

THE IMPACT OF REVALIDATION ON THE CLINICAL AND NON-CLINICAL ACTIVITY OF HOSPITAL DOCTORS

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PREFACE

This project was undertaken to explore how revalidation, as a process, would impact on the different responsibilities of hospital doctors. Revalidation is new, supported by legislation, is high stakes and mandatory. Each doctor will be required to engage in the appraisal process, leaving the possibility that a small number of doctors will be deprived of their livelihood by losing their licence to practice. Public safety is paramount and the need to identify and intervene early with doctors in difficulty is well accepted but the challenge to deliver revalidation effectively, given information limitations and workforce pressures, is considerable.

The focus of revalidation has rested on appraisal; the two processes are not the same and appraisal, intended to be formative and focused on quality improvement, now has to provide a basis on which revalidation judgements are made about continuing fitness to practice. This is a step change in emphasis and the time and commitment to 'new' appraisal cannot be delivered easily in a pressurised NHS where there are increasing demands on practitioners' time. There has been much discussion of a proportionate system of revalidation, recognising that the great majority of doctors registered to practice currently will revalidate without problem. This misses the point; to get to this position all doctors will have to find time, energy and the supporting information to engage with new appraisal and revalidation systems and present an evidenced case to their Responsible Officer (RO) to allow him/her to make a positive recommendation about continuing fitness to practice to the regulator.

It is not widely appreciated that the current consultant contract apportions 25% of the working week to non-clinical activities such as teaching and professional development, leaving the remaining time for direct clinical care. Preparation for appraisal and, thus revalidation, is carried out in this non clinical time. Protection of this time is vital to allow effective revalidation and secure commitment to other non clinical activities.

The survey, undertaken in the spring of 2011, provides a snapshot of how hospital doctors spend their professional time. It illustrates the pressure points in the system before the introduction of new revalidation processes and explores how doctors prioritise their varied responsibilities. It would be all too easy to demonstrate that revalidation will not in itself erode direct patient care and miss the unplanned (longer term) impact on other important professional responsibilities – teaching, training, research, quality improvement, service development and clinical leadership to say nothing of the loss of job satisfaction and reduced morale.

The results shed light on how hospital doctors will engineer time to engage properly with revalidation, the particular challenges facing some groups of doctors and the potential consequences of losing professional input into wider aspects of healthcare development and delivery. Detailed modelling could then be the subject of a further study.

EXECUTIVE SUMMARY

The views of over 2600 doctors working in the NHS (80% consultants, 20% SAS doctors) in Scotland and the North East of England (NEE) are presented in this report and give an up to date insight into how doctors use their time, their concerns about the effort required to deliver revalidation effectively and how they will engineer space in their professional lives given current NHS pressures.

Key facts

1. Hospital doctors in Scotland and the NEE work in excess of their contracted sessions with over 77% of their contracted time devoted to direct clinical care.
2. There are a small but significant number of 9:1 contracts in Scotland and the NEE of England. Such contracts skew the balance of the consultant contract negotiated in 2003.
3. There are gender, part time and specialty differences in the proportion of time spent on direct patient care by consultants. SAS doctors spend proportionately more time in direct patient care.
4. Only a third of doctors can take all their study leave.
5. Lack of time and insufficient cover are major barriers to CPD .
6. Over a quarter of consultants in Scotland and the NEE, rising to a third for SAS doctors, indicated they were in some measure dissatisfied with their job.
7. Almost 60% of all consultants have at least 1 additional professional responsibility with over 85% having some designated responsibility for training grade doctors.
8. 54% of all hospital doctors have time in their job plans for appraisal but there is evidence of surprising variation between sub groups.
9. Over 75% of doctors had an appraisal in the 12 months prior to the survey (consultants 87%). This gap must be closed when revalidation goes live.
10. Over half of doctors believe clinical governance information is not readily available from their employer.
11. Consultants are unclear about access to e-systems for appraisal but are interested in using them in the future.
12. Most doctors believe that revalidation will take significant time over and above appraisal.
13. More doctors in the NEE than in Scotland believe the time taken to prepare for appraisal will be higher than in previous years.
14. Less than 50% of doctors expect to absorb revalidation in their current NHS time.
15. Almost a third of consultants, if faced with reducing their NHS work would limit their non-clinical administration/management activity (this includes service development and clinical governance).

The last section of the survey employed a recognised social science technique to explore independently, relative value judgements about different aspects of professional life to tease out the responsibilities at greatest risk when time is under pressure. This revealed the following:

- Overall, CPD opportunities exert a positive influence on job preference and provides evidence that this will be protected by all doctors.

- Younger consultants value extensive CPD opportunities, teaching and training more than their older colleagues – restricting this in the early years could be especially damaging professionally and short sighted.
- Female and part time consultants value participation in CPD more than their male and full time colleagues and are less deterred by increases in non-clinical administration – this suggests full entitlement of study leave for these groups needs protection.
- Reductions in non-clinical administration/management (including service management and planning and clinical governance activities) are welcomed by doctors suggesting that they are likely candidates for sacrifice – planners and quality improvement leads beware.
- Losing all opportunities for external work would be unwelcome for consultants and, if imposed, risks loss of morale and professional satisfaction – a lesson for 9:1 contracts and the provision of professional leave.
- Males value research opportunities more than females – reflecting other studies which have identified a gender bias in research.

Discussion points

The discussion focuses on a number of themes, namely:

- Different health systems – same messages.
- Unexplained variation between health boards, trusts and specialties requires further investigation.
- Revalidation processes add to the time pressures on already hard pressed doctors.
- CPD and professional leave require protection.
- In a time limited system, revalidation will displace professional input to service development quality improvement and clinical leadership and may disrupt training.
- Hospitals must review their clinical governance systems to ensure information is accurate, relevant and available in a format that informs appraisal.
- Professional organisations developing support tools for revalidation need to promote these more widely
- Less than full time doctors may find it more difficult to maintain professional interests and present sufficient information to revalidate successfully
- Young/newly appointed consultants may require all their SPA time for their own revalidation limiting their wider contributions.
- Specialty doctors have special needs.

In conclusion we have found no strong evidence that direct patient care by consultants will be compromised in the short term by the requirements of new appraisal and revalidation processes. SAS doctors may find it more difficult to protect direct patient care. However, revalidation was introduced as a patient safety and quality improvement initiative and this survey suggests that, at a time of huge pressure on medical time, we are at risk of losing some of the clinical innovation and leadership that drives both. Once time for revalidation is clear, further modelling will be required to quantify the full impact on wider professional responsibilities.

INTRODUCTION

The Royal College of Physicians of Edinburgh (RCPE) led an inter-collegiate research project, funded by the Academy of Medical Royal Colleges and Faculties in the UK (the 'Academy'), to explore the expected impact of revalidation on the clinical and non-clinical activity of hospital doctors. Partner Colleges included the Royal College of Surgeons of Edinburgh (RCSEd) and the Royal College of Physicians and Surgeons of Glasgow (RCPSG) with support from a number of other Royal Colleges (see Appendix A for full membership of the working Group). The survey, undertaken in collaboration with the Health Economics Research Unit of the University of Aberdeen (HERU), was completed between April and June 2011 as appraisal and revalidation systems were being refined by the General Medical Council and the NHS across the UK.

PROJECT OBJECTIVES

Revalidation is being introduced at a time of financial constraint in the NHS and when the GMC, health service managers and government policy developers are encouraging clinical staff into leadership, quality assurance and education and service development roles. The Colleges wished to explore the risk that important (clinical and non-clinical) components of professional work may be compromised by the time and effort required to deliver revalidation. This required:

- understanding how hospital doctors use their time (baseline data);
- exploring how hospital doctors prioritise their non-clinical responsibilities;
- investigating whether any sub groups will be disproportionately affected.

METHODOLOGY

A self-completion 20 page questionnaire was developed by HERU, guided by the project steering group and piloted over the winter of 2010-11. The resulting questionnaire was distributed by HERU to all consultants and Staff Grade, Associate Specialist and Specialty (SAS) doctors in the NHS in Scotland and in 8 NHS Trusts in the North East of England (NEE) between April and June 2011. Thus the sample included hospital doctors from two increasingly divergent health systems. Responses were returned directly to HERU to preserve confidentiality guarantees and HERU undertook data entry, verification and statistical analysis of the results. A full description of the methodology and results is available in the companion research document published by HERU ('Impact of Revalidation on the clinical and non-clinical activity of hospital doctors: Research Report').

RESULTS

Sample size and response rates

Different approaches were required to identify respondents and distribute the questionnaires to the Scottish and North East of England doctors. Full details of the samples targeted and achieved are available in the Research Report. Completed questionnaires were received from 2600 doctors with the following response rates:

	Scotland	North East of England (NEE)
Consultants	41.4% (n= 1753)	34.3% (n= 382)
SAS Doctors	38.9% (n= 375)	28.0% (n= 90)

Checks were undertaken to verify the representativeness of the Scottish sample and revealed slight over representation of females and consultant anaesthetists and variability in response rates between the health boards (34% - 54% for consultants and 32%-44% for SAS doctors). The representativeness of the NEE sample could not be checked against baseline data but was deemed reasonable by steering group members working in the North East of England. The sample characteristics of consultants for Scotland and the NEE were broadly similar in terms of gender, age and contract status (full time or part time) and participation rates in non NHS / fee paying work. The results reveal some differences between Scotland and the NEE but it should be noted that comparison between the two jurisdictions was not a primary objective of the survey. There were some specialty and SAS differences in the sample which could not be explored further due to small numbers in the NEE consultant sample and in both SAS groups, where only those the results of those under the 2008 contract were included, restricting the sample size further.

Sub group analysis was one of the objectives of the survey and the sample size achieved has generally allowed this by gender, age, contract status and, occasionally, by specialty. However some interesting indications of differences commented on in the report cannot be supported statistically due to small sample sizes.

By way of commentary HERU reported a higher return as 'unknown' or 'gone away' for SAS doctors in both Scotland and England suggesting an early revalidation challenge for NHS employers will be to trace these doctors.

Contracted and worked sessions

Key fact 1: Consultants in Scotland and the NEE work in excess of their contracted sessions with over 77% of their time devoted to direct clinical care

Respondents were asked for details of their total PAs and any EPAs agreed within their contract. The total sample (full and part time doctors) revealed an average of 11 contracted sessions with no statistical difference between the Scotland and NEE. Hours worked (including on call commitments) when converted into PAs, revealed that the Scottish consultants worked the equivalent of 12.05 PAs and their NEE colleagues 11.92 PAs.

Sub group differences (Consultants)

There were gender differences with females contracted to work significantly fewer PAs than males in both samples and all working in excess of their contracted hours. Unsurprisingly there are also significant differences between full time and part time consultants (defined as less than 10 PAs) but the gender differences remain in hours worked when only full time female consultants and part time males are considered. There is some evidence that specialty drives the numbers of hours worked. Table 1 summarises the results (overleaf):

Table 1: PAs and EPAs contracted and worked

	Scotland		North East England	
	Contracted	Worked*	Contracted	Worked*
All Consultants	11	12.05	10.8	11.92
Female Consultants	10.2	12.25	10.2	11.4
Male Consultants	11.5	12.85	11.2	12.3
Full Time Consultants	11.6	12.7	11.7	12.6
Part time Consultants	8.0	9.5	7.5	9.1

* Figure derived from total hours worked (including on call) and converted into PAs by assuming 4 hours per PA. This may underestimate total PAs worked as it does not allow for differences in on call PAs – even so all consultants on average still work in excess of contracted time.

The SAS sample achieved was too small to report for NEE but Scottish SAS doctors on the 2008 contract indicate an average contractual commitment of 8.7 PAs with an average of 8.9 PAs worked.

Breakdown within PAs : Direct Clinical Care/Supporting Professional Activities

Consultants were asked to give a breakdown of the contracted hours included in their job plan into direct clinical care (DCC) and supporting professional activities (SPAs). The 2003 consultant contract specifies a 7.5/2.5 DCC/SPA split; the Scottish consultants reported an average 77% of time in their job plans in DCC and the North East consultants reported 78%. Part time consultants had proportionally higher amounts of SPA time as might be expected given their need for a full allocation of time for CPD etc.

Derived analysis from the reported actual hours worked indicates that Scottish consultants worked an average of 76% in DCC and their NEE counterparts 74% in DCC. There were no gender or contractual status differences in the amount of DCC time worked but younger Scottish consultants (aged under 40) showed a small but statistically significant increase over other age groups at 78% DCC time worked.

SAS doctors on average worked over 80% of their time in direct clinical care which was higher than the comparable figure for consultants.

Key Fact 2: There are a small but significant number of 9:1 type contracts in Scotland and the North East of England. Such contracts skew the balance of the consultant contract negotiated in 2003

Pressure is increasing for newly appointed consultants to accept job plans with 90% DCC (colloquially referred to as 9:1 contracts) and this survey reports that 5% of consultants in Scotland and 3% of consultants in the NEE have less than 10% of their job plan devoted to non-clinical activities and therefore has revealed over 75 such contracts in this sample.

Balance of Consultant activities

Scottish consultants spend more time in direct patient care (26.2 hours) than their North East counterparts (24.6 hours) with the reverse trend for clinical administration. This could reflect classification differences. Consultants in the NEE spend more time than Scottish consultants in private CPD activities and medico-legal work.

Key fact 3: There are gender, part time and specialty differences in the proportion of time spent on direct patient care by consultants. SAS doctors spend proportionately more time in direct patient care than consultants

The research report presents the evidence of activities undertaken both as actual hours and proportions of time; the latter to allow comparison by contractual status.

Female consultants in Scotland spend significantly less of their time in direct patient care than their male colleagues and this trend remains when only full time female consultants are included. Female consultants in the NEE do not show a statistically significant difference in direct patient care but they do more clinical administration than their male colleagues. On average all female consultants spend less time in research than males.

All part-time consultants spend proportionately more of their time in clinical administration and in internal and private (as opposed to external) CPD than their full time colleagues but this is only statistically significant in Scotland.

Specialty differences were explored for the largest groups in the sample (medicine, surgery, anaesthetics and psychiatry). In Scotland the range of time devoted to direct patient care varies from 20.9 hours in psychiatry, to 31.9 hours in anaesthetics. In the NEE the range of time devoted to direct patient care varies from 18.8 hours in psychiatry, to 36.6 hours in anaesthetics. Hours spent in clinical administration in Scotland vary from 2.4 hours in anaesthetics to 7.3 hours in medicine. It is unclear how much of this variation is due to underlying differences in the requirements of particular specialities or to demographic differences in the sub group (i.e. gender and/or contractual status).

SAS doctors spend proportionately more of their time in direct patient care than their consultant colleagues. SAS doctors in Scotland spend 66% of their time in actual direct patient care compared with 57% for consultants. SAS doctors in the NEE spend 65% of their time in actual direct patient care compared with 53% for consultants. SAS doctors spend similar proportions of time in clinical administration and less time in non-clinical administration than consultants.

Range of SPA activity

Supporting Professional Activity (SPAs) are defined as those activities considered important for maintenance and enhancement of service quality rather than for direct patient care and include time for teaching, CPD and professional development as part of revalidation.

Key fact 4: Only around a third of doctors can take all their study leave

33% of Scottish consultants and 32% in the NEE reported being able to take *all* their study leave (average of 10 days across the full sample). Further analysis demonstrated that percentages increased to 83% for all consultants once those reporting they were *usually* able to take study leave were included. The trend was similar for professional leave.

SAS doctors reported a similar average entitlement to study leave with similar ability to usually take this and professional leave on request. 31% of SAS doctors in Scotland and 30% in NEE report being able to take all their study leave.

Key fact 5: Lack of time and insufficient cover are major barriers to CPD

87% of Scottish consultants and 91% of consultants in the NEE reported lack of time as the main barrier to CPD with 'insufficient clinical cover' being cited by 64% and 65% respectively. Almost half of the consultants indicated funding pressures caused problems for study leave. SAS doctors reflected this trend.

A number of questions were asked relating to facilities and support available to consultants. Tables A and B (below) give a flavour of the commonly reported problems. Rising clinical workloads resulting from changes in working patterns and changes in trainee hours and shift patterns are significant. Over 65% of all consultants reported taking work home regularly and over 40% believed their current working hours are having an adverse effect on their home life. This result has changed little from an earlier survey of Scottish consultants in 2006.

Of some concern is that 25% feel workload is affecting their health and around 40% believe workload is influencing their standard of care and is unsustainable. On average, consultants reported being unable to take 3 days of entitled annual leave with the main reason again being service commitments.

Working pressures and workload effects were reported differently by SAS doctors although these results must be interpreted carefully due to the small sample size. SAS doctors appeared less exercised by:

- a lack of secretarial and administrative support
- the impact of changes to training grade doctors
- the mismatch of job plan to workload
- actual workload and
- The effect of work on their health and home life.

Table A: Working pressures (Consultants)

	Scotland agree/ strongly agree	NEE agree/ strongly agree
Some of the tasks I perform could be undertaken equally well by someone less qualified than me	79%	75%
I have sufficient secretarial and/or administrative support	61%	71%
Reduced working hours for training grade doctors has increased my workload	76%	66%
I have a good working relationship with managers in my main place of work	73%	80%
I regularly take work home with me	67%	64%
There are insufficient staff in my unit to allow me to delegate tasks	69%	68%
The introduction of rota working for trainees has increased my workload	67%	59%

Table B: Workload effects (Consultants)

	Scotland agree/ strongly agree	NEE agree/ strongly agree
My current workload is adversely affecting my health [#]	25%	25%
My current workload is such that I am unable to provide my desired standards of patient care	38%	38%
My current workload is unreasonable and unsustainable	41%	41%
My current job plan accurately reflects my current workload [*]	45%	40%
My current hours of work are having an adverse effect on my home life	46%	43%

[#] in a separate question over 90% self-assessed as being in good health

^{*}20% of both samples disagreed strongly with this statement implying significant work is required to address job plan inaccuracies as part of appraisal and revalidation.

Key fact 6: Over a quarter of consultants in Scotland and the NEE and a third of SAS doctors indicated they were in some measure dissatisfied with their job.

Consultants were asked to rate their satisfaction on a 7 point scale; across the sample the mean score achieved was 4.9 with over 25% scoring 4 or less on a 7 point scale where 7 equated to extremely satisfied. This lukewarm endorsement of professional satisfaction is a clear signal of a system under intense pressure.

SAS doctors reported a lower average satisfaction score, with a third of Scottish SAS doctors and over 40% of SAS doctors from the NEE scoring 4 or less on the same scale.

Additional responsibilities and duties

Key fact 7: Almost 60% of all consultants have at least 1 additional professional responsibility with over 85% having some designated responsibility for training grade doctors

57% of Scottish consultants and 59% of consultants in the NEE reported having at least 1 additional professional responsibility beyond what would be routinely expected of a consultant.

Respondents were asked to identify the nature of these additional responsibilities, which were extremely varied. The largest single response for both samples was work for the Royal Colleges (12% in Scotland and 10% in the NEE).

85% of Scottish consultants and 87% of consultants in the NEE reported having designated responsibility for training grade doctors. The samples achieved for these questions from SAS doctors were small but indicated that around a quarter of SAS doctors have designated training responsibilities.

Appraisal and preparation for revalidation

Key fact 8: 54% of all doctors have time in their job plan for appraisal but there is evidence of surprising variation between sub groups

62% of consultants in Scotland and 29% of consultants in the NEE reporting having time in their job plans for appraisal. Sub group analysis revealed similar patterns for the Scottish sample and the smaller NEE sample. There were no contractual status differences in either sample. There were specialty differences with over 70% of consultants in psychiatry and anaesthetics having time in their job plans for appraisal but less than 50% of surgical consultants in Scotland. The pattern was different in the NEE where anaesthetics, medicine and surgery had more time than other specialties. There was an age effect in Scotland only with the over 55 year olds consultants having the lowest percentage of time for appraisal. There were no gender differences in Scotland but the much smaller NEE sample showed a slight bias towards males (33% of males compared with 21% of females). There was significant variation across the Health Boards (43% to 78%) and participating English Trusts (14% to 55%) but some of the sub group response levels are small and results should be interpreted with caution.

44% of SAS doctors in Scotland and 16% of SAS doctors in the NEE who were under the 2008 contract had time in their job plans for their own appraisal. For Scotland this contrasts sharply with the consultant results above but mirrors the trend for consultants in the NEE.

Key fact 9: Over 75% of all doctors (87% of consultants) had an appraisal in the 12 months prior to the survey

87% of Scottish consultants and 88% of consultants in the NEE had an appraisal in the 12 months prior to the survey but there is some evidence of variation between Health Boards (73%-86%) and Trusts (57% - 86%). Some of the sub group response levels are small and again results should be interpreted with caution.

Other sub group analysis revealed no gender or contractual status differences for either sample and a small but statistically significant age effect in Scotland only with the youngest (under 40 years) and oldest (over 55 years) groups having slightly lower appraisal rates. Specialty analysis was only feasible for the Scottish sample and indicated higher appraisal rates in psychiatry, anaesthetics and radiology (all over 90%) and the lowest in emergency medicine at 64% and again from a small sample.

75% of SAS doctors in Scotland reported having an appraisal in the 12 months prior to the survey with 76% in the North East.

All designated bodies in the UK have submitted data on their readiness for revalidation with appraisal capability being an important indicator. This overall finding of 75% is an important benchmark.

Key fact 10: Over half of doctors believe clinical governance information is not readily available from their employer

61% of Scottish consultants and 53% of consultants in the NEE disagreed or strongly disagreed that relevant clinical governance information was readily available from their employer. Sub group analysis of the Scottish sample only revealed some health board variation (range 44% to 69%) and some specialty variation ranging from 50% in radiology to 74% in obstetrics and gynaecology. SAS doctors have more mixed views and higher uncertainty levels.

Key fact 11: Consultants are unclear about access to e-systems for appraisal but are interested to use them in the future

There was low awareness and/or uncertainty for all consultants on the availability of an e-system to support appraisal and of College support systems although over half of all doctors expressed an interest in such tools and a willingness to use in the future.

Key fact 12: Most doctors believe that revalidation will take significant time over and above appraisal

82% of Scottish consultants and 84% of consultants in the NEE agreed that revalidation will take significant time over and above appraisal. Sub group analysis of the Scottish sample only revealed no differences by gender but some evidence of age, contract type and specialty differences. The over 55 and under 40 year olds had the lowest agreement and highest uncertainty levels. Part time consultants had much higher uncertainty levels on this question than their full time colleagues. Specialty responses varied from 71% in psychiatry to 87% in anaesthetics. SAS doctors from both samples mirror this trend.

Key fact 13: More doctors in the NEE than in Scotland believe the time taken to prepare for appraisal has increased compared with previous years

45% of Scottish consultants and 66% of consultants in the North East agreed that time spent preparing for the most recent appraisal had increased compared to previous appraisals. It is possible that this reflects a timing difference in the introduction of systematic appraisal but adds to worries about time required for revalidation. Sub group analysis of the Scottish sample revealed no gender, contract status or specialty effects on this question but a wide range of responses by health board (range 29% to 62%) implying differing levels of efficiency and availability of information. There was also a slight age effect with higher uncertainty results for the under 40 year age group, who would have less experience in appraisals as a consultant. SAS doctors from both samples mirror this trend.

Finding extra time for revalidation

Key fact 14: Less than 50% of doctors expect to absorb revalidation in current NHS time

47% of Scottish consultants and 44% of those in the NEE expect to be able to absorb revalidation into current NHS time. 55% of Scottish consultants and 67% of consultants in the NEE agreed that they would find time in non-work/leisure time. 19% of Scottish consultants and 16% of consultants in the NEE agreed or strongly agreed that if they needed to find more time for appraisal and revalidation they would reduce time on *non NHS work-related* activities.

SAS doctors mirrored these trends, if a little less certain in their choices and which may reflect the small sample size.

The responses to this question were not mutually exclusive and some respondents who indicated they would absorb preparation in NHS time also indicated they would find time by adopting 2 or even all of the other options offered. The spread of consultant results is included in Table C with the smaller SAS sample in brackets () (overleaf).

Table C: Options offered for finding time for revalidation

	Agree/strongly agree		Disagree/strongly disagree	
	Scotland	North East	Scotland	North East
Absorb additional preparation within current NHS time	47% (40%)	44% (46%)	47% (48%)	50% (51%)
Reduce time in non-NHS work-related activities	19% (16%)	16% (23%)	73% (64%)	69% (62%)
Reduce non work/leisure time	55% (65%)	67% (66%)	39% (25%)	27% (22%)
Reduce time in other NHS related activities	43% (32%)	41% (41%)	51% (55%)	54% (56%)

The results for analysis of Scottish consultants revealed mixed opinions but there were clear gender differences in the results (Table C above) and some evidence of differences according to contract status, age and specialty. A higher proportion of males than females agreed that they would absorb revalidation into NHS time and/or would reduce time in other NHS related activities. More females (and part time doctors) would opt to reduce non work/leisure time. There was partial evidence of an age effect on absorbing revalidation into NHS time with the oldest age group (over 55 years) having the lowest percentage agreement.

Expected effect of revalidation and appraisal on NHS activities

The survey asked respondents to identify the activities they would be most likely to reduce *if* revalidation required them to reduce another NHS activity.

Key fact 15: Almost a third of consultants, if faced with reducing their NHS work would limit their non-clinical administration/management activity (includes service development and clinical governance)

Over 30% of all Scottish consultants and 35 % of consultants in the NEE indicated they would reduce non clinical administration/management activity. This pattern persists if analysed for only those respondents who indicated earlier in the survey that they would reduce some NHS activity to create time for revalidation.

Table D compares the top 5 items for the Scottish (n= 642) and NEE (n=128) samples for those consultants who indicated they would reduce NHS activity. The NEE sample is much smaller but the trends are remarkably similar. SAS doctors on the other hand showed a preference for reducing direct clinical care, perhaps reflecting the relative restrictions in other areas.

Table D: Top 5 activities (3 for SAS Doctors) identified as targets to generate time for revalidation

	Scottish Consultants	NEE Consultants	SAS (Total)
Non clinical administration/management including service management and planning and clinical governance activities	37%	40%	16%
Clinical – direct patient care	16%	21%	29%
Clinical administration (patient related admin such as letters, case notes, bedside teaching)	11%	13%	17%
Private CPD – i.e. reading journals etc.	9%	4%	
Formal <i>undergraduate</i> teaching	5%	7%	

The relative value to doctors of non-clinical professional activities

In order to triangulate the evidence from the questionnaire and explore further the likely impact of pressure on doctors' time the survey employed a method of eliciting the strength of preferences for key job characteristics using a Discrete Choice Experiment (DCE). These results give an indication of how doctors may trade off time for different

activities if forced to choose (for example when under pressure) and can provide a basis to predict the impact of revalidation under different scenarios. Doctors were asked to select their preferred job between 2 options that differed in 6 predetermined areas.

These attributes or characteristics had been selected by the steering group as being both discriminatory and/or at risk if greater time is required for revalidation:

- Changing the time engaged in teaching/training students and junior doctors
- Changing the level of research opportunities
- Changing requirements to support Non Clinical Administration (defined as non-clinical administration, service management and planning and clinical governance)
- Changing the level of opportunities to participate in outside commitments (e.g. College/BMA/medico legal work)
- Changing opportunities to participate in formal CPD
- Changing levels of income (based on average earnings reported by respondents)

Please note that the inclusion of income allowed the relative strength of these characteristics to be expressed using money as a common metric. Further details of the methodology are available in the research report.

Overall determinants on job choice (Consultants)

Some characteristics exerted a progressive and positive influence on job choice; the more allowed the greater the effect. Others revealed a U-shaped relationship, indicating that either limiting or expanding them had a similar influence on job preference. The effect was rarely symmetrical and the reduction or increase in a characteristic could result in a disproportionate impact on job preference.

Table E includes the effects found to be significant across the full consultant sample.

Table E: Significant effects on job choice (Consultants)

Attribute	Relative negative strength (expressed in £s)	Relative positive strength (expressed in £s)
Ability to participate in CPD (progressive as amount increases)	£1194 – Compensation required to reduce from some to limited CPD	£514 – Equivalent salary sacrifice to move from some to extensive CPD
Reducing the requirement for non-clinical administrative duties and includes management and clinical governance (progressive as amount increases)	£1334 – Compensation required to increase non-clinical admin	£414 – Equivalent salary sacrifice to avoid some non-clinical admin
Opportunities to participate in outside commitments (e.g. College/BMA/medico legal work)	£1670 – Compensation required to reduce from some to no opportunities for outside work	

These results suggest that the relative impact of lost opportunities for CPD is much higher than the opportunity to achieve more CPD, and indicates that consultants value and will protect their current CPD entitlement. This is unsurprising corroboration for a mandatory component of revalidation-CPD will be protected.

A similar shaped trend (albeit in the reverse direction) is apparent for non-clinical administration (management, service development, clinical governance etc.) where the requirement to take on more requires greater incentive than the perceived value of reducing the current commitment. This should serve as a clear warning that although

participation in such activity is attractive to some consultants, it may be among the first to be sacrificed when time is tight.

Finally the strongest of the significant factors influencing choice was the relative negative impact of losing all opportunities for external commitments from a position where there was at least some available. Such professional stimulation is valued by consultants and the loss of this option could have serious impact on their professional status, motivation and morale.

Sub group analysis revealed significant differences according to age, gender and contract status as follows:

Age Effects:

- The attraction of teaching and training varied with age; the under 40 years old and over 55 year olds were most sensitive to a role where the teaching and training components were reduced; the younger group was also the most sensitive to the attraction of roles with increased teaching opportunities;
- Removing opportunities for outside commitments had less of a negative impact on the under 40 year olds than others, suggesting that such consultants had yet to develop outside interests and were consolidating their clinical and other directly related roles;
- Increasing CPD opportunities had a greater positive effect on the under 40 year olds as newly appointed consultants, who, in the main have just completed their training;
- Income exerted a more positive influence on the younger 2 age bands (under 40 and between 41 and 45 years) than others.

Gender effects:

- Reduced research opportunities exerted a larger negative effect on males than females, who in the main survey had reported less research activity;
- Increased non-clinical administration exerted a larger negative effect on males than females and again females reported undertaking proportionately more non clinical administration than males;
- Females expressed a larger positive effect for increased CPD than males and which may reflect a part time bias for female consultants where achieving external CPD can be more difficult (see below);
- Income was less of a positive driver for females than males.

Contract status effects:

- Limiting CPD opportunities exerted a larger negative effect on part-time consultants;
- Part-time consultants also revealed a stronger negative effect of increased non clinical administration.

Overall determinants on job choice (SAS Doctors)

The results are presented for all SAS doctors only as the sample size achieved was too small for sub group analysis. The relative strength of the effects is lower than that found in the consultant sample, rendering robust comparison between the effects difficult. The main messages are as follows:

- In common with consultants, SAS doctors valued CPD activities with a progressively stronger influence exerted as CPD opportunities increased.
- Losing or gaining opportunities to undertake outside commitments revealed a U-shaped influence with both extremes exerting a negative effect and implying that SAS doctors do not seek a change in this area.

This pattern is repeated for research opportunities.

- Reducing teaching and training opportunities exerted a slight negative effect but increasing teaching opportunities produced no significant positive effect.
- Increasing non clinical administration was viewed negatively although there was no positive effect of roles with reduced non clinical administration

Summary of the key messages from the DCE section of the survey

- Overall, CPD opportunities exert a positive influence on job preference and provides evidence that this will be protected by all doctors.
- Younger consultants value extensive CPD opportunities, teaching and training more than their older colleagues – restricting this in the early years could be especially damaging professionally and short sighted.
- Female and part time consultants value participation in CPD more than their male and full time colleagues and are less deterred by increases in non-clinical administration – this suggests full entitlement of study leave for these groups needs protecting.
- Reductions in non-clinical administration/management (including service management and planning and clinical governance activities) are welcomed by doctors suggesting that they are likely candidates for sacrifice – planners and quality improvement leads beware.
- Losing all opportunities for external work would be unwelcome for consultants and, if imposed, risks loss of morale and professional satisfaction – a lesson for 9:1 contracts and the provision of professional leave.
- Males value research opportunities more than females – reflecting other studies which have identified a gender bias in research.

DISCUSSION

These results provide valuable baseline data against which to track the early impact of revalidation against a backdrop of increasing pressure on SPA time. Job planning, although distinct from appraisal, must reflect the professional needs of doctors and ensure adequate time for doctors to discharge their professional responsibilities and prepare for revalidation. The results include important insights into how consultants and SAS doctors prioritise their time and the value they attach to different professional responsibilities. This starts to allow consideration of where clinical input may be lost and how best to combat it; more precise modelling is a subject for a future study.

The effects, although consistent across the full sample, reveal some critical differences between sub groups of doctors and all should be alert to the potentially disproportionate impact of revalidation by gender, age and specialty. SAS doctors may also present a particular challenge to ROs.

Different health systems – same messages

This survey of over 2600 hospital doctors revealed remarkably consistent perspectives on the working pressures facing a group of highly motivated health care professionals committed to their patients and to their colleagues, including their trainees. Revalidation has had a long gestation period; its principles are widely accepted but the underlying processes have generated considerable suspicion and some scepticism. It is therefore of significant note that doctors from 2 increasingly divergent health systems and across different specialties share many opinions and concerns; there is no reason to believe that these views are not representative of hospital doctors across the UK.

Unexplained variation between health boards, trusts and specialties on time for appraisal

Sub group analysis revealed some differences by specialty and location that are of concern if revalidation is a national system required by a national regulator. In particular, variation in time in job plan for appraisal and in appraisal status is worrying; consultants have at least some time allocated in their job plans for appraisal and most doctors reported having had an appraisal in the 12 months prior to the survey. However in the spring of 2011 there was unexplained significant variation between locations and, although sample sizes were sometimes small, this must be reviewed by local management teams and those regional/national ROs who make revalidation recommendation about local ROs. The position for SAS doctors is much less encouraging with far fewer having time for appraisal in their job plans or equivalent. All doctors must have the necessary time to achieve a satisfactory appraisal to allow them to work towards revalidation and this survey reports that a year ago almost half of doctors had no such time.

Revalidation processes add to the time pressures on already hard pressed doctors

Doctors are working under increasing pressure; the survey ably demonstrates that most continue to work over their contracted hours, many struggle to take time away from their workplace whether for annual leave, professional duties or continuing professional development and many more take work home regularly. Of concern is the 25% of consultants across both health systems reporting that current workloads are having an adverse effect on their health and the 38% who believe that workload adversely affects their standards of patient care.

Most doctors believe that new appraisal processes, developed to address the specific needs of revalidation, will take significantly longer, adding to the pressure on their time. Protection of time for professional activities is crucial if these findings are extrapolated across the UK. New appraisal and revalidation systems (including IT support) must be reliable, proportionate and efficient.

CPD and professional leave require protection

Over 80% of all consultants report *usually* being able to take their study leave but less than a third are able to take their full complement due to service pressures and staffing problems. The pattern is similar for professional leave, restricting the development of other interests and limiting consultant contributions to the wider benefit of the NHS. This comes at a time when the regulator demands ever more stringent training standards and managers are seeking clinical input into service development, risk and quality management and to clinical commissioning (in England).

Revalidation quite rightly demands a commitment to CPD, quality improvement activities and responsiveness to colleague and patient feedback but unless this can be achieved efficiently, doctors will continue to doubt its benefit and worry about the reliability of outcomes. An essential component of appraisal is the agreement of a Personal Development Plan (PDP) and doctors' confidence in this aspect will be weakened if CPD and professional leave is limited.

Securing cover to release doctors for study leave to ensure compliance with Royal College CPD standards and facilitating professional leave are important challenges for Medical Directors. The professional development of doctors must not be compromised by rising clinical pressures and/or short term performance goals; this could put senior medical managers in a position of considerable conflict. Indeed systematic failure to agree study and professional leave could be an early indicator of a healthcare provider in difficulty and ignored at some risk.

In a time limited system, revalidation will displace professional input to service development, quality improvement and clinical leadership and may disrupt training

The survey has generated data from 2 main sources – responses to direct questions on how doctors would generate space in their working day and the results of a comparison exercise to elicit value judgements about preferred professional activities. Both quite clearly demonstrate that consultants would protect direct patient care, CPD and (to an extent) non NHS work.

Consultants and SAS doctors reported that they would find time in various ways but only half expected to absorb revalidation into their NHS work and few expected to reduce their direct patient care responsibilities. Doctors expect to have to add to the pressure on their leisure/home life and will engineer some time from non-clinical administrative tasks which include service development, teaching, clinical governance and quality improvement activities. All options bring problems at a time when the GMC is looking to accredit trainers, and policy makers and planners are seeking extra input from the same doctors who are sacrificing some of their annual leave and taking work home.

Over 85% of consultants have teaching and/or training responsibilities in addition to their own CPD and appraisal requirements; if revalidation takes longer than current appraisal processes, there is significant concern that training will suffer adding to the mounting evidence of training difficulties identified in GMC surveys and other recent reports.

The potential longer term implications of a shift in non-clinical activity by consultants merit serious consideration.

Hospitals must review their clinical governance systems to ensure information is accurate, relevant and available in a format that informs appraisal

Of significant concern is the lack of confidence among well over half the doctors surveyed that local clinical governance systems will deliver accurate and relevant data to support appraisal and revalidation. Unless reliable data on clinical outcomes, significant untoward events, complaints etc is properly triangulated, revalidation processes will be ineffective and inefficient and (for a small minority of doctors) problems may be missed.

At best this will add to the time required to gather, reflect on and submit supporting information and at worst it may delay RO decision taking, leading to revalidation deferrals with consequent anxiety, frustration and inefficiency. To have a large percentage of deferrals in the early years of implementation will erode confidence in the system by both doctors and the public. It is essential that the GMC and health system regulators monitor this carefully to ensure local and national data systems support doctors to revalidate.

Professional organisations that are developing support tools for revalidation need to promote these more widely

Awareness of the role of Colleges in supporting the specialist elements of appraisal and revalidation is low among the main body of doctors. There is interest in College portfolios to manage and reflect on information gathered for appraisal but low awareness of their availability. The timing of this report is likely to coincide with the formal enactment of legislation by the Secretary of State for Health, bringing revalidation to the immediate attention of all doctors and prompting questions about processes and support mechanisms. Colleges and others should be ready.

Less than full time doctors may find it more difficult to maintain professional interests and present sufficient information to revalidate successfully

Doctors working less than full time, the majority of whom are female, spend less time on external CPD. ROs and clinical managers should ensure there is adequate time in job plans to achieve College CPD standards as this is central to revalidation. These doctors also express a lower preference for non-clinical administration which is consistent with the pressure on their hours and struggle to achieve CPD.

Less than full time doctors also anticipate requiring more of their leisure time to prepare for appraisal and revalidation as they have less scope to absorb time in their NHS hours. Losing leisure time in this way may erode their interest and energy for training and/or other work for the wider benefit of the NHS. Improved alignment of PDPs with the corporate requirements of hospitals is essential to make best use of SPA time and training budgets for all doctors but particularly for those working less than full time.

Young/newly appointed consultants may require all their SPA time for their own revalidation, limiting their wider contributions

The survey has provided some early indications that younger consultants have job plans with significantly less SPA type activity. The survey has identified at least 75 doctors who appear to have the equivalent of a 9:1 contract, most of whom are younger and therefore newly appointed. These consultants are entering independent practice for the first time and will benefit from the support provided from protected CPD time. If adequate SPA time is not available to them, mandatory responsibilities will dominate and restrict their options. In addition it seems both undesirable and improbable that there will be no teaching or training expectations of these newly appointed consultants; ROs must ensure the SPA aspects of job plans reflect their expectations of consultants.

Specialty (SAS) doctors have some special needs if they are to achieve revalidation

SAS doctors spend proportionately more of their time in direct patient care which limits their opportunity to absorb revalidation into NHS work. Their results mirror the pattern of responses from consultants in most areas but with certain important exceptions; they are less influenced by opportunities for outside commitments, teaching and research and appear less exercised by workload pressures but also report lower overall job satisfaction levels. Significantly the majority did not have time identified in their job plans for appraisal but a quarter had designated teaching responsibilities. Few regularly take work home currently but indicate that this may be one of the ways in which they generate space for revalidation and which may add to dissatisfaction. Creating time in job plans for appraisal and reviewing the teaching/training responsibilities for these doctors should be an early challenge for ROs.

Also the research team noted that a disproportionate number of SAS questionnaires were returned undelivered, raising a concern about the accuracy of workforce data to identify and track revalidation for these doctors. SAS doctors have long felt themselves to be marginalised in terms of their own development needs and this survey provides yet more evidence of this challenge for ROs/Medical Directors.

CONCLUSIONS

This survey of doctors' opinions reveals significant anxiety among consultants and SAS doctors about the impact of revalidation on their professional lives. The snapshot is now 12 months old and other evidence is emerging of more pressure on the job plans of newly appointed consultants by limiting SPA time; 'new' appraisal and revalidation are more complex processes and an inevitable consequence is a reduction in other activity.

Doctors in the UK are highly motivated professionals who participate in and value highly the standards of care they provide, their training role and their responsibility to keep their own skills up to date. It would appear that medical management and clinical governance activities will take second place to direct clinical care, clinical administration and CPD. The professional stimulation of participating in projects for the wider benefit of the NHS will come under pressure if revalidation, as feared, takes longer than current appraisal processes and access to professional leave is compromised. This could affect the work of local management teams, national government driven initiatives, the training, quality and standards work of independent Royal Colleges and Specialist Societies and clinical research.

Doctors understand and accept the necessity of confirming their fitness to practice; to do anything else risks their licence and livelihood. Many have limited scope to fit in additional responsibilities, are worried about achieving their CPD targets and delivering supporting information on the quality of their practice. Clinical governance systems are not yet trusted to provide accurate and relevant data to support revalidation. Worse still the NHS risks developing two classes of doctors and which could divide on age or gender lines; doctors who only see patients and those who are also encouraged to apply their professional expertise to teaching, quality improvement and service development. There is a significant risk that this has the potential to de-professionalise a group of dedicated clinicians and deter others from entering medicine.

This project was never intended to quantify the time required for revalidation but it is clear that consultants with a low ratio of SPA to PA time will find participation in anything beyond their own revalidation very difficult. The controversial 9:1 type contracts may sit just within the rules for those with very restricted job plans but are deeply regrettable and risk significant damage to the professional perspective of young consultants.

Revalidation was introduced as a patient safety and quality improvement initiative and these early results suggest we are at risk of losing some of the clinical innovation and leadership that drives both.

APPENDIX A

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