how to

succeed at revalidation

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How to Succeed at Revalidation

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Abbreviations

ACAT
Acute Care Assessment Tool

AD
Associate Dean

AoMRC
Academy of Medical Royal Colleges

ARCP
Annual Review of Competency Progression

BMA
British Medical Association

BRI
Bristol Royal Infirmary

CCT
Certificate of Completion of Training

CD
Clinical Director

CHI
Commission for Health Improvement

CMO
Chief Medical Officer

COPMeD
Conference of Postgraduate Medical Deans

CPD
Continuing Professional Development

CQC
Care Quality Commission

CRPS
Chronic Regional Pain Syndrome

CSP
: Chartered Society of Physiotherapy

DB
: Designated Body

DEN
: Doctor’s Educational Need

DISQ
: Doctors Interpersonal Skills Questionnaire

DOPS
: Direct Observation of Procedural Skills

ELA
: Employer Liaison Adviser

GDC
: General Dental Council

GIM
: General Internal Medicine

GMC
: General Medical Council

GMP
: Good Medical Practice

GNM
: Gross Negligence Manslaughter

GOC
: General Optical Council

GP
: General Practitioner

GPAQ
: General Practice Assessment Questionnaire

GPAS
: General Practice Assessment Survey

GPC
: Generic Professional Capabilities

HEIW
: Health Education and Improvement Wales

HPC
: Health Professionals Council

ISQ
: Interpersonal Skills Questionnaire

IT
: Information Technology

JRCPTB
: Joint Royal Colleges of Physicians Training Board

LGA
: Local Government Association

MARS
: Medical Appraisal and Revalidation System

MDT
: Multi-Disciplinary Team

mini-CEX
: Mini-Clinical Evaluation Exercise

MSF
: Multi-Source Feedback

NCDA
: National Cancer Diagnosis Audit

NELA
: National Emergency Laparotomy Audit

NICE
: National Institute for Health and Clinical Excellence

NMC
: Nursing and Midwifery Council

NTN
: National Training Number

PA
: Physician Associate

PDP
Professional Development Plan

PEI
Patient Enablement Instrument

PREM
Patient-Reported Experience Measure

PROM
Patient-Reported Outcome Measure

PSQ
Patient Satisfaction Questionnaire

PUN
Patient’s Unmet Need

QI
Quality Improvement

RCs
Royal Colleges

RCGP
Royal College of General Practitioners

RCP
Royal College of Physicians

RCPsych
Royal College of Psychiatrists

RCS
Royal College of Surgeons

RO
Responsible Officer

SAS
Staff and Associate Specialist

SEA
Significant Event Analysis

SI
Supporting Information

SLE
: Supervised Learning Event

SOAR
: Scotland Online Appraise Resource

SWOT
: Strengths, Weaknesses, Opportunities, Threats

UK
: United Kingdom

UKCC
: United Kingdom Central Council for Nursing, Midwifery and Health Visiting

UKRPB
: UK Revalidation Programme Board

VC
: Video Consultation

WPBA
: Workplace-Based Assessment

Chapter 1 Introduction

Working as a health care professional in the twenty-first century is both rewarding and challenging. Being a doctor is a complex role typically with a broad scope of practice, which includes not just one's clinical role but other responsibilities such as teaching, research and management. Whatever clinical area or specialty you are working in, there are increasing public expectations. Medical revalidation, introduced by the General Medical Council (GMC) in 2012, is an evaluation of a doctor's fitness to practice (GMC 2020).

What is this book about? This book reviews the background that led to the implementation of medical revalidation in the United Kingdom (UK). It also provides a comprehensive description of the current revalidation process for all doctors in the UK.

Who is this book for? This book is aimed at:

- All doctors in the UK who are subject to revalidation, including General Practitioners (GPs), Consultants, Staff and Associate Specialists (SASs), Locally Employed Doctors and Doctors in Training
- All doctors who are appraisers and or Responsible Officers
- All who are involved in postgraduate medical education and training
- All medical students and their tutors and lecturers.

Overview of the Book

This book explores the evolution of the regulatory processes in medicine and other health professionals from a UK and international perspective. The current UK regulatory framework is described, as well as the recent drivers for change. The book provides a step-by-step guide to the process of revalidation from the perspective of the appraisee, the appraiser, the Responsible Officer and the employer. Examples of reflective writing are explored mapped to Good Medical Practice (GMP) and the Generic Professional Capabilities (GPCs). We then go on to explore the possible future for medical revalidation in the UK.

Background

The GMC considered the introduction of revalidation as far back as 1998. In 2010, the GMC together with the Chief Medical Officers (CMOs) from the four UK nations issued a joint Statement of Intent, explicitly defining the purpose of revalidation:

> *the purpose of revalidation is to assure patients and the public, employers and other health care professionals that licenced doctors are up to date and fit to practice*
>
> (Pearson 2017)

The process was eventually introduced in December 2012, but this change was not triggered by a single event but rather a cultural and systems shift in the UK and indeed across all health care systems globally. An increased expectation of the public, in part driven by increasingly better informed patients via the use of the internet and social media, and a number of high-profile malpractice cases have focused the attention of the public on the governance arrangements for health care professionals, including doctors. These events have included the scandals at the Bristol Royal Infirmary (Kennedy 2001), the issues at

Alder Hey Children's Hospital (The Stationery Office 2001) and the Mid Staffordshire Report (Francis 2013).

As just one example, Francis (2013) in his final report into Mid Staffordshire discussed the use of appraisal to facilitate cultural change in NHS organizations, with a need for appraisal to be driven by feedback from patients and colleagues.

In the last 20–30 years, the models of care used to provide services to patients have been transformed, resulting in a greater emphasis on doctors working within multi-professional teams.

We are now also in the third medical revolution. The first was the public health revolution epitomized by the discovery that the 1854 cholera outbreak in London was as a result of contaminated water via the water pump on Broad Street, in the Soho area (now Broadwick Street), and not by airborne transmission. This finding led to the emergence of public health medicine.

The second has been the technological revolution over the last 50 years with investment in evidence-based medicine and a focus on quality of care, for example, Magnetic Resonance Imaging, coronary artery bypass graft surgery, joint replacements, chemotherapy, renal dialysis, to mention just a few.

The third medical revolution, triggered by the citizen and driven by knowledge and the internet, has led to digital health strategies delivering direct clinical care and supporting education training and ongoing professional development (Topol 2019).

The purpose of revalidation is to assure the public, patients, employers and other health care professionals that all licenced doctors are up to date and fit to practice.

The process of revalidation is underpinned by each doctor being actively engaged in annual appraisal. Appraisal should be supportive and developmental with a key element being reflection on the breadth of the doctor's professional practice with the desired outcome of improving the quality of care for patients. The reflection process should focus on events and learning and how they have applied that learning in practice (Kolb 1984).

All doctors in the UK are required to revalidate. There are two pathways: those working as GPs, Consultants and SAS doctors who do so through an annual appraisal process; and those doctors in training, in GMC-approved training programs who are subject to an Annual Review of Competency Progression (ARCP). This acts as an annual appraisal.

More recently, the GMC and other stakeholders recognized that, in achieving the UK certificate of completion of training (CCT), doctors in training should have to demonstrate an appropriate and mature professional identity, appropriate to their level of seniority. As a result, the GPCs, a set of common generic outcomes, were introduced across all postgraduate medical curricula (GMC 2017). There are currently 66 medical specialties and 32 sub-specialties in the UK and there has been significant variation across all of these curricula in terms of generic professional practice outcomes and expectations.

Challenges

Is medical revalidation fit for purpose? The UK is nearly through the second cycle of revalidation and it is clear there are still challenges in engagement, the quality of appraisal, and the process of ensuring a consistent approach (Pearson 2017). There remain a number of gaps and areas for improvement.

Moving forward there may be increasing pressure from society for an even more rigorous assessment of each individual doctor's level of knowledge and skill. Revalidation in the future is likely to require further changes to help meet the ever-evolving needs of the public and governments.

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Chapter 2
Regulation in Health – A Brief History

Introduction

In this chapter, we will explore the origins, evolution and development of regulation of the professions of nursing, physiotherapy and medicine. Whilst describing the development of these health care professions we will explore the historical development of the regulatory processes applying to these.

What is Regulation?

Before going on to explore regulation in a number of health professions, it is useful to consider briefly the development of regulation as a concept.

In general terms, regulation describes the rules that are set out in legislation and the processes used to monitor and enforce those rules. Regulation complements other government levers such as taxation and public spending in shaping society. In the business world the aim of regulation is to help in the delivery of better outcomes for the economy, society and the environment. In health care, the purpose of regulation is to ensure that all health professions are fit to practice and hence patient safety and public confidence is assured.

Regulation can have a significant impact on innovation. On the one hand it can stimulate innovative ideas, while on the other hand serve to hinder their implementation. As a result, regulation can either stimulate improvement and/or

investment, or lead to a tick-box approach to regulatory compliance.

There are a number of subtypes of regulation:

- Arbitrary regulations – rules that mandate the use of one of several equally valid options (e.g. driving on the right- or left-hand side of the road)
- Good faith regulations – that aim to define a baseline of acceptable practice (e.g. food hygiene regulations for the hospitality industry)
- Goal conflict regulations – regulations that recognize a conflict between two parties and mandate for the greater good. These are typically conflicts between the individual versus wider society
- Process regulations – these determine how a task should be accomplished.

In addition, it is important to understand the characteristics of the regulator. In peer-regulation the community regulates itself, a form of self-regulation. Unilateral or flat regulation is when regulations are imposed by the body with the power to do so. Statutory regulation is where the authority to define the rules is delegated to an independent third party body. This is the current position with health regulation in the UK whereby the Government delegates power to regulatory bodies such as the General Medical Council (GMC) or the General Dental Council (GDC).

In general, any forward-thinking society would wish for regulation that supports and stimulates innovation, which in turn benefits citizens and the economy. In addition, optimal regulation is one that protects members of the public but does not hinder innovation and/or have unintended negative consequences. Across all sectors there

is a need for regulators to evolve to keep pace with the rapid changes in society, and with the need to maintain the balance of safety and security versus innovation that improves the lives of its citizens.

Regulation in Health Professions

Professionalism and Society

In early history, occupations began to evolve and move into what would now be considered a profession. The key milestones marking this transition from simple activity to a profession include full-time occupation, establishment of training schools or universities, codes of ethics and regulation, licensing legislation and colleague control. Another key component in this transition to a profession was the balance between a level of autonomy of work and the regulatory requirements. Larson added to the characteristics above with the addition of high standards of professional and intellectual excellence, as well as referring to professions as “exclusive elite groups” (Larson 1978, p. 20).

The three original occupations of law, the clergy and medicine arose through the medieval universities of Europe. By the turn of the nineteenth century, with occupation specialization, different bodies claimed and achieved professional status including nursing and teaching.

The concept of medical professionalism probably dates back to the late medieval times when doctors organized a professional guild (Sox 2002). At that point medical professionalism was viewed as the art of practicing medicine to a certain set of standards that were set by the profession itself, essentially self-regulation. This has evolved and responded to societal and political changes.

The professions addressed a range of societal issues and in return society afforded these professions a number of privileges, including monopoly status, the authority to decide who could enter the profession and the ability to influence government policy.

In essence there was an implied social contract (Cruess et al. 2010) where there was an acceptance of the balance between altruism and self-regulation. Although early definitions of the medical profession have been doctor-centered, there has been a shift recognized by regulatory bodies toward a position of medical professionalism as being a social construct, a social contract between doctors and society (Cruess and Cruess 2008).

The social contract is now recognized as a tripartite agreement involving three interconnected societal elements:

1. The government, employers, and health care managers
2. Patients, patient groups and the general population
3. The medical profession and its professional bodies.

Each of these groups has its own responsibilities and roles in fulfilling its side of the contract. There is recognition from certain sections of the medical profession that the social contract is a dynamic entity that is ever-changing in the context of rising systematic pressures and societal expectations. There are many factors that impact upon the contract, including the regulators, social media, print and broadcast media, and professional organizations (Cruess and Cruess 2011).

Recognizing the evolving position, in 2015 Jeremy Hunt, the then Health Secretary, called for a new social contract between the public, health and care services. In a speech to the Local Government Association (LGA) annual conference

in Harrogate, Mr. Hunt urged the public to take more personal responsibility:

- for looking after the elderly
- for their own health
- in using finite NHS resources.

He argued that, while integration of health and social care is vital to delivering the highest standards of health and care, personal responsibility needs to sit alongside system accountability (Hunt 2015).

There is a further element to the evolution of health roles. It has been argued that there has been a significant blurring between the roles of health professions. There are arguments for and against this development. Although roles have evolved and are constantly changing, there is a current strategic position in the UK from governments and the relevant statutory education and training bodies to actively upskill non-medical professions and develop new roles such as the Physician Associate (PA). There are possible risks with this strategy, and some argue that these developments have been accelerated to reduce costs and that there is a risk the system now expects some professions to work beyond their competency ceiling (Oxtoby 2009).

Self-Regulation

While we will explore self-regulation in relation to medicine in greater detail later in the chapter, the concept of self-regulation has been defined as a contract between the profession and the public (represented by the State). As a part of the contract, the profession promises that all members of the public will be served by good doctors and protected from bad ones. In turn the public, via the State,

gives the profession a high level of autonomy over its own affairs. There are arguments for and against self-regulation. The first in favor of self-regulation is that medicine is so complex that doctors themselves are best placed to define standards that differentiate between good and unacceptable practice. The second argument is that if doctors as a body have a sense of ownership of these standards, then they are more likely to adhere to them. The argument goes that such a model of self-regulation, if balanced with processes to ensure the public has a loud voice, is the best to achieve the desired outcome – a safer service for patients.

Professional regulation has two key elements. The first is at the level of the individual doctor. This requires individual doctors to exercise self-discipline. This requirement is of paramount importance considering the clinical scenarios facing most doctors on a daily basis where they have to make decisions, with patients, based on less than optimal evidence (Bate et al. 2012).

The second element lies at the collective level where the profession as a whole is required to ensure that current practice, in general, is in line with the accepted standards in operation at that time. These standards are by their nature changing frequently. For example, the legal framework underpinning the process of obtaining consent in the UK changed significantly after the Montgomery case in 2015 (Chan et al. 2017).

In order to set the context for the current regulatory framework in medicine, explored in Chapter 3, the history of the evolution of regulation for nursing, physiotherapy, and medicine will be briefly explored here. The evolution of regulation of each of these professions are intrinsically linked as the social and political pressures and levers have been similar for each.

The Nursing Profession

The term “nurse” is derived from the Italian word, *nutrire*, meaning to feed, nourish or suckle a baby. The earliest written records of nurses are from the Roman Empire.

In ancient Greece, approximately between 460 and 375 BCE, Hippocrates realized that human disease was based on biology and not supernatural causes. He developed the concept of physical observations and reporting on the holistic health of the patient. He is famous for writing the Hippocratic Oath, which was a pledge that all doctors had to take. Although in recent years the Oath has fallen out of favor, a survey of all medical schools in the UK found that 70% of those responded still used a version of the oath (Green 2017).

Throughout the early middle ages, health care and therefore nursing in England was set within and controlled by the churches, mainly the Roman Catholic Church.

The Reformation, a movement across Europe, began in about 1517 driven in part by Martin Luther, and posed serious political and religious challenges to the Roman Catholic Church and specifically to the authority of the Pope. In England, the Reformation under the reign of Henry VIII led to the Church of England breaking away from Catholicism. This then led to the dissolution of monasteries between 1536 and 1541, and the shutting down of the associated hospitals and infirmary buildings. This has come to be known as the “Dark Age of Nursing” as the English Reformation resulted in many hospitals being closed down. The larger hospitals in London such as St Thomas’ and St Bartholomew’s, although at risk through the Reformation, were able to survive with their management taken over by the City of London. Henry VIII’s