Medical revalidation: a route to excellence?

All doctors who hold a licence to practise will need to revalidate every 5 years. The process includes the consideration of defined items of supporting information at five annual appraisals. These essentials must support professional development and the achievement of excellence in patient care.

Revalidation is the process by which doctors will have to demonstrate to the General Medical Council that they are up to date and fit to practise and that they are complying with the relevant professional standards. All doctors who are required, or who wish, to retain a licence to practise will need to revalidate. The standard of professional performance required to achieve this is a minimum standard, based on the outcome of five annual appraisals during which a defined range of supporting information will be presented and discussed between the doctor and his or her appraiser. Some of this information will be based on that already recorded in effective clinical governance systems and some will be generated specifically for revalidation by the individual doctor.

Until recently the quality of the appraisal process has been widely variable, but appraisal for revalidation has now become more structured and formalized. This has led to concern that the positive elements will be lost in favour of getting through a revalidation 'tick-box' exercise. We need to consider whether medical revalidation can also support the aspirations of those who are striving for professional excellence.

Background: consultation and piloting

The General Medical Council first consulted on revalidation for doctors in 2000 and introduced formal appraisal in 2001. The Shipman enquiry in 2001–5 was followed by the publication of the consultation Green Paper *Good Doctors, Safer Patients* (Department of Health, 2006) and the White Paper *Trust Assurance and Safety* (Department of Health, 2007). In 2008, the Chief Medical Officer for England's working party report (Department of Health, 2008) emphasized that, for revalidation, 'appraisal should remain predominantly formative'.

In 2009 the General Medical Council revised *Good Medical Practice* to provide a framework for appraisal and revalidation, which re-arranged the previous seven domains into four domains and 12 attributes. The General Medical Council has consulted on revalidation (General Medical Council, 2010) and also on the related regulations (General Medical Council, 2011a). In 2011 a revised version of the *Good Medical Practice Framework for Appraisal and Revalidation* was published (General Medical Council, 2011b) and the General Medical Council and the Academy of Medical Royal Colleges agreed guidance on the supporting information that should be brought to appraisal through the revalidation cycle (Academy of Medical Royal Colleges, 2011; General Medical Council, 2011c).

Piloting and consultation

In order to develop and test the new process of appraisal that will be needed to support revalidation, the NHS Revalidation Support Team (England) developed a process of strengthened medical appraisal that was tested through a series of pathfinder pilots in 2010–11. In these, supporting information for each of the 12 attributes of *Good Medical Practice* was evaluated for adequacy in demonstrating good practice, but the process was found to be too complex and challenging (Department of Health, 2011a). Further development and testing has led to the recent publication of the Revalidation Support Team's Medical Appraisal Guide (NHS Revalidation Support Team, 2012a), which describes the process of appraisal in England. In Scotland, the Scottish Online Appraisal Resource, originally developed for GPs, has been modified for all doctors (NHS Scotland, 2012) and the Wales Deanery has developed a system for doctors in Wales (Wales Deanery, 2012).

Where are we now?

Revalidation is expected to begin at the end of 2012, with all licensed doctors revalidated by 2016. Anyone providing care to patients is required to maintain a licence to practise from now on, renewed every 5 years through the revalidation process. Those who do no patient-related work at all will not require a licence, but will nevertheless be entitled to remain on the General Medical Council specialist register. The same applies to the majority of those working long term outside the UK, as it is not up to the local employer to demand a UK licence to practise. For those who may be overseas for a

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short period, or for those taking a career break within the UK, the licence need not be maintained during that period, but will be reissued by the General Medical Council on return.

Doctors in training will also be required to revalidate, but this will be based on their current assessment process through their postgraduate deanery (England and Wales), NHS Education for Scotland or the Northern Ireland Medical and Dental Training Agency.

Responsible officers and organizational readiness

All designated bodies (organizations that employ, or contract with, doctors) were required to appoint a responsible officer from January 2011. Every doctor must have a relationship with one responsible officer, even if the doctor is employed by several different designated bodies. In general, if one of these is within the NHS, then the doctor's responsible officer will be the responsible officer for the NHS employer. The General Medical Council (2012a) has recently asked all doctors to begin to identify their designated body, and thus their responsible officer, and has published a guide to support doctors through the process (General Medical Council, 2012b).

Responsible officers are responsible not only for making a recommendation on whether a doctor should be revalidated, but also for ensuring that clinical governance and appraisal systems in the organization are of sufficient quality to support revalidation and to make revalidation recommendations reliable (Department of Health (England), 2010). In England the Revalidation Support Team has initiated a series of organizational readiness exercises that require self-reporting against a wide range of criteria in relation to policies and processes that should be in place to support revalidation (NHS Revalidation Support Team, 2011, 2012b).

The supporting information

The General Medical Council (2011c) has published generic guidance on the nature of the supporting information that should be brought to appraisal by all doctors. The medical Royal colleges and faculties, through the Academy of Medical Royal Colleges, have agreed on core guidance for all specialties and supplementary guidance for each specialty which sets out the relevant specialty context (Academy of Medical Royal Colleges, 2011). The supporting information may be considered under four broad headings:

General information – providing context about what you do in all aspects of your work

- Personal details (including your General Medical Council reference number)
- Scope of work
- Record of your annual appraisals
- Your personal development plans and their review
- Self-declarations on probity and health.

Keeping up to date – maintaining and enhancing the quality of your professional work

- Continuing professional development – the General Medical Council (2012d) has provided guidance on this.

Review of your practice – evaluating the quality of your professional work

- Engagement with quality improvement activity. This may include:
  Clinical or professional audit
  Clinical outcomes review
  Case review and discussion
- Reporting, and learning from, significant events.

Feedback on your practice – how others perceive the quality of your professional work

- Colleague (multisource) feedback
- Patient feedback
- A summary of, and learning from, complaints and complements.

The appraisal process

Although the supporting information required for appraisal and revalidation is the same across all four countries of the UK, the processes by which appraisal for revalidation is conducted differ to a varying degree. The process in England is described in the Medical Appraisal Guide, which is accessible through the Revalidation Support Team's website (NHS Revalidation Support Team, 2012a). For those in academic medicine, arrangements for joint appraisals between NHS trusts and universities, governed by the Follett principles (Follett and Paulson-Ellis, 2001), will continue for revalidation.

In the Medical Appraisal Guide process supporting information is collected and collated, and then submitted to the appraiser for approval. If the supporting information is considered adequate the appraisal may proceed. During this the doctor and the appraiser consider together the quality of the supporting information and the doctor's progress against the previous year's personal development plan. Areas of intended career development and aspiration are reviewed, and the appraiser then agrees with the doctor a new personal development plan and a summary of the appraisal discussion, structured according to the four domains of *Good Medical Practice*. The appraiser then formally indicates agreement with a series of statements, to the effect that a properly structured appraisal has taken place, that this has considered the doctor's scope of work, supporting information and previous personal development plan, that a new personal development plan has been agreed, and that no information has been presented or discussed that raises a concern about the doctor's fitness to practise.

The responsible officer recommendation

Following five satisfactory appraisals and a consideration of any other relevant information about a doctor's professional performance, the responsible officer will be able to make one of three statements to the General Medical Council (General Medical Council, 2012c):

1. That the doctor is up to date, fit to practise and should be revalidated
2. That the recommendation should be deferred while more information is obtained – for example where the doctor has taken a career break
3. That the doctor has failed to engage with any of the local systems or processes (such as appraisal) that support revalidation.

In the last case the doctor will be referred to a fitness to practise panel of the General Medical Council for consideration of whether the licence to practise should be revoked. It is only the General Medical Council that can give or remove the licence to practise.

Confidentiality

It is important that the confidentiality of patients and the public is protected at all times. This applies to the transfer and use of patient identifiable data to and within electronic portfolios as well as to the security of the portfolios themselves. Guidance has been provided by the NHS Revalidation Support Team (2012c).

The supporting information that a doctor brings to appraisal will not be confidential to the doctor since it will be in a recordable (and therefore accessible) format. This is also necessary since the responsible officer may need to review elements of the supporting information in order to come to a recommendation, and the General Medical Council may wish to see it as part of their fitness to practise processes. The appraisal summary (agreed with the doctor) will be forwarded to the responsible officer. The appraisal discussion is not recorded, however, and therefore this element should remain confidential.

Work still to do

Quality assurance

The appraisal process must be carried out consistently and to a high standard, and the recommendations made by the responsible officer must be a true reflection of the quality of professional practice of the doctor. The responsible officer is responsible for the quality of the appraisal process in his or her organization, and will also be subject to revalidation and thus to one element of quality assurance. Some quality assurance of the responsible officer decisions will be provided through the findings of the General Medical Council fitness to practice panels regarding doctors who are not recommended for revalidation, but there is also a need to provide quality assurance for the positive revalidation recommendations that a responsible officer makes. How this will be done is still being discussed by the General Medical Council and other organizations (General Medical Council, 2011d).

Remediation

One of the potential benefits of revalidation is that the process allows for the identification and support of those doctors who may be starting to fall behind. This should happen at a stage well before any patients are put at risk. There will also continue to be those doctors who refuse help, or who have an unexpected and serious catastrophe where patients could be harmed. There will thus be a spectrum of need within remediation from those who require support and 're-skilling' through those who require a formal remediation programme to those who may be referred directly to the General Medical Council. Health issues may also affect a doctor's fitness to practise, and the work of the Practitioner Health Programme in London has demonstrated how important effective intervention can be (NHS London Specialised Commissioning Group, 2012).

Reports on remediation have been published by the Academy of Medical Royal Colleges (2009) and the Department of Health (England) (2011b), and an Academy of Medical Royal Colleges working party is currently considering how the colleges and faculties should be involved. An essential part of this process is to identify whether there is a problem and where that problem lies – with the organization, with the information available, with the doctor's team or (and perhaps last) with the individual doctor.

A road to excellence?

How do we ensure that the time, money and other resources required for revalidation will lead to better doctors as well as to safer patients? There are great opportunities that must not be missed.

Doctors will all engage with the collection of supporting information that will reflect the quality of their practice and the views of their patients and colleagues about their performance. The annual appraisal process must remain 'predominantly formative' while also addressing the basic requirements of revalidation – if, and only if, this happens will doctors remain engaged with the process and be supported to attain professional excellence.

Where a doctor's performance may be falling behind there must be opportunities for re-skilling and support and appropriate management of health issues. This will require financial and other resources but will build on most doctors' wish to perform well and to improve.

Finally doctors do not work in isolation, but are members of smaller or larger teams that are often multi-professional. Considering information about individuals against a background of information about the quality of care provided by the team or the organization will be a powerful tool to solve problems and to enhance excellence in the organization as a whole. **BJHM**

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KEY POINTS

- All doctors who wish to retain a licence to practise will have to revalidate with the General Medical Council every 5 years.
- Medical appraisal is the key element that will allow doctors to demonstrate that they remain up to date and fit to practise.
- The risk that appraisal will become simply a tick-box exercise must be avoided by continuing to emphasize its formative and developmental role.
- The supporting information brought to appraisal must reflect the quality of a doctor's professional practice and the steps taken to develop this, not the achievement of performance targets.
- Responsible officers are responsible for quality assuring the appraisal process in each designated body, but their revalidation recommendations must also be quality assured.
- Medical revalidation presents an opportunity to identify, support and, where necessary, re-skill doctors who may be falling short in some areas, before there is any risk to patient welfare.
- Provision of supporting information on professional performance and regular formative appraisal will encourage individual professional excellence and thus enhance the quality of care provided by health-care teams and organizations.