Patient and public involvement in medical revalidation

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Research commissioned by the NHS Revalidation Support Team
Word Tree generated by Nvivo showing the immediate contexts in which our interviewees described their perspective.
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## Abbreviations

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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Groups</td>
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<tr>
<td>CQC</td>
<td>Quality Care Commission</td>
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<td>GMC</td>
<td>General Medical Council</td>
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<tr>
<td>ICAS</td>
<td>Independent Complaints and Advice Service</td>
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<td>LETB</td>
<td>Local Education and Training Board</td>
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<td>LHW</td>
<td>Local Healthwatch</td>
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<tr>
<td>LINks</td>
<td>Local Involvement Networks</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>PALs</td>
<td>Patient Advice and Liaison</td>
</tr>
<tr>
<td>PLDP</td>
<td>Performers List Decision Panel</td>
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<tr>
<td>PPI</td>
<td>Patient and Public Involvement</td>
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<td>PPE</td>
<td>Patient and Public Engagement</td>
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<tr>
<td>PLG</td>
<td>Patient Liaison Group</td>
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<tr>
<td>RRN</td>
<td>Regional Revalidation Network</td>
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<td>RST</td>
<td>NHS Revalidation Support Team</td>
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Executive Summary

Introduction

With revalidation operationalised in December 2012, it is timely to begin to describe and evaluate all aspects of the process as it goes forward. This research explores lay representation in revalidation, from both lay and organisational perspectives, in order to:

1. Understand the current implementation of PPI in medical revalidation and provide examples of practice
2. Identify where PPI adds value, in order to inform and support future practice
3. Identify areas where lay representation may strengthen local systems and processes, and; conversely, where systems and processes may be strengthened to support meaningful lay representation in medical revalidation

Methodology

The research adopted a three tier methodology, with each stage informing the next.

We undertook an initial literature review focusing on PPI in revalidation to suggest lines of inquiry informing interviews. We then conducted a series of interviews, purposefully sampled to provide both lay and organisational perceptions in national, regional and local contexts. The data gathered from the 1:1 interviews was then coded to identify key themes. These themes were in turn used to inform the statements presented in the online survey, alongside additional statements developed by the team in consultation with the RST. The rationale for the survey was to provide a breadth of views that would complement the deeper understanding gained through the interviews.

Cultural Historical Activity Theory (CHAT) was used to triangulate the findings of the literature, interviews and online survey, in order to model PPI in medical revalidation in relation to its cultural, political and regulatory drivers and to identify different modes of PPI in practice. This final analysis addressed the primary aims of the research as set out above.

Core findings

Understanding current implementation of PPI in medical revalidation

The research has identified a number of existing models of PPI: some of which form part of revalidation processes as well as a range of other examples outside or predating revalidation. A detailed breakdown of the models of lay participation identified by our interview participants is presented in Appendix 5. These findings are by no means exhaustive, but they do provide an illustration of the variety of lay participation.
Our research participants present a mixed image about their individual understandings of revalidation as concept and process. The overall picture is a “somewhat aware” scenario, with 51% of the respondents stating that they are aware to a certain degree and 37% stating that they are fully aware. Exploring the data in detail reveals that lay representatives generally think they might not understand revalidation in its entirety, merely their own experiences of it. This contrasts with the feelings of organisation representatives, 66% of whom opine that they are fully aware of the purpose and processes of revalidation.

Most lay participants in our interview sample have been appointed to their current roles following prior lay experience elsewhere, in the same organisation or a related one, either by simply being invited to participate or to apply for the role. The skills, attributes and experience considered necessary for recruitment depends very much on the type of role they are already able to fill. However, debates about what skills and attributes should be considered desirable for lay participants – and indeed questions of whether any particular attributes should be required at all – highlights the need for patients and lay roles to be more clearly defined.

For our respondents, the single most important attribute for lay representation is recent experience of being a patient. This is not straightforward: what qualifies as recent is subjective. Additionally, given the demographics of our sample (predominantly white and aged over 60 years), this approach to recruitment may privilege involvement with certain types of medical specialties. Matters of appropriate age and experience for lay representatives were dominant in interviews and survey responses, with most suggesting that the practical day to day work of a lay representative requires a certain level of maturity and therefore appropriate skills sets. Discussions around generic ‘desirable’ experience included administrative capabilities (outside of healthcare), the ability to question and challenge, and facilitating meetings.

These are of course professional skills. The notion that they, along with the maturity and experience they are based upon, might be unofficial pre-requisites for lay representation raises issues about the ‘representativeness’ of lay representation and the implications of this for its role in revalidation. It is not simply a matter of being a patient.

The issue of identity is also related to remuneration. Interestingly, the majority of our lay representatives were not in favour of reimbursement, while organisational representatives are of the opinion that lay representatives should be offered some form of payment. This further raises issues about the contested nature of PPI in revalidation, and of the individuals engaged in PPI. It has been suggested that some views on this might be influenced by personal circumstances; some representatives may not be able to commit a significant amount of their time without recompense. Deciding not to pay an hourly rate in addition to expenses may therefore limit the pool of potential participants.

Only around half (51%) of our lay representatives have been offered or have undertaken any specialist training. It is interesting to note that organisational representatives are generally uncertain as to the current state of training and support available to lay representatives. Participants report that current training provision is mixed: training requirements for lay participants depend upon a match between the roles to which they are recruited and their previous experience and existing skill sets. There is no consensus as to what generic training for lay representatives should look like, since there is no one type of lay representative.
There is significant variation in opinion as to the duration of time that people should serve as lay participants. Arguments are polarised: too long and representatives could lose objectivity, too short and they would not be equipped with relevant knowledge and skills. It is difficult to discern exactly how long people have already been involved, because they have tended to move between various lay roles. There are a range of views about whether lay positions should be subject to a time limit, or limited to one type of role, with no consensus in either survey or interview responses, and no guidance in any literatures.

Differences in opinions and experiences of PPI lead us to question what lay participation is intended to be and to achieve, and whether this is one or many things. This question is germane when discussing issues such as pre-requisites for age and experience, recruitment models and training provision for lay participants. In short, the processes by which lay participants are appointed are clearly important and what is wanted from a representative must be clear if it is to be effective.

Understanding PPI: The importance of clarity of terminology

There is considerable confusion over roles, and what is needed in terms of organisational arrangements to support them. This appears to be because there is confusion over the very terminology of PPI. There is a strong sense that PPI has been adopted as commonplace ‘management speak’; a rubber stamp for inclusive process, which has rendered PPI conceptually vague. In common parlance, for example, it is used to refer to patient feedback, and typically to patient questionnaires. This facet of PPI is clearly very distinct from lay representation, but the terms remain blurred in the literature and in discussions with our participants.

Whilst PPI may be viewed as an obvious concept, various and often very different interpretations are used interchangeably. This is evident in all three of our datasets, and dominated our overall analysis. A lack of clarity or focus makes it difficult to locate specific information on PPI generally, not least when it is relating to revalidation. The terms patient and public are used both as individual entities or together to indicate inclusivity. ‘Engagement’ as an adjective has, since 2012, begun to supersede the term ‘involvement’, but no key documentation has been found to explain or substantiate this change in emphasis - the 2012 Act continues to refer specifically to ‘patient involvement’. This is a crucial point, because clarity of terminology is imperative. We would argue that without clarity of roles, responsibilities and purpose, PPI risks losing its potency as a driver for change and improvement in healthcare via collaboration with patients on various levels.

Interview participants and survey respondents’ levels of knowledge of different roles in lay participation in health care are mixed, as are their views about their roles in revalidation. PPI models referenced by participants include the involvement of service users and carers in service development, the training of medical students and the recruitment of medical and nursing staff. Some survey respondents question not just the nature but the extent to which lay participation should be involved. In common with the interview sample, several survey respondents draw a distinction between governance and/or audit roles, and involvement in decision-making about individual practitioners.
Conceptual vagueness has potential implications for fit for purpose application of PPI in practice, not to mention operational effectiveness. Online resources provide the most comprehensive, accessible and up to date information on PPI in revalidation and commissioned and independent studies provide some focused material. However, while they identify the public and the profession’s desire for PPI (particularly patient feedback), they do not detail in any depth how this can – or should - be achieved. Importantly, we could find no literatures that address how the impact of PPI on revalidation might be measured. Future research would therefore benefit from evaluation models developed specifically with revalidation in mind.

**Defining terminology, strengthening roles**

While there is confusion over roles, three key types of PPI emerge from in-depth analysis of our data. This typology may help to differentiate levels and types of involvement, and might be useful in developing future guidelines to underpin decisions made about PPI in revalidation:

**Patient.** The patient has a unique role in revalidation, since they have an immediate and personal engagement with the doctor and can contribute to the evidence presented for appraisal leading to revalidation. The patient requires tools to enable them to do this but does not need a specific skill set. More effort needs to be made to ensure that patient feedback is equitable and extant patient feedback tools will need revision to ensure this. Patient engagement in revalidation is linked to a specific time: when the patient is in receipt of treatment. It is therefore a snapshot in time, but by including multiple patient feedback, which can include patient forums, a picture of individual practice can be evidenced, reflected upon by the doctor as part of their revalidation, and acted upon if necessary. In regard to ‘the patient’ as an entity it is important to remember that while in all likelihood we are all patients at some point, that does not mean that we are all *always* patients.

**Public.** The public acts as the collective ‘patient voice’ and is representative of all patients in some way. The ‘public’ is represented through organisations like Healthwatch who act for all consumers of healthcare services and work collaboratively with other health networks with shared agendas. As noted above, and concurrent with the rolling out of revalidation, new representational groups have been established and will need time to establish their identity.

**Lay Representative.** Lay is a general term of reference for the involvement of people who are non-professional or non-specialists. It is interesting to note that some of our study participants had medical backgrounds, which they felt to be helpful. Lay representation is less about being a current patient and more about possessing and applying relevant skills and attributes. Our research indicates that lay representatives feel they themselves benefit from having a professional background. Lay input is deemed to be extremely valuable from both lay and organisational perspectives as it provides an external and ‘independent’ voice.

The research suggests that the three key roles identified in this typology can each potentially ‘add value’ to the revalidation process. By virtue of their difference they are able to offer a range of insights and engage in different forms of intervention appropriate to their specific area of interest/expertise. Taken as a whole, these different roles can provide both support and ongoing critique of each aspect of the revalidation process.
PPI as ‘added value’ in revalidation

There is a strong general sense that contributions made by lay participants are valued and that they feel respected: lay participation involves working with organisations rather than in opposition to them. Lay representatives feel that they had come to understand their roles and are able to influence change at opportune moments. The general impression created by this research is that lay participation benefits the organisations involved and is also a positive experience for the lay participants. However, social backgrounds and personal motivations may need to be considered when approaching recruitment for particular roles, perhaps depending on the nature of the role and the resources to be shared as part of the work.

Overall, research participants agree that, as lay representatives stand outside of and somewhat apart from the minutiae of policy and procedures, and are not involved in the quotidian work of health service provision, they were able to stand back and offer another interpretation. Some therefore see lay representatives as an outside ‘other’, in possession of a degree of independence and perhaps even impartiality. Others however see their role as one of advocacy on behalf of patients and the public.

Both lay and organisational representatives strongly agree that lay representation could and should be made much more effective by quality assuring the role. There is also agreement that lay representation effectiveness could be improved by introducing national coordination and greater management for the role – although some feel it is important to maintain local character and autonomy.

In order that the value added by lay representatives can be maximised, the aims and purposes of PPI need to be clarified in terms of the specificity of available roles. We have already mentioned the importance of evaluation designed specifically to measure the impact of PPI on revalidation. This research highlights the need to include a qualitative and quantitative exploration of the ways in which PPI adds value to revalidation processes and outcomes.

Recommendations arising from the research

Short term:
- Stakeholder discussions to clarify purpose/nature of desired patient, public or lay participation
- The production of clear role descriptions for both representative and those recruiting them

Mid term:
- Consistent and transparent recruitment procedures; perhaps involving the development of a set of guidelines
• The provision of induction for representatives; particularly addressing concepts such as confidentiality and data protection, and perhaps administrative skills (chairing meetings, using minutes, etc.)

• The development of mentor or handover systems, to avoid knowledge loss when changing lay representatives, or perhaps stagger recruitment of lay people

• Consideration of proposing a limited terms of service (for example: 3-5 years)

• Development of policy or guidelines regarding remuneration

Longer term:
• Ongoing evaluation and review of the impact and added value of PPI in revalidation
1. **Introduction**

Over the last two decades there has been a marked shift in emphasis in Health provision in the UK towards greater accountability by the profession and greater public and patient involvement in the service they receive.\(^1\) This revised emphasis, while it has been shaped by the broader cultural turn towards managerialism and consumerism in the UK is also a specific response to the findings of high profile public inquiries into significant medical malpractice.

Two key policy initiatives that have emerged as a result of these twin drivers: the revalidation of doctors and patient and public involvement (PPI) across the spectrum of health provision\(^2\). This research explores the points of intersection between these two key policies and seeks to:

4. Understand the current implementation of PPI in medical revalidation through concrete examples of practice
5. Identify where PPI adds value in order to inform and support future practice
6. Identify areas where lay representation may strengthen local systems and processes, and; conversely, where systems and processes may be strengthened to support meaningful lay representation in medical revalidation.

2. **Background**

With revalidation operationalized in December 2012 it is timely to begin to describe and evaluate the process as it goes forward to ensure both value for money and the more qualitative ‘added value’ to patients and the profession.

In order to improve the understanding and learn from examples of PPI in revalidation the RST have commissioned CAMERA to undertake research that will:

- include both organisational and lay perspectives
- be appropriately rigorous in terms of depth and breadth of participant data and its analysis
- offer an evidence base against which the RST will be able to develop guidance on strengthening PPI
- describe the complex network of influences and debates that coalesce around PPI in revalidation

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\(^1\) This is evidenced through a number of key policy documents including: *The Patient’s Charter (1991), Patient and Public Involvement in the New NHS (DOH 1999), Strengthening Accountability: Involving Patients and the Public (DOH 2003), Safety First (DOH 2006), Trust, Assurance and Safety; the Regulation of Health Professionals in the 21st Century (DOH 2007) Real Involvement: Working with People to Improve Services (DOH 2008) Equity and Excellence: Liberating the NHS (DOH 2010)*
comply with the Data Protection Act (1998)

This research using patient and organisational perceptions to inform future guidance both builds on the RST’s previous work with MORI and The Kings Fund\(^3\) and extends it by contextualising the policy within current practice. The CAMERA research team at Plymouth University Peninsula Schools of Medicine and Dentistry is one of the leading centres for medical education research in the UK. The team have developed specific research expertise on the impact of revalidation in the UK through a series of successful research grants from the National Institute for Health Research, the Health Foundation and the General Medical Council (totalling more than £1.2 million).

### 2.1. Revalidation

Revalidation is the mechanism for UK doctors to demonstrate that they remain ‘up to date and fit to practise’ medicine. Its purpose is to “assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and are practising to the appropriate professional standards”\(^4\). It is a five year process during which a doctor presents an annual portfolio of documentation to demonstrate participation in appraisal, including feedback from patients and colleagues and clinical governance data such as clinical audit.

The individual doctor’s portfolio will be reviewed by the doctor’s appraiser who will report the outcome to the local responsible officer (RO). The RO signs off at a local level and forwards the recommendation to the GMC. Should any concerns be identified then the RO will review the ‘evidence’ and make a recommendation to the GMC. The RO may make one of three recommendations: a positive recommendation that the doctor should be revalidated, a request for a deferral because they need more information to make a recommendation about the doctor. This might happen if the doctor has taken a break from their practice (for example, maternity or sick leave), or notify the GMC that the doctor has failed to engage with any of the local systems or processes (such as appraisal) that support revalidation\(^5\).

Revalidation represents a significant change to the current registration system, which was an historical record of qualifications gained rather than an on-going evaluation of FTP, and therefore offered only limited assurance of clinical standards to the public. It is the first time in 150 years that doctors have had to undertake any formal on-going assessment of their practice. So, both in terms of policy and practice, revalidation has enormous implications for medical culture, patient care, and the development of medical professionalism and the professional identity of individual doctors.

### 2.2. PPI

Patient and public involvement describes a wide range of activities and has a variety of purposes. A new, and largely uncritical, vocabulary that has grown up around the legal requirement for Trusts to

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5 [http://www.gmc-uk.org/doctors/revalidation/12394.asp](http://www.gmc-uk.org/doctors/revalidation/12394.asp)
involve patients, through the Local Government and Public Involvement in Health Act (2007), has unfortunately failed to provide a firm conceptual underpinning for this phenomenon. For example, involvement, engagement, participation, user, consumer and particularly public and patient have become terms that are used uncritically, interchangeably and without specificity.

The founding of the Community Health Councils in 1973 is often cited as the beginning of patient and public involvement (PPI) agenda in health. This initiative was given greater impetus by inquiries into serious clinical and service failings, including Bristol (2001) and Shipman (2004) the reports from which unanimously stressed the importance of PPI in improving both the safety and performance of health services. A wave of initiatives aimed at improving PPI in health and embedding it at an individual and collective level followed.

The 2001 Health and Social Care Act is the core piece of legislation that created a legal obligation for NHS organisations to demonstrate PPI in the development and evaluation of the services they provided. Successive legislation has expanded health and social care providers’ responsibilities, particularly in the areas of patient complaints and patient choice.

Local mechanisms were created to facilitate PPI including PPI forums (2003) which were replaced by Local Involvement Networks (LINks) (2008). LINks were created under the Local Government and

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9 Department of Health (1999) Patient and Public Involvement in the New NHS
Public Involvement in Health Act (2007) to cover the 152 local authority areas across England. LINKs have recently been replaced (01/04/2013) by Local Healthwatch (LHW) under the terms of the Health and Social Care Act (2012). In addition to taking on the role of LINKs Local Healthwatch will also take on the signposting and information function of the NHS’ Patient Advice and Liaison (PALs service) and the Independent Complaints and Advice Service (ICAS). Local Healthwatch organisations come under the umbrella of Healthwatch England which is itself a committee of the Care Quality Commission (CQC).

Responsibility for PPI in relation to health services is now the responsibility of Clinical Commissioning Groups (CCGs). Under the Health Act, CCGs are required to appoint at least two lay members on their governing body – one with particular responsibility for governance and one for patient involvement. The LHW will work with the CCGs through the CCG Boards and support them in engaging and evaluating patient involvement. Working with the CCGs will provide the LHW with a key source of information on the quality of services.
Lay representation is part of a much wider PPI agenda that encompasses the whole spectrum of the design, planning and the delivery of health services. Successive reports and white papers have stressed the need for patients to be at the core of health provision and regulation. Most recently
the Berwick report recommended that “Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts”\textsuperscript{10}.

### 2.3. PPI in revalidation

PPI in revalidation currently has two distinct modes – firstly through the patient feedback as a requirement of the doctors portfolio and secondly in terms of lay involvement through representation on the boards and panels of various stakeholder groups.

The NHS and patient associations believe that there should be better opportunities for lay involvement in revalidation and that greater involvement would bring a range of benefits. Indeed, our own completed research has identified the need to re-establish the patient at the heart of the policy\textsuperscript{11}. While ongoing research examining revalidation as it is rolled contains emerging themes about patient feedback as part of the revalidation process\textsuperscript{12}. The structure of current governance arrangements to support Revalidation in England is detailed in Figure 2 below.

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\textsuperscript{10} National Advisory Group on the Safety of Patients in England, (August 2013) \textit{A Promise the Learn – A Commitment to Act} p.18

\textsuperscript{11} Archer, J. Regan de Bere, S. Nunn, Suzanne. \textit{et al} (2012) \textit{Revalidation: in policy} 
\url{http://www1.plymouth.ac.uk/peninsula/research/camera/revalidation/Documents/Stage-One-Report.pdf}

\textsuperscript{12} Archer, J. Regan de Bere, S. Nunn, Suzanne (due to be completed in December 2013) \textit{Revalidation in Practice}
Each regional team includes all Designated Bodies in its area with responsibility for revalidation. The Responsible Officer in each Designated Body is a prescribed connection to the regional RO.

3. Methodology
A range of established complimentary empirical research methods have been selected to provide a sound evidence base from which to answer the research question developed in collaboration with the Revalidation Support Team. The research uses both qualitative and quantitative methods in order to generate data with appropriate depth and breadth. The triangulation of findings and attention to points of convergence and divergence in the perceptions and views of lay and organisational representatives provides the overview necessary to both locate where PPI already adds value to medical revalidation and identify areas where it could be strengthened. Modelling PPI in medical revalidation as a dynamic system generates a ‘rich’ description that will help identify areas of strength and opportunities for potential development as the policy rolls out.

4. Overview of Methods
The research has been undertaken using methodologies selected on the basis of their suitability to answering the research questions contained in the study.
4.1. Methodological framework

- Literature review (to establish the processes and rationale for PPI in medical regulation in the context of greater patient and public involvement in healthcare)
- Thematic analysis of online survey and interview data (to identify lay and organisational perceptions)
- Cultural Historical Activity Theory (CHAT) to triangulate the findings of the literature, interviews and online survey in order to model PPI in medical revalidation in relation to its cultural, political and regulatory drivers

In order to work with a representative sample of opinion we used a combination of online survey and in-depth interviews. The online survey provides a breadth of views while the interviews add depth to our understanding of what they mean for the sample.

Taking the research design beyond thematic analysis by using CHAT adds value to the study. It helps to place the findings of this research into the broader context of PPI, medical regulation and the relationship between medicine and society. In doing so, it provides evidence upon which further action may be based.

4.2. Literature review

The literature review provides an evidence base to underpin the research. The review includes published documents and a selection of appropriate ‘grey literature’.

The objectives of the literature review are:

1. to understand the scope of the literature
2. to inform lines of questioning in interviews

In order to achieve these objectives within the timeframe we adopted a hybridised form of review: informed by a systematic approach but presented as a more traditional narrative review. The resulting review describes and synthesises a variety of evidence on PPI in revalidation\(^\text{13}\).

4.3. Interviews

In order to understand the attitudes, perceptions and experiences of those participating in the system we conducted 10 interviews with both lay and organisational representatives purposefully selected to encompass local, regional and national perspectives.

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The interviews were conducted via established telephone interviewing methods and used an open ended question format with the questions/prompts agreed with the RST. The interviews were transcribed verbatim, and imported onto the qualitative data analysis package NVivo for management and analysis. Thematic analysis was performed on the raw data, in order to address the following questions:

- What are the most common themes?
- Are the themes common to both patient and organisational representatives?
- How are they played out in relation to PPI in medical revalidation?
- What systems are identified that support transparency and improved communication in relation to PPI?

The themes that emerged through the interviews were used to inform the statements presented in the online survey.

4.4. Online Survey

Online surveys are inexpensive to conduct and have the potential to collect a lot of data quickly. Hence it is an appropriate method given the limited timeframe for the research and the need to gather an appropriate volume of data to create a representative sample of views. Online questionnaires have been shown to demonstrate fewer response errors compared to paper
based questionnaires and increased response rates have also been demonstrated while using online questionnaires as compared to paper based. An online questionnaire allows for adaptive presentation of questions based on participant responses further contributing to increased response rates. PUPSMD has rolled out its own bespoke online questionnaire solution which is securely hosted, is fully customisable depending on research needs, allows for exporting data to SPSS/Excel/R for analysis, and offers the option to print the questionnaire for offline data collection as well.

The sampling frame was identified with the RST and contacts the research team have already established through previous revalidation research. The target groups included English Responsible Officers and their local patient representatives in addition to national patient groups.

The survey used closed questions with a Likert scale, but with the opportunity for respondents to expand on their answers at the end. A closed question format with 'skip logic' was chosen to elicit a higher response rate in a short timeframe, as it is better suited to busy clinicians and others with multiple-roles.

The survey included a brief overview of the research and was available online for 3 weeks with a mid-point email reminder.

Respondents are asked to self-declare socio-demographic information in order to identify the representativeness of the sample but they are not required to submit any personal information.

4.5. Cultural Historical Activity Theory (CHAT)

The literature review, the survey results and the interview data results were triangulated and presented within an overall framework of cultural and historical activity (CHAT). CHAT allows us to model the roles of different groups, policies, processes and events related to PPI in medical revalidation, and to illustrate how they shape the nature of involvement within the system.

CHAT is relevant to examining PPI in medical revalidation because it provides an accessible and flexible framework with which to identify and examine any contradictions (indicated by the arrows in the diagram) that play out as it is implemented.

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16 Office of National Statistics 5 class version http://www.ons.gov.uk
5. Literature Review

5.1. Data collection and management

PPI and to a lesser extent PPE are common acronyms and so were not used as search terms. We expected that even when the acronym was predominantly used by an author the full wording would be given in the text by way of convention for the purposes of clarity.

There is a considerable body of literature relating to patient and public involvement. As a key word search in Google Scholar ‘patient and public involvement’ yielded 777,000 results. This wider literature falls broadly into two groups, the individual and the collective, of which the individual in the context of their own wellbeing predominates. This literature generally conforms to the following conceptual framework.

<table>
<thead>
<tr>
<th>Level of engagement</th>
<th>Mode of engagement</th>
<th>Influence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Decision-making about care</td>
<td>Advocacy and self-determinism</td>
</tr>
<tr>
<td></td>
<td>Providing patient feedback</td>
<td>Informing clinical practice</td>
</tr>
<tr>
<td>Collective</td>
<td>Participation in planning</td>
<td>Representation and involvement in</td>
</tr>
<tr>
<td></td>
<td>design and delivery of services</td>
<td>decisions</td>
</tr>
</tbody>
</table>

The search strategy involved combining scoping searches of Google Scholar and MEDLINE to identify directly relevant published material with our research groups existing databases on PPI/revalidation. These were supplemented with ancestry searches and forward citation searches\(^\text{17}\). In ancestry

\(^{17}\) Schlosser R. W, Wendt O, Bhavnani, S. Nail-Chiwetalu, B. ‘Use of information-seeking strategies for developing systematic reviews and engaging in evidence-based practice: the application of traditional and
searches, the reference list of a relevant article is scrutinised to identify additional relevant citations whereas in forward citation searches, the researcher tracks the ‘after-life’ of a specific reference and identifies subsequent citations. In this way the circulation of information on a given subject can be understood and key published sources identified.

We set the date parameters from 2001 to the present. This start date was selected since it was through the Health and Social Care Act (2001) that it became a legal obligation for NHS organisations to demonstrate PPI in the development and evaluation of the services they provided. 2001 was also a key date in the history of revalidation since in 2001 the GMC resolved to request Government to put in place the required legislative framework for revalidation with NHS appraisal as the vehicle for revalidation.

The search criterion was deliberately specific due to the extensive general literature on PPI and revalidation but the eligibility remained broad in order to capture the nature of the material.

Search terms entered in Google Scholar and MEDLINE

- Patient and public involvement AND revalidation
- Patient and public engagement AND revalidation
- Lay represent AND revalidation

Therefore a number of tightly focused searches around key terms were conducted in order to capture relevant material.

Aside from the data parameters we developed a set of inclusion and exclusion criteria in order to retain the focus of the review.

We excluded documents that were very general in scope with a heavy weighting to either PPI or revalidation (104).

Documents not relating to medical revalidation were excluded (16) i.e. Pharmacy and dentistry but documents contextualising PPI in revalidation in medical specialisms i.e. anaesthesia and psychiatry were included (4). These documents suggested questions relating to the scope of lay involvement and the skills/qualities that lay representatives may need to undertake their role.

Papers about the measurement of perceptions, particularly those that investigated the subjective aspects of judgement (3) were included because we felt they gave important insights into the transparency and usage of data and presented several key issues pertinent to PPI in revalidation as it develops. We excluded specific evaluations of individual patient survey/questionnaires (6) since evidence on the performance of particular tools was felt to be of less relevance than how the findings should be used in revalidation, but we included papers that made relevant general points about patient feedback (4). From this literature we developed interview questions 10 and 11 relating to the form of data and the ‘lifetime’ of the feedback.

We found 8 commissioned or independent reports by respected research institutions and these were included in the total of 22 papers for review. The 22 documents were supplemented with ancestry searches and forward citation searches where necessary to yield a final total of 28.

In addition to the published literature we also undertook a review of information available on the internet as a ‘grey literature’ search.

Grey literature is commonly defined as “that which is produced on all levels of governmental, academics, business and industry in print and electronic formats, but which is not controlled by commercial publishers”\(^\text{18}\). When researching contemporary practices grey literature can be the best source of up-to-date information, but it needs to be treated with caution since it is not usually subject to peer review and must be evaluated accordingly. Grey literature would commonly include:

- conference papers/conference proceedings
- newsletters
- pamphlets
- reports
- fact sheets, bulletins
- government documents
- surveys
- informal communication (e.g. blogs, podcasts)

Grey literature can become extremely unwieldy as its production, dissemination and interconnectedness increases exponentially through new formats and the World Wide Web. We set the limit of our searches of individual websites with the three-click rule which suggests that information should be found with no more than three mouse clicks or the user will become frustrated and abandon the task at hand\(^\text{19}\). This rule has been demonstrated to be something of an urban myth but since many designers use the rule it seemed a useful benchmark. We also word searched sites, where possible, for ‘revalidation’, ‘lay’ and ‘PPI’.

While acknowledging that social media is now a key way in which information and opinion are disseminated, particularly in the context of community engagement, we felt that twitter feeds and other social media opportunities like Facebook were beyond the scope of the current research. We also excluded information from the individual Royal Colleges since these tended to have a tight focus on patient feedback in the context of the specialism and took its lead from the GMC. We looked at the Academy of Medical Royal Colleges website for a synthesis or more general information/policy


\(^{19}\) This is an unofficial web design rule Zeldman, Jeffery (30 May 2001). *Taking Your Talent to the Web: Making the Transition from Graphic Design to Web Design*. New Riders. p. 448. – It has its critics ...
documents/tools specifically related to PPI in revalidation but this was not evident, although the Academy Patient/Lay Group was listed under committees. We found a variety of networks/communities of practice, for example [http://www.networks.nhs.uk/nhs-networks/revalidation-in-london-responsible-officer-network](http://www.networks.nhs.uk/nhs-networks/revalidation-in-london-responsible-officer-network) often with a highly localised focus and limited information on PPI in revalidation.

In general we found a significant amount of grey literature relating to increasing PPI activity across all levels of healthcare; however literature specifically referring to PPI in revalidation was limited. For example, NHS Networks have produced a series of ‘Smart Guides to Engagement’ specifically aimed at those involved in CCGs but ‘revalidation’ as a word search produced no matches in these documents[^20].

Given the inconsistent nature of the material we focused our search to the databases of 8 key stakeholders by way of a ‘snapshot’ acknowledging that these are not the only sources of grey literature.

<table>
<thead>
<tr>
<th>General Medical Council</th>
<th>Centre for Patient Leadership (CPL) provides training and support to patient leaders across lay and health organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.gmc-uk.org/doctors/revalidation">www.gmc-uk.org/doctors/revalidation</a></td>
<td><a href="http://www.centreforpatientleadership.com">www.centreforpatientleadership.com</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Revalidation Support Team (RST) is a DOH funded body which exists to support the implementation of revalidation. It works in partnership with NHS England, the Department of Health (England), the GMC and other designated bodies, to deliver an effective system of revalidation for doctors in England.</th>
<th>Healthwatch England is the national consumer champion in health and care. It has been given significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services. It leads and supports the Healthwatch network, made up of 152 independent community-focused local Healthwatch organisations.</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.revalidationsupport.nhs.uk">www.revalidationsupport.nhs.uk</a></td>
<td><a href="http://www.healthwatch.co.uk">www.healthwatch.co.uk</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Local Involvement Networks (LINks) and the National Association of LINks members (NALM) are now joined under the Healthwatch and Public Involvement Association (HAPIA) a public involvement charity</th>
<th>INVOLVE: national advisory group that supports greater public involvement in NHS, public health and social care research</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>The Patients Association is an established healthcare charity advocating for better access to accurate and independent information for patients and the public;</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.patients-association.com">www.patients-association.com</a></td>
<td></td>
</tr>
</tbody>
</table>

The grey literature search yielded a further 6 documents from a potential 554.

Figure 5. Summary of literature review
5.2. Findings

Although the documents deemed ‘too general’ (104) in the published literature and 548 in the grey literature were not included in our review they highlight the volume of related published material found within even the narrow search criteria. The grey literature search yielded the most up to date information which was generally of a high quality as would be expected from its host organisations. Across both types of literature we were able to identify 3 definitive categories of literature supplemented by ‘Other’:

- Policy / technical information
- Commissioned and independent studies
- Peer reviewed papers
- Other

5.2.1. Policy / technical information

The policy documents were produced by professional bodies in addition to lay and health organisations and published on their websites. Not surprisingly the content reflects the primary focus of the host sites. For example the GMC site was orientated towards the profession and contained material on patient feedback for the purposes of revalidation.

Some of the Royal Colleges also produced their own evaluations of PPI. For example The Royal College of General practitioners published a comprehensive briefing Guide entitled Effective Patient and Public Involvement. This document described ways in which General practitioners could work with local agencies to improve healthcare\(^{21}\) but it did not specifically address revalidation.

5.2.2. Commissioned and independent studies

Some research has already been undertaken into the perceptions of doctors, the public and regulation. These have tended to be descriptive rather than analytical surveys and as such are largely atheoretical. For example, in 2005 the DOH published *Attitudes to medical Regulation and Revalidation of Doctors: Research among doctors and the general public\(^{22}\)*, the results of a survey commissioned by MORI in the wake of the Shipman Inquiry. This study used both quantitative and qualitative research to find little public understanding/knowledge of assessment of medical practice following qualification. It found a willingness on the part of the public to give feedback on doctors and from doctors to receive it (with certain caveats) as part of appraisal. It was followed a year later by a report from the Picker Institute entitled, *The views of members of the public and doctors on the*

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\(^{21}\) RCGP Centre for Commissioning (August 2011) *Briefing Guide: Effective Patient and Public Involvement*

\(^{22}\) Department of Health (July 2005) *Attitudes to medical Regulation and Revalidation of Doctors: Research among doctors and the general public*.
standards of care and practice they expect of doctors. This qualitative study provided a broad evaluation of Good Medical Practice and made a series of recommendations in advance of the publication of a revised edition.

In 2012 the GMC commissioned research by the National Centre for Social Research to undertake a qualitative study to examine public attitudes and the standards expected of doctors by the public. The findings of the report contributed to a revised edition of Good Medical Practice and for the first time the publication of a guide for patients setting out what they should expect from their doctor. Although the report describes contemporary expectations of professionalism it does not discuss revalidation or PPI within the process.

5.2.3. Peer reviewed papers
Articles in peer reviewed journals were divided between patient involvement in care and patient feedback form the perspective of both patients and doctors. Only two papers specifically focused on revalidation and these explored patient feedback. The papers were predominantly reviews or commentaries, only 2 reported on direct research with patients and these were focused on patient questionnaires.

5.2.4. Other
Frequently asked questions (FAQ) were on most websites but they were general rather than specific to revalidation.

Practical information about how to get involved (lay) through the CCGs was available but this was general rather than specifically related to revalidation.

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23 Picker Institute (March 2006) Setting Standards: The views of members of the Public and doctors on the standards of care and practice they expect of doctors.

24 GMC. The Standards Expected of Doctors: Patient and public attitudes  
http://www.natcen.ac.uk/media/1101400/gmc_standards_expected_of__doctors_final_report_v2.pdf_51766111.pdf

25 GMC What to Expect from your Doctor: A guide for patients  
http://www.gmc-uk.org/static/documents/content/What_to_expect_from_your_doctor_-_a_guide_for_patients.pdf


Rubin, P. ‘Commentary: The Role of Appraisal and Multisource Feedback in the UK General Medical Council’s New Revalidation System’ Academic Medicine, (2012) 87:12 1654-1656

27 Adrian Edwards A., Evans, R., White., P., and Elwyn, G. ‘Experiencing patient-experience surveys: a qualitative study of the accounts of GPs’ British Journal of General Practice (2011) 157-66. The research used qualitative semi-structured interviews with 30 GPs and concluded that patient evaluation is seen as a key part of MSF for practising doctors but cautions that clarity is needed about the purpose of evaluation.

Collins, K. O’Cathain, A. ‘The continuum of patient satisfaction—from satisfied to very satisfied’ Social Science & Medicine (2003) 57:5 2465–2470. A paper exploring how 30 dermatology patients describe what it meant to them to be either satisfied or very satisfied with their healthcare. Concludes that attention to the differences between the two constructs provides a useful means to highlighting areas of patient concern and that researchers reporting the results of patient satisfaction surveys should cease to collapse them.
There was practical information for feedback, forms and guidance on the GMC website but these were aimed at doctors. However the GMC do include a section for patients on the revalidation section of their website and it includes a pdf entitled ‘what to expect from your doctor’. The GMC does not provide any guidance about lay involvement in revalidation other than in terms of patient feedback. It does provide a PDF entitled ‘What to expect from your Doctor: A guide for patients’ on the website but it is in the ‘Good Medical Practice’ section of the site. There is however a link to this document through the Healthwatch website. The guide contains information about revalidation including sections on complaints and how patients can contribute to their doctor’s appraisal. It also provides contact details for the GMC, the Health Service Ombudsman and NHS England.

### 5.3. Conclusions

In deciding on the parameters of the literature search it became immediately obvious that there was considerable confusion over the terminology. This not only meant that the literature often suffered from a lack of clarity of focus but also made it difficult to locate information. This was particularly the case with the broader literature where patient and public were used both interchangeably as individual entities or together to indicate inclusivity. ‘Engagement’ as adjective has gained currency and had begun to supersede ‘involvement’ at some point in early 2012. No key document was found to support this change in emphasis, indeed the 2012 Act referred specifically to ‘patient involvement’. Clarity of terminology is a priority since conceptual vagueness can impact on effective operationalization.

Online resources provided the most comprehensive, accessible and up to date information but again the lack of specificity in the terminology made resources difficult to find. Commissioned and independent studies provided the most focused information on PPI and revalidation. However while they identified the public and the professions desire for PPI, particularly patient feedback, they did not really discuss how this should be achieved or, importantly, how once achieved its impact could be measured. Since revalidation is a ‘new’ process then future research needs to have an evaluation element built in. The reviewed literature mirrored this qualitative bias.

### 6. Interviews

#### 6.1 Data collection and management

In order to understand the attitudes, perceptions and experiences of those currently participating in PPI, we conducted ten research interviews with both lay and organisational representatives purposefully selected to encompass local, regional and national perspectives.

<table>
<thead>
<tr>
<th></th>
<th>Lay</th>
<th>Org</th>
<th>Local</th>
<th>Regional</th>
<th>National</th>
<th>Role(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lay representative on revalidation committee for an independent hospital group</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CCG lay member for P&amp;P engagement</td>
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<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PCT PLDP/DMG lay chair (now lay rep with CCG)</td>
</tr>
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<td>4</td>
<td></td>
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<td></td>
<td>Lay representative on Health Education England LETB</td>
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</tr>
<tr>
<td>5</td>
<td>✓</td>
<td>✓</td>
<td>Lay representative on a Regional Revalidation reference group and a Health Education Revalidation Steering Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>✓</td>
<td>✓</td>
<td>Chair of national Lay/Patient group and a lay representative on a national revalidation working group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>✓</td>
<td>✓</td>
<td>Lay representative on the UK Revalidation Implementation Advisory Board and on a national revalidation Work Advisory Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>✓</td>
<td>✓</td>
<td>Medical Director of an NHS Trust</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>✓</td>
<td>✓</td>
<td>NHS England Programme Manager (Revalidation and Clinical Strategy) Area Team</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>✓</td>
<td>✓</td>
<td>Royal College lead for revalidation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Figure 6. Interview participant sample**

The interviews were conducted via established telephone interviewing methods and used an open ended question format with the interview schedule agreed with the RST. The questions were intended to focus on key issues which the RST and our literature review had identified as particularly significant for the development and implementation of PPI in revalidation.

The interviews were transcribed verbatim, and imported onto the qualitative data analysis package NVivo for management and analysis. Thematic analysis was performed on the raw data, in order to address the following questions:

- What are the most common themes?
- Are the themes common to both patient and organisational representatives?
- How are they played out in relation to PPI in medical revalidation?
- What systems are identified that support transparency and improved communication in relation to PPI?

The themes that emerged through the interviews were used to inform the statements presented in the online survey.

We undertook a total of ten telephone interviews with individuals able to present a range of organisational and lay perspectives on current models of PPI and on potential future developments in this sphere, particularly with regards to lay involvement in revalidation.

The interviews lasted between 45-60 minutes and were conducted using a semi-structured interviewing technique. The interview prompt questions are reproduced in Appendix 2.

**6.2. Findings**

Transcripts of the interviews were thematically analysed using Nvivo9 qualitative data analysis software. A coding framework was developed incorporating both deductive codes – derived from the literature review and existing knowledge, and largely mirroring the questions asked in the interviews – and inductive codes created during the process of data analysis. Figures 8 and 9 below show the coding framework after the coding of the whole interview sample was complete.
<table>
<thead>
<tr>
<th>Code</th>
<th>Sub-code</th>
<th>Sources</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples – current PPI</td>
<td>10</td>
<td></td>
<td>85</td>
</tr>
<tr>
<td>Examples of impact</td>
<td>8</td>
<td></td>
<td>21</td>
</tr>
<tr>
<td>Independent ‘eye’ or ‘other voice’</td>
<td>10</td>
<td></td>
<td>72</td>
</tr>
<tr>
<td>Acting for all</td>
<td>5</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Medical ‘jargon’</td>
<td>4</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Wider view</td>
<td>5</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Involvement in revalidation processes</td>
<td>10</td>
<td></td>
<td>121</td>
</tr>
<tr>
<td>Appraisal</td>
<td>4</td>
<td></td>
<td>22</td>
</tr>
<tr>
<td>Governance</td>
<td>8</td>
<td></td>
<td>36</td>
</tr>
<tr>
<td>RO decision making</td>
<td>5</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Lay rep motivations</td>
<td>7</td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>Lay skills and qualities needed</td>
<td>10</td>
<td></td>
<td>132</td>
</tr>
<tr>
<td>Administrative skills</td>
<td>7</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Age</td>
<td>7</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Challenging or questioning</td>
<td>10</td>
<td></td>
<td>41</td>
</tr>
<tr>
<td>Communication skills</td>
<td>4</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Experience</td>
<td>9</td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>Legal understanding</td>
<td>6</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Patient feedback</td>
<td>9</td>
<td></td>
<td>38</td>
</tr>
<tr>
<td>Patient or lay identity</td>
<td>10</td>
<td></td>
<td>35</td>
</tr>
<tr>
<td>Potential – future PPI</td>
<td>10</td>
<td></td>
<td>75</td>
</tr>
<tr>
<td>Recruitment</td>
<td>10</td>
<td></td>
<td>47</td>
</tr>
<tr>
<td>Already known or involved</td>
<td>10</td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>Regional variation</td>
<td>8</td>
<td></td>
<td>41</td>
</tr>
<tr>
<td>Relationships with organisation</td>
<td>10</td>
<td></td>
<td>64</td>
</tr>
<tr>
<td>Remuneration</td>
<td>10</td>
<td></td>
<td>28</td>
</tr>
<tr>
<td>Suggestions for improvement</td>
<td>8</td>
<td></td>
<td>36</td>
</tr>
<tr>
<td>Time as lay rep</td>
<td>10</td>
<td></td>
<td>51</td>
</tr>
<tr>
<td>Training for lay reps</td>
<td>10</td>
<td></td>
<td>46</td>
</tr>
<tr>
<td>Support for lay reps</td>
<td>5</td>
<td></td>
<td>11</td>
</tr>
</tbody>
</table>

**Figure 7.** Parent and child nodes, with child nodes aggregated into parent nodes

### 6.2.1. Existing models of PPI

Our interviewees identified a number of existing models of PPI, including some which form part of revalidation processes as well as a range of other examples outside or predating revalidation.
A detailed breakdown of the models of lay participation identified by our interview participants is presented in Appendix 5. These findings are by no means exhaustive, but they provide an illustration of the variety of lay participation.

The most common model referred to was lay representation on governance committees at local or regional levels, either in PCTs prior to April 2013, or since then in CCGs, as well as in independent settings, Health England LETBs and NHS England Local Area and Regional Revalidation Teams. Notably those working as Lay Chairs or lay representatives are involved in the implementation of revalidation at local and regional levels through specifically focused Revalidation Steering Groups or Regional Revalidation Reference Groups. Revalidation has also impacted upon the work of lay members of other committees with highly relevant remits, including Performers List Decision Panels and LETB Assessment Record of Continuous Progression (ARCP) panels where lay representatives are privy to information about the individual performance of practitioners and trainees. At national level, lay representatives are involved in monitoring and shaping the implementation of revalidation through membership of committees and working groups involving key policy stakeholder organisations.

Beyond revalidation, our interview participants described a variety of models of PPI, ranging from the presence of service users or carers in consultant appraisals, to the provision of feedback to GP practices through Patient Forums and lay representative or non-executive director status on a variety of committees. Although not directly referencing revalidation, these perspectives add valuable insights into lay representation to the limited data available only a year after the introduction of revalidation.

### 6.2.2. Value of lay involvement

There was a strong sense amongst participants that the main value added by lay representatives was that they brought a different perspective to meetings and discussions. This was variously described as bringing ‘a wider view’ or a ‘helicopter view’, or as being an ‘external conscience’. It was generally felt that, as lay representatives stand outside of and somewhat apart from the minutiae of policy and procedures, and are not involved in the quotidian work of health service provision, they were able to stand back and offer another interpretation.

In a notable example, the ability of lay representatives to query the use of medical jargon – particularly the frequent use of acronyms – was cited as an example.

“And everybody apart from myself on the committee are approaching it with a medical background and all I’m doing is providing the balance of ‘What does that mean? Could you please explain?’ And they’re then ending up with the set of language which is decipherable by any reasonable person whereas before the set of language may have been great if you’ve got an entire medical background but even there, there might have been misinterpretation. Now everything is clarified and very clear at the outset.” R001-L-L (Local lay representative on revalidation committee of independent hospital group)

“Sometimes it’s necessary to cut through the medical terminology, medical jargon and get down to very basic things.” R004-L-R (Regional lay representative on Performers List Decision Panel)
“...it is very easy when a group of professionals are together to go into um, ‘group-think’ as well as ‘group-speak’…” R009-L-R (Lay representative on Health Education England LETB)

In these instances, it was not just the language which was being challenged but the underlying assumption on the part of health services administrators and/or medical practitioners that everyone would share their body of knowledge and perhaps also their institutionalized ways of thinking and working.

Two participants suggested that they saw their role as lay representatives as being to work to represent everyone – including practitioners – and do not simply lobby for a uniquely patient/public point of view.

“I’m not looking just for the hospital and for the patient, I’m looking for the doctor as well…” R001-L-L (Local lay representative on revalidation committee of independent hospital group)

“...but to try and, for everybody’s sake, including the practitioner, to make the right decisions at the right time.” R004-L-R (Regional lay representative on Performers List Decision Panel)

This view was not universal though, another participant stated that:

“...one of the key things is to make sure that we keep in our heads that we’re there to represent the patients and the public.” R005-L-L (Local lay representative on CCG)

However, another participant argued that:

“I think that’s one of the fundamental problems […] that anybody claiming to be a lay-representative or a public/patient representative […] there is no such individual who can honestly […] give a coherent response on behalf of the whole of the public.” R008-L-R (Lay representative on Regional Revalidation Reference Group and local Health Education England Revalidation Steering Group)

Some therefore see lay representatives as an outside ‘other’, in possession of a degree of independence and perhaps even impartiality. Others however see their role as one of advocacy on behalf of patients and the public. These different conceptualisations of the role of lay people in health services is also reflected in the use of differing terminologies, centring on the use of ‘lay’ versus ‘patient’. In addition, the description of these roles as lay ‘members’ or as lay or patient ‘representatives’ also carry significance as the latter term implies that the individual is intended to represent a wider constituency. Clarity over the role which lay people or patients are appointed to fulfil is therefore important. However, how participation should be defined and by whom (as how people self-define their role is as important as any written role description set out at organisational level) remains at issue.

6.2.3. Skills and qualities (characteristics)

6.2.3.1. Experience and age
When asked what skills or qualities a lay representative should possess, a number of participants referred to their own experiences or backgrounds and how these had been beneficial in their lay work. Notably, there were descriptions of previous experience in business management, human resources, local government and other public sector roles at senior levels.

“I mean, it certainly helped me that I had managed those teams as a director in a local authority in terms of being able to you know, understand the process.” R005-L-L (Local lay representative on CCG)

“So going back to your question, what is really needed from a lay person is general business experience, the ability to comprehend what’s being explained in these meetings and the whys and wherefores of it [...] I actually have administration and corporate experience...” R001-L-L (Local lay representative on revalidation committee of independent hospital group)

“If we are, as we often are, asked to chair meetings, participate [...] fully, whether or not we’re chairing, [...] to be able to hold coherent thoughts, to be able to [...] make good sense of the minutes, challenge them if we think they’re inaccurate and so on, it requires a set of skills that you usually associate with a professional background. It doesn’t have to be [...] my background [...] but it does have to be some kind of professional background.” R008-L-R (Lay representative on Regional Revalidation Reference Group and local Health Education England Revalidation Steering Group)

Such professional or managerial backgrounds meant that when coming to act as lay representatives, these people were already accustomed to administrative tasks such as attending, contributing to and chairing meetings, and reading preparatory materials and minutes. In some senses, experience of bureaucracy was therefore felt to be positive.

In addition, there were a number of references to specific types of knowledge that lay representatives may need. These typically related to the need to understand or engage with legalities, particularly with regard to confidentiality and data protection issues, or HR matters.

“...they’ve got to be aware of legal process [...] when you’ve got two barristers in a room [...] e.g. at a performance panel hearing... it’s quite a challenging meeting so I think they need to be able to cope with, with the challenges that are presented to them.” R003-O-R (NHS England Area Team Programme Manager (Revalidation and Clinical Strategy)

“...through my involvements in businesses I have a great understanding - although I am not a lawyer - of legal documents.” R001-L-L (Local lay representative on revalidation committee of independent hospital group)

“...so there’s a bit about understanding early on about the, the logistics of it all and the confidentiality and things like that.” R002-O-L (Medical Director NHS Trust)

However, some of participants recognised that requiring such experience would ensure that only certain sectors of society would become involved and that this might be problematic if lay participation is intended to be representative:

“I used to have to report to a governing body so I was used to as a professional, working to a lay-governing body. We’re used to all that so that’s good. On the other hand,
are we truly representative of the public and the patients? We’re not. Of course we’re not. [...] we’re a very skewed cross-section.” R008-L-R (Lay representative on Regional Revalidation Reference Group and local Health Education England Revalidation Steering Group)

“I took the view that you, you know, you ought to bring people on. I mean we’re all volunteers, I mean, we’re not paid to do this, we’re all unpaid volunteers and there ought to be opportunities to get other people, [a] wider group [of] people involved in these activities.” R006-L-N (Lay representative on the UK Revalidation Implementation Advisory Board and on a national revalidation Work Advisory Group)

Indeed, the lay participants in our interview sample were typically retirees – with 6 of the 7 identifying themselves as such - and one also referring to two other lay representatives they knew being a retired nurse and a retired hospital consultant.

“I think inevitably it attracts a certain section of the population for example [...] people who [...] suddenly find themselves with a little bit more time on their hands, maybe they’ve taken early retirement or something like that, like myself. [...] I think that I would love to see more young people taking part. I think that that is difficult because they would not necessarily have developed some of those skills that you need but again, mentorship might be a way into doing that.” R009-L-R (Lay representative on Health Education England LETB)

“...there is a problem with membership of a lot of these groups that there is a tendency to be dominated by the retired which is unhealthy. [...] and it happens across the board and that also means that very often, we don’t get a representative spectrum of membership of [...] the public. [...] we’re not representatives, we’re not a good sample of [...] the public.” R010-L-N (Chair of national Lay/Patient group and a lay representative on a national revalidation working group)

Questions of prerequisite age and experience are closely linked to other matters raised in this report. If administrative or managerial experience and/or some legal knowledge are to be required of lay representatives as conditions for their recruitment then clearly, the available pool of potential recruits would be limited and those recruited – if experience was required – would almost certainly be older people.

However, whether this is significant goes back to the question of what lay participation is intended to be and to achieve. If the role is intended to be representative, then should those taking up the roles also be representative? And, if so, should they be representative of the general population or should their make-up reflect the demography of health service users? At what level should ‘representativeness’ be important – local, regional or national? What characteristics are important – age, gender, ethnicity? If the role is simply ‘lay membership’ does representativeness matter? Would representative lay participation be beneficial in the implementation of revalidation? Is what matters truly representativeness in a measurable sense or simply diversity, so that varied voices and perspectives are heard?

Such issues are significant when discussing other matters such as recruitment models and training provision for lay participants – as our participant above notes mentorship could be a solution and
widen the recruitment pool. However, it must also be recognised that lay participation is voluntary and that it therefore means that participants can only be drawn from amongst those who are willing and able to give their time to contribute. This pragmatic concern will of course impact upon recruitment whatever theoretical models of representativeness might be desired.

6.2.3.2. Challenge

Beyond matters of experience and knowledge, one key part of the role which demanded particular personal qualities from lay participants was raised repeatedly by our interviewees. This was the idea that it was vital for lay participants to question and challenge organisational or medical perspectives, agendas, or behaviours.

“Sometimes to ask very naïve questions because naïve questions in my experience, actually sometimes elicit an important bit of information that hasn’t actually been established up until that point.” R004-L-R (Regional lay representative on Performers List Decision Panel)

“I think that […] the role that we’ve got is about challenging transparency all the time.” R005-L-L (Local lay representative on CCG)

“…it is important to have the self-confidence to be able to challenge and if necessary, to stop a process if you feel that things are not working in the way they should be.” R009-L-R (Lay representative on Health Education England LETB)

Linking back to the notion of the lay participant as ‘outsider’ or ‘other’, the value of challenge is that it could bring clarity by forcing further discussion and might shift organisations away from pursuing familiar patterns of activity simply through habit.

However, as discussed below (Relationships with organisations and practitioners), the importance placed upon an ability to question and challenge does not necessarily equate to lay participants being in a position of opposition to organisations or practitioners. In fact, rather than being adversarial or combative, most participants characterised the process as being respectful and collaborative.

6.2.4. Recruitment

The process by which lay participants are appointed is clearly important. Most of the lay participants in our interview sample had been appointed to their current roles following prior lay experience elsewhere in the same organisation or a related one, either by simply being invited to participate or by being invited to apply.

“I suspect […] I was invited because of their pre-knowledge of what I’d already contributed to within their group.” R001-L-L (Local lay representative on revalidation committee of independent hospital group)
“...but I think was invited to take the independent lay-chair role because of the experience I’d had [...elsewhere...].” R004-L-R (Regional lay representative on Performers List Decision Panel)

“So I’ve done general lay-rep work for the [...] Deanery and as a consequence of that or leading on from that, I got involved with revalidation, both locally within the [Health Education England LETB and] regional in the [...] of England.” R008-L-R (Lay representative on Regional Revalidation Reference Group and local Health Education England Revalidation Steering Group)

In only three cases did participants refer to participation being linked to prior status as a patient or carer.

However, some interviewees also referred to competitive appointment processes, even where they may have been invited to apply.

“Well, it changed, for this round in terms of the clinical commissioning group, we were interviewed by the chairman, chief exec, a patient representative [...] from LINks [...] Whereas in the past, non-exec’s for PCT’s were interviewed by the chairman, a chairman from another PCT, and then usually an independent expert, so it was, I felt that that process was much more robust and the process we went through for CCG’s was actually, probably not as objective as the previous process for PCT’s [...] I’m not the only who has concerns about that. I was very pleased I got the job, but it was very robust when it was done previously, the way it was done before.” R005-L-L (Local lay representative on CCG)

“I have worked for what is now the LETB in [...] for three years as a lay-representative partner which is their terminology. I have just recently last month, been through a competitive process to serve for a further three years.” R009-L-R (Lay representative on Health Education England LETB)

Some participants also noted that they had been provided with clear role descriptions, and this seems to have been viewed positively:

“...you have a role description; you know what it is that you’re supposed to do and what it is that you’re supposed to deliver on...” R009-L-R (Lay representative on Health Education England LETB)

“...we tend, we are doing more and more of that so we do have a, we’ve had a process where we write a sort of job-spec [in] interview candidates and we’ve done that for some of our committees...” R002-O-L (Medical Director NHS Trust)

However, the second participant quoted above also stressed that role descriptions should be supportive if used, and felt that although helpful for lay roles on committees, such methods could put off potential volunteers for lay participation in other areas, particularly those involving patients. The concern seems to be that a role description could become a barrier and dissuade people from participating if it were too demanding in terms of skills and experience. This participant characterised lay participation as becoming ‘more of a co-production’ in which lay people could bring forward ideas and drive change rather than being invited to contribute in clearly defined and limited
ways. This perspective was a minority view; however, as other participants more strongly favoured limitations and clearly defined roles.

### 6.2.5. Remuneration

Lay representatives were generally reimbursed for their travel expenses, with some receiving an hourly rate of pay in addition to this. One interview participant reported a salary/honorarium of £7500 per annum for a lay role (maybe lay chair or lay non-exec director, not clear) which was subject to tax and national insurance contributions.

However, there was little information forthcoming about what the hourly rates are. One person received £32.50 per hour for a local lay role, whilst another referred to a lay role being paid at less than the £85 per hour paid to clinical assessors for work with a PLDP but did not specify an exact amount. Another, involved in a Regional Revalidation Reference Group cited a rate of £150 per half day, which could be calculated at around £35 per hour. One participant, discussing their work as lay chair of a PLDP stated that they had suggested an hourly rate and the organisation had agreed to pay it.

Clearly, there is some variation around remuneration for lay representatives and one organisational interviewee stated that this issue was under discussion:

> “...currently, the jury is out as to what the national rate should be and I’m sure if you asked the question of all the area teams they would give you a different figure.” R003-O-R (NHS England Area Team Programme Manager (Revalidation and Clinical Strategy)

Participants expressed a range of views about remuneration:

> “…we don’t do it for the money.” R005-L-L (Local lay representative on CCG)

However, the same participant also said:

> “I would not do a non-executive job without being remunerated more than my expenses, but that’s my personal position. I need to be paid for how I spend my time but, because I’m on my own [...] other people may not be [...] in that position.” R005-L-L (Local lay representative on CCG)

In contrast, another lay participant said:

> “No, I don’t think so. Um, well, from my position, no, but then I’m retired and I can afford, you know, I, I don’t need an income.” R010-L-N (Chair of national Lay/Patient group and a lay representative on a national revalidation working group)

Discussing how the hourly rate he was paid had been reduced, another stated:

> “All of us said, actually, privately, frankly, if they turned round and said to us “We can’t afford to pay you anything, are you willing to do it for expenses, travelling expenses only?” we would all have said “Yes” and [...] that I suspect might be a way for a cash strapped NHS to move in the future.” R008-L-R (Lay representative on Regional Revalidation Reference Group and local Health Education England Revalidation Steering Group)
Other views were varied:

“That if you are going to go through a very robust appointment process and you are going to get people who have the skills and the capabilities and the behaviours and the capacity to be able to do the work, there is going to have to be some payment involved. Not huge, not huge, but some recompense in there. [...] I think that if there isn’t some recompense in there a lot of potential talent will be lost.” R009-L-R (Lay representative on Health Education England LETB)

“...there’s variation, but I think, in principle, yes, I think, you know, if you want someone to do a job, you probably should pay them something to do it.” R007-O-N (RC lead for Revalidation)

“I personally think no, but I have to say, I have colleagues who do think that who think that they ought to be remunerated for it but that’s a personal choice.” R006-L-N (Lay representative on the UK Revalidation Implementation Advisory Board and on a national revalidation Work Advisory Group)

Several points are raised regarding remuneration therefore. Firstly, individual’s views on this question may be coloured by their personal circumstances - some people may not be able to commit a significant amount of their time without recompense. Deciding not to pay an hourly rate in addition to expenses may therefore limit the pool of potential participants.

The extent to which lay participants are remunerated will also need to be assessed with regard to organisational resources, particularly if such participation is to be extended.

6.2.6. Extent of lay participants’ involvement, esp. revalidation

Interview participants were asked what aspects of revalidation, or health services more broadly, they felt lay involvement should play a part in. Opinions on this were mixed. One participant, for example, did not feel that involving lay people in appraisals would be helpful:

“I think having additional people, for example, in an appraisal would be quite inhibiting, and might not give the appraisal as much value for the participant.” R007-O-N (RC lead for Revalidation)

However another participant, a clinician with experience of having service users or carers present in pre-revalidation appraisals, had found this to be a positive experience and felt that a similar model could be used within revalidation appraisals:

“...so it’s something we’ve tried and it, those who did it thought it was really good, we just need to make it a bit more systematic and fitting in with the new appraisal process...” R002-O-L (Medical Director NHS Trust)

This participant also had a generally positive and open view of the potential for lay involvement in many aspects of revalidation, including some form of contribution to RO decision-making processes and quality assurance matters alongside appraisal. The participant even felt that there may be some scope for lay involvement in some instances of RO decision-making where there were concerns about doctors’ practice:
“...but we are thinking of do we need, where there are difficulties, do we need lay-involvement in helping to decide what to do. We haven’t come across that yet, but I think, I think there are opportunities throughout, not just this, but governance and, and quality assurance anyway...” R002-O-L (Medical Director NHS Trust)

Such a degree of openness towards the possibility of extensive lay participation in all aspects of revalidation related processes was not shared across the sample, even amongst lay participants themselves. In other comments the same participant also acknowledged that it may not be appropriate for lay participants to be present in appraisals where it was expected that performance difficulties might be discussed with the practitioner being appraised:

“I think if there is a concern about a doctor that’s going to be maybe a difficult appraisal [...] that might need somebody such as BMA or HR or a professional colleague, because I could see that [...] maybe going through a different process, maybe performance management and I wouldn’t want to put a lay-person in a position where [...] it gets more unnecessarily complicated and what [...] if it was felt that it was going to [...] be a disadvantage...” R002-O-L (Medical Director NHS Trust)

Concerns about lay involvement in performance management or fitness to practise related matters were voiced repeatedly by interview participants.

“I think somebody responding to concerns, I would say no. I suppose, at the early stages but that’s a really difficult one to judge, really, I, I think, no I would say not responding to concerns. Appraisal, yes, maybe.” R003-O-R (NHS England Area Team Programme Manager (Revalidation and Clinical Strategy)

Expanding on this, the participant stated that a carefully selected lay chair on a PLDP is acceptable lay involvement in performance management issues but that wider lay involvement – and specifically patient involvement – would be unwelcome in such aspects:

“...I think there are some instances with the performance panels, where I said earlier you have highly confidential data, things that potentially could result in a GP being suspended, I wouldn’t want wide lay involvement and I would, would want us to have screened the chair. So I wouldn’t want sort of, patient representation on something like that, nor would a doctor, nor would, nor would a doctor either and actually I think we would have an issue with the defence union as well...” R003-O-R (NHS England Area Team Programme Manager (Revalidation and Clinical Strategy)

Selection of lay representatives is clearly an important question then, and the criteria for selection must go back to the issue of what lay participation is supposed to be for or to achieve. Furthermore, the distinction between lay and patient involvement is also highlighted again. Another lay participant, a PLDP chair, also highlighted this distinction with particular reference to performance panels:

“So I think patient engagement in that process is probably not appropriate. Appropriate in terms of enabling them to make their complaints about people, and for us to do the process and then to give feedback as to what we’ve done. I think, you know, there’s a
fine line there. You have to be careful because you’re talking about somebody’s career.”
R005-L-L (Local lay representative on CCG)

Other participants also expressed concerns about the involvement of lay people in such areas, either because of concerns over confidentiality or because of doubts over whether their presence would add value to the process.

Although there was disagreement about the extent to which lay people should be involved in the actual activities of revalidation, there was a general sense amongst participants that lay participation at a governance level – in healthcare generally as well as specifically in relation to revalidation was welcome in audit or quality assurance processes. However, it is notable that these types of governance committee were the most commonly held by our participants, so it is possible that their own experiences have influenced their perceptions of what is appropriate.

“I guess I see it as something that, um, at the moment, the way things are, I, I kind of, I could see it as having a role in, you know, maybe in assurance process.” R007-O-N (RC lead for Revalidation)

“I think that first and foremost it is to be there in terms of assuring process...” R009-L-R (Lay representative on Health Education England LETB)

“Well, auditing I think auditing yes, but not involved in the appraisal itself.” R010-L-N (Chair of national Lay/Patient group and a lay representative on a national revalidation working group)

There was, therefore, a general sense that lay participation in revalidation was welcome to some degree, but no consensus about where the boundaries should be set. One participant warned that pushing the PPI agenda too strongly may damage the revalidation scheme itself, as it is still in its infancy and only tentatively accepted by some in practice and within organisations:

“I mean [...] an annual board paper on revalidation that goes to the public [...] it’s [...] what I’m prepared to share. So what I’m prepared to share is [...] how many people have had appraisals and [...] what the revalidation recommendations have been [...] but not, not at a personal level, sort of at an organisational level. [...] I know that the patient/public representation is [...] people are saying they want more and it, there’s not enough [...] but it does feel to me like it’s sufficiently fragile to [...] potentially make it too difficult.” R007-O-N (RC lead for Revalidation)

6.2.7. Training for lay participants

Evidently, training requirements for lay participants would depend upon the roles to which they are recruited and their previous experience and existing skill sets. Our participants reported that current training provision is mixed.

“...any training they’ve had, I think has been training on the job i.e. um, sometimes they fly by the seat of their pants I think is the best way to describe it.” R003-O-R (NHS England Area Team Programme Manager (Revalidation and Clinical Strategy)
“...well we have training, we’ve done [...] audit training which we did across the CCG’s in [...] the region... and we have regular [...] updates on safeguarding training as well.” R005-L-L (Local lay representative on CCG)

However, there was widespread agreement that some induction or training would be beneficial:

“I think there probably does need it, certainly, [...] if I was pitched into this now, I would be very much at sea.” R004-L-R (Regional lay representative on Performers List Decision Panel)

“I think there should be a very simple [...] curriculum which [...] could then be cascaded down to those people at lower levels...” R006-L-N (Lay representative on the UK Revalidation Implementation Advisory Board and on a national revalidation Work Advisory Group)

“If somebody as a lay-person comes in from out of the cold without pre-knowledge of the environment and as importantly, without the organisation having any knowledge of the individual, then there must be some kind of mentoring or process of induction.” R001-L-L (Local lay representative on revalidation committee of independent hospital group)

When discussing training, several participants mentioned the possibility of existing or departing lay participants being involved in some form of mentoring scheme for new recruits. This was seen to be a way in which experienced lay participants could share the knowledge and experience that they had accrued, in order to ensure that these were not lost.

6.2.8. Length of service as a lay participants

Another area where there was significant variation was the length of time that people have or potentially should serve as lay participants. In some cases, it was difficult to discern how long exactly people had been involved because they had moved between various lay roles. There were a range of views about whether lay positions should be subject to a time limit. One participant held a role on a revalidation committee of a group of independent hospitals, and felt that either he or the organisation would determine when he should leave, without a defined time limit being necessary:

“My decision on my contribution to the revalidation committee was, my statement was, when I’m not contributing, tell me and I will leave. [...] If it were to become a secondary knowledge and I knew that I wasn’t contributing I would leave the revalidation committee.” R001-L-L (Local lay representative on revalidation committee of independent hospital group)

Others did specify that there were time limits, but it seemed that the same individuals could re-apply to serve another term:

“...generally in the past when I’ve worked with lay-chairs, we’ve limited their time on a committee to three years and then it’s reviewed.” R003-O-R (NHS England Area Team Programme Manager (Revalidation and Clinical Strategy)

Where specific terms of service were mentioned, these were generally of 3 or 5 years. Two participants mentioned that recent developments – either the change from PCTs to CCGs, or the
introduction of revalidation – had resulted in them being asked to stay on for perhaps longer than their designated term, in order to bring some continuity.

This observation points to an issue which was identified by several participants, which is that when lay people leave their roles they can take with them a lot of experience and knowledge, and that this can be a significant loss to the organisations with whom they have worked. However, in contrast, there was also recognition that new lay participants could bring fresh perspectives:

“...the flip-side, I suppose of people leaving after three years is that they take an awful lot of knowledge with them.” R003-O-R (NHS England Area Team Programme Manager (Revalidation and Clinical Strategy)

“I think that there’s two schools of thought there. First of all if you’ve got somebody with a lot of experience it’s a shame to, not to carry on using that experience on the other hand it’s always refreshing to have new blood.” R004-L-R (Regional lay representative on Performers List Decision Panel)

A number of participants suggested that there should be mechanisms in place to combat this knowledge loss and to support the induction of new lay participants, such as some form of mentoring or staggered recruitment – already used in one participant’s CCG. In such models, experienced or departing lay participants would support new ones:

“...they should have, I think, access to people like me who know the history, I think that’s [...] one of those situations where there are people who understand history but there ought to be people brought on to keep the [thing] turning over so there’s a fresh mind, fresh approach to the way these things are tackled.” R006-L-N (Lay representative on the UK Revalidation Implementation Advisory Board and on a national revalidation Work Advisory Group)

“We’ve got a process where we’ve been, all been appointed for different lengths of time [...] Yeah, I’ve been appointed for four, and the other two colleagues; one is for three and one is for two years [...] So that we don’t lose the knowledge you know, if people come up for their time and they don’t want to be renewed or it’s not appropriate to renew them, then you know, we’d appoint somebody else and then they’d learn from the other two.” R005-L-L (Local lay representative on CCG)

“...in an ideal world, I think the deanery would have gradually phased out the current team and gradually brought a new team in; not suddenly lost a lot of expertise and had a brand new team coming in. But you know, you start from where you are rather than where you’d want to be.” R009-L-R (Lay representative on Health Education England LETB)

“...it’s a problem, because there is rarely a handover when one person is coming towards the end of their period of activity of tenure. In my experience, this doesn’t happen. There isn’t an opportunity for somebody to shadow somebody else, it rarely happens.” R010-L-N (Chair of national Lay/Patient group and a lay representative on a national revalidation working group)
A further issue centring on length of service was the concern expressed by some interviewees. They reasoned that while lay participants who held their roles for a long time may develop their knowledge and skills, they might also lose their ‘lay’ identity and voice:

“...that means we are no longer objective outsiders seeing things with fresh eyes from a public perspective. We’re increasingly, whether we like it or not, seeing ourselves as part of the team in the deanery or in the revalidation group or whatever so your very question is a dilemma because the more trained up we become the implication would be we get to know more about how systems and procedures work and [...] how change can be affected in the NHS which is tricky as it’s a big bureaucracy. The more we get familiar with that and trained up to understand that the less we become what I would call, you know, a pristine lay-person who comes in with fresh eyes and objectivity so there is a difficulty.” R008-L-R (Lay representative on Regional Revalidation Reference Group and local Health Education England Revalidation Steering Group)

“...those people become professionals at what they do and that has kind of a mixed impact, I think on the one hand [...] it obviously makes them very knowledgeable about the systems they’re working within and [...] sometimes able to [...] offer solutions [...] and things which, [...] but it can also take the edge off their independence and their challenge.” R007-O-N (RC lead for Revalidation)

6.2.9. Lay participants’ relationships with organisations and practitioners

Several of our participants commented positively on their experience of the relationship between lay participants and the organisations they worked with. Notably, there was a general sense that contributions made by lay participants were valued and that they felt respected. Most also felt that the data shared with them by organisations was adequate and that they could ask for further information if they deemed it necessary:

“I don’t have any difficulty with the information that I’m aware of and I haven’t identified any areas where things are being hidden. [...] I don’t feel [laughs] I’m trying to think of nice terminology, I’m not being excluded [...] You know, I’m a part of the team.” R001-L-L (Local lay representative on revalidation committee of independent hospital group)

“I’m very pleased that at all levels, there is a real and genuine endeavour to, to have lay-people involved. Our views are listened to courteously and with respect and you do feel that you know, that your ideas are taken, well, they do help to shape policy. So we’re not just being regarded as token. All very good.” R008-L-R (Lay representative on Regional Revalidation Reference Group and local Health Education England Revalidation Steering Group)

Two participants, one lay and one organisational, commented that, in committee work, it can take some time for members to understand each other and to ‘gel’, but both felt that this process was progressing well:

“I found in April and May because nobody knew me and I didn’t know anybody else apart from one person [...] the group were tending to [...] skate round each other a little bit
[...], not necessarily totally trusting everybody round the table. Well, we’ve got rid of that because everybody does trust everybody now around the table. [...] and all the members of the group make their contribution, and are well supported...” R004-L-R (Regional lay representative on Performers List Decision Panel)

“I think if somebody had videoed our panel in April and video it now it’s a very different panel, and it’s all about learning to trust who you work with, knowing how much you can give and people’s views isn’t it? You know, what people bring to the table.” R003-O-R (NHS England Area Team Programme Manager (Revalidation and Clinical Strategy)

Concerns about working relationships and the sharing of information were only really expressed by lay representatives working at national level, on matters pertaining to policy development and implementation:

“...there are circumstances where I think [...] you feel that [...] you’re being listened to, recognised and that [...] there’s a genuine relationship, but then there are other circumstances I think sometimes you’re being listened to and then [...]they say...’I’ve heard that’ [...] and that’s the end of it.” R006-L-N (Lay representative on the UK Revalidation Implementation Advisory Board and on a national revalidation Work Advisory Group)

“I don’t think we get, we’re not getting the full story but we get some figures from the GMC but I don’t think we get all the information we require.” R010-L-N (Chair of national Lay/Patient group and a lay representative on a national revalidation working group)

Beyond simply their own relationships with organisations, one participant stressed the importance of balance in committees where there were multiple groups being represented, particularly between lay people and practitioners.

“I would stress it’s a privilege both on the revalidation committees and all the other, the sort of doctors who come forward to serve on those committees are really committed to developing the profession and developing the next generation. So not only are they probably very good doctors as well, but they are also wonderful ambassadors for the medical profession. So working with them is obviously a pleasure.” R008-L-R (Lay representative on Regional Revalidation Reference Group and local Health Education England Revalidation Steering Group)

“I’m worried if there aren’t enough serving GPs and secondary care professionals to actually add the voice of common sense when we’re formulating policy. They’re too busy doing the job they get paid for, you know, and, and that’s the worry that, that there isn’t enough of their input. But in terms of lay-voice, I’m not sure I would join the clamour to say there ought to be more lay-involvement. In the areas I work in, I think it’s at least enough.” R008-L-R (Lay representative on Regional Revalidation Reference Group and local Health Education England Revalidation Steering Group)

Generally, it seems that lay participation involves working with organisations rather than in opposition to them.
6.2.10. Lay participants’ motivations

Lay participants are volunteers, and suggested a variety of motivations for participating:

“…when I was young I was given so many opportunities by different companies and I like to give back and my time to the revalidation committee of … is a situation of giving back…” R001-L-L (Local lay representative on revalidation committee of independent hospital group)

“I wanted to carry on doing something and I’d always been involved in health and social care…” R005-L-L (Local lay representative on CCG)

“…So I just felt that it’s an important principle […] it means a lot to me that I’m actually doing something […] doing some good, it sounds awful, that, doesn’t it? Doing some good.” R006-L-N (Lay representative on the UK Revalidation Implementation Advisory Board and on a national revalidation Work Advisory Group)

“I think sometimes people get involved in those type of roles because they’ve maybe got a particular sort of axe to grind about a particular part of the health service or something like that.” R007-O-N (RC lead for Revalidation)

“I have a personal interest inevitably because I live within the area in which I work as a lay representative and I have an interest in the health service […] and thus the training that is being delivered in this area, both as a patient myself, as a parent and as a carer for somebody with some chronic health conditions.” R009-L-R (Lay representative on Health Education England LETB)

The general impression created by the sample of interviews is that lay participation benefits the organisations involved and is also a positive experience for the lay participants. However, participants’ backgrounds and personal motivations may need to be considered when approaching recruitment for particular roles, perhaps depending on the nature of the role and the data to be shared as part of the work.

7. Online Survey

In order to obtain breadth of opinion about PPI in the appraisal and governance of doctors (revalidation), the research team administered an online questionnaire based around the emerging themes from the interviews. However, during the interviews it was evident that current levels of PPI in the appraisal and governance of doctors were rather scarce. As a result, in consultation with the NHS Revalidation Support Team (RST), it was deemed appropriate to extend the scope of the survey to include opinions of lay representatives who are not explicitly involved with revalidation but who might be able to offer valuable insights on PPI within revalidation.
7.1 Data collection and management

An online questionnaire based survey was selected as they are inexpensive to conduct and have the potential to collect a lot of data quickly, hence it is an appropriate method given the limited timeframe for the research and the need to gather an appropriate volume of data to create a representative sample of views.

A preliminary set of questions was identified around the emerging themes from the interviews. These questions were specifically targeted towards value of PPI in the appraisal and governance of doctors and administrative arrangements. As mentioned earlier, it was realised during the interview process that there is a scarcity of PPI representatives involved in the appraisal and governance of doctors. Accordingly, it was decided to extend the scope of the survey to include PPI representatives who are not currently involved in the appraisal and governance of doctors. As a result of this development and in consultation with the RST, additional questions were identified to collect information on desired personal attributes/skills along with training and development support.

The sampling frame was identified in consultation with the RST and contacts already established through CAMERA’s revalidation research networks. The target groups included English Responsible Officers and their local patient representatives in addition to national patient groups. A predominantly closed question format with ‘skip logic’ was used to elicit higher response in a short timeframe than open-ended questions. The questionnaire included closed questions with a combination of visual analogue scale (slider scale with range -2 to +2) and five point Likert scale questions, alongside open text questions providing the opportunity for respondents to expand on each answer should they choose to. The respondents were presented with a brief overview of the research objectives to ensure participants understand the purpose of the survey before completing it. The survey was open for three weeks starting from 8th of November 2013. Respondents were also asked to self-declare socio-demographic information in order to identify the representativeness of the sample. Confidentiality was assured but as with the majority of online surveys 100% anonymity was not guaranteed.

In order to obtain the ranked themes (table 4 -7), the response categories of the individual items were combined. Responses ranging from 0.1 – 2 were recoded as ‘Accepts’, responses ranging from -2 – -0.1 were coded as ‘Rejects’ and 0 as Neutral. Following this, frequency distributions of the transformed items were obtained to extract the relevant figures and rankings. In some cases it was difficult of draw out the key themes from the rest. For such cases additional criteria like interquartile range (IQR), strong accepts or strong rejects were used to draw out the key themes.

Alongside the quantitative data returned by the survey, there was also a valuable sample of qualitative data entered into free text boxes placed at the end of each section of the survey. Such data were produced by 28 survey respondents. The answers given in the free text boxes of the survey were extracted from the survey data, organised for analysis and imported into the NVivo9 qualitative data analysis software programme. Separate nodes were created for each survey recipient and for the answers to each particular survey question. This allows the data to be viewed by looking at an individual respondent’s whole contribution of free text data or by looking at all the answers provided to each individual question by the whole cohort.
In addition, the qualitative survey data were thematically coded using the same coding framework developed for the analysis of the interview data. This framework was found to be entirely appropriate for the survey data and no new thematic codes were created. One separate code was created outside of this framework to mark comments made by the respondents about the design and wording of the survey itself, to facilitate reflection on the research tool.

7.2 Questionnaire Findings

7.2.1 Demographics
The online questionnaire was distributed widely using mailing lists and a total of 150 participants completed and provided usable responses (53% female, 42% male, 5% did not respond). The majority (67%) of the respondents were aged over 50 years and 91% of the respondents identified themselves from White (English/Welsh/Scottish/Northern Irish/British) ethnic background. Table 1 summarises the regional distribution of responses from across England. A large proportion (58%) of the respondents identified themselves as being from the Midlands, East and North of England. Among the respondents, organisational representation was evenly distributed across all the regions but lay representation was higher (40% of all lay respondents) were identified as being from the Midlands and East of England.

Table 1. Distribution of responses per region (n=150)

<table>
<thead>
<tr>
<th>Regions</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>England – London</td>
<td>16%</td>
</tr>
<tr>
<td>England – Midlands and East</td>
<td>35%</td>
</tr>
<tr>
<td>England – North</td>
<td>23%</td>
</tr>
<tr>
<td>England – South</td>
<td>16%</td>
</tr>
<tr>
<td>No Specific Region</td>
<td>10%</td>
</tr>
</tbody>
</table>

Table 2 summarises respondent’s perspective as to if they considered themselves a lay or organisational representative. Overall, the responses for organisational representatives were evenly distributed across the regions. However, around 39% of the lay representatives were from the Midlands and East, and identified themselves as local representatives. The responses were evenly distributed in terms of gender for lay representatives but two thirds of the organisational representatives were female.

Table 2. Group Representations (n=150)

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Representatives</td>
<td>48%</td>
</tr>
</tbody>
</table>
7.2.2. Awareness and involvement of Medical Revalidation

The respondents present a mixed picture about their individual awareness of revalidation as depicted in Figure 9. The overall picture seems to present a “somewhat aware” scenario with 51% of the respondents stating that they are aware to a certain degree and 37% stating that they are fully aware. However, closer examination of the data reveals that lay representatives generally think that they are not well aware about revalidation (tending towards “Not at all”) in comparison to a significant number of organisation representatives (66%) who opine that they are fully aware about revalidation.

Figure 8. Awareness about revalidation (-2 implies ‘Not at all’ and 2 implies ‘Fully’)

On the issue of general public awareness about revalidation, there was unanimous agreement (92%) from the respondents about the lack of awareness of revalidation as shown in Figure 10.
Concerning current involvement in supporting PPI within medical revalidation, 25% of the respondents expressed in the affirmative and 75% of the respondents mentioned that they were not involved in supporting PPI within medical revalidation. Among those who are currently involved in revalidation, the distribution between lay and organisational representation was fairly even, but this was predominantly at the local level.

**Table 3. Current Involvement in supporting PPI in revalidation**

<table>
<thead>
<tr>
<th>Support PPI in Medical Revalidation</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>25%</td>
</tr>
<tr>
<td>No</td>
<td>75%</td>
</tr>
</tbody>
</table>

**7.2.3. Value of lay representation in revalidation**

The respondents overwhelmingly agreed (81%) that lay representatives could make a significant contribution towards the appraisal and governance of doctors, with both lay and organisational representatives equally expressing a similar view. Only a handful of local organisational representatives were agnostic or disagreed about the value of PPI in revalidation.
Figure 10. Value of PPI in revalidation

The preceding interviews were already pointing towards this trend and the survey findings validate this perception about the importance of PPI within revalidation. In order to further understand PPI within medical revalidation, survey questions were presented on, how precisely should PPI manifest within revalidation, where it would be of greatest value and which aspects of PPI will prove to be difficult while attempting to recruit. The complete ranked list is available in Appendix 4.

Table 4. Lay representation involvement in revalidation

<table>
<thead>
<tr>
<th>1. Quality Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Steering groups responsible for governance</td>
</tr>
<tr>
<td>3. Organisational response to significant events</td>
</tr>
<tr>
<td>4. The response to complaints against doctors</td>
</tr>
</tbody>
</table>
The data presented in Tables 4 and 5 show that the respondents were unanimous about the areas where they considered PPI would be of greatest value, and consequently where lay representatives should be involved. The respondents also felt that recruiting lay representatives in these areas would be fairly unproblematic (Table 7).

In their answers to the free text questions, survey respondents commented about their knowledge of current models of lay participation and its potential. Again their views were mixed and reflected a similar range of opinions to those offered by the interview participants. Current models include the involvement of service users and carers in service development, the training of medical students and the recruitment of medical and nursing staff (all mentioned by one respondent). Another respondent commented that although there was a lot of lay representation across the trust that they worked in they were not sure if this extended to lay involvement in revalidation.

Others questioned the extent to which lay participants should be involved and, in common with the interview sample, several respondents drew a distinction between governance or audit roles, and involvement in decision-making about individual practitioners:
“I strongly believe patients’ voices are very important within all areas of the NHS.” S006
“I do see a value in involving lay representatives in some activities, but not all.” S007
“It would, generally speaking, be very unprofessional for a Lay member to influence fitness to practice judgments.” S010

“As a start I think lay people should be involved in the systems rather than individual decisions which I think would be complex and raise the possibility of less consistency in the way we deal with particular issues.” S013

“I am very pro-patient or public engagement but I would strongly recommend they are involved in QA rather than direct process.” S014

“In my experience, the Lay Rep can bring an element of rigour to the process. While a professional may overlook shortcomings in a fellow professional’s conduct, the Lay Rep sees it from the prospective patient’s point of view and can/should flag up the issues.” S025

7.2.4 Skills and attributes for effective lay representation
The question was presented depending on the respondent’s perspective (lay or organisational) and the most important skills identified from the lay representative and organisational perspectives are listed in Table 8 and Table 9. Both the groups strongly converged on a similar set of experiences required for the role.

Table 8. Experience personally valued by lay representatives

<table>
<thead>
<tr>
<th>1. Recent experience of being a patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Experience and skills in management outside healthcare</td>
</tr>
</tbody>
</table>

Table 9. Experience valued by organisations while appointing lay representatives

<table>
<thead>
<tr>
<th>1. Recent experience of being a patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Experience and skills in management outside healthcare</td>
</tr>
</tbody>
</table>

The respondents were also asked to identify what they considered to be the key skills required to be an effective lay representative.
Table 10. Required skills to be an effective lay representative

| 1. Ability to listen actively                      |
| 2. Ability to clearly explain a point of view, with impact |
| 3. Ability to represent the point of view of the general public |
| 4. Ability to represent a collective patient view |
| 5. Ability to make clear notes of what you see and hear |

In common with the interview data, the skills, attributes and experience that respondents considered necessary for lay work, depended very much on the type of role that those lay participants were to fill.

Two respondents referred to recent experience as a patient being important in some roles:

“I think that being a recent patient is the most important.” S005

“...for patient representation recent patient experience and involvement in patient groups are useful. For lay involvement this is not as crucial.” S001.

In other responses, however, a wide range of views was expressed, with one respondent feeling that their health services background had been important, whilst another argued that managerial experience – but specifically from non-healthcare environments – was required:

“My original background was in pharmacy and I have maintained a strong interest in health matters. My experience does allow me to contribute fairly fully to meeting and practical ward based matters [...] I feel quite strongly that members of the public wishing to join Lay re-validation groups should be able to demonstrate high levels of experience which are in turn supported by appropriate health service based references.” S011

“I feel that Lay Reps should have, or have had experience of senior management in either the private sector or in a not-for-profit organisation outside the health sector.” S025.

Some cited particular skills and attributes, perhaps prompted by the options offered in the survey:

“Good influencing skills are important and the ability to work in a team is also a helpful skill to bring to this.” S012

“Involvement in Revalidation requires an experienced and level headed person who can quickly understand issues and bring in the perspective of the general public.” S016
“Lay members with common sense and life experience are essential.” S019

However, others noted that requiring particular skills could limit access to lay participation to particular groups of people:

“Lay involvement should not require any special abilities and be open to all although obviously some skills will make the contribution more meaningful.” S024

“The whole point is for normal people who are not versed in the management of the NHS to have a say in how things work, simply not being a doctor isn’t sufficient for someone to be a lay rep.” S008

In response to the survey section asking about the value of being able to convey ideas in writing, two representatives commented that this could potentially limit the diversity of lay representation:

“Points 7 and 9 [in Q12 of survey] are written in a way which may exclude people with disabilities/specific communication needs.” S004

“Some people have great skills and abilities but because of disability or other reasons are unable to get there point across in writing or take notes themselves.”

Again then, the skills and attributes considered desirable for lay participants – and indeed the questions of whether any particular attributes should be required at all – highlights the need for roles to be clearly defined. Further discussion is also required about how to ensure that recruitment to lay participant roles is not discriminatory.

7.2.5. Training development and support for lay representation

The training, development and support related question was customised in terms of its presentation to lay and organisational representatives. Following this question a common question was presented to canvass opinions about how lay representations could be made more effective.

The lay representatives (Table 11) felt that they had clear roles and were also able to influence change at opportune times. However, around 49% lay representatives were not offered or did not undertake any personalised training help them in effectively disposing their responsibilities as lay representatives. Predominantly similar views were obtained from organisational representatives. However, it was interesting to note that organisational representatives were increasingly uncertain as to the current state of training and support available to lay representatives (Table 12).
Table 11. Training, development and support - lay perspective

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Yes</th>
<th>No</th>
<th>Uncertain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken or offered personalised training</td>
<td>46%</td>
<td>49%</td>
<td>5%</td>
</tr>
<tr>
<td>Had clarity on what is expected from the role</td>
<td>73%</td>
<td>19%</td>
<td>8%</td>
</tr>
<tr>
<td>Had the opportunity to influence change</td>
<td>72%</td>
<td>10%</td>
<td>18%</td>
</tr>
</tbody>
</table>

Table 12. Training, development and support offered - organisational perspective

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Yes</th>
<th>No</th>
<th>Uncertain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken or offered personalised training</td>
<td>46%</td>
<td>25%</td>
<td>30%</td>
</tr>
<tr>
<td>Had clarity on what is expected from the role</td>
<td>52%</td>
<td>14%</td>
<td>35%</td>
</tr>
<tr>
<td>Had the opportunity to influence change</td>
<td>70%</td>
<td>10%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Again, various views were offered about whether training was important for lay participants:

“Appropriately 'recruited', trained and supported lay representatives with motivation may wish to be involved in all aspects of the process.” S004

“[Some skills] can be learned and a familiarity/knowledge could negate against some of the desirable attributes of being a 'lay' representative.” S004

“Consistent and accessible training of expectations and support for the role may be more effective measures than national coordination and management.” S008

One respondent referred to the idea of experienced lay participants mentoring new recruits, an idea also discussed by some interviewees:

“The best trainers of prospective Lay members are people who have lay experience of PPI who would be prepared to undergo more formal training.” S010
The responses (Figure 12) indicate that both lay and organisational representatives agree (85%) that lay representation could be made much more effective by quality assuring the role. The respondents also agreed (Figure 13, Figure 14) that the effectiveness of lay representation could be improved by introducing national coordination of the role (67%) in conjunction with greater management of the role (76%). However, as per the responses the need for greater management of the lay representative role should take precedence over the need for a national coordination initiative.

Figure 11. Need to Quality assure the lay representative role (-2 implies ‘Strongly Disagree’ and 2 implies ‘Strongly Agree’)
Figure 12. Need for national coordination of lay representative role (-2 implies ‘Strongly Disagree’ and 2 implies ‘Strongly Agree’)

Figure 13. Need greater management of lay representative role (-2 implies ‘Strongly Disagree’ and 2 implies ‘Strongly Agree’)
7.2.6. Administrative arrangements for lay representation

On being asked about the length of time lay representatives should occupy their roles without losing objectivity, the respondents were not able to decisively converge on a provided time frame. Even though 42% of respondents did agree on tenure of 4-5 years, most of the respondents using the open text question noted the subjective nature of the situation. In other words, the view that respondents seem to present is that the tenure is dependent of the individual representative and objectivity may not necessarily be related to number of years spent in the role.

Figure 14. Length of time lay reps should occupy role

Also in common with the interviews, concerns were voiced by survey respondents about the potential for lay participants to become ‘professionalised’:

“Lay representatives should not be professionalised. This may make their effective engagement more of a challenge but should not preclude their involvement or narrow the field to ‘professional’ lay people.” S008

“Someone considered to be a lay representative but who is 60 and has spent 30 years acting as a lay representative really isn’t lay anymore.”

However, another respondent (S015) stated that they had been involved in their local NHS organisation as a lay representative for 25 years and clearly did not see this as a negative.
A theme that emerged from the interviews related to the reimbursement for lay representatives’ time. According to the survey, the respondents agreed (61%) that some sort of reimbursement should be offered to the lay representatives for their time. Interestingly, a majority of the lay representatives (47%) were not keen on accepting reimbursement in contrast to the organisational representatives (67%) who were of the opinion that lay representatives should be offered reimbursement.

Figure 15. Reimbursement for lay representatives’ time (-2 implies ‘Strongly Disagree’ and 2 implies ‘Strongly Agree’)

7.2.7. Lay/Patient/Public terminology and definitions
Several survey respondents discussed the use of terminology surrounding lay participation in health services. There is clearly no consensus on how this participation should be described. The difficulties surrounding the use of terminology seem both to derive from and to drive further disagreement over which models of participation are preferable or even appropriate, and who should be recruited to fill participant roles.

“Lay involvement is not the same as patient involvement. These terms are often used interchangeably and mean different things. Lay involvement has a role to play in good governance. Patient involvement ensures that the patient voice is heard and that services and professional practice has the patient and their experiences at its centre.” S001

There was also some criticism of the survey, which centred on the use of the term ‘lay representative’ in the questions:
“...constantly referring to them as lay representatives is confusing. Really what is important is patient involvement.” S009

“...the survey language as a whole assumes that all lay people are either patients or representatives. That ignores the active citizen who may or may not be a lay member in NHS bodies. It suggest the survey was constructed by someone without practical experience of PPI. The revalidation process needs "lay members" much more than "lay representatives" as that is really a nonsense phrase.”

“We would often use NEDs in the above roles. We also rely on patients to give feedback in patient surveys but I think this is different to what you are asking about above?” S021

“There is no definition of lay people and therefore is difficult to answer the questions accurately. If by lay people you mean non-doctors i.e. the general public [...] You need to be much more specific about what you mean by lay people or your feedback will be flawed and will not provide you with the clarity you are seeking.” S022

However, dissatisfaction with the language used in the survey may simply reflect these participants’ different views on who should be involved in the health services and to what extent. The issue of terminology is contentious because it reflects much wider disagreements about the nature of lay participation. One survey respondent’s comment aptly summarised the need for clarity of purpose and definitions:

“All lay representation is potentially problematic for all involved. You need a really clear idea of what the representative needs to bring, what skills they need, the resources they need to do their role, plus a recruitment process. Depending on these things, it can work well or badly.” S027

Even if role descriptions and recruitment policies are set out, it is impossible for a programme of lay participation to meet all demands. Some are opposed to almost any involvement at all, whilst others advocate patient or lay involvement in all aspects of the health service. Clearly, these are differences that cannot be reconciled. However, in those instances where lay participation does occur, setting out clearly the extent of the roles and what is expected of those who fill them would be beneficial.

8. Cultural Historical Activity Theory (CHAT)

The CHAT model is uniquely suited to gaining insights into how the wider socio-political context impacts on local practices and subjectivities. For example: ideological or practical difficulties in systems may lead inexorably to some form of action - such as shifts in individual or collective goals, or revision of introduced technology. These matters are important to this research because such changes may represent unintended consequences of action arising from PPI in medical revalidation. Our models will therefore be used to describe:
• Local systems and processes that encourage or inhibit PPI
• Continuities and discontinuities between organisational and lay perspectives
• The ways in which wider socio/cultural change have shaped PPI in medical revalidation
• Areas where PPI adds value and areas that can be strengthened in the future

8.1. CHAT Findings

Figure 16. Basic CHAT modelling of patient, public and lay representation in revalidation

Figure 18 shows the basic CHAT model, while figure 19 below tabulates the elements in more detail and maps them against Engeström’s generic component attributes.

<table>
<thead>
<tr>
<th>ACTIVITY SYSTEM FOR NON–MEDICAL INVOLVEMENT IN REVALIDATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Component of Activity System (generic)</td>
</tr>
<tr>
<td>Revalidation Activity System (specific)</td>
</tr>
<tr>
<td><strong>Subject</strong></td>
</tr>
<tr>
<td>‘the individual or subgroup whose agency is Patients, the public and lay representatives</td>
</tr>
</tbody>
</table>
chosen as the point of view in the analysis’ Engeström 1996 p.67

| **Object** |
| 'the “raw material” or “problem space” at which the activity is directed and which is moulded or transformed into outcomes with the help of physical and symbolic, external and internal tools’. Engeström 1996 p.67 |
| Non-medical representation in the revalidation process |

| **Instruments** |
| The Object is ‘moulded or transformed into outcomes with the help of physical and symbolic, external and internal tools (mediating instruments and signs). Engeström 1996 p.67 |
| Patient feedback forms  
Patient survey  
Systems  
The Revalidation pages on the GMC and the Royal Colleges websites  
Information from Patient advice/advocacy services |

| **Rules** |
| ‘the explicit and implicit regulations, norms and conventions that constrain actions and interactions within the activity system’.  
Engeström 1996 p.67 |
| Annual appraisal  
Organisational structures and protocols  
Content of revalidation portfolio  
GMC (Licence to Practise and Revalidation) Regulations 2012  
Fitness to Practise regulations  
Health Acts (2001 and 2012) |

| **Community** |
| ‘Comprises multiple individuals and/or subgroups who share the same general object’.  
Engeström 1996 p.67 |
| The medical community: including GMC, RO’s, doctors, administrators etc.  
The non-medical community including members of the public and lay representatives |

| **Division of labour** |
| ‘refers to both the horizontal division of tasks between the members of the community and to the vertical division of power and status’.  
Engeström 1996 p.67 |
| Doctors, patients and lay representatives.  
Medical administrators |


**Figure 17. Tabulation of CHAT components mapped against Engeström’s generic component attributes**

Each of the components of the activity system contains a number of elements and tensions may exist between both the discrete components and the elements within them. For Engeström, these tensions, which he terms ‘contradictions’ are the drivers of innovation and change in the activity system. He argues that contradictions are cumulative internal and external structural tensions within and between activity systems, and often reference historical precedent and other activity systems. Those that reside in each component of the system he calls ‘primary contradictions’ and we can list the specifics of these against the components of our activity system.
### PRIMARY CONTRADICTIONS

<table>
<thead>
<tr>
<th>Component of Activity System</th>
<th>Revalidation Activity System (specific)</th>
</tr>
</thead>
</table>
| **Subject**                  | • The restructuring through the Health Acts (2001 and 2012) created new interest groups i.e. Healthwatch and CCGs and therefore a new range of subjects.  
• Conflation and confusion of terminology  
• Different ‘types’ of subject |
| **Object**                   | • The non-medical representation component of revalidation is not clearly defined  
• Different groups within the Subject have different access to representation and require different ‘types’ of representation to achieve the Object |
| **Instruments**              | • Quality of evidence able to be captured - patient feedback,  
• Equity of patient involvement |
| **Rules**                    | • Representation in/across revalidation not standardised  
• Variations in length of tenure and payment for lay representatives  
• Recruitment and role descriptions vary  
• Equity of patient feedback |
| **Community**                | • Diverse community with different aims and purposes |
| **Division of labour**       | • Layers of responsibility  
• Division of labour and accountability not always clear or uniform  
• May require additional layers of support for lay members  
• Power invested in ‘actors’ |

**Figure 18. Examples of Primary contradictions in the activity system**

The most immediately obvious contradiction concerns the Subject since it contains a number of different groups, each with different aims and purposes in relation to revalidation. As a fundamental contradiction it becomes embedded within every component of the activity at some point. For example, with a primary contradiction in the Subject the Object loses clarity because different subgroups of the Subject want different things, this in turn impacts on the Instruments as the means of achieving the Object.

Aside from the overarching contradiction contained within the Subject, there are other primary contradictions that are not unique to individual components. For example, both Instruments and Rules present ‘patient feedback’ as a contradiction but for different reasons. Patient feedback forms a contradiction in the Instruments in terms of the form of the feedback to ensure equity and the systems/processes for its collection and presentation. Whereas in Rules the contradiction lies in who provides and collates patient feedback. These two are connected through the Division of Labour.
which determine the power relations embedded in the access to/to the use of/ and the efficacy of the *Instruments*.

Secondary contradictions appear between the components of an activity system, they are indicated in Fig 21 by solid arrows.

*Figure 19. Secondary contradictions*

Taking secondary contradictions pertaining to the *Subject* by way of an example, on our basic model, we can see how these are recognised as being played out in practice. In the *Subject/Instrument* contradiction The *Subject* determines the *Instruments* in relation to the *Object* but if the *Instruments* change either of themselves or in their importance to the *Activity* then the subject may need to adapt. If it is impossible to create the necessary *Instruments*, the *Subject* may need to supplement, re-design or abandon them. To take the example of patient feedback, lay representatives we interviewed broadly felt that patient feedback was a work in progress with one interviewee being pragmatic enough to recognise that “It will never be perfect” (R001). One interviewee commented on the equity of current patient feedback, citing “disabilities, dementia or are currently sort of, very ill uh, haven’t got the capacity. So I don’t think we move into carers particularly well, I think that’s a weakness” (R002). Our interviewees are telling us that the available *Instruments* for patient feedback are inadequate to achieve the *Object* of patient representation in revalidation. As PPI
becomes an increasingly important agenda the Instruments for feedback will need to adapt to accommodate this increasing importance to the Activity (revalidation). If however it is not possible to develop the appropriate Instruments then the’ ideal of patient involvement may need to be revised. What the CHAT models are able to describe for us is the interconnectedness of all aspects of the activity and that by making one change intended and often unintended consequences will ensue. Then example of patient feedback serves to illustrate the diversity contained within the groups involved. The complexity of the Subject needs to be unpacked before both the desired Object of public, patient and lay representation in revalidation leading to improvements in patient care can be clarified, and the necessary Instruments developed to ensure that. When we tease out the separate strands of the Subject we can see the emergence of three distinct modes of engagement across three spheres of influence: Public, private and institutional. We can see that each activity system has a slightly different object that is fully contextualised by the sphere of influence and the specificity of the Subject.

**Figure 20. Examination of the primary contradictions in the Subject**

Each separate activity system will contain its own primary and secondary contradictions but by examining the constituent parts of the Subject a more nuanced understanding that identifies the contribution that each part can make to the whole.
The different *Subjects* encompass the whole community, but they are only able to achieve the *Object* within their context. In order for these different *Objects* to be realised, specific *Instruments* will need to be devised with the *Subject* in mind. Once this is recognised then we can see that a range of distinct objects become available, which in combination, can encompass the whole activity across a range of contexts from a variety of perspectives.

CHAT is in essence a practical theory. It provides a framework for looking at the relationship between individuals and groups and the ways they communicate and operate in the real world. It recognises that if one element is changed, for example if ROs were mandated to include lay representatives in their decision making, as suggested by one interviewee, then other consequences would necessarily follow. *Instruments* would need to be developed to accommodate and reflect this change, the power structure in the *Division of Labour* would shift to reflect this new lay role and the *Rules* would need to take account of this. This intervention however, would only affect the institutional sphere. Its intended consequence would be to contribute to *Object* [3] by providing a lay perspective in an institutional context, but it would not impact on *Objects* [1] or [2] because they are outside the lay sphere of influence. It is worth noting that should such an intervention take place it would have consequences (intended or otherwise) in other related activity systems located in the institutional sphere and CHAT could help to understand this ripple effect.

Using CHAT as a framework to explore PPI in revalidation can therefore provide a number of key insights that signal, not only where an intervention may be required (to achieve a desired outcome) but also potentially what form those interventions might need to take and their potential impact.

9. **Discussion and conclusions**

Through the CHAT analysis of the data three distinct PPI roles have emerged: the patient, the public and the lay, that in combination provide a broad sweep of engagement, from the individual personal relationship of a patient with their doctor to the broader relationship between the health service and the public it serves. CHAT provides insights into how these different relationships are currently structured, draws attention to where there are tensions, and to the scope of possible interventions.

Over the last two decades there has been a marked shift in emphasis in Health provision in the UK towards greater accountability by the profession and greater public and patient involvement in the service they receive. Two key policy initiatives that have emerged are the revalidation of doctors and patient and public involvement across the spectrum of health provision.

While there is broad agreement on the desirability of PPI in revalidation the actual level of involvement is somewhat contested. Currently there are two main modes; individual patient feedback that is included as part of the evidence in the doctor’s appraisal portfolio leading to revalidation, and lay representation on a variety of panels and boards.

This research has specifically examined lay involvement in revalidation from both lay and organisational perspectives. This research captures a key moment in the development of PPI in revalidation in that the supporting structures of both revalidation and PPI are still at a very early stage: with the commencement of revalidation (03/12/2012) broadly coinciding with a number of structural changes to the NHS linked to the PPI agenda. These structural changes include the streamlining of LINks and the information and the signposting functions of from the NHS’ Patient
Liaison (PALs service), and the establishment of a new group, CCGs, with local responsibility for commissioning services.

Evidence from the interviews and the survey identify a very mixed picture of both readiness and understanding about PPI in revalidation across the UK within these new structures. However there was a clear consensus from both organisational and lay perspectives that lay representation would add value in areas related to quality assurance, and that recruitment to these roles would be fairly easy.

The key finding from the research evidenced across the literature, the interviews and the survey relates to the identity of those involved.

Patient and public in particular are terms where the distinction has become collapsed. Patient refers to the small local relationship between individuals or small medical teams, whereas the public encapsulates the collective of patients as a stakeholder group. Patients’ needs are answered by the tenets of professionalism but the public’s are answered by regulation. Therefore in conceptual terms although the terminology and much of the literature assimilates public and patients, they are two distinct ontological groups. Lay representation too, we have discovered through the research is not an unproblematic category. Participants critiqued the conceptualisation of their role through the lack of distinction between ‘lay member’ and ‘lay/patient representative’ as titles: recognising that they not only have a different conceptual emphasis but may also be responsible to the interests of different groups.

Tritter, argues that “most patient and public involvement is indirect involvement where information is gathered from service users by health professionals and managerial staff to inform service delivery and development but health service managers and clinical staff make the final decisions”\(^{28}\). Lay involvement in revalidation through representation on panels and boards is therefore a very direct way in which ‘PPI’ can be built into systems and practices, evidenced and evaluated. However there needs to be not only clearer definitions about the lay role but also consideration as to who is defining that role.

Using CHAT to model the research we were able to disaggregate the Subject and identify three distinct categories of involvement within that group (Fig. 34). Each of these Subjects (patient, public and lay) has a quite different role to play and needs a different set of skills to undertake that role effectively.

9.1. Patient

The patient has a unique role in revalidation, since they have an immediate and personal engagement with the doctor and can contribute to the evidence presented for appraisal leading to revalidation. The patient needs Instruments to enable them to do this but does not need a specific skillset. Although more effort needs to be made to ensure that patient feedback is equitable and the extant Instruments will need revision to ensure this. Patient engagement in revalidation is linked to a specific time: when the patient is in receipt of treatment. It is therefore a snapshot but by including

multiple patient feedback, which can include patient forums, a picture of individual practice can be evidenced, reflected upon by the doctor as part of their revalidation, and acted upon if necessary. In regard to ‘the patient’ as an entity it is important to remember that while in all likelihood we are all patients at some point but that does not mean that we are all always patients.

9.2. Public
The public acts as the collective ‘patient voice’ and is representative of all patients in some way. The ‘public’ is represented through organisations like Healthwatch who act for all consumers of healthcare services and work with other health networks. As noted above, concurrent with the rolling out of revalidation new representational groups have been established and will need time to establish their identity.

9.3. Lay
Lay is a term of reference for the involvement of people who are nonprofessional or non-specialists. Some of our participants though had medical backgrounds, which they felt to be helpful.

Being a lay representative is less about being a current or recent patient and more about skills and attributes. Our research found that lay representatives were felt to need a number of ‘professional skills’ including being able to assimilate information, chair meetings etc. which indicated that lay representatives would themselves benefit from a professional background. It was also felt that they needed excellent communication skills and not be afraid to ask questions even if these questions seemed naive. This of course, as our participants recognised limited the pool of available representatives.

Lay input was deemed to be extremely valuable from both a lay and organisational perspective as it provided an external and ‘independent’ perspective. There were however concerns that lay representatives could lose their objectivity if they remained in post too long (3-5 years tenure was suggested by our participants, who also suggested that in order not to lose expertise a mentoring system for new representatives would be beneficial. Available training was mixed and this was in part due to a lack of clear definition for the roles.

10. Recommendations
Drawing on the findings of the research, several key issues emerge that may inform guidance for those engaging patients, the public and lay representatives in medicine.

At a policy level:

- A need to clarify purpose/nature of desired patient, public or lay participation
- The production of clear role descriptions for both representative and those recruiting them
- Consistent and transparent recruitment procedures; perhaps involving the development of a set of guidelines
- Consideration of proposing a limited terms of service (for example: 3-5 years)

In employing organisations:
- The provision of induction for representatives; particularly addressing concepts such as confidentiality and data protection, and perhaps administrative skills (chairing meetings, using minutes, etc.)
- The development of mentor or handover systems, to avoid knowledge loss when changing lay representatives, or perhaps stagger recruitment of lay people
- Remuneration: hourly rate + travel expenses appears to be becoming standard for lay representatives

Appendices

Appendix 1. Participant information and consent forms

Patient and public involvement in medical revalidation

Information for participants

[v2 24/09/2013]

Thank you for your interest in this research. Please read this information sheet carefully before deciding whether or not to participate in the interview stage of the research. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you of any kind and we thank you for considering our request.

What is the aim of the project?

With revalidation started in December 2012 it is timely to begin to describe and evaluate the process as it goes forward to ensure both value for money and the more qualitative ‘added value’ to the profession and patients. The Revalidation Support Team (RST) in recognising the importance of patient and public involvement in revalidation have commissioned this research in order to:
understand the current implementation of patient and public involvement in medical revalidation

identify where patient and public involvement adds value in order to inform and support future practice

identify areas where lay representation may strengthen local systems and processes, and; conversely, where systems and processes may be strengthened to support meaningful lay representation in medical revalidation.

The research will inform the RST’s work in producing guidance on strengthening patient and public involvement which will be published in February 2014.

**What type of participants are needed?**

We are interested in speaking to both lay and organisational representatives who are involved in revalidation in order to gain a deeper understanding of the ways in which patients and the public are involved in revalidation processes.

**What will participants be asked to do?**

Should you agree to take part in this project, you will be asked to complete and return the consent form at the bottom of this page. One of the research team will then contact you to arrange a convenient time for them to interview you on the telephone.

**Time commitment**

Approximately 1 hour

**Can participants change their mind and withdraw from the project?**

You may withdraw from participation in the project at any time and without any disadvantage to yourself of any kind. You are not required to give a reason for your decision to withdraw.

**What data/information will be collected and what use will be made of it?**

This stage of the research involves an open-questioning technique where the precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops. In the event
that a line of questioning does evolve in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s) and also that you may withdraw from participation in the research at any time and without any disadvantage to yourself of any kind.

Individual interviews will be recorded and transcribed. Digital audio tapes will be sent to the transcriber using an encrypted memory stick, who is bound by a confidentiality agreement. Your interview transcript will be combined with those of the other participants and the dataset will be analysed as a whole.

Participants will be provided with a summary of the transcript of their interview with a member of the research team and the initial thematic coding. Hard copies of data will be kept in a secure cabinet and locked at all times. Electronic data is stored on a shared hard drive on University servers these are encrypted and password protected.

The data collected will be used as primary research material for a research report *Patient and public involvement in medical revalidation* to be submitted to the RST. This report will inform the RST’s work in producing basic guidance on strengthening patient and public involvement which will be published in February 2014. Results of this project may also be published in peer review journal articles. In each case any quotes used will be attributed to the professional orientation of the interviewee i.e. patient, responsible officer

**What if participants have any questions?**

If you have any questions about our project, either now or in the future, please feel free to either contact:

<table>
<thead>
<tr>
<th>Dr Sam Regan de Bere</th>
<th>or</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead for Medical Humanities</td>
<td>Dr Suzanne Nunn</td>
</tr>
<tr>
<td>CAMERA</td>
<td>Research Fellow CAMERA</td>
</tr>
<tr>
<td>Tel No: 01752 586777</td>
<td>Tel No: 01752 586823</td>
</tr>
<tr>
<td><a href="mailto:S.Regandebere@plymouth.ac.uk">S.Regandebere@plymouth.ac.uk</a></td>
<td><a href="mailto:Suzanne.nunn@plymouth.ac.uk">Suzanne.nunn@plymouth.ac.uk</a></td>
</tr>
</tbody>
</table>

**Complaints**

If you have any complaints about the way in which this study has been carried out please contact the principle investigator Dr Sam Regan de Bere in the first instance, this may be followed by a complaint to the administrator of the Faculty Human Ethics Committee.

**This project has been reviewed and approved by the University of Plymouth**
Patient and public involvement in medical revalidation

Consent form for participants

[v2 24/09/2013]

I have read the Information Sheet Version2 Date 24/09/2013 concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that;

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My participation in the project is entirely voluntary</td>
<td>Y / N</td>
</tr>
<tr>
<td>2. I am free to withdraw from the project at any time without any disadvantage and without having to give a reason for my decision to withdraw</td>
<td>Y / N</td>
</tr>
<tr>
<td>3. Audio-tapes will be retained in secure storage</td>
<td>Y / N</td>
</tr>
<tr>
<td>4. The interview will use an open-question technique where the precise nature of the questions which will be asked have not been determined in advance.</td>
<td>Y / N</td>
</tr>
<tr>
<td>5. The results of the project may be published and I understand that any quotes used will be attributed to my professional orientation.</td>
<td>Y / N</td>
</tr>
</tbody>
</table>
Appendix 2. Interview prompt questions

From a lay perspective:

1. What does lay representation mean to you?
   - Generally and specifically in relation to revalidation

2. What qualities do lay representatives need?

3. From a personal perspective what contribution do you think patients and the public as lay representatives bring to local systems and processes supporting revalidation?
   - Personal experience / anecdotal evidence
   - Individual feedback for doctors
   - More general opportunities to feedback and take part

4. In what ways has lay representation made a difference?
   - Personal experience / anecdotal evidence
   - Measuring impact
     - Individual clinical practice
     - Governance

5. What do you think lay representation should include and is there anything you as a lay representative would not want to do?

6. Are there any additional areas where lay input might be valuable?
   - Being more closely involved in decision making
     - Following an investigation
     - As non-executive directors
     - Active role in training
Managing and developing PPI
  - Building opportunities for feedback

The appraisal process
  - Involvement in RO decision making
  - Auditing of appraisal

7. How do you think current lay role(s)/involvement in revalidation could be made more effective
   - Definition of role(s)
   - Involvement across all functions related to revalidation
     - Appraisals
     - Governance
     - Responding to concerns
     - Revalidation processes
   - Development of relations across stakeholder organisations

8. How could lay representation be developed in the future
   - Recruitment of lay representatives with defined roles and training
   - Specific task groups/champions
     - equality and diversity
   - Dedicated training and formal recognition
     - Nationally or regionally co-ordinated?

9. How would you describe the role of lay representatives in the feedback given to doctors by patients
   - As ‘adding value’, as custodians of the doctor/patient relationship or as mediators in that relationship

10. What form of data/evidence is available to lay representatives and is it fit for purpose?
    - Patient feedback questionnaires
      - GMC suggest 45 questionnaires with an expected return of 34
      - Ambiguity/validity of terms like ‘good’ and ‘satisfactory’
    - Patient satisfaction questionnaires
      - Contextualisation of feedback
    - Other types of evidence
    - Equity of feedback
      - Measures to ensure inclusion
      - Building opportunities for feedback

11. What do you think happens to your input?
Responsibility
  o Transparency of process
  o ‘ownership’
  o ‘Lifetime’ of feedback
  o Ethical considerations

From an organisational perspective:

1. What does lay representation mean to you?
   ➢ Generally and specifically in relation to revalidation

2. What qualities would you look for in lay representatives?

3. From an organisational perspective what contribution do you think patients and the public as lay representatives bring to local systems and processes supporting revalidation?
   ➢ Personal experience / anecdotal evidence
   ➢ Individual feedback for doctors
   ➢ More general opportunities to feedback and take part

4. In what ways has lay representation made a difference
   ➢ Personal experience / anecdotal evidence
   ➢ Measuring impact
     o Individual clinical practice
     o Governance

5. What do you think lay representation should include and is there anything from an organisational perspective that you would not want lay input?

6. Are there any additional areas where lay input might be valuable?
   ➢ Being more closely involved in decision making
     o Following an investigation
     o As non-executive directors
     o Active role in training
   ➢ Managing and developing PPI
     o Building opportunities for feedback
   ➢ The appraisal process
     o Involvement in RO decision making
     o Auditing of appraisal

7. how could current lay role(s)/involvement in revalidation be made more effective
Definition of role(s)
Involvement across all functions related to revalidation
  - Appraisals
  - Governance
  - Responding to concerns
  - Revalidation processes
Development of relations across stakeholder organisations

8. How could lay involvement be developed in the future
   - Recruitment of lay representatives with defined roles and training
   - Specific task groups/champions
     - equality and diversity
   - Dedicated training and formal recognition
     - Nationally or regionally co-ordinated?

9. How would you describe the role of lay representatives in the feedback given to doctors by patients
   - As ‘adding value’ or as custodians of the doctor/patient relationship or mediators in that relationship

10. What form of data/evidence is available to lay representatives and is it fit for purpose?
    - Patient feedback questionnaires
      - GMC suggest 45 questionnaires with an expected return of 34
      - Ambiguity/validity of terms like ‘good’ and ‘satisfactory’
    - Patient satisfaction questionnaires
      - Contextualisation of feedback
    - Other types of evidence
    - Equity of feedback
      - Measures to ensure inclusion
      - Building opportunities for feedback

11. What do you think happens to your input?
    - Responsibility
      - Transparency of process
      - ‘ownership’
      - ‘Lifetime’ of feedback
      - Ethical considerations

Appendix 3. Online survey questions
Patient and public involvement in the appraisal and governance of doctors

Demographic Information

1. In which region are you based? *

Please choose only one of the following:

- England - London
- England - Midlands and East
- England - North
- England - South
- No specific region

2. Which of the following best describes the perspective from which you are taking part in this survey? *

Please choose only one of the following:

- Lay representative (local)
- Lay representative (regional)
- Lay representative (national)
- Organisational representative (local)
- Organisational representative (regional)
- Organisational representative (national)

Medical Revalidation awareness and involvement

3. How informed do you feel about the revalidation of doctors? *

Not at all | Fully

Help Text: Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis (every 5 years) that they are up to date and fit to practise. Revalidation aims to give
extra confidence to patients that their doctor is being regularly checked by their employer and the GMC.

4. How well informed do you think the general public is about the revalidation of doctors? *

5. Are you currently involved specifically in supporting PPI in medical revalidation? If not your views are still important. *

Please choose only one of the following:

- Yes
- No

PPI - Public and patient involvement

SECTION 1: The added value of lay representation in the appraisal and governance of doctors

6. Lay representatives can make a significant contribution to the appraisal and governance of doctors *

Please choose the appropriate response for each item:

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>I prefer not to comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
</tbody>
</table>

7. Lay representatives should be involved in: *

Please provide your response using the slider scale against each option:

<table>
<thead>
<tr>
<th>Recruitment of appraisers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appraiser training</td>
</tr>
<tr>
<td>Meetings where appraisers share their experience of the role</td>
</tr>
<tr>
<td>Meetings with local team responsible for coordinating the appraisal system</td>
</tr>
<tr>
<td>Quality assurance (QA) of appraisal</td>
</tr>
<tr>
<td>Steering groups responsible for governance (including revalidation)</td>
</tr>
<tr>
<td>The response to complaints against doctors</td>
</tr>
<tr>
<td>The organisations response to significant events</td>
</tr>
<tr>
<td>Assessing concerns raised about doctors and deciding what action to take</td>
</tr>
<tr>
<td>The recommendations being made about doctors fitness to practice to the GMC</td>
</tr>
</tbody>
</table>
8. Lay involvement is a scarce resource, so would add the greatest value in:

Please provide your response using the slider scale against each option:

<table>
<thead>
<tr>
<th>Option</th>
<th>Response Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment of appraisers</td>
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<tr>
<td>Appraiser training</td>
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<tr>
<td>Meetings, where appraisers share their experience of the role</td>
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<tr>
<td>Meetings with local team responsible for coordinating the appraisal system</td>
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<tr>
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<tr>
<td>The organisations response to significant events</td>
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<tr>
<td>Assessing concerns raised about doctors and deciding what action to take</td>
<td></td>
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<tr>
<td>The recommendations being made about doctors fitness to practice to the GMC</td>
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</tbody>
</table>

9. Recruiting lay representatives into this area would be problematic

Please write your answer(s) here:

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Response Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>if involved with recruitment of appraisers</td>
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<tr>
<td>if involved in appraiser training</td>
<td></td>
</tr>
<tr>
<td>For meetings, where appraisers share their experience of the role</td>
<td></td>
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<tr>
<td>For meetings within local teams responsible for coordinating the appraisal system</td>
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<tr>
<td>In quality assurance (QA) of appraisal</td>
<td></td>
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<tr>
<td>In steering groups responsible for governance (including revalidation)</td>
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<tr>
<td>In the response to complaints against doctors</td>
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<tr>
<td>In the organisations response to significant events</td>
<td></td>
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<tr>
<td>In assessing concerns raised about doctors and deciding what action to take</td>
<td></td>
</tr>
<tr>
<td>Where they need to be involved in recommendations being made about doctors fitness to practice to the GMC</td>
<td></td>
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</tbody>
</table>

10. If you would like to add any additional comments about this section the please write them below:

Please write your answer here:
SECTION 2: Personal attributes and skills required for effective lay representation

11. The experience you personally bring to the lay representative role is based on

Only answer this question if the following conditions are met: Answer was 'Lay representative (local)' or 'Lay representative (regional)' or 'Lay representative (national)' at question '2 [RST1]' (2. Which of the following best describes the perspective from which you are taking part in this survey? ) Please write your answer(s) here:

<table>
<thead>
<tr>
<th>Recent experience of being a patient</th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous experience as a volunteer in the health care sector</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active role in local patient groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience and skills in health sector management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience and skills in management outside healthcare</td>
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<td></td>
</tr>
<tr>
<td>Experience of working at board level in organisations</td>
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</tr>
<tr>
<td>In a clinical role e.g. nurse, doctor or other health care professional</td>
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<td></td>
</tr>
</tbody>
</table>

11. What experience would you look for when appointing to a lay representative role?

Only answer this question if the following conditions are met: Answer was 'Organisational representative (local)' or 'Organisational representative (regional)' or 'Organisational representative (national)' at question '2 [RST1]' (2. Which of the following best describes the perspective from which you are taking part in this survey? ) Please write your answer(s) here:

<table>
<thead>
<tr>
<th>Recent experience of being a patient</th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
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</thead>
<tbody>
<tr>
<td>Previous experience as a volunteer in the health care sector</td>
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<td></td>
</tr>
<tr>
<td>Active role in local patient groups</td>
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<tr>
<td>Experience and skills in health sector management</td>
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<tr>
<td>Experience and skills in management outside healthcare</td>
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<td></td>
</tr>
<tr>
<td>Experience of working at board level in organisations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a clinical role e.g. nurse, doctor or other health care professional</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. What attributes/skills are needed by lay representatives in order to contribute effectively towards appraisal and governance of doctors?
Please write your answer(s) here:

<table>
<thead>
<tr>
<th>Ability to listen actively</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to clearly explain a point of view, with impact</td>
</tr>
<tr>
<td>Ability to represent a collective patient view</td>
</tr>
<tr>
<td>Ability to represent the point of view of the general public</td>
</tr>
<tr>
<td>Familiarity with medical language e.g. major health conditions and procedures</td>
</tr>
<tr>
<td>Be familiar with the way doctors work</td>
</tr>
<tr>
<td>Ability to convey ideas in writing</td>
</tr>
<tr>
<td>Ability to review and pull together information from different sources</td>
</tr>
<tr>
<td>Ability to make clear notes of what you see and hear</td>
</tr>
<tr>
<td>Understand HR processes and employment legislation</td>
</tr>
</tbody>
</table>

13. If you would like to add any additional comments about this section the please write them below:

Please write your answer here:

---

SECTION 3: Training, development and support for lay representatives

14. In my role as a lay representative I have:

Only answer this question if the following conditions are met: Answer was 'Lay representative (local)' or 'Lay representative (regional)' or 'Lay representative (national)' at question '2 [RST1]' (2. Which of the following best describes the perspective from which you are taking part in this survey? )

Please choose the appropriate response for each item:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Uncertain</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken or been offered personalised training for the role</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had clarity on what is expected from the role</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had the opportunity to influence change</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14. Lay representatives in our organisation have:

Only answer this question if the following conditions are met: Answer was 'Organisational representative (local)' or 'Organisational representative (regional)' or 'Organisational representative
(national)' at question '2 [RST1]' (2. Which of the following best describes the perspective from which you are taking part in this survey?

Please choose the appropriate response for each item:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Uncertain</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken or been offered personalised training for the role</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had clarity on what is expected from the role</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had the opportunity to influence change</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

15. Lay representation could be made more effective by

Please write your answer(s) here:
- Quality assuring the role
- Introducing national coordination for the role
- Greater management of the role

16. If you would like to add any additional comments about this section the please write them below:

Please write your answer here:

SECTION 4: Administrative arrangements for lay representatives

17. How long can a lay representative remain in his / her role without losing objectivity? *

Please choose only one of the following:
- 1 - 3 Years
- 4 - 5 Years
- Other

18. Lay representatives should be paid for their time in addition to being reimbursed for expenses.
SECTION 5: About you

19. Please state your gender

Please choose only one of the following:

- Female
- Male

20. Please state your age group

Please choose only one of the following:

- 16 to 18 years old
- 19 to 30 years old
- 31 to 40 years old
- 41 to 50 years old
- 51 to 60 years old
- 61 to 80 years old
- Above 80 years old

21. What is your ethnic origin?

Please choose only one of the following:

- White - English/Welsh/Scottish/Northern Irish/British
- White - Irish
- White - Irish
- White - Gypsy or Irish Traveller
- Mixed/multiple ethnic groups - White and Black Caribbean
- Mixed/multiple ethnic groups - White and Black African
☐ Mixed/multiple ethnic groups - White and Asian
☐ Asian/Asian British - Indian
☐ Asian/Asian British - Pakistani
☐ Asian/Asian British - Bangladeshi
☐ Asian/Asian British - Chinese
☐ Black/African/Caribbean/Black British - African
☐ Black/African/Caribbean/Black British - Caribbean
☐ Other

Additional Comments

22. If you would like to add any comments about your answers to the questions in this survey or, more generally, about patient public involvement in the revalidation process, please write them below:

Please write your answer here:

Thank you for taking the time to complete this survey.

A final report will be published in February 2014 and will be available on the RST website.

Submit your survey.

Thank you for completing this survey.
Appendix 4. Online survey complete responses

Lay representation involvement in revalidation (Table 4)
Survey Q7 “Lay representatives should be involved in:”

The key themes highlighted below are selected as over 40% of respondents ‘strongly accepted’ these options and at the same time less than 15% of the respondents elicited strong rejection for these options.

<table>
<thead>
<tr>
<th>Item</th>
<th>Accepts (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Quality Assurance</td>
<td>77.3</td>
</tr>
<tr>
<td>2. Steering groups responsible for governance</td>
<td>74</td>
</tr>
<tr>
<td>3. Organisational response to significant events</td>
<td>70</td>
</tr>
<tr>
<td>4. The response to complaints against doctors</td>
<td>69.4</td>
</tr>
<tr>
<td>5. Assessing concerns raised about doctors and deciding what action to take</td>
<td>66.7</td>
</tr>
<tr>
<td>6. Meetings where appraisers share their experience of the role</td>
<td>65.3</td>
</tr>
<tr>
<td>7. The recommendations made about doctors fitness to practise to the GMC</td>
<td>60</td>
</tr>
<tr>
<td>8. Meetings with local teams responsible for coordinating the appraisal system</td>
<td>61.3</td>
</tr>
<tr>
<td>9. Recruitment of appraisers</td>
<td>58.6</td>
</tr>
<tr>
<td>10. Appraiser training</td>
<td>56</td>
</tr>
</tbody>
</table>

Greatest value for PPI in revalidation (Table 5)

Survey Q8 “Lay involvement is a scarce resource, so would add the greatest value in:”

The key themes highlighted below are selected as over 40% of respondents ‘strongly accepted’ these options and at the same time less than 15% of the respondents elicited strong rejection for these options. Additionally the IQR for the selected themes are 1.1 and the rest are over 2.

<table>
<thead>
<tr>
<th>Item</th>
<th>Accepts (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Steering groups responsible for governance</td>
<td>86.4</td>
</tr>
<tr>
<td>2. Quality Assurance</td>
<td>82.3</td>
</tr>
</tbody>
</table>
3. Organisational response to significant events 73.5
4. The response to complaints against doctors 73.2
5. Assessing concerns raised about doctors and deciding what action to take 69.6
6. Meetings with local team responsible for coordinating the appraisal system 69.2
7. Meetings, where appraisers share their experience of the role 67.2
8. The recommendations being made about doctors fitness to practice to the GMC 65.1
9. Appraiser training 60.9
10. Recruitment of appraisers 54.6

Problematic areas for PPI recruitment (Table 6)

Survey Q9 “Recruiting lay representatives into this area would be problematic:”

The key themes highlighted below are selected as less than 40% of respondents ‘strongly rejected’ these options.

<table>
<thead>
<tr>
<th>Item</th>
<th>Accepts (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If involved in Appraiser training</td>
<td>51.3</td>
</tr>
<tr>
<td>2. If involved with recruitment of appraisers</td>
<td>48.1</td>
</tr>
<tr>
<td>3. Involved in recommendation being made about doctors fitness to practice</td>
<td>39.8</td>
</tr>
<tr>
<td>4. For meetings within local teams responsible for coordination of appraisal system</td>
<td>38.4</td>
</tr>
<tr>
<td>5. Meetings where appraisers share their experience of the role</td>
<td>36</td>
</tr>
<tr>
<td>6. Assessing concerns raised about doctors and deciding what action to take</td>
<td>32.1</td>
</tr>
<tr>
<td>7. The response to complaints against doctors</td>
<td>30.9</td>
</tr>
<tr>
<td>8. Quality assurance</td>
<td>30.6</td>
</tr>
</tbody>
</table>
9. Organisational response to significant events 30.2
10. Steering groups responsible for governance 29.8

Experience personally valued by lay representatives (Table 8)

Survey Q11 Lay “The experience you personally bring to the pay representative role is based on:"

The key themes highlighted below are selected as over 50% of respondents ‘strongly accepted’ these options and at the same time less than 15% of the respondents elicited strong rejection for these options.

<table>
<thead>
<tr>
<th>Item</th>
<th>Accepts (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recent experience of being a patient</td>
<td>85.2</td>
</tr>
<tr>
<td>2. Experience and skills in management outside healthcare</td>
<td>83.7</td>
</tr>
<tr>
<td>3. Active role in local patient groups</td>
<td>76.6</td>
</tr>
<tr>
<td>4. Experience of working at board level in organisations</td>
<td>73.4</td>
</tr>
<tr>
<td>5. Previous experience as volunteer in health care sector</td>
<td>66.7</td>
</tr>
<tr>
<td>6. Experience and skills in health sector management</td>
<td>36.5</td>
</tr>
<tr>
<td>7. In a clinical role (doctor, nurse or other health professional)</td>
<td>25.4</td>
</tr>
</tbody>
</table>

Experience valued by organisations while appointing lay representatives (Table 9)

Survey Q11 organisation “What experience would you look for when appointing to a lay representative role:”

The key themes highlighted below are selected as over 40% of respondents ‘strongly accepted’ these options and at the same time less than 15% of the respondents elicited strong rejection for these options.

<table>
<thead>
<tr>
<th>Item</th>
<th>Accepts (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recent experience of being a patient</td>
<td>82.5</td>
</tr>
<tr>
<td>2. Experience and skills in management outside</td>
<td>70.3</td>
</tr>
<tr>
<td>Item</td>
<td>Accepts (%)</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>1. Ability to listen actively</td>
<td>100</td>
</tr>
<tr>
<td>2. Ability to clearly explain a point of view, with impact</td>
<td>100</td>
</tr>
<tr>
<td>3. Ability to represent the point of view of the general public</td>
<td>95.5</td>
</tr>
<tr>
<td>4. Ability to represent a collective patient view</td>
<td>93.6</td>
</tr>
<tr>
<td>5. Ability to make notes of what you see and hear</td>
<td>90.9</td>
</tr>
<tr>
<td>6. Ability to pull together information from different sources</td>
<td>87.4</td>
</tr>
<tr>
<td>7. Ability to convey ideas in writing</td>
<td>75.6</td>
</tr>
<tr>
<td>8. Be familiar with the way doctors work</td>
<td>72.9</td>
</tr>
<tr>
<td>9. Familiarity with medical language e.g. major health conditions and procedures</td>
<td>63.7</td>
</tr>
<tr>
<td>10. Understand HR processes and employment legislations</td>
<td>50.5</td>
</tr>
</tbody>
</table>

**Required skills to be an effective lay representative (Table 10)**

Survey Q12 “What attributes/skills are needed by lay representatives in order to contribute effectively towards appraisal and governance of doctors?”

The key themes highlighted below are selected as over 50% of respondents ‘strongly accepted’ these options and at the same time less than 5% of the respondents elicited strong rejection for these options. The selected themes also have an IQR of less than 1 as compared to the others, which have higher IQR.
### Appendix 5. Current and recent models of PPI and lay participation identified by our interviewees

Each row in the table describes an individual lay role. It should be noted that some participants held or had held more than one of these roles. The table includes both roles which demonstrate lay participation in revalidation and also other non-revalidation lay roles. Information is given on key themes arising from our analysis of the data – such as recruitment, training, remuneration and length of service – in order to provide examples of current or recent practice. Columns have been filled only where clear and specific information was provided on a particular aspect of a role.

<table>
<thead>
<tr>
<th>Role</th>
<th>Recruitment</th>
<th>Responsibilities</th>
<th>Access to data</th>
<th>Training</th>
<th>Term of service (if defined)</th>
<th>Remuneration</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ L</td>
<td>By invitation – prior experience of working with organisation; former patient of hospital group</td>
<td>Attend quarterly, 2 hour long meetings; review documentation before and after meetings;</td>
<td>Key performance indicators (summary data)</td>
<td></td>
<td></td>
<td>Travel expenses</td>
</tr>
<tr>
<td>✓ L</td>
<td>Service users or carers</td>
<td>Attend committee meetings; review documentation</td>
<td>Revalidation papers, policies, planning</td>
<td></td>
<td></td>
<td>Travel expenses</td>
</tr>
<tr>
<td>✓ R</td>
<td>By invitation – prior experience on other panels</td>
<td>Chair panel meetings discussing practitioners’ performance, fitness to practise and revalidation. Estimate 8 panel hearings per year across 3 counties.</td>
<td>All relevant data including confidential and financial but lay reps screened and are not patients</td>
<td>Legal briefings; other training previously ‘on the job’ but now training for whole panel planned.</td>
<td>3 years</td>
<td>Travel expenses + locally decided hourly rate</td>
</tr>
<tr>
<td>✓ R</td>
<td>By invitation – prior experience</td>
<td>Chair panels - general performance and revalidation linked; revalidation panels with RO, 2 senior clinical assessors and administrator; 5-6 days per</td>
<td>Meaningful data</td>
<td>Quarterly debriefs with other lay reps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lay representative on national revalidation implementation advisory groups</td>
<td>Appointed – prior experience on other committees</td>
<td>Draft policy documents from various stakeholder organisations; confidential statistical data on progress of revalidation (no names)</td>
<td>Travel and admin expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient reps on Royal College committees, inc. governing council</td>
<td>Attend meetings – some including discussion of revalidation policies and guidance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lay rep on local revalidation steering group (LETB)</td>
<td>Attend and chair meetings + preparatory reading; submit reports on activities</td>
<td>Will be induction for new team from an existing lay rep</td>
<td>5 years £32.50 per hour + travel expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lay rep on RO Advisory Group</td>
<td>By invitation - subgroup of local revalidation steering group.</td>
<td>Access to all relevant data; ePortfolios. Included in confidential discussions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lay rep on Regional Revalidation Reference Group</td>
<td>By invitation – prior lay rep experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Travel expenses (60p per mile) + £150 per half day</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Approved</strong></td>
<td><strong>Note</strong></td>
<td><strong>Role</strong></td>
<td><strong>Experience</strong></td>
<td><strong>Training</strong></td>
<td><strong>Tenure</strong></td>
<td><strong>Expenses</strong></td>
</tr>
<tr>
<td>-------------</td>
<td>----------</td>
<td>----------</td>
<td>----------------</td>
<td>--------------</td>
<td>-------------</td>
<td>--------------</td>
</tr>
<tr>
<td>✓</td>
<td>L</td>
<td>Lay rep on LETB</td>
<td>Reappointed by competitive process – prior experience in same role</td>
<td>Sits on ARCP (Assessment Record of Continuous Progression) panels – annual appraisals for trainees. No decision-making power – lay role focuses on oversight of governance and process. Also sits on school boards.</td>
<td>Adequate data provided; opportunity to access original detailed data if required.</td>
<td>eLearning package provides training on equality and diversity. 3 or 4 training days per year on various topics (e.g. chairing skills and process changes). Has received training on incorporating revalidation into annual appraisal process for trainees.</td>
</tr>
<tr>
<td>✓</td>
<td>N</td>
<td>Patient member of national Royal College patient liaison groups</td>
<td>Appointed to RC PLG then asked to represent RC on umbrella PLG</td>
<td>Lead for revalidation on umbrella group; attend meetings and various sub-groups. Discuss and advise on the implementation of revalidation. Feedback info to PLGs and comment on developments.</td>
<td>Some general overall data provided but not all detail that is desired.</td>
<td>Induction from RC on joining PLG; none on joining umbrella group</td>
</tr>
<tr>
<td>✗</td>
<td>L</td>
<td>Service user or carer present in pre-revalidation annual appraisals (medics volunteered to have)</td>
<td>Member of NHS trust’s service user/carer forum (not treated by medic being appraised)</td>
<td>Attend practitioner’s annual appraisal and contribute to the appraisal meeting</td>
<td></td>
<td>Training session on appraisal system</td>
</tr>
<tr>
<td>Service User or Carer Present</td>
<td>Lay Rep on Individual Patient Funding Panel</td>
<td>Lay Rep on Clinical Priorities Group</td>
<td>Lay Chair of Performers List Decision Panel</td>
<td>Non-Executive Director and Vice-Chair NHS Trust (Pre CCG)</td>
<td>Lay Representative on CCG</td>
<td>Lay Rep for Deanery</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>---------------------------------------------</td>
<td>------------------------------------</td>
<td>---------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td><strong>X</strong></td>
<td>Travel expenses + hourly rate</td>
<td>Travel expenses + hourly rate</td>
<td>Travel expenses + hourly rate</td>
<td>Travel expenses + hourly rate (at rate suggested by lay rep and agreed by organisation)</td>
<td>Travel expenses + hourly rate (at rate suggested by lay rep and agreed by organisation)</td>
<td>Travel expenses + hourly rate (at rate suggested by lay rep and agreed by organisation)</td>
</tr>
<tr>
<td><strong>L</strong></td>
<td>By invitation – prior experience on other committees</td>
<td>To consider and implement NICE guidelines</td>
<td>Chair panel hearings and meetings discussing practitioners’ performance and fitness to practise; prepare for hearings and meetings; sometimes attend pre-briefings for panel hearings; check minutes. Typically 6-10 hours per month commitment</td>
<td>Formal appraisal process</td>
<td>To consider and implement NICE guidelines</td>
<td>To consider and implement NICE guidelines</td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>Chair panel hearings and meetings discussing practitioners’ performance and fitness to practise; prepare for hearings and meetings; sometimes attend pre-briefings for panel hearings; check minutes. Typically 6-10 hours per month commitment</td>
<td>Chair panel hearings and meetings discussing practitioners’ performance and fitness to practise; prepare for hearings and meetings; sometimes attend pre-briefings for panel hearings; check minutes. Typically 6-10 hours per month commitment</td>
<td>Chair panel hearings and meetings discussing practitioners’ performance and fitness to practise; prepare for hearings and meetings; sometimes attend pre-briefings for panel hearings; check minutes. Typically 6-10 hours per month commitment</td>
<td>Chair panel hearings and meetings discussing practitioners’ performance and fitness to practise; prepare for hearings and meetings; sometimes attend pre-briefings for panel hearings; check minutes. Typically 6-10 hours per month commitment</td>
<td>Chair panel hearings and meetings discussing practitioners’ performance and fitness to practise; prepare for hearings and meetings; sometimes attend pre-briefings for panel hearings; check minutes. Typically 6-10 hours per month commitment</td>
<td>Chair panel hearings and meetings discussing practitioners’ performance and fitness to practise; prepare for hearings and meetings; sometimes attend pre-briefings for panel hearings; check minutes. Typically 6-10 hours per month commitment</td>
</tr>
<tr>
<td><strong>L</strong></td>
<td>To implement NICE guidelines</td>
<td>To implement NICE guidelines</td>
<td>To implement NICE guidelines</td>
<td>To implement NICE guidelines</td>
<td>To implement NICE guidelines</td>
<td>To implement NICE guidelines</td>
</tr>
<tr>
<td><strong>L</strong></td>
<td>Operating rules and guidance; minutes; supervisors’ reports; Deanery reports; occupational health reports</td>
<td>Operating rules and guidance; minutes; supervisors’ reports; Deanery reports; occupational health reports</td>
<td>Operating rules and guidance; minutes; supervisors’ reports; Deanery reports; occupational health reports</td>
<td>Operating rules and guidance; minutes; supervisors’ reports; Deanery reports; occupational health reports</td>
<td>Operating rules and guidance; minutes; supervisors’ reports; Deanery reports; occupational health reports</td>
<td>Operating rules and guidance; minutes; supervisors’ reports; Deanery reports; occupational health reports</td>
</tr>
<tr>
<td><strong>L</strong></td>
<td>Legal advice; some legal training</td>
<td>Legal advice; some legal training</td>
<td>Legal advice; some legal training</td>
<td>Legal advice; some legal training</td>
<td>Legal advice; some legal training</td>
<td>Legal advice; some legal training</td>
</tr>
<tr>
<td><strong>L</strong></td>
<td>Travel expenses + hourly rate</td>
<td>Travel expenses + hourly rate</td>
<td>Travel expenses + hourly rate</td>
<td>Travel expenses + hourly rate (at rate suggested by lay rep and agreed by organisation)</td>
<td>Travel expenses + hourly rate (at rate suggested by lay rep and agreed by organisation)</td>
<td>Travel expenses + hourly rate (at rate suggested by lay rep and agreed by organisation)</td>
</tr>
<tr>
<td><strong>L</strong></td>
<td>Attend meetings</td>
<td>Attend meetings</td>
<td>Attend meetings</td>
<td>Attend meetings</td>
<td>Attend meetings</td>
<td>Attend meetings</td>
</tr>
<tr>
<td><strong>L</strong></td>
<td>Contribute to annual reviews of trainees at panel meetings; contribute to appointment of Access to all relevant data; ePortfolios.</td>
<td>Contribute to annual reviews of trainees at panel meetings; contribute to appointment of Access to all relevant data; ePortfolios.</td>
<td>Contribute to annual reviews of trainees at panel meetings; contribute to appointment of Access to all relevant data; ePortfolios.</td>
<td>Contribute to annual reviews of trainees at panel meetings; contribute to appointment of Access to all relevant data; ePortfolios.</td>
<td>Contribute to annual reviews of trainees at panel meetings; contribute to appointment of Access to all relevant data; ePortfolios.</td>
<td>Contribute to annual reviews of trainees at panel meetings; contribute to appointment of Access to all relevant data; ePortfolios.</td>
</tr>
<tr>
<td><strong>L</strong></td>
<td>£7500 per year (taxable and NI liable) + extra for chairing sub committees</td>
<td>£7500 per year (taxable and NI liable) + extra for chairing sub committees</td>
<td>£7500 per year (taxable and NI liable) + extra for chairing sub committees</td>
<td>£7500 per year (taxable and NI liable) + extra for chairing sub committees</td>
<td>£7500 per year (taxable and NI liable) + extra for chairing sub committees</td>
<td>£7500 per year (taxable and NI liable) + extra for chairing sub committees</td>
</tr>
<tr>
<td><strong>L</strong></td>
<td>£32.50 per hour + travel expenses</td>
<td>£32.50 per hour + travel expenses</td>
<td>£32.50 per hour + travel expenses</td>
<td>£32.50 per hour + travel expenses</td>
<td>£32.50 per hour + travel expenses</td>
<td>£32.50 per hour + travel expenses</td>
</tr>
<tr>
<td><strong>L</strong></td>
<td>£32.50 per hour + travel expenses</td>
<td>£32.50 per hour + travel expenses</td>
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<td>Patient forum for GP practice</td>
<td>By invitation (probably randomised)</td>
<td>Feedback on quality of service provision</td>
<td>Included in confidential discussions.</td>
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