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Medical revalidation

From compliance to commitment



Key messages

- Revalidation is a regulatory process and is intended to complement clinical governance, with the one strengthened by the other. The GMC is introducing revalidation in a staged process, from December 2012 to March 2016, with this period being described as the first 'cycle'.
- The NHS Revalidation Support Team commissioned The King's Fund to undertake a qualitative assessment of the impact medical revalidation has had to date on the behaviour of doctors and the culture of organisations within seven case study sites across England.
- Our study reinforces that it is still early days for revalidation. Designated bodies, appraisees and appraisers are focused on implementing the *process* of revalidation. This has introduced new processes, formalised appraisal systems, and increased adherence to policies and statutory requirements.
- Appraisers, appraisees and representatives from across the wider organisations identified and voiced both negative and positive consequences to the process of revalidation. Signs of tick-box behaviour in particular provide an early warning of the danger of focusing on compliance and process alone.
- Doctors were receiving mixed messages about the purpose of revalidation. All could identify potential benefits, particularly the developmental opportunities. However, there was some cynicism about the overarching purpose of assuring the public of doctors' fitness to practise.
- While some benefits will be realised through time, leaders in the system should not rest on their laurels. More needs to be done to refine the process and to clarify the purpose of revalidation. This will ensure that revalidation contributes to both quality improvement, which impacts on patient care, and individual professional development. Many in our study expressed aspirations to achieve that.
- Revalidation had started to create a level playing field for doctors within organisations, a change that was particularly relevant for those groups who have traditionally felt marginalised. It has also begun to include feedback from peers and patients.
- Leadership at the individual, organisational and system level will support the process to move beyond compliance. It will enable doctors to see beyond the process of revalidation and genuinely support its purpose.

Introduction

The journey to medical revalidation began in June 2000, when the General Medical Council (GMC) published a consultation document *Revalidating doctors: ensuring standards, securing the future* (General Medical Council 2000). Proposals for revalidation were outlined in the 2007 White Paper *Trust, assurance and safety: the regulation of health professionals in the 21st century* (HM Government 2007) and it became a statutory obligation for all employing organisations in the United Kingdom on 3 December 2012.

Since 2000, the NHS has undergone many changes, including the introduction in 2005 of the concept of a patient-led NHS; the introduction of patient choice in 2006; and in 2008 the Darzi review *High-quality care for all*, which promised ‘an exciting time for commissioners and providers of healthcare while patients should receive much better care as a result’ (Department of Health 2008). Darzi broadly supported professional revalidation, commenting that: ‘change was most effective when it responds clearly to a patient need but also when it is driven by clinicians’. The findings and recommendation from Robert Francis’s reports into Mid Staffordshire NHS Foundation Trust Public Enquiry and the subsequent Berwick report and Keogh review have all contributed to the shifting context in which revalidation now finds itself.

Shipman

The Shipman Inquiry’s fifth report section 26:26 provides a snapshot of the feelings and thoughts of doctors:

The GMC received many responses to its Consultation Paper. Most respondents were supportive of the principles of revalidation and approved the proposed methods of collecting of information, the proposed content of the revalidation folders and the method of scrutiny. Various concerns were expressed. In particular, it was felt that doctors would need a good deal of guidance. Almost all respondents approved the idea of a link between appraisal and revalidation. Many stressed the need to ensure that the formative nature of appraisal was not lost. Many respondents were concerned about what revalidation was going to cost the GMC. It was suggested that the GMC should undertake a cost benefit analysis. There was also a suggestion that, before the GMC adopted the proposals, they should be tried out in pilot studies.

The Shipman Inquiry (2004)

Recent newspaper reports, stimulated by the anniversary of the death of Dr Harold Shipman, have highlighted varying perspectives on revalidation. Some of these perspectives reinforce the influence of a constantly changing context within which revalidation sits. In his interview with the *Evening Standard* (10 January 2014), Dr Mark Porter, Chairman of British Medical Association (BMA), reflects that ‘many doctors have been frustrated by the implementation because heavy workload and financial pressures in the NHS leave little time and space for the quality improvement that revalidation promised’.

Our study

In October 2013, The King’s Fund was commissioned to produce a small research report that captured the experiences and reflections of responsible officers (ROs) in London. Responsible officers are legally responsible for making recommendations to the GMC about doctors’ fitness to practise. This study now widens that London-based research. The NHS Revalidation Support Team (RST) commissioned The King’s Fund to undertake on their behalf a qualitative assessment of the impact to date of medical revalidation on the behaviour of doctors and the culture of organisations within seven case study sites across England.

The seven organisations were selected by the RST to ensure diversity of region, sector and size. Sites were also selected for their readiness and capability to engage. This qualitative assessment was carried out alongside, but independent of, a wider quantitative evaluation of costs and benefits by the RST. It was also intended to contribute to a future programme of longitudinal research that the RST is commissioning separately.

The research used semi-structured discussion guides to explore views in focus groups with doctors and in telephone interviews with a wider group of staff. We asked both doctors and those within the wider organisation at each site to give us their views of the main impacts on behaviour and culture. We asked them to provide examples of change where possible. We were not speaking to a homogeneous group, and opinions varied greatly according to perceived impact.

Methods

The sites selected were all involved in pre-piloting work with the RST, meaning that they provide some useful lessons about the activities of ‘early adopters’ of revalidation. They included:

- two primary care area teams (3,200 doctors)
- two secondary care trusts (1,014 doctors)
- a mental health trust (170 doctors)
- an independent provider (145 doctors)
- a locum agency (950 doctors).

Within each site we spoke to a small sample of individuals – a group of appraisers and a group of doctors who have been appraised (subsequently termed ‘appraisees’) – and carried out four to six interviews with a selection from a wider group of staff, including, for example, an RO (in many organisations also the medical director), a chief executive officer, a non-executive director, a human resources director, a nursing director and a patient representative.

We held 14 focus groups (2 per site, each 90 minutes long) and interviewed 36 individuals within the wider organisation; in total we spoke to 126 individuals, most of whom were doctors. The table below gives the breakdown of roles.

Table 1: Breakdown of roles

Role	RO	CEO	NED/ Chair	Appraiser	Appraisee	Wider organisation (eg, Director of Nursing, Patient representative, Revalidation manager)
No (%)	6 (5)	3 (2)	3 (2)	47 (38)	43 (34)	24 (19)

All discussions began with broad questions to ascertain views of revalidation and its purpose. We then explored both perceived aspirations in relation to behaviour and cultural change, and views on the extent to which these aspirations were currently being realised. We ended with a reflection on any unintended consequences, and the barriers and enablers to revalidation reaching its full potential.

This study was qualitative in nature, meaning that it explored views and experiences in depth. Small sample sizes mean that the findings are not statistically representative but may be indicative of the views of a wider population.

This report provides analysis of the impact of revalidation to date on behaviour and culture, from the perspective of those interviewed. It also offers commentary on how this regulatory process can be used by leaders at all levels to make a contribution to creating the culture of excellence in patient care that we are all working towards.

Revalidation: its purpose and potential

Revalidation is a regulatory process and a good example of the challenges and opportunities facing leaders when implementing a major change process. It is intended to complement clinical governance, with the one strengthened by the other.

The GMC is introducing revalidation in a staged process, from December 2012 to March 2016. This period is being described as the first 'cycle', by the end of which the majority of doctors who already held a licence to practise in 2012/13 in the United Kingdom will have been revalidated or will have had a recommendation made to the GMC regarding their revalidation (which could include deferrals and non-engagement options). The target was for 20 per cent of doctors' recommendations to be complete by March 2014 (the first full year of revalidation), a further 40 per cent by March 2015 and the remainder by March 2016.

The official guidance for introducing revalidation states:

Revalidation will be based on a local evaluation of doctors' practice through appraisal, and its purpose is to affirm good practice. By doing so, it will assure patients and the public, employers, other healthcare providers, and other health professionals that licensed doctors are practising to the appropriate professional standards. It will also complement other systems that exist within organisations and at other levels for monitoring standards of care and recognising and responding to concerns about doctors' practice.

(Department of Health et al 2011)

Revalidation requirements

To revalidate, doctors must:

- be taking part in an annual appraisal process
- have completed at least one appraisal based on good medical practice
- have collected and reflected on all six types of supporting information.

There are six types of supporting information that doctors will be expected to provide and discuss at their appraisal at least once in each five-year cycle. They are:

1. continuing professional development (CPD)
2. quality improvement activity
3. significant events
4. feedback from colleagues
5. feedback from patients
6. review of complaints and compliments.

Source: GMC (2012)

Revalidation works in conjunction with annual appraisals, which form part of the basis for recommending a doctor's suitability for revalidation. Appraisals have been a contractual obligation since 2003. But until 2012, they did not have to include quality improvement or reflection, and uptake was not measured closely.

A timeline of the evolution in medical appraisal

- 1998 Department of Health document *A first class service: quality in the new NHS*. Clinical governance set up and promotion of lifelong learning and CPD (Department of Health 1998).
- 1999 Department of Health document *Supporting doctors, protecting patients*. Compulsory appraisal to be introduced, to be an important part of GMC revalidation of doctors (Department of Health 1999).
- 2001 Appraisal introduced into the NHS.
- 2003 Appraisal became a contractual obligation for consultants.
- 2004 Appraisal became a contractual obligation for GPs.
- 2005 NHS Clinical Governance Support Team document *Assuring the quality of medical appraisal* produced descriptors of good practice (NHS Clinical Governance Support Team 2005).
- 2006 Department of Health document *Good doctors, safer patients*. Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients (Department of Health 2006).
- 2006 General Medical Council document *Good medical practice* updated to reflect appraisal and revalidation (General Medical Council 2006).
- 2008 Royal College of General Practitioners (RCGP) document *Good medical practice for general practitioners* updated to reflect revalidation needs of GPs (RCGP 2008a).
- 2008 Appraisal was also included as an obligation for Staff and Associate Specialists (SAS) doctors in the 2008 contract.
- 2008 RCGP document *Principles of GP appraisal* sets out policy and principles of appraisal (RCGP 2008b).
- 2009 NHS Revalidation Support Team document *Assuring the quality of medical appraisal for revalidation* sets out a quality framework for organisations providing appraisal (NHS Revalidation Support Team 2009).

Source: GMC (2012)

Compliance with regulatory processes is compulsory. Any doctor in the United Kingdom wishing to retain a licence to practise will be required to participate in revalidation. All organisations providing health care, defined as ‘designated bodies’ in the *Medical Profession (Responsible Officers) Regulations 2010* and the *Medical Profession (Responsible Officers) (Amendment) Regulations 2013*, are obliged to support their doctors throughout the process. Figures released by the GMC in December 2013 indicated that 25,000 of the recorded 260,000 doctors had attained revalidation (GMC Press Release, 3 December 2013).

Revalidation was an imposed change that many doctors viewed as inevitable and some commented was too long in the making. During research for our earlier study in London, one RO said: ‘It seems ridiculous that consultants can practise anything from 20, 30, 40 years without receiving formative feedback, unlike other specialist professionals in health and industry’ (Nath 2013a).

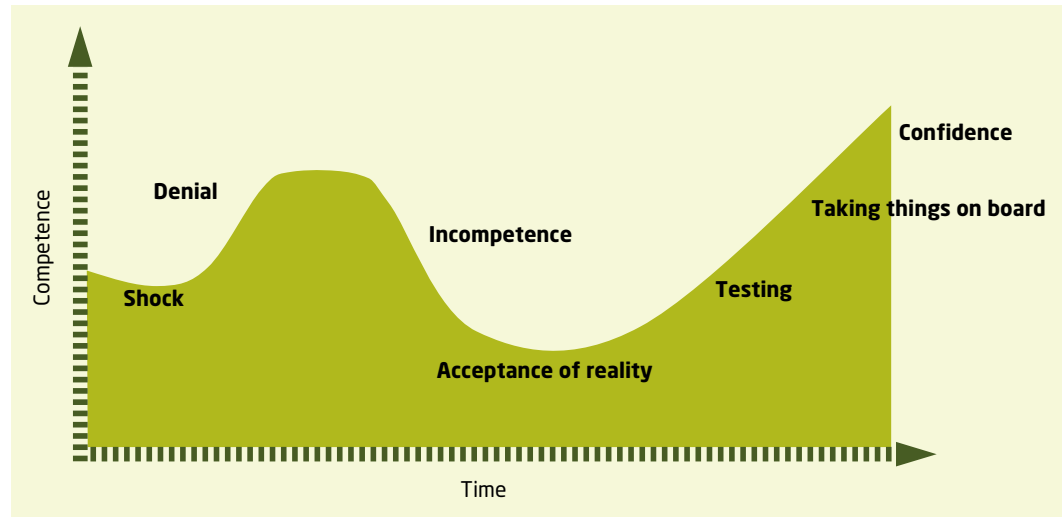
For those managing the process of revalidation, compliance is a measure of success. However, many are looking to revalidation to accomplish more than its original parameters.

Both the Keogh review (NHS England 2013) and Berwick report (National Advisory Group on the Safety of Patients in England 2013) highlight the importance of doctors feeling able to give, receive and act on feedback. Keogh provides evidence of the

continuing reluctance with which doctors give formative feedback to peers. It is our proposition that, with the right leadership, revalidation can contribute to strengthening the culture in which feedback is well received and becomes a catalyst for change.

Revalidation is still in the early stages of implementation. It was met with the standard range of reactions associated with a major change. The most commonly known model for these reactions, often referred to in health, is based on responses to major trauma. It relates to the work of Kübler-Ross's 'transition curve' and has been adapted below in Figure 1 (Kübler-Ross 1969).

Figure 1: The Transition Curve



There are various ways to help individuals who are at different points on the transition curve: understanding people's fears; demonstrating a willingness to listen and consult; involving people in planning; praising successes; assimilating feedback and making minor changes; and using a coaching approach to help doctors after the first cycle of revalidation to use the process to innovate on quality and to create further patient improvement and excellence.

Historically the NHS is an organisation described as 'change weary'. To enable a new change process to move from compliance to commitment, leaders at different levels need to be encouraged to use skills and behaviours actively alongside process to change cultures. In order to achieve transformational or large 'breakthrough' changes, leaders now need to recognise how several smaller changes and the interplay between them provide the basis for wider change (Moss-Kanter 1985).

Compliance and commitment

For the successful introduction of revalidation, compliance (necessary to meet regulatory and statutory requirements) is good as a short-term measure while working in the long term towards commitment (embracing continuous professional development). If the ambition of revalidation is ultimately to improve quality by ensuring compliance, the process of revalidation may be a sufficient goal, certainly for the short term. Those working towards achieving a revalidated medical workforce could successfully argue that it doesn't matter if doctors and organisations engage with the potential benefits it could bring – as long as they comply with the process.

If, on the other hand, the level of quality improvement needed requires doctors to voluntarily and proactively make changes to their practice and the way that they communicate and share learning with others, then we argue that greater commitment is required. At the birth of clinical governance 14 years ago, an article in the *British Medical Journal* described the optimum context:

*The feature that distinguishes the best health organisations is their culture...
An organisation that creates a working environment that is open and participative, where ideas and good practice are shared, where education and research are valued and where blame is used exceptionally is likely to be one where clinical governance thrives.*

(Scully and Donaldson 1998)

For it to gain traction in ensuring long-term quality improvement doctors need to believe that revalidation has a value in improving their own practice and the culture they work in. This requires focus and energy within designated bodies and the wider system (the GMC, royal colleges, and so on).

Moving from compliance to commitment requires leadership. Our work has reinforced the principle that ‘a commitment to deliver high quality care should be at the heart of everyday clinical practice’ (Scully and Donaldson 1998) – as it was with the ambition that underpinned clinical governance.

Revalidation is not a panacea, but one part of the quality improvement agenda. Creating cultures in which continuous improvement and quality prevail has been a challenge to leaders in organisations across the world. Yet for many organisations that are implementing change processes, this dimension of leadership receives little more than cursory consideration.

Impact on culture: our findings

During our analysis of the impact on culture in the seven organisations we visited, we drew on Edgar Schein’s 1990 work on organisational culture, particularly the descriptions of the ‘levels at which culture manifests itself’ (Schein 1990). At what Schein calls the ‘artefact’ or surface level, there was evidence that the introduction of revalidation had physically brought new processes, formalised appraisal systems, increased adherence to policies and statutory requirements. In our study, this was observed and recorded in the appraiser and appraisee groups of doctors.

It’s made things a lot more formal, which is a good thing and a bad thing: good that it’s more standardised but it’s become less of an individual thing.

Appraiser

More structured format and feedback. Gives the opportunity to peer review clinical cases. Encourages you to be more stringent in Personal Development Plan (PDP) Groups. Reassures the public. Does not review outcomes. Encourages reflection, which is good I think.

Appraisee

We found generally that doctors agreed that ‘something was needed’ to validate quality standards, indicating that there was some belief in the value of revalidation, if not in the process:

A necessary and overdue process but overly bureaucratic and unlikely to change that behaviour in those doctors that it might need to.

Appraiser

A big stick, but a necessary one. It should be a tool for improvement but does require openness and a feeling of relative security.

Appraisee

Schein argues that ‘it is possible for groups to hold conflicting values that manifest themselves in inconsistent behaviour while having complete consensus on underlying assumptions’. This was brought to life in the different assumptions our research discovered about the overarching purpose of revalidation to assure the public of doctors’ fitness to practise.

- ROs were very clear that revalidation was not simply about fitness to practise, nor about ‘catching another Shipman’. Rather they felt the focus should be on using effective and formative appraisal to engender a reflective workforce seeking continual clinical improvement.
- CEOs and chairs varied in their interpretations, seeing revalidation as one of the tools to help them achieve their own organisational goals, such as creating an evidence base for improvement, encouraging clinical leadership and an increased patient focus.
- More widely, human resource or operations directors’ stated aims were much more focused on performance and compliance.

Among doctors there was confusion about the purpose of revalidation as various messages were being heard. All could identify potential benefits, particularly around the developmental potential of revalidation for the doctor community. However, there was cynicism about the overarching purpose of assuring the public of doctors’ fitness to practise. A number saw this as a primarily political process, designed to show that there was now a process in place to ‘catch a Shipman’.

Avoiding Shipman number two is the reason it was sold to the profession. I think that is, that’s where it all started from.

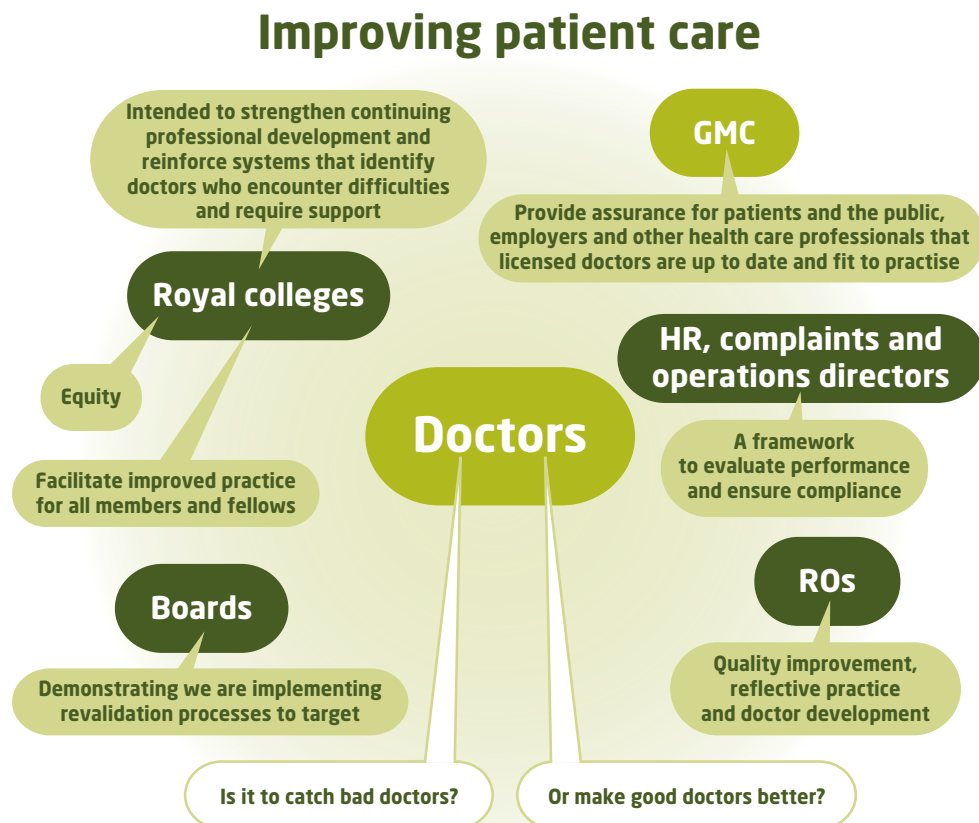
Appraisee

The doctors who are doing quite well will take it on board and sigh and think, okay, something else I have to do, but actually I wasn’t very confident at the time that it would pick up the rogue practitioners, which is presumably what it was designed to do, and I’m still not entirely confident that it will do that.

Appraiser

Figure 2 (below) shows the diversity of opinions expressed on the purpose of revalidation and the confusion this caused for doctors.

Figure 2: Differing messages about the purpose of revalidation



Positive and sustained changes to behaviours and culture will require engagement with the benefits and intention of revalidation from frontline doctor to executive colleague. There is an opportunity for leaders at different levels in the process to contribute to a shared vision where revalidation is seen as a contributor to a culture in which excellence in patient care and professional practice are seen to be interdependently linked.

Choosing a compliance- or a commitment-based approach to quality improvement is not a question of ‘either/or’. Revalidation has multiple aims, and there will be different, but valid, approaches to achieving these. Learning theory suggests that complex behaviour is learned gradually through the modification of simple behaviour. At the start of a change process that begins with compliance, repeated actions such as reflective practice can become normalised. This is consistent with some of our findings. But if sustained behaviour change and cultural change that supports continual quality improvement are intended, then commitment is necessary, from all those involved, at all levels.

Table 2: Different benefits of compliance and commitment

Compliance	Commitment
Explicit culture, conscious messages	Implicit culture, unconscious messages
Complying	Exceeding and redefining
Systems focus	Embodied practice
Legislation and policy supported	Values supported
Achieving targets	Fundamental change
Quality assurance	Quality improvement
Lowest bar/minimum standard	Aspirational
Autocratic	Democratic
Quantitative	Qualitative
Minds	Hearts
Single responsibility (RO)	Multiple levels of leaders
Energy goes into process	Energy goes into communication
Doing things right	Doing the right thing

Compliance-driven impacts

Focus on process

Our study reinforces that it is still early days for revalidation. Designated bodies, appraisees and appraisers are focused on getting the *process* of revalidation implemented thoroughly to comply with the regulatory requirements. Most impacts in the organisations we visited were currently being driven by the need for compliance to regulation on revalidation and clinical governance. This meant that at the time of this study it was difficult for those interviewed to identify the impact of revalidation on doctor behaviour and on organisational cultures, beyond those changes that were resulting from complying with the process itself.

Recent organisational and management changes also made attribution of impact more difficult as they appeared to have initiated a positive focus on quality and improvement. All referred to recent and ongoing influences such as the Francis report, policies to give patients a stronger voice such as the Friends and Family Test, the Quality and Outcomes Framework and Care Quality Commission metrics. Some organisations were actively using revalidation to help support these developments.

It's difficult to isolate revalidation as opposed to the other kind of organisational and structural changes we're making. We've seen our medical community escalate over the last 18 months as they become more involved in a positive direction.

Chair

Specific process issues for certain sectors and specialties heightened anxiety about revalidation and consequently influenced views.

- Locum doctors were particularly concerned about how seasonal employment for those working abroad can be sustained within the current model of revalidation.
- The time cost of revalidation, significant for all, was particularly challenging for the private sector and unsalaried or sessional GPs who were less able to give themselves dedicated time within working hours for appraisal preparation.
- Specialties with less contact with patients or other colleagues (for example, anaesthesia or legal) were anxious about how to capture sufficient evidence to support their revalidation.

Some of the responses to our study indicated that the culture pre-dating revalidation contributed to how it was received and implemented. For example, there was a difference between how the private sector and the NHS are using the data, leading to different approaches towards performance management versus quality improvement. In the mental health sector there are few quantifiable outcome measures. This means that revalidation decisions and discussions are based on qualitative evidence – making them more vulnerable to subjectivity, both positive and negative.

Investment and compliance at system and organisational level

At a system level there has been heavy investment in implementing and complying with the regulatory aspect of revalidation – for example, the establishment of the RST to support implementation of revalidation, investment in the creation of the RO role (development of which required both time and money) and in the RO network.¹

Across all seven sites there was evidence of organisational investment in the processes required to support the smooth implementation of medical revalidation.

- **Investment in both the RO and appraiser functions.** This investment included identification, recruitment and development of the RO role and training programmes for both ROs and appraisers. The fact that a clinician (the RO) is driving these changes from within has in itself the potential to begin to change cultures.
- **IT systems** (either bought-in or locally developed), **designated personnel and processes** for supporting their doctor population to carry out the tasks required. It is a requirement for the designated body to provide doctors with good information on their performance across the whole scope of their practice. We heard of some issues with the accuracy and completeness of data provided to doctors, but the infrastructure for providing data was in place in the sites that took part in the study.
- **Clinical governance** for those who did not previously have such formal structures in place. Several organisations noted increased documenting of clinical incident reporting and patient feedback systems (although collecting patient feedback is an area that our study shows requires more work). Revalidation had also improved governance and data recording systems.

1 Each region facilitates and supports one or more regional RO network. These networks give responsible officers the opportunity to share best practice, learn from each other and be kept up to date with developments in revalidation as they happen. All designated bodies (NHS and non-NHS) should ensure they are linked to their regional RO network. See www.revalidation.support.nhs.uk/responsible_officer/responsible-officer-training-and-networks.php (accessed on 30 January 2014).

- **Setting a minimum, comparable quality standard.** Organisations described raised expectations of excellence as a result of revalidation. Doctors, especially those within the private sector, expressed discomfort that these raised expectations were not necessarily supported to become reality through sufficient investment in professional development.

The impact of setting a comparable quality standard provided some organisations with a tool that could be used for performance management with the bottom 1 to 2 per cent of doctors. There was discussion, for example, about creating an electronic benchmark of all doctors from which to remove undesirables (in private practice) or nip lax practice in the bud (NHS). In addition, organisations (and sectors) described varying approaches to how remediation² was being addressed and indeed interpreted. In the private sector we heard of the instigation of processes for re-checking doctor credentials, skills and practice.

Revalidation has gone some way in raising the profile of governance and of clear-cut quality. It's caused us, internally, to think carefully about how we can use the data that we have about every practitioner to effectively benchmark individuals against each other and that is going to become a very increasingly powerful tool for us.

Medical director

- **Increased profile and importance of appraisal.** Doctors reported that increased investment and time were taken in their organisations to ensure all doctors were undertaking appraisal. However, doctors in some organisations felt there had still been insufficient investment in appraisal processes.

We heard that revalidation generated the conversation about getting processes right around appraisal. This was seen as a potential catalyst for having conversations that will in the long term have an impact on behaviour and culture.

It gives us real leverage ... everybody has an up-to-date appraisal and a work programme and ... their objectives are aligned to the objectives of the organisation. Revalidation will be an important tool as the organisation becomes more focused on particular areas of work and how we use medical skills and how we change the role of consultants.

Director of nursing

I looked at the appraisal as an opportunity to support doctors, give them guidance, and that's how I stepped in.

Appraiser

- **Boards were also demonstrating compliance to regulatory requirements.** Revalidation was being discussed at board level, primarily in the form of a report from the RO on process-outcomes, that is, numbers appraised, numbers revalidated, numbers deferred and so on. A focus on measuring process comes more naturally in target-driven culture. One driver reinforcing this was a process measure known as the Organisational Readiness Self-Assessment (ORSA). The report produced by the RST required organisations to complete 'implementation indicators'. It was designed explicitly to 'help designated bodies in England develop their systems and processes for the implementation of revalidation' (NHS RST 2013). With hindsight ORSA would have benefited from including indicators that also measured how engaged doctors and other colleagues were with the vision behind revalidation. This might have helped to highlight the importance of engagement and avoid a focus on process measures alone.

² Remediation is 'the overall process agreed with a practitioner to redress identified aspects of underperformance. Remediation is a broad concept varying from informal agreements to carry out some reskilling, to more formal supervised programmes of remediation or rehabilitation.' See: www.revalidationsupport.nhs.uk/responsible_officer/Responding_to_concerns_responsible_officers/responding_to_concerns_glossary/responding_to_concerns_glossary_q-r.php (accessed on 27 February 2014)

Revalidation-driven compliance at doctor level

While opinions varied greatly as to the perceived impact of revalidation on culture and doctor behaviour, all groups agreed that revalidation was driving compliance in the following areas.

- **Appraisal rates had increased**, especially in those sites where appraisal had not been universal, or for those doctors who had not previously engaged in appraisal.

I'm pretty confident that our medical staff fully understand that this is an obligation and that they have got to demonstrate that they're up to date so that they are fit to practise and that they do comply with the relevant professional standards and that obviously appraisal plays a part in forming that judgement.

HR director

One of the problems with appraisals prior to these criteria was that there was no quality control ... if people don't engage, there was very little we could do about that. There was very little to help encourage people to change and I suppose this is a crude way of trying to elicit that change or get some proof of that change.

Appraiser

- **Increased CPD.** Doctors spoke of keeping up to date educationally, through greater uptake of statutory requirements as a consequence of complying with revalidation requirements. We heard that some doctors were now prioritising CPD and mandatory training by allocating time to training, and where they were doing it before, they now document it more fully. We did not hear in our study that increased CPD was yet feeding through to changes in practice on a large scale, although this was clearly an aspiration. Doctors from locum agencies reported that policies were now in place for supporting CPD where they did not exist before.
- **Data collection.** The necessity to undertake revalidation was forcing practitioners to engage with the process of data collection and audit where historically engagement has been minimal. One appraisee commented that 'data collection that you can reflect upon is useful'.
- **Greater use of GMC guidelines.** Doctors spoke of using and referring to GMC guidelines more, for example, in relation to standards for clinical audit.

The effects on quality improvement of these changes in doctors' working practices were perceived both positively and negatively.

The multiple reactions to this process were in part consistent with the theories of the psychologist Fritz Roethlisberger, including:

- fear of loss of status or obsolescence of skills and knowledge, particularly in more established doctors
- inconvenience of adjusting to real and perceived difficulties (internalising new processes and procedures for revalidation, increased workload in pressurised environment)
- cognitive dissonance where doctors feel that what they are being asked to do devalues previous practices (Roethlisberger and Dickson 2003).

Positive consequences

On the whole, appraisers, appraisees and representatives from the wider organisation identified a range of positive consequences that resulted from revalidation.

- **A structure for learning.** Many doctors believed that simply going through the actions required by revalidation had brought a more formalised process to their existing behaviours; for example around reflection, peer review, developing new knowledge, CPD. For those not already doing so, appraisal for revalidation had prompted more

awareness of the need for reflection. As with CPD, we did not hear that the structure imposed by revalidation was yet feeding through to changes in practice on a large scale, although this was clearly an aspiration.

For some sites, the increased focus on statutory training had the potential to create and regulate what acceptable CPD should be. It was seen to have challenged perceived maverick behaviour and resulted in doctors being prevented from following 'special interests'. It increased probity around the introduction of new techniques and created a norm where skills were no longer taken for granted. An example given was of individuals from some surgical specialties no longer being able to say 'this is what I've always done'. Revalidation was already enabling some doctors to challenge colleagues who weren't making sufficient time for CPD.

It's brought a degree of transparency that we didn't have before, either within the practices or between practices ... I mean it's not unusual now for somebody to bring you their significant events, which have been discussed across the multidisciplinary team and the practice, so the knowledge should raise everybody's safety level.

Appraiser

It makes consultants understand that they've got to keep up to date. [A] surgeon recently was speaking to me around revalidation – whether he should be continuing doing a very specialist bit of surgery as he was winding down to retirement. He agreed to stop as [he] couldn't keep up to date.

CEO

- **A greater awareness and ownership of data about their practice and interest in its quality.** We heard from some doctors that revalidation was encouraging a form of peer review and that they were being compared with colleagues in terms of practice which some thought would drive standards up.

It feels as if it's been a consequence of this that you are actually making better use of the data.

Appraiser

- **Increased accountability.** Across many of the sites there was evidence that revalidation was beginning to lead to a feeling of increased accountability among doctors. Some also talked of a growing willingness to take responsibility where they may not have done in the past, for example, for implementing organisational policies. Some doctors reported greater self-regulation and self-scrutiny. They reported being much more conscious of their behaviour, in particular how it is viewed by colleagues, for example, senior doctors changing their behaviour towards juniors due to the feedback mechanism.

... he's actually ... stopping making inappropriate jokes as well that's not bothering the juniors in an inappropriate way, he's actually calmed down quite a lot which I felt was quite positive actually.

Appraiser

Doctors have all ... without any hesitation agreed that they're happy to go through that (revalidation) so I think that must mean that they're conscious that there is this obligation now for them to be able to demonstrate that ... they're still a fit practice whether on health or other grounds.

Clinical strategy

- **Increased communication around errors and earlier identification of problems.** In some organisations revalidation was seen to be 'forcing transparent communications about concerns' and serious untoward incidents (SUIs), both within and between teams and organisations. This increased the focus on safety and on improvement across the system. There was more open reporting of issues, driven by the knowledge that if

doctors did not raise them they could subsequently be blamed. This is often described as ‘conformity’ – that is, behaviour driven by a sense of being watched. While the result is positive, the driver prompts questions about the sustainability of such change.

Some doctors reported feeling more able to raise concerns about colleagues with their medical directors because of confidence that action would now be taken. A human resources director had seen a change in culture from defensive union to legal responsibility for expressing concern about a colleague. Within the same organisation, individuals questioned whether existing cultures, particularly those that are highly competitive, truly enabled junior doctors to raise concerns openly. The key as revalidation progresses will be to demonstrate action is being taken to address concerns that are raised, but to do so in a way that is transparent and supportive.

It has brought it into the open that a conversation has to take place about practice[...] the challenge or the opportunity for the organisation is whether or not it's going to grab that opportunity with both hands and follow it through.

HR

- **Increased equity in decision-making and integrating marginalised groups.** At an organisational level and for certain groups of doctors, revalidation was seen to be helping to create more of a level playing field, and as a result breaking down traditional centres of power. One unintended consequence mentioned was that of bringing a focus to sub-groups perhaps not previously included in clinical governance and appraisal processes. Doctors such as locums and non-consultants were able to demonstrate the good work they do through the vehicle of appraisal.

We've engaged the SAS doctors nicely, that was a group that had worried me because they were like a lost tribe so from a cultural point of view, they're happier and they're on board.

RO

For some marginalised groups revalidation has brought structure where it may not have existed before.

For ... independent practitioners ... it's bringing some governance to them which wasn't present before. They were happily sitting in limbo between the NHS and the fully employed doctors, not actually engaging the revalidation and trying to keep their head below the radar.

Medical director

- **Positive impacts on the emotional well-being and morale of doctors.** We heard from ROs and senior executive team members that doctors who have embraced revalidation reported feeling happier and more confident.

According to those managing the process of revalidation, receiving patient feedback through the process of revalidation has had a positive impact on some doctors. Some reported feedback as being ‘absolutely glowing’ (revalidation manager).

- **More cognisant of patient views.** A shift in doctors’ behaviour in respect to their interactions and communications with patients was mentioned, due to awareness of patient feedback and the need to see complaints as part of the appraisal process.

They've been clear about what patients have said about them, and I think it's ... changing attitudes, particularly with younger doctors. So a consultation ... with a patient becomes much more of a dialogue rather than a set of instructions that they issue. I think revalidation had focused consultants' and doctors' minds that actually these things are quite important.

CEO

Negative consequences

Appraisers, appraisees and representatives from across the wider organisations identified and voiced negative consequences to the process of revalidation.

- **The time and emotional cost of revalidation.** Many doctors, as well as several representatives of the wider organisation, spoke about the heavy time commitment required and the burden of paperwork. We heard doubt and uncertainty that the effort required to comply with revalidation was worth the hours put in. Some doctors were beginning to question the necessity of ‘obsessional collecting of data’ (appraiser). Others were doing the paperwork in their own time. For some in our study revalidation was seen to be a distraction from clinical practice, reflective practice and from time to be creative or ‘explore’.

Few doctors mentioned using supporting professional activities (SPA) time to complete revalidation-related activity. Recent reports and press discussion about SPA have suggested that the extent to which this time is used for revalidation warrants further investigation. At the introduction of revalidation in 2012, the BMA annual meeting raised concerns that ‘the erosion of SPA time in job plans could have an impact on doctors’ ability to provide evidence for revalidation’.

There are very few employers or practices that can actually say ‘yes this is your appraisal time and I’ll give you this much time on a monthly basis’. Most doctors do it in their own time. It’s never part of their working time.

Appraiser

Individuals described the impact of revalidation on mental well-being: anxiety, fear, stress prompted by trepidation around both the outcome and process. As a result of anxiety, some felt less disposed to honesty and more likely to stick closely to prescribed processes (that is, compliance).

I don’t have the time. I’ve got my appraisal in three weeks’ time ... but I don’t have time. I go to work. I’ve got three kids. I don’t have the time at home to sit there and put on what I’ve done in the day. So hence I’m absolutely stressed.

Appraisee

- **Tick-box behaviour.** For some simply complying with processes was leading to complacency and abrogation of responsibility among doctors who were unthinkingly following a regimented process. This appeared to be exacerbating the mismatch between reality (that is, compliance, box-ticking) and public or regulatory expectations in relation to the purpose of revalidation.

... Is this doctor good enough for this organisation? That’s one – tick box – revalidate.

Appraiser

It’s not an open-minded process. There’s nothing in it for doctors to sort of integrate or to try to bring something new in. All it’s looking at is what you’re doing and how you’re doing. So it’s not an inventing process; it’s just a duplication process, and after some time duplication becomes boring.

Appraisee

If doctors start to see this as just a process that they need to tick boxes and go through ... there is a danger that as soon as they start to think ‘well we just need to get through the process and everything will be fine’ they will start taking short cuts. So it’s key that they actually see revalidation as a real activity out there that’s having real benefits.

Chief executive

- **Increased signs of risk aversion.** We heard that some were seeing evidence of risk aversion, for example, surgeons declining complex cases for fear of the consequences if there were any incident involved; and appraisers being selective about whom they chose to appraise through a perceived potential responsibility for outcomes.
- **Reduced willingness to share more serious errors.** A small number strongly believed that revalidation was hindering openness, through the removal of confidential appraisal. For example, doctors were less likely to discuss serious SUIs in their appraisal for fear of 'being reported to the GMC' and so selected less serious cases or those in which they were not directly involved. The consequence of this is potentially catastrophic: a lost opportunity for learning that could save lives and a step backwards in terms of openness.

A lot of the appraisees are worried about documenting significant events. On significant events in particular there's anxiety about the confidentiality of the process. I have done several appraisals where they've said, you know, 'can you guarantee if I discuss the significant event that somebody won't ... investigate my practice and refer me to the GMC?'

Appraiser

My feeling was ... the previous system was more confidential ... more exploratory and in some cases more successful in that there was real reflection and the current system is more exasperating.

Appraiser

- **Devalued appraisal.** Some felt strongly that appraisal has been devalued, becoming summative rather than formative, which removed the opportunity for appraisees to discuss issues most useful to them. This was described as a 'dumbing down' of appraisal (for those already at a high standard) or of being held to overly ambitious standards (for those who have significant areas for development). Equally it was felt to have the potential to suppress innovation. We heard that revalidation had taken the creativity out of learning and that revalidation 'had kidnapped appraisal' (appraisee).

Appraisal was previously a very different beast, and it very much depended on the type of doctor you were appraising ... and I found now that it's standardised ... things that are tick-box. It's a shame because ... some of the value of appraisal was for some doctors there were specific things that their appraisal gave them ... something that they could explore, whether it was personal issues or other things to do with their jobs, and there just isn't the time to do that now.

Appraiser

- **Emphasising the divide for marginalised groups.** For locums in particular revalidation was also felt to be exacerbating existing divides, in which they are blamed or 'scape-goated' (appraisee) more readily for mistakes in the organisations they work for, emphasising their difference from permanent staff. From our focus group discussions with locum appraisees there was a fear that revalidation was leading to organisations becoming more risk-averse.

An unintended consequence that could be either positive or negative

- **Retirement or termination of contract.** Our research suggested that some doctors had left the system through failure or lack of will to complete the process of revalidation. This is currently seen to be affecting mostly older doctors, who find the process overly onerous. Some saw the early retirement or termination of contract to be a positive unintended consequence of revalidation in removing those who are not inclined to participate in continual medical education and statutory processes.

While this may be true, we also heard how the impact of revalidation for part-time doctors, locums and those without access to dedicated time within paid hours was challenging and, for some, genuinely unworkable. It may be that additional communication is needed to clarify the right amount of preparatory activity appropriate for revalidation. If this issue is widespread, the inherent risk of losing the experience of good doctors through a perceived inability to follow the process is a very real one. The issue has been raised in the trade press and should be viewed within the context of a system policy towards a seven-day service and current capacity and service provision issues.

We suggest further quantitative analysis on the numbers of doctors retiring as a result of revalidation.

Commitment to change: current practice

We found evidence of a greater commitment to using revalidation as a tool for quality improvement at all levels, among:

- ROs
- executive teams
- appraisers and appraisees.

These individuals interpreted revalidation as a force for development, underpinning innovation and creating culture change. Their commitment to this goal for revalidation has a power to drive sustained quality improvement and improved patient care – a goal that goes far beyond compliance.

I think to my mind the focus has changed. It was something being done to us, now I think it feels something that I've got far more ownership of and as such it feels like a more helpful process.

Appraisee

As [doctors] become more involved in the process rather than just being observers, we've seen an increase in the morale within the medical profession, because they now see themselves more as part of the solution than part of the problem ... Revalidation is part of that toolkit that we're using, it's an important aspect of the cultural change that we're trying to engender.

Chair

This echoes the findings of a joint study on medical models of leadership that found that while engaging doctors had slowed decision-making in some contexts, it did offer the benefit of generating greater commitment to those decisions. The study, by Professor Chris Ham and Birmingham University, also found that the quality of individuals in leadership roles was perceived to be critical to their effectiveness (Ham and Birmingham University 2013).

ROs

All ROs interviewed were committed to revalidation as a tool for improvement of all doctors, rather than just a framework for quality assurance. They differed in their personal approaches and aspirations for revalidation but it was clear that what united them was their ownership of the task.

I've always been quite clear that it's nothing whatsoever to do with Shipman and the rest of it. The system's not designed to do that, it's designed for patient safety and quality health care and proving as it were that doctors are up to date and fit to practise and I think it goes some way to achieving that. I think ... the appraisal MAG [Medical Appraisal Guide] form is the minimum required and the more people do, the better and the more reflective that it is, the better.

RO

Several ROs were seeking to spread that sense of commitment to others in their organisations. They were attempting to create and nurture the engagement of others with revalidation and its benefits, drawing on the principles of effective medical leadership to ensure revalidation is 'owned' by all in the organisation. Some of their initiatives included:

- communicating aims with the board, first in order to seek investment, but also to ensure that the senior executive team and board are engaged with revalidation and its potential benefits
- establishing responsibility for revalidation at directorate level to ensure that doctors themselves are driving the process and ultimately the benefits
- developing a governance structure that engages the executive team as well as patient representatives
- regularly communicating with doctors about revalidation and its benefits.

I made a big presentation to the board last year, trying to get the administrative resources. I've done a lot of work, at ground level, at operational level. We've run road shows for doctors across the country. I've made presentations to general managers, to matrons, put out some things on our intranet, tried to spread the word... I've managed to get set up a corporate revalidation committee, which is chaired by one of the senior directors. And so now we have a definite route into the senior management team, because the minutes and reports from that will go into the senior management team.

RO

Chairs and the executive team

While the wider board appeared to have had little involvement in revalidation beyond assuring themselves of implementation, several of the senior executives and chairs we spoke to were highly engaged in the concept of revalidation for quality improvement. Most engaged were those who had identified the power of revalidation to support wider initiatives in their organisation such as:

- clinical excellence
- a safety net for cost improvement programmes
- clinical leadership
- a patient focus.

Examples of how revalidation is supporting wider goals include the following:

To get the medics more attuned to our patients and carers. So part of what we want to do is not only to do the technical aspects of revalidation, but to make sure that ... our medics understand the patient and carer's perspective.

Chair

To enhance the offering that our doctors make in terms of clinical practice, clinical curiosity, clinical leadership and clinical excellence. All this collected as part of the whole portfolio and revalidation.

CEO

Against the background of some fairly major cost improvement programmes... it is another sort of safety net in a way ... It's another check that we are not compromising and not having negative impacts.

Chair

We've been pushing really hard as an organisation on raising the bar on patient experience, safety, quality and clinical outcomes. Well, if you take those four principles, I mean they're all about clinical effectiveness, but that's about what doctors do – they don't do anything else, that's the job. So we've been pushing all of those different things, and what we're seeing is people identifying them through revalidation.

CEO

If organisations are to take ownership of the longer-term benefits of revalidation, the type of leadership and vision seen in these examples needs to be embraced more widely. However, there was variation in boards' approaches to revalidation. For example, at one board the chair had already initiated conversations about the potential benefits of revalidation to the organisation. At another organisation almost all strategy around revalidation (beyond process metrics) was happening at the RO level. This was partly because the current scale of fiscal challenge meant that revalidation was a lower priority at board level than it might otherwise have been.

The board are aware of my aims, have provided funding for them, and they are ultimately responsible for ensuring the process happens well. So I report to the board on progress. Beyond that, in terms of driving the sort of culture change that one might see arise out of appraisal, I'm not convinced that is going to happen from board level.

RO

... to be honest, provided all is going well, I don't think it's particularly high on the board's agenda. It is definitely felt that the board has got much more troubling things to worry about at the moment. You know, they've got a £xxx million organisation to keep going in the face of a huge financial crisis.

RO

... [the board] knew it had to be done but importantly for us is how we all support [revalidation] as the right thing to do, how it can help us develop the agenda that we've got in the hospital around safety and quality, efficiency ... Our view is that if we get the safety and quality sorted to some extent, the money will sort itself.

Chair

However it is rolled out, we know that when an initiative is discussed and acted on at the highest level of an organisation, for instance at the board, this then sets the tone for how it is viewed by other leaders. We know, for example, that board members' behaviour and attitudes to the question of discussing and improving clinical quality is critical to promoting a culture in which quality and patient safety is prioritised (Machell et al 2010).

Appraisers and appraisees

Our research found examples of individuals already making more sustainable changes to their practice, prompted at least in part by revalidation.

■ Proactively keeping up to date educationally and getting involved in shared learning.

People starting to identify things through revalidation, eg, publishing in terms of journals and extracts, or they apply for local or national awards. So we've seen a lot of things coming through, some really good exciting stuff actually – I think it's having a role because it's making people think about what they do. I've seen some really good-quality bits of work that they've put forward for revalidation with some good addendums, and some good research.

CEO

Other examples included:

- doctors being encouraged to read up on the latest guidance, for example, a locum doctor prompted by his appraisal to read up on a difficult case in advance
- doctors prompted by appraisal to enrol themselves on courses
- a doctor prompted to get involved in national audit.

- ### ■ Actively and openly seeking learning with peers and patients.
- Going beyond compliance in terms of collecting the stated number of feedback forms, to seek and share more learning from colleagues and patients. Specific examples included:
- peer-review meetings that are better structured and more focused on patient outcomes

- greater ability to challenge peers, for example, an appraisee who had recently challenged a colleague on their attitude towards and uptake of CPD in a peer-review meeting.

... it has given us a chance to talk to our colleagues, to talk to other practices, and check other practices' quality improvement, and that's how we are standardising, probably our practice.

Appraiser

I think the barriers that ... it was a labour-intensive addition of their busy working day ... have perhaps dissipated. From the impressions that I get that actually most doctors see the value in it and actually seem to think that – it is perhaps too strong a word to say – it's the incentive they have needed. But it does encourage them to actually continue with their learning. I mean the appraisers' attitude I think is they get the benefit from actually going to see doctors outside their normal areas, and that by sitting down and talking to their colleagues in this way they both learn, they both benefit from the exchange of information that was not available to them in the past.

Patient/public representative

- **Reflective practice.** Many doctors expressed the potential for revalidation to lead to more reflective practice. While this wasn't yet widespread, there were signs of some doctors becoming more reflective as a result of revalidation. Few doctors (appraisers or appraisees) felt that revalidation had yet prompted true reflection among those who weren't already inclined. However, for those who were, the appraisal form had the effect of prompting reflection:

As I was writing [my appraisal form] I was reflecting ... and I came to a point where I realised that there was an action that I couldn't write under good medical practice if I had not done anything about it. And it actually induced me to ... make a change – actually identify something that I was unhappy with that I had, for various reasons to do with departmental harmony, shied away from.

Appraiser

Those interviewed from the wider organisation also identified a differentiation between the willing and the less willing. Their aspiration was that if a larger number of individuals are supported to reflect more, this has the power to change culture.

More broadly, we saw evidence that there was greater awareness of the need for reflection, which may lead to more embedded change. One organisation reported that their doctors had logs for things like significant complaints which doctors are required to reflect on and respond to and therefore are obliged to respond to feedback.

Reflective practice

Reflective practice has been described as a self-regulating learning process, a popular method for developing professionals in health and education, applicable to all individuals. It enables self-managed learning, improving individuals' abilities to communicate and make considered and balanced decisions. Donald Schön is credited with making a significant contribution to the theory and practice of reflective practice, writing:

The practitioner allows himself to experience surprise, puzzlement, or confusion in a situation which he finds uncertain or unique. He reflects on the phenomenon before him, and on the prior understandings which have been implicit in his behaviour. He carries out an experiment which serves to generate both a new understanding of the phenomenon and a change in the situation.

(Schön 1998, p 68)

Table 3: Summary of compliance and commitment

Evidence of compliance	Evidence of commitment
<ul style="list-style-type: none"> ■ Focus on process ■ Investment in RO and appraiser functions ■ Investments in IT systems, processes and resources in HR ■ Increased clinical governance processes ■ Performance benchmarking ■ Higher profile and increased appraisal rates ■ Board monitoring of process-outcomes ■ Increased CPD, mandatory and statutory training ■ Data collection and greater doctor ownership of their data ■ Greater use of GMC guidelines ■ Increased reporting and conversations about incidents, but less willingness to share the more serious errors 	<ul style="list-style-type: none"> ■ Commitment to benefits (especially at RO, CEO and chair level) ■ Individual doctors proactively keeping up to date and getting involved in shared learning ■ Actively and openly seeking learning with peers and patients ■ Reflective practice

Commitment, leadership and vision: unlocking the potential of revalidation

Many doctors and representatives of the organisations with whom we spoke identified the potential for revalidation to have far-reaching benefits. Clearly such aspirations are not realised overnight. Below is a summary of areas where those we spoke to felt revalidation could, with the right leadership, have impact, as well as an indication of the barriers that leaders will need to address to unlock this potential.

- **Reflective practice among those who most need it**, such as those doctors who lack the insight and ability to see the benefits of reflective practice. Often from a leadership development perspective, those who resist the most are the ones who will benefit the most. Nurturing reflective practice among this resistant group is not easy.
 - Organisations said they were working hard to challenge those who did not think they needed to do anything until their own revalidation date.

We do have 228 doctors who we are chasing to get their appraisals done. There's still a kind of an ostrich thing about the whole thing ... I think the thing that worries me most is still this perception that people only need the one appraisal in order to be revalidated and I think one of the key messages we're going to have to start getting across is well actually, you need an appraisal for every year before you get revalidated. So if their revalidation date is year three for instance, they would need three annual appraisals.

RO

- More vexing perhaps were those in a senior position whose attitude and behaviour was felt to be regularly inappropriate but rarely challenged.

You can get feedback from staff which, as an example, you know they might frequently mention a particular name of a senior medical person who doesn't behave in a very good way with colleagues. Now if you keep hearing that name I think there's a responsibility in the organisation to do something about it.

Human resources director

- Forms alone were perceived to be an ill-designed mechanism for reflection. It was felt by appraisers and appraisees that either doctors were reflective before revalidation or those not inclined would be able to ‘surface comply’ – go through the motions of filling in the paperwork but not engage with what it means for their practice.

I overhear conversations of people saying, ‘oh yes, I spoke to my receptionist and I told her to do this, put that in your portfolio, that’s reflective learning’, and, you know, just bumping up their hours. It’s a question of just getting all the information on there rather than taking a step back and thinking ‘what do I need to do to, you know, deliver a high standard of care for my patient?’

Appraisee

- A barrier to greater reflection (for those who were inclined) was felt to be lack of dedicated time, and indeed (for the more cynical) the amount of time taken up with form-filling.
- Those in the wider organisation felt that while true reflection was not happening on a large scale currently, it would over time as a more reflective culture became normative.

While that [personal reflection and peer reflection on practice] changes behaviour, it brings about a different culture as well. It brings out a different culture of openness, willingness to learn, willingness to accept some criticism as well at times. And not take that as a personal thing but it is a way of actually improving.

Chair

- **Information-sharing across agencies** to ensure those working across different sectors, settings or constantly moving between different organisations, are learning based on their full range of practice.
- We heard from doctors and ROs in the organisations visited that whole practice scrutiny was ‘broader than before, but still not comprehensive’ (appraiser). While doctors are obliged by the Code of Conduct for Private Practice to declare if they are practising privately, we heard in our study that many are simply choosing not to. For revalidation the consequence is that their whole practice will not be subject to reflection and feedback. The revalidation process, as doctors and organisations saw it, is still reliant on doctors volunteering information, although moves were being made in at least one organisation to monitor whole practice.

We are asking, ‘where else do you work, where was this data collected, which hospital were these figures from?’ And I think within the next year we will be using an independent hospital network data, the thin data that give us that overview. And it will be just mandated to all the doctors that work independently for us, that we are going to want to see a whole overview of practice.

Medical director

The appraisals that they are undergoing in those hospitals are often poor quality and I think that a lot of those doctors are not including within their appraisal, much if any of their independent sector data.

Medical director

- Doctors and organisations felt that agencies in the private sector and the NHS should be sharing information. They expressed a desire that true information governance should be promoted across the sectors.
- For locum agencies and trusts, one participant commented that this would require the development of better and different relationships, beyond simple commercial transaction.

- **Achieving excellence.** While doctors and representatives of the wider organisation stated that revalidation had set organisational expectations of excellence, it was not yet felt to be having an impact on doctors. Some doctors felt strongly that revalidation could help people to aspire to a higher level, or encourage better behaviours such as investigative activities, but that it was not yet doing so. In contrast to the formative approach of pre-revalidation appraisal, the more summative and prescriptive process of appraisal for revalidation was felt to encourage doctors to aim for a minimum standard. This was particularly felt in organisations that set a high bar for excellence or had already achieved good standards of appraisal.

I think it's tending towards the lowest common denominator because increasingly we are having to say, 'significant event, tick, audit, tick,' and there's very little guidance for us out there as to what the quality of things like the audits should be.

Appraiser

As a result, a gap was seen to be opening up between the expectations of excellence held by organisations and the public and what doctors perceive to be the reality.

As a member of the public I am very impressed and reassured that actually there is this process of ongoing revalidation. It actually gives me confidence in the system and that we actually are continuing to get excellent doctors.

Patient representative

One CEO said that for him the key was to provide data at the relevant level to make personal learning about practice possible, warning that currently the NHS and hospitals were good at 'punching out high-level data that are so high-level that it doesn't mean anything to anyone'.

- **Investing in the outcomes of revalidation.** Doctors – appraisers and appraisees – felt that revalidation may have prompted earlier identification of issues and increased scrutiny, but questioned what actually changed or improved as a result. The process of gathering and managing information, for instance, gathering and managing complaints data, gathering patient views and so on, was seen to be dominating but doctors and organisations were not necessarily yet acting on the content of them.
 - This was partly felt to be a matter of allowing sufficient time for doctors to make the required changes to their behaviour.
 - But it also related to system investment. For example, if an appraisal highlighted that a core constraint to a senior doctor improving care in their department required investment in a new facility, the finance for this was not always possible. Clearly, fiscal realities were at play here. Quality improvement activity becomes the lower priority where it is competing with management responsibilities and clinical work.
 - Areas for development were identified during the process of appraisal for revalidation but some doctors did not subsequently feel supported to make changes. This was expressed both in terms of investment to support personal development and in terms of clinical leaders addressing poor performance in their teams. Those who felt strongly expressed a perception that development was said to be viewed by some organisations as 'a favour rather than a responsibility'. Some organisations were reported to be providing little resource for development beyond that statutorily required.
 - It was felt that revalidation had the potential to improve consistency in the quality of medical care across the country. Leaders were not yet seen to be unlocking this potential, but increased use of benchmarking and shared learning could support this.

One RO expressed his aspiration for the link between appraisal and business strategy, providing a powerful vision for how revalidation could support quality improvement:

I'll think we've got this right when we get to the point where what comes out of appraisal, in terms of the summaries of appraisal and people's personal development plan, feed through into the job-planning discussions that then happen in the directorate. And that in turn then feeds through into the business-planning process of the organisation and whatever strategic direction then comes out of all of that in turn feeds back into appraisals, so that appraisals are taking place within that context where there is a clear message about what the strategic direction of the organisation is. Then you almost get a sort of cyclical effect.

RO

- **A service that is more patient-centred**, primarily through the mechanism of feedback in the revalidation cycle making patient views more personally relevant to doctors. Some organisations felt they were already responsive to patients: in the private sector because they are customers, there was a profit incentive to behave in a way that created repeat business; in mental health, wider cultural change had brought increased collaboration with service users and their carers. In other organisations doctors were not seeing a change here, with patients perceived to be a secondary concern in the revalidation process. Some doctors reported collecting less patient feedback now for their appraisal due to prescriptive processes.

Many doctors commented that changes to the current design of patient feedback into revalidation are required if it is to support the development of a more patient-centred service.

- Processes for collecting patient feedback were seen to be variable and not sufficiently robust to be useful to doctors or patients. Some questioned patient awareness of revalidation and the impact of the feedback they give. Some doctors called for 360-degree feedback to be made more frequent than a five-year requirement, for more rigour to be applied in how patients are selected, and in the methods used to ensure patients can be open and honest.
- Many doctors expressed a need for: more help to collect patient feedback; for clarification of the requirement for specialties with little or no access to patients; and for practical support to get the job done within the time available to doctors.

It's very difficult to get your own patient feedback. It is very difficult to do that in a way that's going to get accurate feedback and open feedback.

Appraisee

Some individuals saw real potential for revalidation to create a link between the doctor and their patients' views and to be a lever for improving patient safety and experience. This was not just in terms of alterations made to behaviour prompted by fear of poor feedback, but in the substance of that feedback leading into improvements in care. One patient representative aspired to seeing doctors more aware of the communication and information needs of their patients, so that the service provided is based on the patient 'as a whole person'.

Conclusion

There are still two years to go until the first cycle of medical revalidation is complete, and still time for revalidation to have considerable impacts on doctors' behaviour and culture in a way that supports quality improvement.

Revalidation has already driven compliance, which has in turn:

- extended appraisal to those who did not have it before
- raised awareness of the benefits of reflective practice and open information-sharing
- encouraged uptake of CPD
- created information systems to support these processes.

For those who were already carrying out these activities previously, doctors told us that revalidation had formalised what they were already doing. It has also involved the creation of the role of RO – a clinician – to which legal responsibility for the process is devolved, supported by a framework of appraisers (also doctors).

We heard that the process was not perfect. But the regulatory mechanism does appear to be driving compliance with this process. In some instances, this was having an influence on behaviour that ranged from surface compliance and compliance with minimum requirements to commitment to continuous quality improvement.

While some benefits will be realised through time, leaders in the system would be ill-advised to rest on 'early laurels'. The stability post-implementation can be used to refine the process, and more importantly to give attention to clarifying the purpose of revalidation. This will help it to achieve the higher aspirations expressed by many who took part in our research for it to contribute to both quality improvement which impacts on patient care and individual professional development.

We heard that revalidation had started to create a level playing field within organisations, a change that was particularly relevant for those groups who have traditionally felt marginalised. It has sought to include feedback to doctors from peers across professions in health and from patients. For revalidation to become more stimulating and elicit the generative benefits it can deliver, leaders (including individual doctors undertaking revalidation) need to be encouraged to be more innovative. Imagine a time when doctors' quality improvement work is focused on making a contribution towards integration; and when CPD is focused on orchestrating and making possible the changes needed to redefine and tighten descriptions for doctors in formal leadership roles.

In contrast, if revalidation starts and ends with a process, it will not lead to sustained behavioural and cultural change. More attention to process may lead to more compliance in the short term. What leads to culture change is when behaviour is internalised so that doctors are motivated to improve the quality of patient care – when no one is watching.

Leadership at the individual and organisational level will support this change. It will be needed to enable doctors to see beyond the process of revalidation and genuinely affiliate with its purpose.

We now outline our recommendations for how leaders at all levels can support revalidation as a tool for committed quality improvement.

Recommendations: moving from compliance to commitment

The United Kingdom is the first country in the world to introduce the mandatory regulation of its medical workforce. The scale of the task and the change processes that it brought have meant that those tasked with the introduction of medical revalidation have focused on achieving compliance, a necessary first step.

In the lead-up to the formal introduction of revalidation, resources were targeted on the establishment of and support for the RO (responsible officer) role and on encouraging organisations (designated bodies) to strengthen processes and systems to enable them to capture better clinical governance data and, where necessary, to improve their existing appraisal systems.

We believe that compliance and focus on process is a necessary first stage; however, our study and our many years' experience of developing leaders in health, tell us that moving revalidation from compliance to commitment will bring greater benefits to patient care and ultimately lead to sustainability. Moving revalidation from compliance to commitment will require action by leaders at all levels:

- system (GMC, Faculty of Medical Leadership and Management (FMLM), royal colleges, NHS England, NHS Employers)
- organisational (designated body)
- individual (appraisee, appraiser, RO).

Some of these recommendations are appropriate to all levels, some to specific audiences (as indicated accordingly). We encourage leaders at all levels to take stock of how the introduction of revalidation has been received and to review their progress in the following areas.

Strengthen and refine the existing process

- Leaders at all levels need to take stock of what is working well and build on this by taking action locally. Our study suggests that they should:
 - retain the elements that work well: doctors' participation in an annual appraisal, including reflections on their contribution to a culture of quality improvement; the development of doctors as appraisers
 - add a voluntary education programme for appraisees on appraisal for revalidation and the practices required, such as reflection
 - assess the number of hours in reflective practice being asked for against other types of improvements doctors feel can be made
 - consult meaningfully on refining the process where needed (for example, to tailor it to particular groups) to ensure appraisal is formative.

Move beyond the process: unlock the potential for quality improvement

- Providing additional guidance and support for participation in clinical governance activity and quality improvement initiatives should ensure these issues are included in appraisals and appropriately documented for revalidation. Organisations should ensure SUIs are reported, recorded and utilised in quality improvement reviews.
- Leaders need to commit the necessary resources to maintain, refine and evaluate the process and its impact against aims. This would unlock the potential for quality improvement, particularly in designated bodies employing locums, recognising the contribution they make to delivering patient care in primary, secondary and mental health settings.
- Leaders should ensure consistent messaging on the purpose of revalidation at a national and organisational level. They must translate the benefits of revalidation to the organisational context, for instance through:
 - discussion at board level to agree on how to use revalidation as an enabler for cultures that drive high quality for patients
 - consistent communication of this message throughout the organisation, including HR and operations functions
 - evolving the ORSA to include measures designed to capture engagement and impact on quality improvement.
- Leaders must also personalise the process by:
 - investing in face-to-face communication of the organisation's vision for quality improvement, with revalidation as a process that helps to drive this (organisational)
 - enacting the vision for quality improvement through effective medical engagement; encouraging doctors to identify the benefits of revalidation for their own work (organisational and system).
- At an individual level, doctors should keep an open mind to revalidation as a potential enabler to help doctors improve the quality of care that they provide for their patients.

Encourage a learning culture where high quality is recognised and mistakes are learned from

- Leaders at all levels should support doctors in benchmarking themselves against comparable organisations and specialisms. This could be achieved by:
 - investing in and evaluating the accuracy of current data systems that support revalidation with doctors and patients
 - encouraging doctors to identify and participate in relevant quality-driven audits, and to share results widely
 - creating platforms in which innovation and best practice is shared across sectors
 - supporting the development of safe and compassionate learning cultures, within and across organisations and sharing issues about individual practice.
- At all levels, leaders should review current mechanisms for patient and peer feedback into both appraisal and revalidation to ensure they are honest, valued and acted on.
- Within systems and organisations, leaders should ensure consistent follow-through on issues at both local and system level by:
 - supporting the corrective actions emerging from appraisal, that is, learning and development, and service improvements
 - developing and evolving a strategy and funding for remediation to enable appropriate support to be given
 - demonstrating that those who are not fit to practise will not be revalidated.

Our view is that medical revalidation, with the right conditions, can be a valuable driver of behaviours and cultures that support sustained quality improvement. The time to develop those conditions is now.

Above all, leaders should bear in mind that large-scale change requires them to have the tenacity and vision to create a process that is valued by all who are involved in it. As we have previously stated, what is of most value is what is practised when no-one is watching.

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