes. While our analysis is at an early stage, there was some evidence that older, more senior doctors may be the least likely to make changes (doctors aged 60-69 no change 64.3% (2,211/3,437) compared to 46.3% (1,731/3,739) of 30-39 year olds). There was scepticism amongst doctors about whether revalidation has led to improved patient safety, and about whether the process will identify doctors in difficulty at an earlier stage. Responding doctors had mixed views about whether revalidation will improve standards of practice.

Are revalidation mechanisms facilitating the identification and remedy of potential concerns before they become safety issues or fitness to practise referrals?

Respondents to the survey who work as appraisers were asked questions about their role. A tenth of appraiser respondents had formally escalated a concern about at least one of their appraisees (412/3,944 = 10.4%). Nearly a quarter of responding appraisers identified concerns about at least one of their appraisees that they did not formally escalate (887/3,944 = 22.5%). A majority of these appraisers were able to deal with all such concerns within the appraisal process itself (759/883 = 86.0%). The most frequently cited reason for concerns was a lack of appraisee reflective practice.

A majority of responding Responsible Officers (ROs) felt that the number of concerns being raised about doctors had not increased since the introduction of revalidation (170/271 = 62.7%).

How do Responsible Officers fulfil their statutory function of advising the GMC about doctor's fitness to practise and what support do they have in this role?

Many responding ROs share the process of reaching their revalidation recommendations about doctors with others such as deputies or a revalidation committee, and some in large organisations ratify decisions made by delegates. The majority of responding ROs work with and value the GMC's Employment Liaison Service.

However, contrary to GMC guidance less than a third (113/349 = 32.4%) of the ROs that responded to the survey, inform doctors of the revalidation recommendation they make about them prior to communicating it to the GMC.

Are patients being effectively and meaningfully engaged in revalidation processes?

Two thirds (11 out of 17) of PPI representatives felt that patients were unaware of revalidation or understand its aims and purpose. There appears to be a discrepancy between the largely positive value attributed to PPI in revalidation by representatives and its perceived effectiveness in its current form, through for example patient feedback. PPI representatives raised issues of time, anonymity, and perceived negative repercussions as barriers to patient feedback.

Conclusion

The early findings outlined in this short report offer insights into how revalidation processes are operating in practice, three years since its introduction. There is some evidence of variation between the experience and perceptions of certain groups of doctors and certain groups of patients. On-going quantitative and qualitative research will continue to explore the complexity of revalidation and to pursue in-depth understanding of its impacts. Further findings will be reported in due course.

1 Introduction

The introduction of revalidation by the General Medical Council (GMC) in December 2012 represented a major change in the regulation of medical professionals in the United Kingdom. Doctors are required to have, wherever possible, a prescribed connection to a designated body, typically their employing organisation.[1] Each year they must collect supporting information about their practice and reflect on this information at an appraisal meeting. Information from the appraisal process is then brought together with data from other sources by a Responsible Officer (RO), a senior doctor within each designated body, who makes a recommendation approximately every five years about whether the doctor should be revalidated. The GMC then makes the final decision.

Long debated, by policy-makers and the profession, the advent of medical revalidation has raised questions about its purpose(s), design,[2] and costs.[3 4] However the concept of extending proactive regulatory oversight across the entirety of a professional's career has gained traction in healthcare. In the UK, the Nursing and Midwifery Council introduced its own revalidation scheme in Spring 2016,[5 6] and other healthcare regulators have considered comparable programmes.[7 8] Internationally, the Medical Board of Australia is consulting about potential revalidation models.[9] Understanding the impacts of revalidation, for individual doctors, the medical profession as a whole, for patients and the public, and not least for the GMC, are therefore crucially important as the first cohorts pass through the process. The research reported here sets out to identify and analyse revalidation's regulatory impacts to date. This is primarily to ensure future developments of the GMC's model are evidence-based, but it is also likely to inform policy decisions elsewhere. However, with this in mind it is important to put this interim report into context reporting, as it does, only one year into a three year study.

1.1 Research overview

UMbRELLA was commissioned to conduct independent research led by a group of academics and revalidation implementers from across the United Kingdom. The research began in January 2015 and is due for completion in January 2018. The overarching aim of the research is:

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

To address this aim, the study seeks to collect and evaluate empirical evidence on the extent to which revalidation is fulfilling six regulatory aims, with six corresponding research questions, developed as part of an evaluative framework by the CAMERA research group with the GMC in 2013.[10]

The UMbRELLA study addresses these six main research questions (RQs), as shown in Table 1, which are further broken down into 25 constituent sub-questions, mapped against revalidation's component activities.

Table 1: Research 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?**
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 Responsible Officers (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?**

This interim report reviews progress to date of the UMbRELLA study, presenting emerging findings mapped against these RQs.

1.2 Study design

To address these RQs, research activities were operationalised into seven work packages, organised by methods. The work packages, and progress in each of them, are described in more detail below (section 2).

This mixed methods approach allows the research to assess impacts at population level as well as exploring impacts on individual professionals.

1.3 Ethical approval

The study has research ethics approval from the University of Plymouth Faculty of Health & Human Sciences and Peninsula Schools of Medicine and Dentistry Research Ethics Committee (application ref: 14/15-390; amendment ref: 14/15-443).

1.4 Patient and Public Involvement Forum

The UMbRELLA study is supported by a Patient and Public Involvement (PPI) Forum. The Forum is made up of PPI representatives involved in medical revalidation nationally and regionally. The Forum is responsible for overseeing the design, implementation and evaluation of all PPI aspects of both the UMbRELLA study and a separate Department of Health (England) funded revalidation evaluation study. It has played an active role in the development and delivery of the UMbRELLA research, and has for example contributed to the development of survey questionnaires. The Forum meets quarterly.

2 Research Progress

This section of the report briefly summarises progress to date against the selected methods in each of the seven work packages.

2.1 Work package 1: Literature reviews

The study includes a series of literature reviews which have been designed to address particular aspects of revalidation as it has been implemented.

2.1.1 Supporting information

2.1.1.1 Patient feedback

A systematic review with narrative synthesis is being conducted to explore the use and application of patient feedback internationally. This review, which builds on earlier work by the CAMERA research group exploring PPI in regulation,[11] looks broadly at 'patient feedback'. It is going beyond a definition solely focused on questionnaire data, to consider the value of complaints, compliments, letters, and online reviews, as potential feedback data for doctors in practice.

2.1.1.2 Multisource feedback (MSF)

A systematic review with a mapping synthesis is currently reaching a conclusion in exploring the evidence for, and importantly the gaps in, our understandings of the utility of multisource feedback. Building on earlier work by CAMERA researchers,[12] work is underway to explore the relationship between MSF and relationships, both personal and professional, within clinical teams. This work, as part of an NIHR funded PhD, will seek to inform this evaluation in due course in helping to understand the role of MSF in reflective practice and behaviour change.

2.1.2 Evidence for appraisal

In a separately funded but related piece of on-going research, the CAMERA research group at Plymouth is leading a realist review[13] of medical appraisal.[14] Its emerging findings have already informed the development of interview guides for work package five of the UMbRELLA study and with the end of the review in March 2016, the CAMERA group will be moving shortly to publication of their findings.

2.1.3 ROs and decision-making

The role of Responsible Officers (RO) and their decision-making practices will be explored through empirical research, but it is also the focus of a wide-ranging narrative integrative literature review, focusing on the psychology of judgement and decision-making practices across professional groups and settings. Whilst there is currently no literature on RO decision-making specifically, there is a plethora of literature across various occupational settings highlighting the subjective and often implicit biases that can impact decision-making processes. The occupational settings covered range from those negotiating immediate risk and high levels of uncertainty, such as emergency medical practice, the military, firefighting and aviation; through to environments where risk can be deferred, as with judicial decision-making; or where risk is low but levels of ambiguity remain high (i.e. management and assessment). The review has sought to identify, compare and integrate judgement and decision-making characteristics, across various professional settings; identifying common attributes and working towards a model for RO decision-making. The review will embed our empirical findings in a theoretical understanding of judgement and decision-making, and potentially support the development of further research with ROs. A paper for peer review publication is nearly ready for submission.

2.2 Work package 2: Statistical analyses

This work package entails analyses of linked anonymised datasets relating to registrant characteristics, revalidation decisions, complaints and fitness to practise referrals provided by the GMC, and data detailing appraisal activity in Wales and Scotland. These latter datasets have been provided by the Wales Deanery from its Medical Appraisal and Revalidation System (MARS) and by NHS Education for Scotland from its Scottish Online Appraisal Resource (SOAR).

In 2016, descriptive and inferential statistical analyses will be undertaken to explore appraisal rates, revalidation decisions and trends in fitness to practise data by demographic and professional characteristics.

2.3 Work package 3: Surveys

In 2015, UMbRELLA conducted three surveys targeting key stakeholder groups:

- Doctors as appraisees and appraisers
- Responsible Officers
- Representatives of patient interest groups and lay representatives

All survey questionnaires were developed collaboratively with input from key stakeholders including the PPI Forum, and piloted prior to data collection. All questionnaires included best answer, closed response, binary and Likert scale items as well as open 'free text' items.

2.3.1 Doctors as appraisees and appraisers

Between June and August 2015, we undertook a survey of doctors as appraisees and appraisers using email contact details provided by the GMC following an opt-out process. The process resulted in 719 doctors opting not to receive information about the survey. The survey was primarily conducted using a market-leader online survey tool *Qualtrics* with invitation emails sent to 156,610 doctors licensed to practise, excluding those in specialty training (for whom the model of revalidation is different and from whom data will be collected separately through the GMC's National Training Survey 2016). Paper copies of our questionnaire were distributed to 16 doctors who requested this approach. The survey included sections asking about:

- Job role(s), specialties and the healthcare settings in which they worked
- Appraisal history, most recent appraisal experience and views of appraisal
- Experiences of collecting supporting information
- Use of guidance about revalidation, supporting information and appraisal
- Opinions on revalidation
- Experiences as appraisers, where relevant.

The emerging findings of this survey are discussed in some detail in the later pages of this report.

2.3.2 Responsible Officers

An online survey of all 595 ROs from across the UK was developed and distributed jointly between June and September 2015 by UMbRELLA and a complementary research study examining organisational impacts of medical revalidation in England, funded by the Department of Health Policy Research Programme.[15] This survey was distributed and will be

reported in full by researchers at Manchester Business School. The survey asked ROs to describe the policies and processes in place in their designated body or bodies to support or inform revalidation, and also asked about their role as RO and how they make revalidation recommendations to the GMC.

2.3.3 Representatives of patient interest groups and lay representatives

An online survey was used to explore how PPI is understood, used and experienced in the revalidation of doctors from the perspective of patient representatives and organisations. Preliminary survey questions were identified and designed on the basis of our underlying RQs combined with emerging themes from the doctor survey data. A draft survey was designed and distributed to members of the PPI forum as a pilot.

The final survey used a multitude of closed and statement questions requiring a Likert scale response. A number of 'free text' questions were also included to supplement these questions and gain greater insight through the thematic analysis of responses.

The survey was distributed between November 2015 and January 2016 through established networks of the PPI forum, relevant stakeholders and signatories of the statement of support,[16] again using online survey tool *Qualtrics*. Individuals who were unable to access the online survey were sent a paper version.

2.4 Work packages 4, 5, and 6: Recruitment of participants for in-depth qualitative work

During the survey of doctors, respondents were asked if they would like to receive information about participating in further research activities. These include having their appraisal meeting recorded, being interviewed about their appraisal experiences and for their appraiser to be interviewed. For doctors in Scotland and Wales – where we are able to access data via the MARS and SOAR systems – we have also sought consent to access appraisal portfolios.

Potential participants were able to consent to take part in the three aspects of the research separately. The numbers of participants who have expressed an interest in taking part are shown in Table 2.

Table 2: Appraisees recruited to participate in qualitative work

	Number of participants recruited
Appraisal recording	169
Interviews	239
Documentary analysis	28

The target for the study is to collect 90 linked appraisal and interview datasets, with 20 also linked to their documentation. Actual data collection in these streams of work is underway and will continue into 2017. So far, we have undertaken interviews with 48 appraisees and 23 appraisers, and have recorded 30 appraisal meetings.

Interviews are also planned with ROs and GMC Employer Liaison Advisers (ELAs). The qualitative research will produce rich datasets which will complement the survey data and secondary data analyses.

2.5 Work package 7: Root cause analysis of fitness to practise referrals

The final work package of the study is currently being finalised and implemented. We plan to review the appraisal portfolios of doctors prospectively referred to GMC fitness to practise procedures and identify whether the portfolios contain indications of any concerns about their practise. This part of the study would be conducted in Wales and Scotland using data held in the MARS and SOAR systems drawing on root cause analysis methodologies.

3 Emerging findings

In this section of the report we present early findings, mapped against the six core research questions. The findings reported here are not final. Analyses of these data as well as new empirical research are ongoing.

Findings from our survey are reported here in frequency tables – which simply count the responses received for each answer option to a question - and in some cases as cross tabulations showing responses broken down by selected respondent characteristics. The focus on subgroup analyses is driven by our research questions, which ask whether doctors' experiences vary according to respondent characteristics, such as ethnicity or main job role. These analyses especially are reported in their infancy and should be interpreted with care.

In places, free text responses allowed respondents to select an 'other' answer option and write in their response. In addition, the surveys contained a number of open 'free text entry' questions which sought to gather further detailed information about respondents' experiences or views. Full thematic analyses of these free text data are on-going, but where appropriate some examples of issues arising have been provided.

3.1 Descriptive statistics

3.1.1 Doctor survey response profile

The descriptive statistics presented in this report are based on those doctors that fully completed the survey. 26,171 doctors of 156,610 invitees responded providing a response rate of 16.7%. A comparable recent online survey distributed to 95,636 members of the British Medical Association, generated an 8.3% response rate.[17] Doctors are a frequently surveyed participant group, and response rates have typically declined in recent years.[18 19] Other surveys focused on revalidation specifically have reported data from 2,499 appraisees and 719 appraisers,[20 21] and from 1,066 General Practitioners.[22]

Although perhaps achieving less response than other more resource intensive survey methodologies may have, such as mail only or mixed modes of delivery,[19] our online survey produced an extensive dataset about doctors' experiences and views of appraisal and revalidation. Whilst surveys with fewer than 1,000 participants produce higher response

rates,[23] the census approach to survey distribution importantly sought to open participation in this evaluation of revalidation to as many doctors as possible. A detailed analysis comparing the proportions in each subgroup between the population and survey respondents has shown that the characteristics of the 16.7% sample achieved are broadly representative of the profession as a whole.

Initial analyses of the data compared the demographic and professional profile of survey respondents to that of the total population, using registrant data from the GMC for all doctors on the survey mailing list. These data were linked to our survey data using the anonymised UIDs. We compared the profile of respondents to the whole population, and also compared the profile of respondents to that of non-respondents. Differences in proportions of each demographic subgroup between the survey data and the mailing list, and between respondents and non-respondents, were small. For example, Tables 3 and 4 below, show the comparison between the survey respondents (responders), those who did not respond (non-responders), and the whole population (total mailing list) when looked at by sex and by age bands.

Table 3: Proportion data for responders, non-responders and the total population by sex

Sex	Responders %	Non-responders %	Total population (mailing list) %	Difference between profiles of responders and non-responders	Difference between profiles of responders and population (mailing list)
Female	41.36	41.86	41.77	-0.5	-0.41
Male	58.64	58.14	58.23	0.5	0.41

Table 4: Proportion data for responders, non-responders and total population by age

Age Group	Responders %	Non-responders	Total population (mailing list) %	Difference between profiles of responders and non-responders	Difference between profiles of responders and population (mailing list)
Under25	0.01	0.01	0.01	0.00	0.00
25-29	2.13	4.51	4.11	-2.38	-1.98
30-34	6.22	10.97	10.18	-4.75	-3.96
35-39	12.40	18.61	17.57	-6.21	-5.17
40-44	14.90	19.45	18.69	-4.55	-3.79
45-49	15.22	15.54	15.49	-0.32	-0.27
50-54	16.42	12.73	13.35	3.69	3.07
55-59	15.38	9.05	10.11	6.33	5.27
60-64	9.19	4.96	5.67	4.23	3.52
65-69	5.19	2.64	3.07	2.55	2.12
70+	2.93	1.54	1.77	1.39	1.16

Given the small differences in proportions of subgroups and our on-going focus on subgroup analyses to explore variations in experiences and views and associations with respondent characteristics, no weighting was applied to the survey data. This decision was confirmed by analysing a selection of question responses using unweighted data and data weighted for all respondent characteristics. Both sets of analyses returned comparable results. More details about the preparatory work leading to this decision can be found on our website at: www.umbrella-revalidation.org.uk.

In the initial phase of survey analysis, we produced frequency tables giving the number and breakdown of responses for each question. Most questions were not compulsory, and participants were in places routed through the survey depending on their responses to key questions. Therefore the number of responses to each question varies. The percentages reported relate to responses to the individual question being reported, not total responses to the survey overall. As the survey response is not random calculating confidence intervals would be inappropriate. However, for information purposes and to give an estimate of the uncertainty around the results, the 95% confidence interval for any percentages reported here – if the sample were random – would be no wider than ±0.55%. Due to the large sample size, small differences are statistically significant, therefore we have focused on reporting materially significant differences.

Cross tabulation analyses were performed on the data, initially focusing on eight key respondent characteristics. These analyses were carried out on a combination of characteristics provided by the GMC (respondents' age, sex, country[2], place of primary medical qualification (PMQ) and prescribed connection) and data collected in the UMbRELLA survey (ethnic group, main role, and specialty group).

Of the survey respondents, 58.6% (15,346/26,171) were male and 41.4% (10,825/26,171) were female. The majority (24,957/26,171 = 95.6%) had a prescribed connection to a designated body for revalidation, whilst 4.6% (1,214/26,171) did not. Just over half the respondents (14,854/26,171 = 56.8%) had obtained their PMQ in the UK, with 28.9% (7,550/26,171) being International Medical Graduates (IMGs) and 14.4% (3,765/26,171) qualified in the European Economic Area (EEA).

Tables 5 - 9 below summarise the breakdown of survey respondents by age, country, ethnic group, main role and specialty group.

Table 5: Survey respondents by age

Age (10 year bands)	Frequency	Percent
20-29	560	2.2
30-39	4,871	18.9
40-49	7,867	30.6
50-59	8,101	31.5
60-69	3,585	13.9
70 and over	743	2.9
Total	25,727	100.0

Table 6: Survey respondents by Country

Country	Frequency	Percent
England	20,149	77.0
Northern Ireland	546	2.1
Scotland	2,183	8.3
Wales	1,173	4.5
Other or unknown	2,120	8.1
Total	26,171	100.0

[2] The GMC derives the location data from the address of each doctor's workplace. Where that address cannot be linked to a part of the UK or a region of England, the address at which the doctor is attached for revalidation or the correspondence address held for that doctor is used instead.[24]

Table 7: Survey respondents by main role

Main Role	Frequency	Percent
Associate Specialist	925	3.6
Consultant	10,320	40.5
Staff grade/Specialty doctor	2,694	10.6
Trust Grade	928	3.6
Resident Medical Officer	280	1.1
GP partner/principal	4,318	16.9
Salaried GP	1,411	5.5
Sessional GP	317	1.2
Locum GP	1,120	4.4
Locum (all other roles)	861	3.4
Management/leadership	368	1.4
Medical Legal Adviser	93	0.4
Other non-clinical role	177	0.7
Other – None of the above	1,696	6.6
Total	25,508	100.0

Table 8: Survey respondents by specialty group

Specialty Group	Frequency	Percent*
Anaesthetics and intensive care	2,370	9.3
Emergency medicine	1,259	4.9
General practice	7,742	30.4
Medicine	3,190	12.5
Obstetrics and gynaecology	956	3.8
Occupational medicine	499	2.0
Ophthalmology	613	2.4
Orthopaedics	958	3.8
Paediatrics	1,499	5.9
Pathology/laboratory medicine	617	2.4
Psychiatry	1,908	7.5
Public Health	399	1.6
Radiology	798	3.1
Surgery	1,964	7.7
Other	3,603	14.2

Participants were able to select multiple answers. Fourteen options were available mapped to SoMEP,[17] plus an 'other' option with free text entry space.

Table 9: Survey respondents by ethnic group

Ethnic group	Frequency	Percent
White	16,531	63.2
Asian	5,214	19.9
Undeclared	2,219	8.5
Black	813	3.1
Mixed	516	2.2
Other	878	3.4
Total	26,171	100.0

On-going analyses of these data will develop more sophisticated interferential analyses to consider associations between registrant characteristics and experiences of or opinions about appraisal and revalidation.

3.1.2 RO survey response profile

The RO survey was fully completed by 374 of the 595 ROs invited from across the UK; a response rate of 62.9%. The response rate was not significantly different between the different countries, or between the different regions within England. There was however a lower response rate from responding ROs responsible for designated bodies with less than 20 doctors connected with them. The response rate was also higher for ROs of public sector DBs compared with ROs of DBs not in the public sector, but further analysis suggests that this was an indirect effect due to there being a smaller proportion of small DBs in the public sector. Response rates were also lower for responding ROs responsible for locum agencies and for hospices.

3.1.3 PPI Survey response profile

A total of 41 participants responded to the PPI survey. Some were lay representatives (19/41) and others were members of an organisation but representing their own views (17/41). A few employers (1/41) or organisational representatives responded expressing the views of their organisation (4/41).

3.2 RQ1: 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?

Revalidation seeks to bring all doctors licensed by the GMC into a governed system, extending proactive regulatory oversight across the lifespan of medical careers. Appraisal is the key element of revalidation which should be consistent for all doctors based on the GMC's guidance, and the one place where all doctors must essentially present the same evidence to the same standards. It is therefore a central focus in evaluating revalidation's ability to assure doctors' fitness to practise and that this is achieved similarly for all doctors.

The GMC is subject to the Public Sector Equality Duty set out in the Equality Act 2010, and must therefore seek to ensure that its activities do not impact disproportionately on groups of registrants sharing protected characteristics. Many of the study's research sub-questions ask if revalidation evaluates doctors' fitness to practise. Furthermore, we seek to determine whether revalidation is experienced similarly by doctors, as it has been implemented, or whether there are differences which can be linked to particular characteristics, such as job role, work setting, or shared protected characteristics.

Key findings:

1. 41.8 % (9,833/23,514) of responding doctors agreed or agreed strongly that appraisals are an effective way to improve their clinical practice compared to 30.7% (7,231/23,514) who thought that they are not effective in this regard, with the remainder neither agreeing nor disagreeing.
2. Less than a third of respondents (8,412/25,983 = 32.3%,) believed that revalidation has had a somewhat or very positive impact on the appraisal process, with marginally fewer believing that it has had a somewhat or very negative impact (7,870/25,983 = 30.3%) and the remainder believing that the impact has been neither positive nor negative (9,701/25,983 = 37.3%).
3. Since the introduction of revalidation 37.3% (7,235/19,435) of responding doctors spend more time on activities that inform their appraisal. Only one fifth (3,850/19,435 = 19.8%) spend less time and 43% (8,350/19,435) report no difference.
4. Respondents in most job roles (18,047/23,179 = 78% of the sample) had appraisal rates of 90% or higher. Roles such as staff grade doctors had slightly lower rates (2,203/2,694 = 81.8%), whilst non-primary-care locums and trust grade doctors had relatively low rates (602/861 = 69.9% and 593/928 = 63.9%).
5. There is an important minority of respondents (2,120/26,169 = 8.1% of the whole cohort) with a licence to practise but with no known UK location, who had much lower rates of participation in appraisal (931/2,120 = 43.9%); compared with 94.4% (22,706/24,049) of respondents in the UK.

3.2.1 Appraisal participation

In our sample, 90.3% (23,637/26,171) of respondents stated that they had had a medical appraisal at some point in their career. Of those doctors, 94.5% (22,286/23,579) had done so within the previous 12 months and 98.9% (23,314/23,579) within the previous 24 months. This compares with figures from the last Annual Organisational Audit (AOA) analysis which showed that 86.2% of doctors had had an appraisal in England in the financial year 2014-15.[25]

Appraisal rates varied significantly between UK and non-UK respondents. Only 43.9% (931/2,120) of responding doctors, who were licensed to practise in the UK but with no known UK location – where the GMC does not hold details of a UK address or designated body, reported that they had ever had an appraisal compared with 94.4% (22,706/24,049) of respondents in the UK.

The reasons doctors gave for never having had an appraisal are summarised in Table 10.

Table 10: Why have you not yet had a medical appraisal?

Reasons	Frequency	Percent
I am new to the UK	1,105	44.0
I have recently completed training	339	13.5
I have taken a break and my appraisal has never happened as a result	139	5.5
Appraisal is not offered by my employer(s)	118	4.7
I have postponed my appraisal	91	3.6
I have been unable to schedule an appraisal	80	3.2
I am approaching retirement	30	1.2
My employer has postponed my appraisal	24	1.0
Other	587	23.4
Total	2,513	100.0

Explanations of the 'other' reasons were provided by 569 respondents. These revealed that the main reason for not having had an appraisal – given by almost half of these respondents – was that the doctor practised abroad. This group of doctors was composed of UK nationals who have moved abroad to work and non-UK nationals who had trained and/or practised in the UK and later returned to their country of origin or a third location. Our sample contains 2,120/26,169 doctors (8.1%) in all without a known UK location.

Responding doctors who graduated in the UK were more likely to have ever had an appraisal (14,378/14,853 = 96.8%) than those who graduated outside the UK (IMG: 6509/7,550 = 86.2%; EEA: 2,750/3,764 = 73.1%). Unsurprisingly, respondents were more likely to have ever undertaken an appraisal if they had a prescribed connection for the purposes of revalidation (prescribed connection and ever had an appraisal: 23,006/24,955 = 92.2%) compared to those without a prescribed connection (no prescribed connection and ever had an appraisal 631/1,214 = 52.0%).

Most respondents when grouped by their main role achieved appraisals rates above 90% but some important groups reported lower appraisal rates (Table 11).

Table 11: What is your main role and have you ever had an appraisal?

Doctor's main role	Have you ever had an appraisal?	
	Yes	No
Consultant	9,833 (95.3%)	487 (4.7%)
Associate Specialist	863 (93.3%)	62 (6.7%)
Staff grade/Specialty doctor	2,203 (81.8%)	491 (18.2%)
Trust Grade	593 (63.9%)	335(36.1%)
Resident Medical Officer	168 (60.0%)	112 (40.0%)
GP partner/principal	4,276 (99.0%)	42 (1.0%)
Salaried GP	1,348 (95.5%)	63 (4.5%)
Sessional GP	307 (96.8%)	10 (3.2%)
Locum GP	1,066 (95.2%)	54 (4.8%)
Locum (all other roles)	602 (69.9%)	259 (30.1%)
Management/leadership	354 (96.5%)	13 (3.5%)
Medical Legal Adviser	83 (89.2%)	10 (10.8%)
Other non-clinical role	142 (80.2%)	35 (19.8%)
Other. Please write in:	1,341 (79.1%)	355 (20.9%)
Total	23,179 (90.9%)	2,328 (9.1%)

Rates also varied across healthcare setting, with lower rates of ever having had an appraisal for responding doctors recently retired from medical practice (449/648 = 69.3%), followed by those working in public health (602/880 = 74.5%), medical research (1,925/2,260 = 85.2%), secondary/tertiary care (12,495/13,960 = 89.5%), industry (309/340 = 90.9%), the armed forces (286/312 = 91.7%), community health services (1,157/1,252 = 92.4%), medical education (3,871/4,153 = 93.2%), to a lesser extent mental health (1,824/1,917 = 95.1%) and occupational health (582/612 = 95.1%) and the highest appraisal rates going to primary

care – general practice (7,510/7887 = 95.2%). The possibility of such variations in appraisal across medical specialties has been raised before.[26]

3.2.2 Appraisal experience

Of those who had had an appraisal within the last twelve months, only a minority of respondents selected their own appraiser (8,541/23,579 = 36.2%). Of those who did, the majority felt that they could find an appropriate appraiser (8,162/8,536 = 95.6%). Appraisal meetings mainly took place face to face (22,763/23,580 = 96.5%) with the remainder conducted by video-link (553/23,580 = 2.3%), telephone (85/23,580 = 0.4%), or by other means (179/23,580 = 0.8%). On average respondents spent 3 hours a week on activities that informed their appraisal (mean = 5.8 hours, median 3.0 hours, SD = 12.5 hours, taken from sample n=20,342), such as undertaking CPD and quality improvement tasks. The hours spent on various aspects in preparation for their actual appraisal are summarised in Table 12.

Table 12: Average time spent in hours on specific activities directly related to preparation for or attendance at most recent appraisal

Hours	N	Mean	Median	SD
Collate supporting information prior to appraisal	22,997	13.0	6.0	30.8
Complete appraisal paperwork	22,956	9.0	5.0	15.8
Travel to and from the appraisal meeting	21,817	1.4	0.5	4.6
Attend the appraisal meeting	22,793	2.0	2.0	0.9
Complete and /or agree the appraisal summary	22,568	1.0	1.0	0.9

Responding doctors' perceptions of appraisal were positive overall when asked their agreement to a series of key statements as summarised in Figures 1 and 2.

Figure 1: Respondents' agreement with statements about most recent appraisal

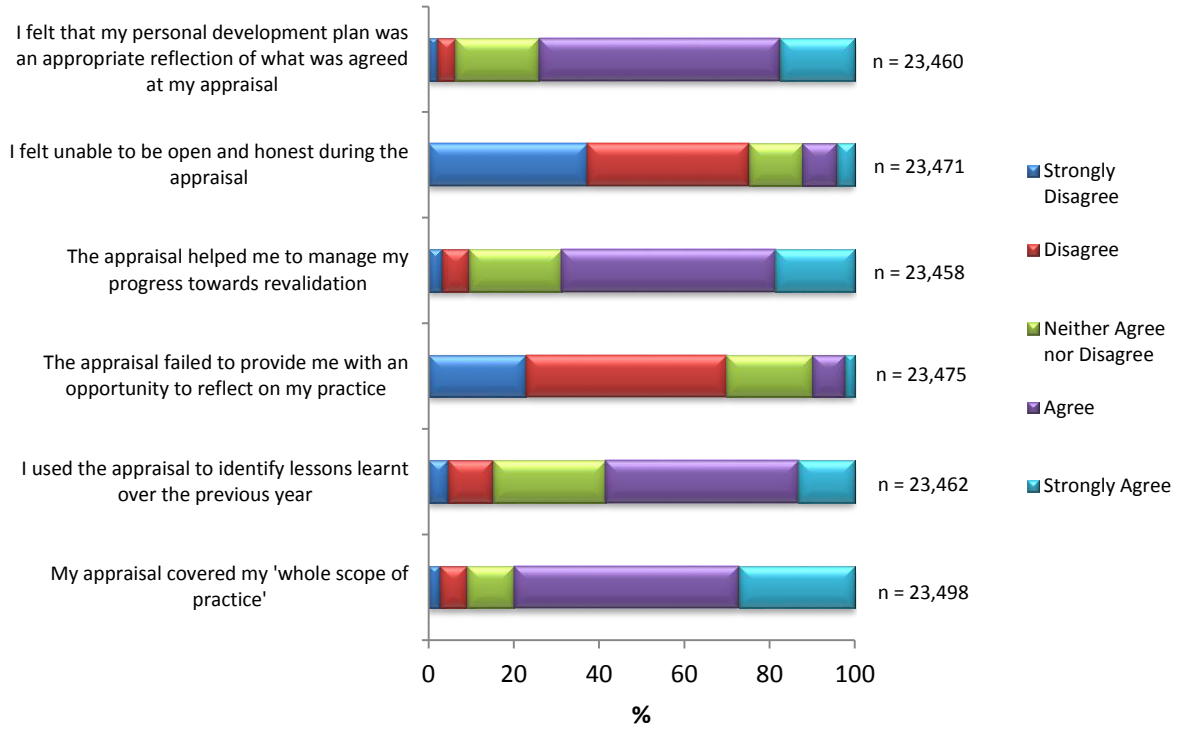
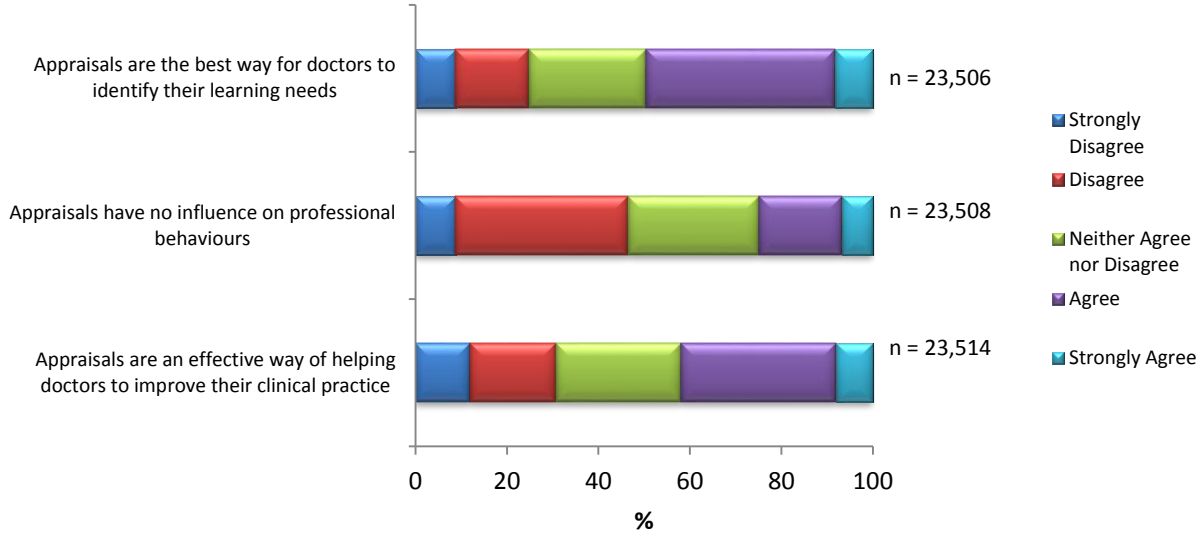


Figure 2: Respondents' agreement with statements about overall appraisal experience



3.2.3 Impact of revalidation on appraisal

Overall, responding doctors were divided when asked about their opinion of the positive or negative impact of revalidation on appraisal, see Table 13.

Table 13: Doctors' opinions about the impact of revalidation on the appraisal process

Impact of revalidation	Frequency	Percent
Very negative	2,619	10.1
Somewhat negative	5,251	20.2
Neither negative nor positive	9,701	37.3
Somewhat positive	6,664	25.6
Very positive	1,748	6.7
Total	25,983	100.0

Of the 26,171 doctors who completed the survey, 19,435 (82.5%) had been appraised within the 12 months preceding the survey and had also undergone appraisal prior to the introduction of revalidation. Overall respondents felt the demands of appraisal – in terms of time spent on activities connected to it - has increased since the implementation of revalidation. They reported that, prior to the implementation of revalidation; they spent less time or the same amount of time on activities informing their appraisal – such as attending CPD or undertaking audit or QI activity – than they do currently. They also reported spending less time prior to the introduction of revalidation on those activities directly related to appraisal preparation and attendance at appraisal, such as collating their portfolios and completing documentation (see Table 14).

Table 14: Comparison between time spent prior to appraisal and time spent now, on activities that informed appraisal and activities directly related to appraisal preparation and attendance

		Time spent prior to revalidation				
	N	A lot less	A little less	Neither less nor more	A little more	A lot more
Activities that informed appraisal	19,435	3,105 (16.0%)	4,130 (24.3%)	8,350 (43.0%)	1,968 (10.1%)	1,882 (9.7%)
Activities directly related to appraisal	19,421	4,862 (25.0%)	3,969 (20.4%)	5,814 (29.9%)	2,107 (10.8%)	2,669 (13.7%)

3.3 RQ2: 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?

Revalidation requires that doctors collect a portfolio of supporting information (SI) about their practice, for discussion at their appraisal meetings. The SI is intended to allow doctors to demonstrate their fitness to practise and to assist them in reflecting upon their practice. The GMC mandates that doctors must submit supporting information across six categories: continued professional development; quality improvement activity; significant events; feedback from colleagues; feedback from patients; and a review of complaints and compliments.

The expected frequency of submission varies across the six categories. Doctors should submit information about their CPD activities every year, whilst patient and colleague feedback is generally required at least once per five year cycle. Significant events and a review of complaints and compliments should be included in appraisal discussions when they have arisen.

The GMC and other organisations, such as employers, professional associations and Royal Colleges, provide guidance and in some cases mechanisms by which doctors can collect SI.

Key findings:

1. Responding doctors overwhelmingly used GMC guidance and found it helpful (18,523/24,937 = 74.3%).
2. In line with what might be expected, some clinical specialties had lower rates of patient feedback submission, e.g. public health (25.3%, n=92/364) and pathology doctors (20.6%, n=118/574) compared with rates in surgery (70.5%, 1,111/1,576); while others continued to find patient feedback difficult to collect especially in anaesthetics (689/1263 = 55.6% reporting difficulties), psychiatry (556/1,123 = 49.5%) and emergency medicine (281/627 = 44.8%).
3. When patient feedback was available, respondents found it the most helpful type of SI in terms of reflecting on their practice (patient feedback extensively helpful for

reflection 21.5% (2,901/13,467), colleague feedback 19.8% (3,023/15,285), and significant event analysis 17.5% (2,972/17,022).

3.3.1 Supporting information: submission rates

Table 15 shows the frequency with which 9 different types of supporting information (SI), plus an 'other' option, were submitted by doctors as part of their last appraisal. These categories include the six types of SI required for revalidation by the GMC, plus additional SI suggested by stakeholder groups. There is a notable range in the data between the most submitted types of SI - record of CPD and the PDP - and the least commonly submitted type of SI, patient feedback. These findings are in line with GMC policy where only CPD is required at each and every annual appraisal.[27]

Table 15: Types of SI submitted for 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

** Column sum > 100% since doctors submit more than one type of SI (N = 23,565).*

When considering SI submission rates in relation to respondent characteristics, there were some differences observed across the different groups. While further analyses are ongoing there are some trends in relation to respondent characteristics, such as main role, specialty, or the healthcare setting in which a doctor practises and the types of SI submitted. For example, for Significant Events Analysis (SEA), the submission rate for general practice as a specialty group was high at 93.8% (6,691/7,453) whilst for secondary care specialties the rates ranged from 60.6% (radiology, 421/695) to 74.3% (obstetrics and gynaecology, 628/845). There were low submission rates for respondents in 'non-clinical'/non-patient facing specialty groups such as pathology (302/574 = 52.6%) and public health (180/364 = 49.5%).

The full data are summarised in Table 16 but unsurprisingly perhaps the non-patient facing specialties had far lower rates of submission for patient feedback, with 20.6% (118/574) of respondents in pathology and 25.3% (92/364) of those in public health, than those respondents working directly with patients.

Table 16: Feedback from patients per specialty group

Specialty group	Frequency	Percent*
Anaesthetics and intensive care	1,272	58.5
Emergency medicine	634	62.9
General practice	3,766	50.5
Medicine	1,631	60.6
Obstetrics and gynaecology	602	71.2
Occupational medicine	300	62.9
Ophthalmology	383	73.4
Orthopaedics	584	72.5
Paediatrics	833	62.4
Pathology/laboratory medicine	118	20.6
Psychiatry	1,134	62.5
Public health	92	25.3
Radiology	405	58.3
Surgery	1,111	70.5
Other	1,914	59.9

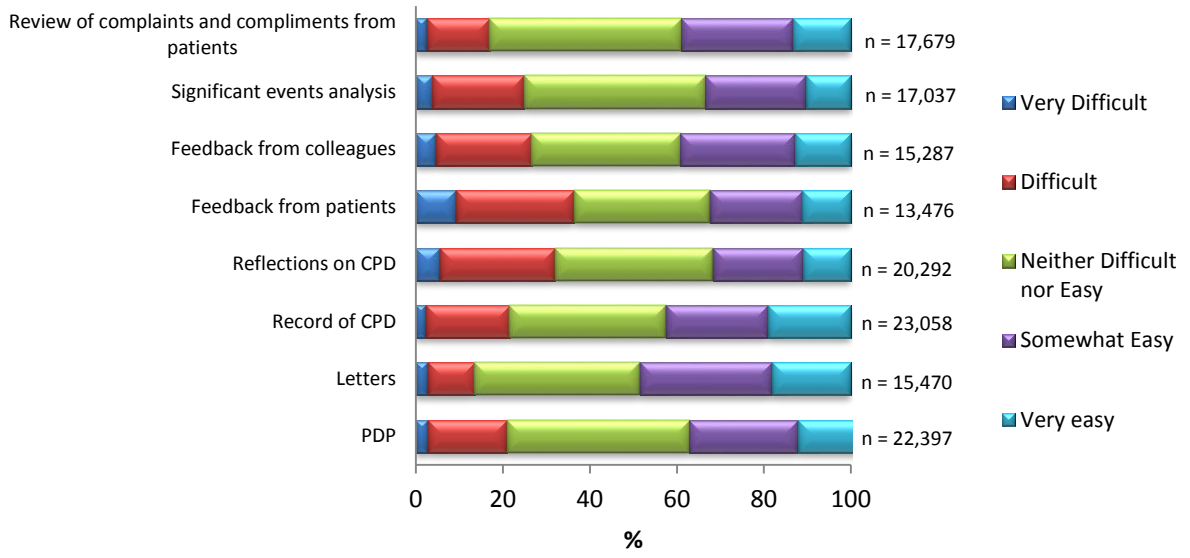
** Column sum > 100% since doctors can select more than one specialty*

It is clear from our survey data that respondents often submit SI as part of their appraisal portfolio which falls outside the six categories required by the GMC. An analysis of a sample of 10% (n=876) of the free text comments given by respondents, revealed that responding doctors also submitted informal feedback from colleagues, patients or management (often in the form of letters, cards or emails), work-based data such as performance figures, workload data, prescribing data and evidence relating to other roles (for example as an Educational Supervisor, appraiser or Responsible Officer).

3.3.2 Supporting information: ease or difficulty of collection

Levels of difficulty in collecting supporting information varied according to the type of SI, as shown in Figure 3.

Figure 3: Difficulty ratings for collecting different types of SI



When considering the experiences of submitting SI in relation to respondent characteristics there were some differences observed across the different groups. While further analyses are ongoing it is worth highlighting that for example; respondents in some specialty groups more frequently reported difficulties in collecting patient feedback (Table 17). For instance some degree of difficulty was reported by 54.6 (689/1,263) of those working in anaesthetics and intensive care, by 49.5% (556/1,123) of those in psychiatry, and 44.8% (281/627) of those in emergency medicine.

Table 17: Difficulty of collecting patient feedback by specialty group

Specialty group	Somewhat or Very Difficult	
	Frequency	Percent
Anaesthetics and intensive care	689	46.7
Emergency medicine	281	39.6
General practice	1,407	28.3
Medicine	533	31.7
Obstetrics and gynaecology	137	27.0
Occupational medicine	88	26.3
Ophthalmology	109	30.4
Orthopaedics	148	27.5
Paediatrics	261	31.3
Pathology/laboratory medicine	38	11.7
Psychiatry	556	44.2
Public health	33	13.8
Radiology	133	29.1
Surgery	311	30.7
Other	608	29.2

On examining a sub-sample of free text responses in relation to patient feedback, the most prominent barriers reported by respondents to its collection, were again those related to the respondent's speciality, role and/or setting. Anaesthetists, pathologists, psychiatrists, those working in palliative/hospice care, intensive/emergency care and those not in a predominantly clinical role (e.g. academics) or without a regular place of work (e.g. locums) repeatedly detailed how both their role/speciality and associated characteristics of their patients (e.g., mental health, age, etc.) inhibited patient feedback collection and in some cases perceived value:

> 'I am an anaesthetist, so it is difficult for patients to separate and remember my role with their journey through surgery. In ICU again many of my patients are comatosed, may spend a long time recuperating and again teasing out and remembering me is difficult for them.' (UID 9314000)

Where respondents had collected patient feedback, a significant minority (4,445/13,537 = 32.8%) had distributed the questionnaires themselves. This seemingly conflicts with advice given to organisations by the GMC[27 28] which state that patient feedback questionnaires should be administered independently of doctors.

In some instances, distributing the questionnaires personally was the respondent's solution to a poor response from patients:

> ‘My solution was to inform the patients of the purpose and importance of the questionnaire and that I regarded their co-operation as a favour to me. (UID 304419)

And an opportunity to persuade:

> ‘[I have] to emotionally blackmail some of them into giving up their time to do it’. (UID 66316448)

Other responding doctors relied on colleagues but perceived this as a hindrance to response rates and patient understanding:

> ‘I depended on admin staff to hand out and collect the forms which they would often forget to do. The patients needed help in reading the forms on occasion so that these patients tended not to complete them.’ (UID 1304866)

Some respondents stated that the overall patient feedback process and specifically the tools (questionnaires) were limited by selection and response bias. Selection bias was a result of patient characteristics, for example:

> ‘Questionnaires were developed to be filled in on-line and many elderly patients were unable to access this’ (UID 13306494)

> ‘A significant proportion of my patients, that I see, do not speak, read or write English hence it was difficult to get a fair representation of the patient group.’ (UID 3341791)

Response bias was also a concern as some responding doctors believed that patients may have felt it necessary to give positive feedback:

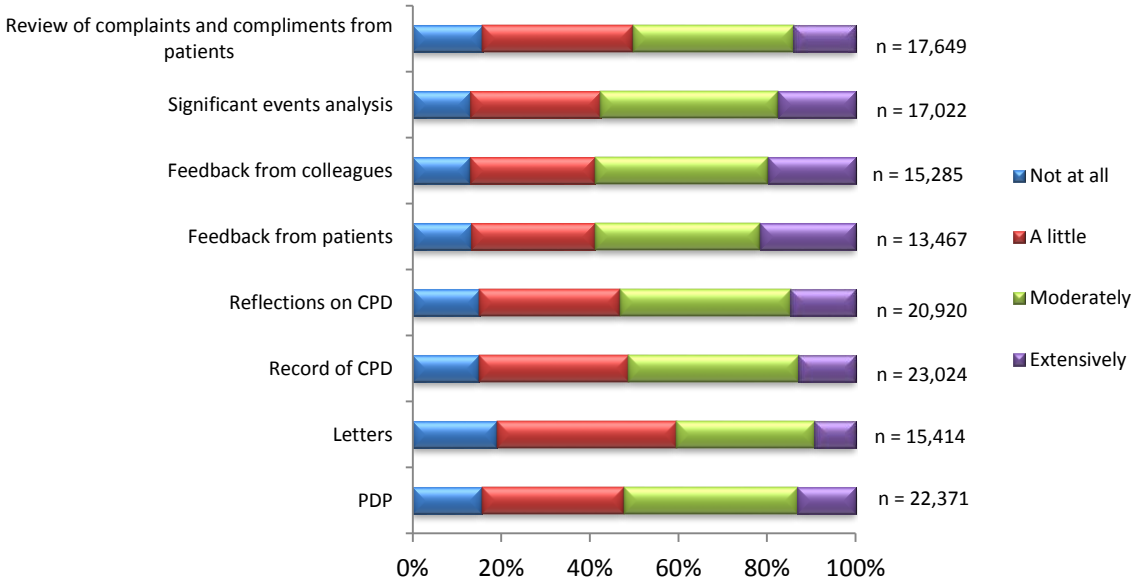
> ‘It was difficult for the patients to give negative feedback as they were asked to hand the forms back in person.’ (UID 1304866)

3.3.3 Supporting information: reflection on practice

Patient feedback was the type of SI which the highest proportion of respondents reported experiencing some degree of difficulty in collecting. Despite this, it was also one of the types

of SI which was most frequently rated as having enabled reflection on practice (Figure 4). Colleague feedback and SEA were also highly rated in this regard.

Figure 4: Shows how different types of SI helped doctors reflect on their practice

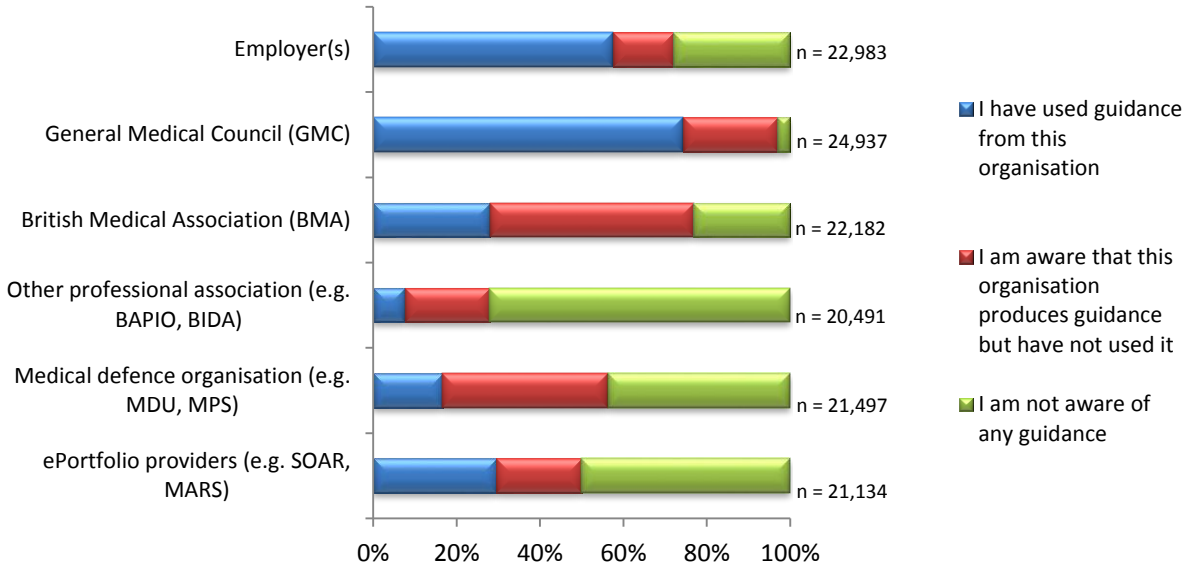


Across all SI categories, a higher percentage of UK qualified than EEA qualified and IMG respondents rated SI as 'not at all' useful for helping them to reflect upon their practice. For the recording of CPD, 18.6% (2,624/14,090) of UK qualified respondents selected this option in comparison to 13.6% (354/2,601) of EEA qualified respondents and 7.6% (481/6,333) of IMGs. Evidence of QI activity was rated as 'not at all' useful for reflection by 17.1% (2,121/12,438) of UK qualified respondents, 14.0% (313/2,234) of EEA qualified respondents, and 8.2% (464/5,662) of IMGs. 14.9% (1,648/11,066) of UK qualified respondents selected this option for SEA, compared to 12.9% (211/1,637) of EEA qualified respondents and 8.4% (363/4,319) of IMGs, and for colleague feedback the percentages were 15.4% (1,321/8,558) for UK qualified respondents, 12.1% (234/1,931) for EEA qualified respondents, and 9.0% (430/4,796) for IMGs.

3.3.4 Guidance about supporting information, revalidation, and appraisal

Our survey findings evidence how far responding doctors are aware of and make use of guidance from the GMC and other bodies such as employers, professional associations and Royal Colleges, with overall figures shown in Figure 5 below.

Figure 5: Doctors' use and awareness of guidance about revalidation and appraisal



Where respondents had previously indicated that they were members of any Medical Royal College or Faculty, they were also asked about their knowledge and use of guidance from those organisations. Across the 26 Colleges and Faculties, the percentage of members who had used the organisation's guidance ranged from 22.7% to 89.5% (mean 56.9%). Responding doctors predominately used GMC guidance to help in their preparation for appraisal and revalidation. Table 18 summarises which specific GMC guidance was used.

Table 18: Items of GMC guidance used

Specialty group	Frequency	Percent*
Supporting information for appraisal and revalidation	11,569	62.6
GMP framework for appraisal and revalidation	10,077	54.5
Summary revalidation guidance	8,377	45.3
A guide for doctors to the General Medical Council (Licence to Practice and Revalidation) Regulations 2012	7,861	42.5
I have used GMC guidance, but do not remember the title(s)	5,025	27.2
Meeting our requirements in the first cycle	3,165	17.1
Other	532	2.9

** Column sum > 100% since more than one can be selected (N = 18,523).*

Other items of GMC guidance listed by respondents as having been used included *Good Medical Practice* and its *Duties of a Doctor* subsection, cited by 109 and 15 doctors respectively. A further 54 respondents reported having used the GMC website to look for

information or having had direct contact with the GMC, either through the ELA, presentations made by GMC staff, or individually by telephone, email or letter.

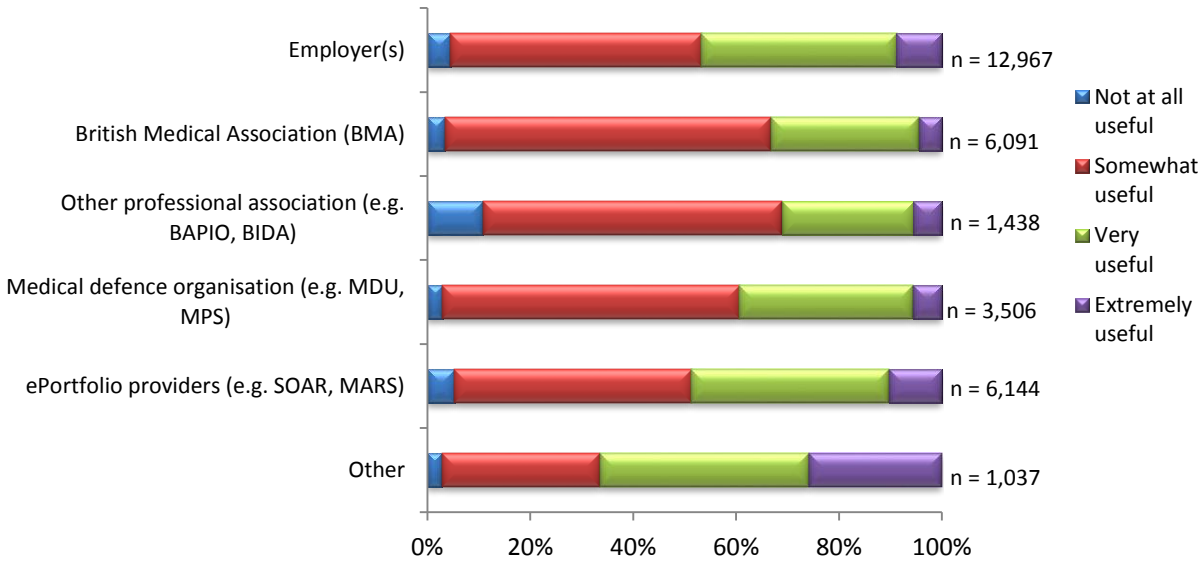
As shown in Table 19 below, a majority of responding doctors rated all items of GMC produced guidance as being useful to some extent.

Table 19: Usefulness of GMC produced guidance

		Percent			
	Frequency	Not at all useful	Somewhat useful	Very useful	Extremely useful
GMP framework for appraisal and revalidation	9,986	2.4	51.5	39.2	6.9
Supporting information for appraisal and revalidation	11,465	2.2	49.0	41.5	7.3
Summary revalidation guidance	8,253	2.5	49.0	41.1	7.4
Meeting our requirements in the first cycle	3,106	3.3	44.4	43.0	9.3
A guide for doctors to the General Medical Council (Licence to Practice and Revalidation) Regulations 2012	7,740	3.2	50.2	39.0	7.6
Other	501	7.0	28.1	37.9	26.9
I have used GMC guidance, but do not remember the title(s)	4,818	4.5	66.3	26.2	3.0

Guidance from other sources was also generally rated as useful to some extent, as shown in Figure 6 below.

Figure 6: Usefulness of guidance from other sources



3.4 RQ3: Is engagement in revalidation promoting medical professionalism by increasing doctors' awareness and adoption of the principles and values set out in *Good Medical Practice*?

Research to address this question is in its initial stages. The findings reported here present responding doctor's opinions on revalidation and its potential to improve standards of practice and to identify doctors whose performance does not meet the standards set out in *Good Medical Practice.* Other findings focus on whether or not responding doctors are making changes to their practice, learning activities or behaviour as a result of appraisal.

Key findings:

1. The majority of responding doctors (13,565/23,547 = 57.6%) reported that they made no change to their clinical practice, professional behaviour or learning activities as a result of their most recent appraisal; compared to those that reported a change (9,982/23,547 = 42.4%). This was particularly the case for older doctors in more senior positions; for example, 64.3% (n=2,211/3,437) of 60-69 year olds reported no change compared to 35.7% (1,226/3,437) who reported a change. Whereas 46.3% (1,731/3,639) of 30-39 year olds reported no change in contrast to the 53.7% (2,008/3,739) reporting a change.
2. There was scepticism amongst respondents that revalidation has led to improved patient safety, with 42.9% (11,136/25,955) disagreeing that it will improve patient safety, compared to 19.5% (5,064/25,955) who agreed it will and 37.6% (9,755/25,955) who neither agreed nor disagreed. Similarly, 46.1% (11,963/25,968) disagreed that failing doctors will be identified through the process compared to 22.9% (5,954/25,968) who thought that this would happen and 31% (8,051/26,968) that neither agreed nor disagreed. Responding doctors held mixed views about revalidation's potential to improve standards of practice: 36.5% (9,468/25,971) agreed it will not do so, compared to 29.6% (7,668/25,971) who thought that it will, and 34% (8,835/25,971) who remained neutral.

Despite the generally positive feedback about appraisal as described above (section 3.2.2), the majority of respondents (13,565/23,547 = 57.6%) did not change any aspect of their

clinical practice, professional behaviour or learning activities (e.g. CPD) as a result of their most recent appraisal. Table 20 shows that older responding doctors appeared less likely to make a change than younger respondents. This relates to lower proportions of those in more senior roles making fewer changes – namely consultants and GP partners/principals (Table 21).

Table 20: Changes to practice, behaviour or learning activities as a result of the most recent appraisal, by age

	Made a change as a result of last appraisal	
Age (10 year bands)	Yes	No
20-29	130 (59.1%)	90 (40.9%)
30-39	2,008 (53.7%)	1,731(46.3%)
40-49	3,262(44.9%)	4,007(55.1%)
50-59	2,966(38.0%)	4,841(62.0%)
60-69	1,226(35.7%)	2,211(64.3%)
70 and over	241(37.5%)	402(62.5%)
Total	9,833(42.5%)	13,282(57.5%)

Table 21: Changes to practice, behaviour or learning activities as a result of most recent appraisal, by main job role

	Made a change as a result of last appraisal	
Doctor's main role	Yes	No
Consultant	3,539 (36.1%)	6,266 (63.9%)
Associate Specialist	397(46.1%)	465 (53.9%)
Staff grade/Specialty doctor	1,302 (59.3%)	894 (40.7%)
Trust Grade	418 (71.2%)	169 (28.8%)
Resident Medical Officer	94 (57.3%)	70 (42.7%)
GP partner/principal	1,616 (37.9%)	2,651(62.1%)
Salaried GP	646 (47.9%)	702 (52.1%)
Sessional GP	133 (43.5%)	173 (56.5%)
Locum GP	495 (46.4%)	571 (53.6%)
Locum (all other roles)	351 (58.6%)	248 (41.4%)
Management/leadership	154 (43.5%)	200 (56.5%)
Medical Legal Adviser	27 (32.9%)	55 (67.1%)
Other non-clinical role	51 (36.7%)	88 (63.3%)
Other. Please write in:	626 (47.2%)	699 (52.8%)
Total	9,849 (42.6%)	13,251 (57.4%)

Reviewing a sample of 10% (n=878) of the descriptions of changes made by those respondents who provided such information identified categories of change as summarised in Table 22.

Table 22: Changes made following appraisal

Change category	Detailed change type	Occurrence in subsample
Area of Change/Improvement	Improved Clinical Knowledge/Practice	183
	Organisation	120
	Career Progression	98
	Communication	71
	Increased CPD	62
	Increased Audit / QIA	50
	Improved PDP	33
	Support Junior Doctors / Staff Members	16
	Understanding of Appraisal and Revalidation	15
	Time Management	9
	Guidance/ Administrative Knowledge	6
	Plan for Retirement	6
Learn from SEA		10
Self-Awareness from Feedback	Communication with Colleagues	54
Receptive to Patients	Communication with Patients	35
Personal Life	More confident	278
	Life Balance	30
Reflection		59

Again, analysis of a sample of 10% of these comments (n=1,154) revealed a series of reasons as summarised in Table 23. The most common reason was that nothing had been identified which required that a change be made.

Table 23: Reasons for not having made changes after most recent appraisal

Reason category	Occurrence in subsample
Nothing identified as requiring change	636
Automatically reflect and make changes	184
Appraisal is a burden	98
Already made required changes	95
Not Applicable	46
Retiring	36
Greater Practice and Service Constraints	28
Bad Appraiser / Appraisal	23
Habit / Too little time / Too much work	23
Not had appraisal	12

Overall responding doctors had mixed feelings about the impact to date, and the potential future impacts, of revalidation (as opposed to appraisal) on practice and behaviour. Generally respondents were sceptical that revalidation has led to improved patient safety, standards of practice and that failing doctors will be identified through the process. The main findings are summarised in Table 24.

Table 24: Opinions about revalidation and its impacts on practice/behaviour

Statements	N	Percent				
		Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Revalidation allows doctors to demonstrate that they are up to date and fit to practise	26,019	11.0	18.4	26.4	37.9	6.2
Revalidation has led to an improvement in patient safety	25,955	16.1	26.8	37.6	16.2	3.3
Revalidation will not improve the standards of doctors' practice	25,971	5.6	24.0	34.0	27.0	9.5
Revalidation will fail to identify doctors in difficulty at an earlier stage	25,968	3.8	19.1	31.0	33.9	12.2

3.5 RQ4: Are revalidation mechanisms facilitating the identification and remedy of potential concerns before they become safety issues or FTP referrals?

The second of revalidation's dual aims – to assure that doctors are both up to date and fit to practise – requires that its mechanisms function to identify potential concerns about practice, and ideally remedy these locally before they become regulatory fitness to practise issues.

Here, we report survey responses from appraisers about appraisal's capacity to identify and address concerns and from ROs about their role in monitoring doctors' on-going fitness to practise.

Key findings:

1. 10.4% (412/3,944) of responding appraisers formally escalated a concern about at least one of their appraisees.
2. 22.5% (887/3,944) of responding appraisers identified concerns about at least one of their appraisees that they did not formally escalate. A majority of these appraisers were able to deal with all such concerns within the appraisal process itself (759/883 = 86.0%).
3. Concerns were most frequently raised about the doctors' lack of reflective practice (45.5% (186/409) of reasons given).
4. Two thirds (170/271 = 62.7%) of responding ROs felt that the number of concerns about doctors had not increased since the start of revalidation; whilst 15.8% (94/271) reported an increase in case load.
5. The most common action taken by ROs when concerns existed about doctors was to deal with them locally (79.5% of responding ROs, n = 276/347).

3.5.1 Appraisal and concerns about practice

The majority of the appraisers who responded to the survey (3,196/4,365 = 73.2%) had appraised between 1 and 10 doctors during the period April 2014 to March 2015, 14% (611/4,365) appraised 11-20 doctors, 3.8% (162/4,365) appraised >21 doctors and 9.1% (396/4,365) of responding appraisers had not conducted any appraisals during the period.

Of those who had conducted appraisals, Table 25 shows the number of respondents who either: identified concerns about at least one of the doctors they appraised which required formal escalation; identified concerns about at least one appraisee which did not require formal escalation; or, did not identify any concerns about any of the doctors they appraised. 'Formal escalation' was defined as escalation to the Appraisal Lead, RO or other relevant person.

Table 25: Appraisers who identified concerns

No of appraisers who identified at least one concern	Frequency	Percent*
Concerns identified that required formal escalation	412	10.4
Concerns identified that did not require formal escalation	887	22.5
No concerns identified	2,827	71.7

** Column sum > 100% since appraisers can identify both types of concern*

Responding appraisers who had identified concerns requiring formal escalation during this period had typically only done so in the case of a single doctor (319/405 = 78.8%). A further group of respondents reported having identified concerns requiring formal escalation in two cases (66/405 = 16.3%) whilst the remainder reported three or more cases (3 cases: 13/405 = 3.2%; 4 cases: 4/405 = 1.0%; 5+ cases: 3/405 = 0.7%). In all, 412 of appraisers that responded to the survey identified one or more concerns requiring formal escalation about 528 doctors. The nature of the concerns identified is summarised in Table 26. 'Lack of reflective practice' was the most frequently identified concern requiring formal escalation.

Table 26: Nature of concerns identified by appraisers that required formal escalation

Nature of concerns	Frequency	Percent*
Lack of reflective practice	186	45.5
Poor relationships with colleagues	120	29.3
Clinical knowledge or skills not up to date	105	25.7
Health issues	89	21.8
Other personal issues	66	16.1
Poor relationships with patients	49	12.0
English language skills	24	5.9
Other – None of the above	177	43.3

** Column sum > 100% since appraisers can identify multiple concerns about an individual doctor (N = 412).*

Responding appraisers also identified concerns which they did not feel warranted formal escalation. Eight hundred and seventy seven of responding appraisers reported identifying such concerns in the appraisals of 1,592 doctors. Again, most respondents identified concerns for only one (489/877 = 55.8%) or two doctors (251/877 = 28.6%). Table 27 shows the range of concerns identified by responding appraisers that they did not feel required formal escalation.

Table 27: Nature of concerns identified by appraisers that did not require formal escalation

Nature of concerns	Frequency	Percent*
Lack of reflective practice	433	48.9
Poor relationships with colleagues	292	33.0
Other personal issues	215	24.3
Health issues	165	18.6
Clinical knowledge or skills not up to date	146	16.5
Poor relationship with patients	58	6.5
English language skills	43	4.9
Other – None of the above	284	32.1
Total	1,636	184.8

** Column sum > 100% since appraisers can identify multiple concerns about an individual doctor and/or concerns about multiple doctors (N = 887).*

Again 'lack of reflective practice' featured highly in the concerns identified by respondents. The total number of concerns categorised was 1,636 by 887 responding appraisers. Our data suggested that cases featuring multiple types of concern about a single doctor were more likely to be formally escalated by respondents than cases which only focused on a single issue.

In cases which were not escalated, the majority of responding appraisers (759/883 = 86.0%) had been able to reach agreement on a course of action with the appraisee(s) involved. Only 2.6% (23/883) of respondents reported that they had not been able to do so.

Despite not formally escalating concerns, 42.2% (373/884) of responding appraisers had sought advice on how to address the issues they had identified. Within this group of respondents, 57.4% (214/373) approached their appraisal lead and 29.0% (108/373) approached the RO. Responding appraisers working in primary care were most likely to refer to an Appraisal Lead for advice (86.8%, n=112/129) compared to only 42.1% (83/197) of secondary care respondents.

Responding appraisers also reported that appraisees sometimes expressed concerns about medical colleagues in the course of their appraisal meeting, with 15.2% (600/3,946) of respondents stating that this had occurred in at least one of the appraisals that they had conducted between April 2014 and March 2015. Most responding appraisers (3,942/4,388 = 89.8%) were confident that they knew who to inform if concerns were raised as their organisation had a clear process in place. However, 6.4% (281/4,388) reported that their organisation's process was not clear and 3.8% (165/4,388) answered that they did not know where to seek advice from.

3.5.2 Responsible Officers and fitness to practise

A majority of surveyed ROs (170/271 = 62.7%) reported that the number of cases of doctors causing concern had remained about the same since the introduction of revalidation, although a notable minority (94/271 = 15.8%, n=94) reported that the number of such cases had increased.

Of the ROs responding, 47.6% (169/355) reported that arrangements for managing cases of doctors causing concern had changed since the introduction of revalidation, and 65.5% (232/354) of responding ROs reported having a written policy for managing fitness to practise referrals to the GMC.

Table 28, below, shows the actions taken in cases of doctors causing concern as reported by responding ROs. Formal local investigation and seeking advice from a GMC ELA were the most common actions. Notably, significant numbers of responding ROs also reported having referred doctors to Occupational Health services, having placed restrictions on areas of practice and having made formal fitness to practise referrals to the GMC.

Table 28: Action taken by Responsible Officers in cases of doctors causing concern

Action taken	Frequency	Percent
Formal local investigation	276	79.5
Advice sought from GMC Employment Liaison Adviser	262	75.5
Referral to the Occupational Health department	212	61.1
Restrictions placed on areas of practice	191	55.0
Formal local disciplinary action	182	52.4
Fitness to Practice referral to the GMC	165	47.6
Referral to the National Clinical Assessment Service	159	45.8
Required to undertake further training	156	45.0
Other actions	87	25.1
Don't know	13	3.7
Total	1,703	100.0

Additionally, 28.3% (100/353) of responding ROs reported that they had, in at least one case, made a positive revalidation recommendation about a doctor despite having some residual concerns about the doctor. Further information about the circumstances in which they made such decisions was provided by 86 of these ROs. Initial analysis of these comments has highlighted a number of issues warranting further exploration. One theme was that some responding ROs find the interpretation and application of the RO protocol difficult when trying to make revalidation decisions.[29] Some respondents reported that the criteria was not suited to those practising in non-clinical areas, or with little or no patient contact. Others identified that whilst they may have concerns about a doctor, they may not be able to evidence the concern and therefore felt compelled to make a positive recommendation:

> ‘The definition of concern is broad and ill-defined. I have concerns about several of my colleagues but nothing objective and little in writing. This is not a robust enough evidence trail for action or not giving a recommendation that is positive.’ (RO for an NHS Foundation Trust)

In some cases, the quality of SI was identified as a cause for concern. This can happen where there is no concern about the doctor’s practice but the quality of evidence in their portfolio is not of the requisite standard:

> ‘More often than not the concern relates to the quality of the evidence in the doctor’s portfolio rather than the doctor per se. Some doctors whom I have some concern about produce excellent portfolios.’ (RO for a Teaching Hospital Foundation Trust)

Conversely, a doctor may produce a portfolio of SI which meets the requirements but the RO may have access to other information about their practice:

> ‘Minor behavioural concerns that were addressed at the time but subsequently have escalated again. In some cases, doctors they tick all the boxes and can evidence everything that they need to - as an RO you can only really act on the evidence before you and not the "gut reaction."’ (RO for an Acute District General Hospital)

Survey responses from both appraisers and ROs highlighted the range of activity that takes place at local level where there were concerns about doctors’ practice and showed that revalidation mechanisms – namely appraisal – can be a means by which concerns are identified or a channel through which they are raised.

3.6 RQ5: How do ROs fulfil their statutory function of advising the GMC about doctor’s fitness to practise and what support do they have in this role?

Responsible Officers hold a key role in the revalidation system, with responsibility for bringing together available information about a doctor and making a revalidation recommendation about them to the GMC every five years. ROs are also responsible for

monitoring the on-going fitness to practise of doctors with a prescribed connection to their organisation. Understanding how ROs perform these tasks and especially how they make their recommendations is an important part of this research.

Key findings:

1. Surveyed ROs indicate that they share the process of making their recommendation decisions with other stakeholders such as deputies, stakeholder groups and occasionally ratify the decisions of others.
2. The majority of responding ROs (94.9%, n=355) work with the Employment Liaison Service (ELS) with 90.9% (340/374) of them rating Employment Liaison Advisor (ELA) advice as useful.
3. Contrary to GMC guidance, less than a third (113/349 = 32.4%) of responding ROs tell their doctors, prior to contacting the GMC, about their revalidation recommendation. 51.9% (181/349) communicated after and 15.8% (55/349) responding ROs indicated that they did not communicate decisions at all.

3.6.1 Responsible Officers: making revalidation recommendations

ROs reach their revalidation recommendations in a variety of ways. Survey responses reveal that 88.1% (311/353) of ROs review the case documentation, such as appraisal summaries, prior to deciding their revalidation recommendation, 41.4% (146/352) discuss the case with someone else and 22.4% (79/353) discuss the case in a formal group. 25.5% (90/353) reported that they confirm revalidation recommendations made by someone else. ROs may use several of these options in combination, and 11% (39/355) of the ROs surveyed also reported that they used other approaches, falling beyond these categories. These included: triangulation of information; one to one meetings with doctors; clinical governance meetings; the creation of a new decision-making group; discussions with ELS/ELAs; and discussion within RO networks.

It is evident that, whilst the statutory responsibility for making revalidation recommendations rests with the RO, many share the process with others. How far support structures are developed, and how far they are needed, may depend on the type and size of

the designated body in which the RO is located. Designated bodies range from organisations employing one or two doctors to large acute hospital trusts and NHS England Local Area Teams and Education and Training Boards responsible for revalidating several thousand doctors.[30]

Surveyed ROs from small organisations suggested that they had less need of formal internal support structures, with one reporting that making revalidation recommendations is:

> 'Easy in a small organisation with personal knowledge of all the doctors.'
> (RO for a small hospice)

Another stated:

> 'I apply the appropriate legal standards when making decisions and review all evidence personally, without delegating this or relying on a committee.'
> (RO for an independent healthcare provider)

Others – based in larger organisations - indicated that support was needed to make revalidation recommendations:

> 'Needs to be well supported by a team of medical managers who know what is involved and who are proactively dealing with issues not ducking them in the hope I will action through relayed action recommendations.'
> (RO for an acute trust)

The GMC established its ELS to create closer working relationships between the medical regulator and employers. The service has 18 Employer Liaison Advisers; each covering a different geographical area.[31] Only 6.4% (24/374) of responding ROs had never used the ELS. A majority, 65.0% (243/374), rated advice from their ELA as 'very useful' and a further 24.9% (93/374) reported finding it 'quite useful.'

The GMC protocol for making revalidation recommendation: Guidance for Responsible Officers and Suitable Persons[29] sets out guidelines for ROs; including their responsibilities when making recommendations, the various types of recommendation that can be made (positive; defer due to on-going local procedures; defer due to lack of evidence; notification

of non-engagement) and the sources of information about doctors' practice which ROs may draw upon. Only 1.6% (6/374) of the ROs who responded had never used the protocol document, with a majority rating it as either 'quite useful' (213/374 = 57.0%) or 'very useful' (148/374 = 39.6%) when making revalidation recommendations. However, contrary to the advice stated in the protocol,[29] only 32.4% (113/349) of ROs reported that they did communicate their recommendation to the individual doctor prior to making it to the GMC, whilst 51.9% (181/349) responded that they did so after having made the recommendation. 15.8% (55/349) of responding ROs stated that they never communicated revalidation recommendations to their doctors at all.

3.7 RQ6: Are patients being effectively and meaningfully engaged in revalidation processes?

Revalidation aims to give extra confidence to patients about their doctor's ability to demonstrate that they are "up to date and fit to practise in their chosen field and able to provide a good level of care."[32] Part of this assurance is to actively engage patients effectively and meaningfully in the process. To begin to explore this aspect, we conducted a small sample, short survey of PPI national and regional representatives.

Key findings:

1. Two thirds (11 out of 17) of participants felt that patients are unaware of revalidation; whilst just under a third (5 out of 17) were unable to say and only 1 out of 17 felt patients were aware of revalidation . Similarly, just under two thirds (11 out of 17) felt patients did not understand revalidation's aims and purpose; with 2 out of 17 disagreeing and 4 out of 17 unable to say.
2. There appears to be a discrepancy between the largely positive value attributed to PPI in revalidation and its perceived effectiveness in its current form; with less than half (8 out of 18) agreeing that PPI makes a meaningful contribution to the revalidation of doctors.

3. Patient representatives felt that barriers to patient feedback included issues with a lack of time (16 out of 17), a lack of anonymity (15 out of 17), and the fear of repercussions (15 out of 17).

3.7.1 Current PPI in medical revalidation

While a majority of PPI respondents felt that their involvement in revalidation processes was valuable, only half felt that current patient feedback systems helped doctors to improve their practice (Table 29). Furthermore, a third of respondents felt current revalidation feedback processes were not user friendly for all patients. This sentiment echoes concerns raised by some doctors (section 3.3.2).

Table 29: Attitudes towards current revalidation feedback processes and PPI

	Percent				
	Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**	**Unable to say**
Current revalidation feedback mechanisms provided by you or the organisation you represent are user friendly for all patients	5.6	27.8	11.1	16.7	38.9
Patients are actively engaged in current revalidation processes	16.7	11.1	22.2	16.7	33.3
Patient involvement in current revalidation processes is valuable	-	-	11.1	66.7	22.2
Current patient feedback systems for revalidation are effective	11.1	16.7	16.7	11.1	44.4
Current patient feedback systems for revalidation help doctors to improve their practice	-	27.8	22.2	27.8	22.2

*N=18

3.7.2 Patient awareness and understanding of revalidation

Despite individual efforts of the respondents, they felt generally that patient awareness and understanding of revalidation is of concern (Table 30). Over two thirds of participants felt that patients are unaware of revalidation or understand its aims and purpose. No respondents agreed that patients understand how they can be involved in revalidation.

Table 30: Patient awareness and understanding of revalidation

	Percent				
	Strongly Disagree	Disagree	Agree	Strongly Agree	Unable to say
Patients are aware of revalidation	23.5	41.2	5.9	-	29.4
Patients understand the aims and purposes of revalidation	29.4	35.3	5.9	5.9	23.5
Patients understand how they can be involved in revalidation	35.3	35.3	-	-	29.4

*N=17

3.7.3 PPI in identifying good and poor doctor performance

While the majority of respondents agreed, or strongly agreed, that current feedback mechanisms would help to identify both excellent, and poorly performing, doctors or healthcare teams, there was slightly less acceptance that patient feedback mechanisms in their current form make a meaningful contribution to revalidation (Table 31). This contrasts with the value responding doctor's place on patient feedback informing their reflective practice (section 3.3.3).

Table 31: To what extent do you agree or disagree that current patient feedback mechanisms used in revalidation can…

	Percent				
	Strongly Disagree	Disagree	Agree	Strongly Agree	Unable to say
Help to identify excellent doctors	-	16.7	38.9	16.7	27.8
Help to identify excellent healthcare teams	-	16.7	38.9	16.7	27.8
Help to identify poorly performing doctors	-	22.2	27.8	22.2	27.8
Help to identify poorly performing healthcare teams	-	27.8	33.3	11.1	27.8
Make a meaningful contribution to the revalidation of doctors	-	27.8	27.8	16.7	27.8

*N=18

Comments about the perceived inadequacy of patient feedback as it is currently constructed, identified a number of issues such a lack of rigour, the potential for patients to fear negative consequences, issues of confidentiality and restrictive feedback tools:

> 'The process is not rigorous enough since doctors can pick their "easy" patients to give fairly undifferentiated feedback.'" (ID 86.14.249.8)

> 'I am also not convinced the GMC rules for validating questionnaires and the administration process are operating satisfactorily within some designated bodies.' (ID 194.176.105.165)

> 'Patients may not provide honest feedback because they may be afraid of negative consequences.' (ID 86.157.210.33)

> '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.' (ID 141.163.129.55)

> 'The current GMC questionnaire is limited in the way it fails to provide assistance to patients in clarifying the intentions of the questions.' (ID 109.151.56.176)

Some of these concerns may be borne out by our - survey data showing a significant number of responding doctors distribute their own questionnaires (section 3.3.2).

3.7.4 PPI in revalidation and appraisal

Of 17 respondents, 16 felt that patients' views should be taken into account when decision are being made about a doctor's performance; 15 felt patients should be involved in working with ROs and those responsible for co-ordinating local appraisal systems; 15 respondents agreed that they should participate in audit of appraisal systems; 13 felt patients should participate in the audit or evaluation of completed appraisals; and the same proportion felt patients should be involved in the selection, training and quality assurance of appraisers.

3.7.5 Barriers to patient feedback

Our respondents placed a lack of time (16 out of 17), a lack of anonymity (15 out of 17), the fear of repercussions (15 out of 17) and issues with accessibility of information (15 out of 17) as the most important potential barriers to patient feedback.

4 Next steps: plan for 2016

Over the course of the next calendar year, we will continue to collect and analyse data as per our research programme plan.

Secondary analyses of revalidation and fitness to practise data held by the GMC, and appraisal data held in SOAR and MARS will be analysed with a focus on identifying any associations between appraisal rates, revalidation recommendations, and deferral rates, with respondent characteristics.

Analyses of data collected through the survey of doctors, RO survey data and the PPI survey will be extended to include further modelling, alongside full qualitative thematic analyses of the free text data. We also plan to repeat these surveys, in adapted forms, during 2016.

Specifically, an analysis of free text survey responses relating to the use of SI, and any issues in accessing, collecting or using SI as an aid for reflective practice are on-going and will extend our understanding of how doctors approach the use of SI in practice. Statistical analyses comparing responses from appraisers with those of appraisees will be conducted.

Qualitative data collection will continue, through interviews, appraisal recordings and portfolio analyses. We will also extend our interviews to speak to Responsible Officers and GMC Employer Liaison Advisors. These data will be used to further explore the value of SI in appraisal, and will look carefully at differing perspectives of SI, reflective practice and behavioural change.

It is clear that ROs operate different in their different roles. Our on-going research will examine this through qualitative interviews with ROs and ELAs. This work will focus on exploring in more depth how ROs make their recommendations to the GMC and how they

apply the GMC's guidelines in practice. Complementary research underway, funded by the Department of Health in England, will examine the organisational dimensions of ROs' recommendation making activity.

Specifically, doctors' perceptions of the quality and value of patient feedback will be explored through interviews with appraisees and appraisers and through analyses of recorded appraisals and of appraisal portfolios. In addition, we will look at the levels and modes of patient involvement in revalidation from the perspectives of patients, lay representatives and public organisations representing patient interests through analysis of our survey of these groups. This element of our research will look beyond current patient feedback to consider other ways in which patients can or could meaningfully engage in revalidation processes.

Finally, we intend to develop and undertake qualitative work looking at the efficacy of appraisal as a means for identifying early concerns about poor performance.

5 Conclusion

This interim report summarises early emerging findings from the UMbRELLA study. Drawn from initial analyses of survey data, the findings outlined here demonstrate the complexity of revalidation as a policy intervention. Our empirical data suggest that there are variations between groups of doctors in how elements of the revalidation process are perceived and experienced.

The study will continue to collect data and to conduct further analyses of the data already collected to date. Further findings will be reported in due course.

6 References

1. United Kingdom. SI 2685: Health care and associated professions (doctors). The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012, 2012.
2. Archer J, Regan de Bere S, Nunn S, et al. "No one has yet properly articulated what we are trying to achieve": a discourse analysis of interviews with revalidation policy leaders in the United kingdom. Academic medicine : journal of the Association of American Medical Colleges 2015;90(1):88-93.
3. House of Commons Health Committee. Revalidation of Doctors, Fourth Report of Session 2010-2011, Volume 1: Report together with formal minutes and oral and written evidence. London, 2011.
4. RST. Measuring the costs and benefits of medical revalidation. London: Revalidation Support Team, 2013.
5. Nursing and Midwifery Council. Revalidation: how to revalidate with the NMC requirements for renewing your registration. Secondary Revalidation: how to revalidate with the NMC requirements for renewing your registration 2015.
6. Middleton L, NicolaRyley, DeniseLlewellyn. Revalidation: a university health board's learning from pilot partner engagement. Nursing Management 2015;22(5):24-30.
7. General Pharmaceutical Council. Summary report - Revalidation stakeholders meeting. London, 2012.
8. General Dental Council. Continuing assurance of fitness to practise. Secondary Continuing assurance of fitness to practise 2016. https://www.gdc-uk.org/Aboutus/policy/Pages/policyitem.aspx?policy=Continuing%20assurance%20of%20fitness%20to%20practise.
9. Archer J, Pitt R, Nunn S, et al. The evidence and options for medical revalidation in the Australian context: final report, 2015.
10. Archer J, Regan De Bere S, Brennan N, et al. Evaluating the strategic impact of medical revalidation: Building an evaluation framework. London: GMC, 2013.
11. Regan De Bere S, Nunn S, Archer J. Systematic review of patient and public involvement (PPI) in medical revalidation PROSPERO 2014:CRD42014013105. PROSPERO, 2014.
12. Archer JC, McAvoy P. Factors that might undermine the validity of patient and multi-source feedback. Med Educ 2011;45(9):886-93.
13. Pawson R, Greenhalgh T, Harvey G, et al. Realist review – a new method of systematic review designed for complex policy interventions. Journal of health services research & policy 2005;10(suppl 1):21-34.
14. Brennan N, Bryce M, Pearson M, et al. Understanding how appraisal of doctors produces its effects: a realist review protocol. BMJ Open 2014;4(6).
15. Department of Health. Projects, initiatives and long-term programmes of research currently funded by the Department of Health Policy Research Programme. London, 2015.
16. Taylor J, Et al. Medical revalidation: a statement of support from UK patient organisations. In: General Medical Council, ed. London: General Medical Council,, 2012.
17. Bourne T, Wynants L, Peters M, et al. The impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK: a cross-sectional survey. BMJ Open 2015;5(1).
18. McLeod CC, Klabunde CN, Willis GB, et al. Health Care Provider Surveys in the United States, 2000–2010: A Review. Evaluation & the health professions 2013;36(1):106-26.
19. Cho YI, Johnson TP, VanGeest JB. Enhancing Surveys of Health Care Professionals: A Meta-Analysis of Techniques to Improve Response. Evaluation & the health professions 2013;36(3):382-407.
20. NHS Revalidation Support Team. The Early Benefits and Impact of Medical Revalidation. London: NHS Revalidation Support Team, 2014.
21. NHS Revalidation Support Team. The Early Benefits and Impact of Medical Revalidation: Technical Annex. London: NHS Revalidation Support Team, , 2014.
22. Royal College of General Practitioners. A report on the results of the 2015 RCGP Revalidation Survey. London, 2016.
23. Cook JV, Dickinson HO, Eccles MP. Response rates in postal surveys of healthcare professionals between 1996 and 2005: an observational study. BMC health services research 2009;9:160.
24. General Medical Council. The state of medical education and practice in the UK 2015. London: General Medical Council, 2015.

25. NHS England. Senior Responsible Owner's Report to Ministers on the implementation of the Responsible Officers Regulations and Medical Revalidations, 2014/14. London, 2015.
26. Nath V, Seale B, Kaur M. Medical Revalidation: From compliance to commitment. London: The King's Fund, 2014.
27. General Medical Council. Supporting information for appraisal and revalidation. http://www.gmc-uk.org/static/documents/content/Supporting_information_for_appraisal_and_revalidation.pdf: General Medical Council, 2012.
28. General Medical Council. Ready for revalidation: Supporting information for appraisal and revalidation. London: General Medical Council, 2012.
29. General Medical Council. The GMC protocol for making revalidation recommendations: Guidance for Responsible Officers and Suitable Persons. Fourth edition. London: General Medical Council, 2015.
30. General Medical Council. List of designated bodies. Secondary List of designated bodies 2016. http://www.gmc-uk.org/help/list_of_designated_bodies.htm.
31. General Medical Council. Employer Liaison Service. Secondary Employer Liaison Service 2016. http://www.gmc-uk.org/concerns/11956.asp.
32. General Medical Council. An introduction to revalidation. Secondary An introduction to revalidation 2016. http://www.gmc-uk.org/doctors/revalidation/9627.asp.