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Medical Revalidation, a key component of quality improvement in UK healthcare

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Dr Mike Bewick, Deputy Medical Director, NHS England

Professor Jenny Simpson, Clinical Director Revalidation NHS England

THE NHS CONSTITUTION
the NHS belongs to us all

The story so far

- Revalidation - a topic for discussion and debate for over 25 years
- Medical Director role became statutory, early 1990s
- Clinical governance introduced in the NHS mid-1990s, along with medical appraisal
- Thinking then was that the wider system would embrace clinical governance as a quality improvement/patient safety organisational system

However..

- At that time, there was no real leverage to give clinical governance the status it needed in terms of organisational priority
- Clinical governance only applied to the NHS, did not impact either locums or the independent sector – which is where the greater risk lies
- Clinical governance became little more than a perfunctory exercise, with little impact on organisations or individuals working in them

Early 2000s

- Renewed focus on quality improvement, with major drive to involve clinicians in management and reducing the level of bureaucracy in the NHS
- Followed by the enquiry, led by Dame Janet Smith QC, into the activities of Dr Harold Shipman, a Manchester GP who was responsible for the deaths of more than 200 of his patients

Dame Janet…

- Asked the then Chief Medical Officer, Professor Sir Liam Donaldson, to lead a review of the way in which the medical profession was regulated – the most radical review since the inception of the UK's General Medical Council
- The review began in 2006, ending a year later
- It resulted in a white paper: 'Trust, Assurance and Safety', published late in 2007

Trust, Assurance and Safety, 2007

- Resulted in an extensive programme of work to implement the recommendations of reform to medical regulation
- 2 of the workstreams – ‘Medical Education ’ and ‘Tackling Concerns Locally’ described a process of affirmation of doctors’ fitness to practise on a regular basis – Medical Revalidation

Trust Assurance and Safety, 2007

- Described a new role – that of the Responsible Officer
- He or she would be the most senior doctor in the organisation and would make a recommendation to the GMC about each individual doctor working in their organisation, on whether or not they remained up to date and fit to practise

Trust, Assurance and Safety, 2007

- The responsible officer's recommendation would be based on a regular appraisal, at which a prescribed set of supporting information would be presented, along with patient and colleague feedback, to a trained and quality assured appraiser
- Medical revalidation would be required by every doctor holding a licence to practise in the UK

Medical revalidation, by statute

The UK government decided to introduce medical revalidation, by statute

Driven by a collaboration between:

- the profession
- the regulator (General Medical Council)
- the government (Department of Health)

Across all 4 countries in the UK

Early challenges:

- Difficulty in establishing roles – GMC/DH/Royal Colleges/patient groups/professional groups
- Information systems not by any means developed consistently across the service
- All systems and flows of information had to include the private sector and locum agencies – who were reluctant to share information initially



Early challenges:

- Professional resistance to concept of performance management
- Medical appraisal already established – but as a supportive, developmental process, not as performance management
- Royal colleges initially sought a major role in assuring the quality of doctors' practice, which they would have been unable to deliver.

Implementation of revalidation

- 2007– 2012: design, testing, piloting, organisational development, led by Revalidation Support Team funded by the DH.
- 3 December 2012: first cohort of doctors revalidated
- 2013/14: 20% of remaining doctors
- 2014/15: 40% of remaining doctors
- 2015/16: 40 % of remaining doctors

By March 31, 2016, every one of the 163,000 doctors registered in the UK with a licence to practise, will have been through their first revalidation cycle

Revalidation – the crossroads:

We are at the point at which the process could either:

- be completely embedded in and embraced by the quality improvement agenda, building on the systems which have had to be put in place to support revalidation; or
- become a ‘tick-the-box, jump-through-the-hoops’ exercise for doctors, with little impact on care for patients

Systems underpinning revalidation

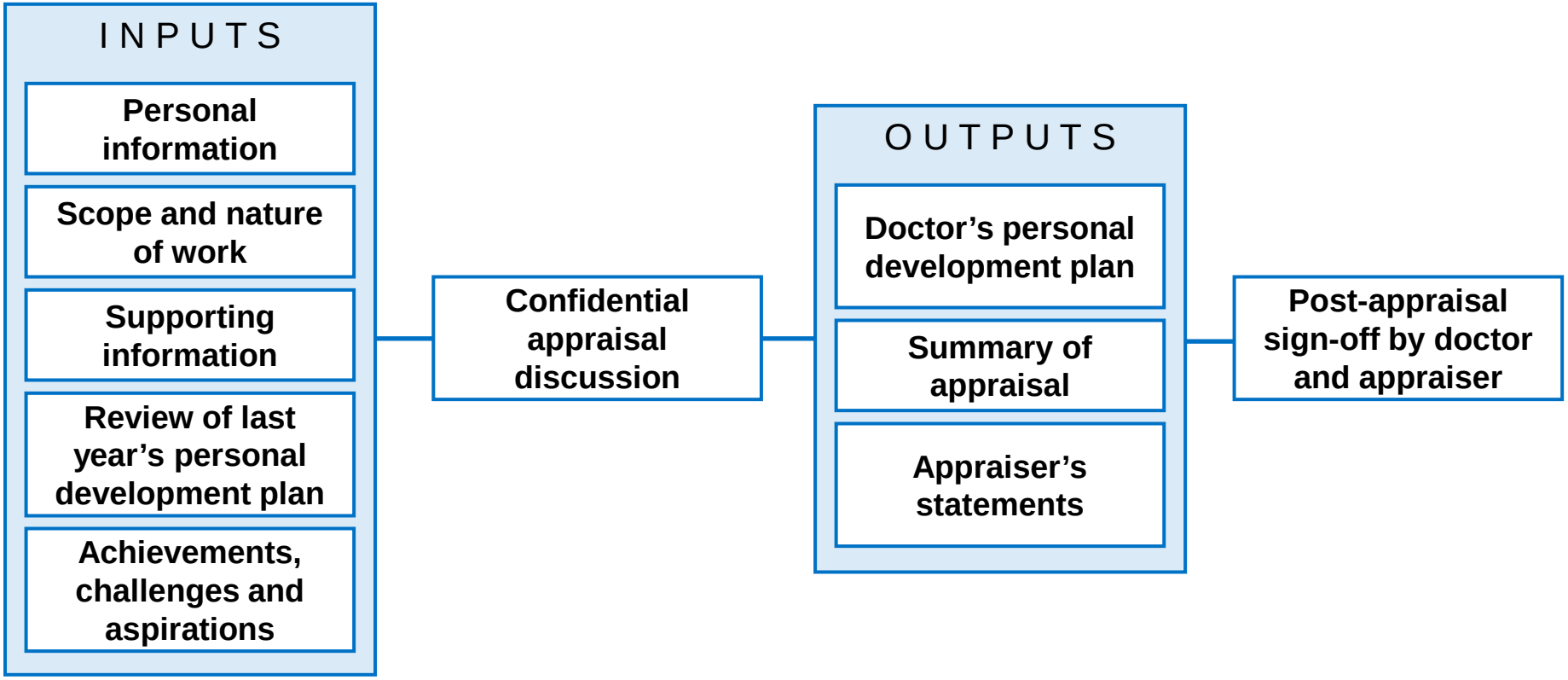
The responsible officer's recommendation is based on:

- 5 annual appraisals, each triangulated against information on the doctor from other systems of clinical governance and based on the doctor's entire scope of work. Failure to disclose an area of work presents a probity issue
- a detailed review of patient and colleague feedback over each 5-year cycle

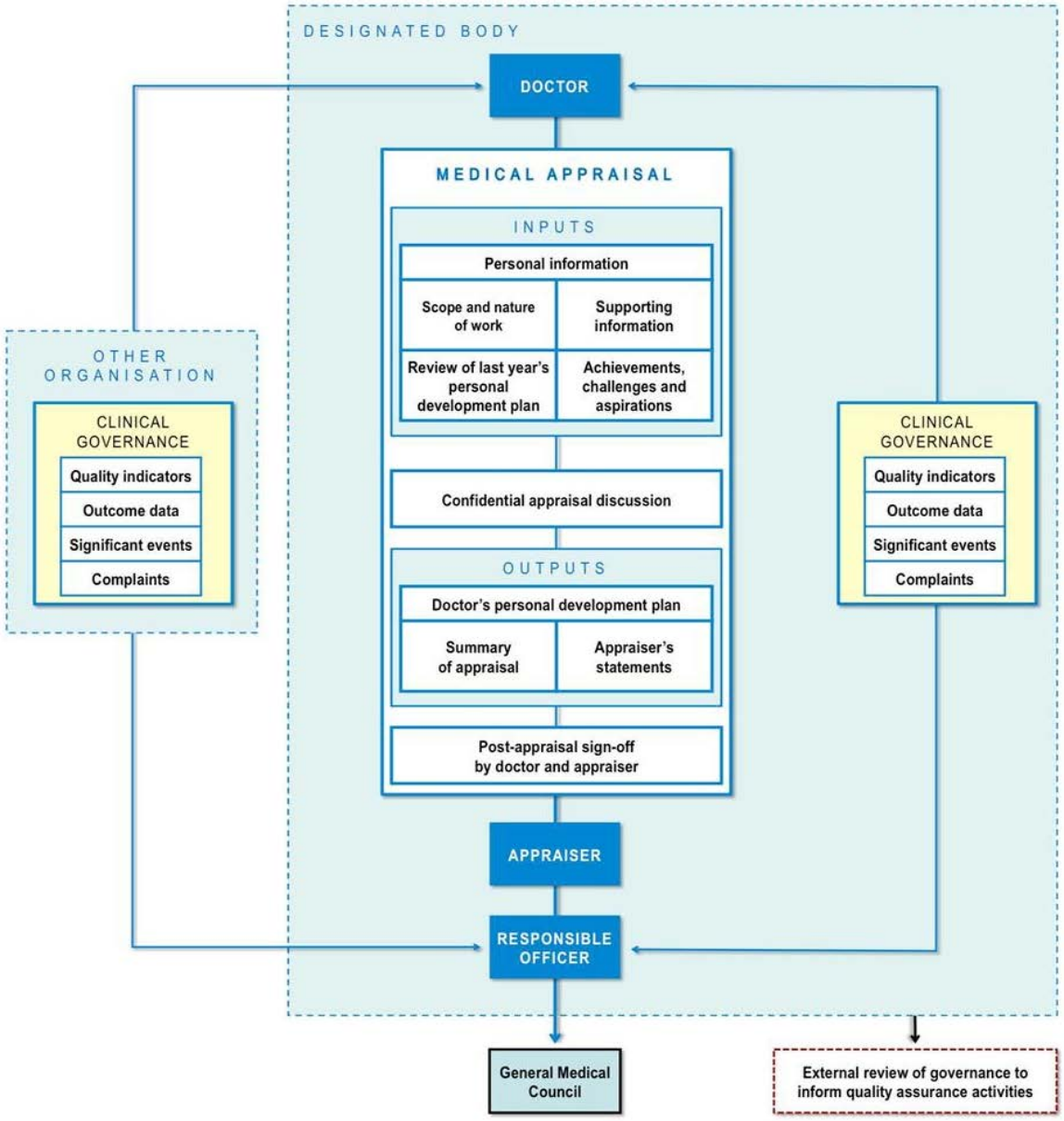


The Process of Medical Appraisal

Appraisal covers the whole of the doctor's practice



Information flows For revalidation:



Governance of the system

- Key issue – revalidation is only credible if the governance is watertight
- Based on a hierarchy of responsible officers:
  - Each organisation employing or contracting with doctors is designated by the government (becoming a ‘designated body’) - and thereby obliged to appoint a responsible officer
  - Each responsible officer is also a licensed doctor. Therefore they must relate to their own responsible officer and be bound by the principles laid out in the General Medical Council’s code, ‘Good Medical Practice’

Governance of the system

- So – some 700 or so designated bodies each have a responsible officer
- Each of these relates to one of 4 regional responsible officers
- These 4 responsible officers relate to the Medical Director of NHS England
- He is appraised and revalidated by an independent designated body

Basic rules - set out in regulation

- Each doctor may have only one responsible officer
- The connection is prescribed – a doctor cannot choose their responsible officer
- If there is believed to be a conflict of interest, a prescribed process must be followed to reach a solution
- The date of the doctor's revalidation is set by the GMC

Basic rules - set out in regulation

- The responsible officer's recommendation may be a positive affirmation, a deferral because of insufficient information or for some other reason – or a statement of failure to engage
- Both responsible officers and appraisers must be trained to a national standard, undergo appropriate CPD and attend network meetings on a regular basis to ensure that their decision-making and thresholds for intervention are peer reviewed and calibrated
- Organisations are, by law, obliged to support and resource the necessary system

Revalidation – provides opportunities:

- In order for doctors to practise in the UK, they must, by law, collect information on everything they do and submit it for scrutiny
- Organisations, by law, must ensure that the necessary information is available
- To be revalidated, every doctor must have their work assessed within a managed system
- Every doctor must submit information on every single aspect of their work as a doctor

Revalidation – provides opportunities to:

- Identify and act on failing doctors' failing performance at a much earlier stage as a matter of course
- Monitor doctors' performance across the different roles they undertake
- Ensure that doctors must not only undertake CPD to the required levels – but the CPD must also be appropriate, relevant and proportionate to the doctor's scope of worker

And, fundamentally, to…

…Collect information systemically, across the entire system, on an industrial scale that we have never had before in the UK

A chance to try your hand…

Scenario 1:

A trainee is found to have pictures on a social networking site which appear to show regular alcohol excess. One entry suggests he was out drinking heavily at a club until 4:00am when he was due to start work at 8:00am that morning.

What would you do?



Scenario 1 - Investigation Reveals:

Further investigation reveals the doctor:

- was cautioned by police for being drunk and disorderly as a student and received ‘a stern talking to’ by the Undergraduate Dean
- was fined and received penalty points for speeding 2-3 years ago during FY1 [62mph in a 40mph zone]
- struggled to pass exams as a student having to re-sit end of year exams on 2-3 occasions
- was thrown out of a seminar during FY2 as he fell asleep
- no major concerns expressed during clinical attachments though occasional comments about ‘lack of organisational skills’
- educational supervisor gives a general picture of a capable individual who has always enjoyed an ‘active social life’
- the doctor says on the evening in question, a friend’s birthday celebration, he only had 4 units of alcohol and the entry on the social networking site was untrue

What should you do now? What further information do you need?

Scenario 2

A 62 year old male GP is reported to have missed their appraisal. The reason you are given is that he was too busy to collect his supporting information and ‘it’s a complete waste of time anyway’

What more do you need to know? What should you do?

Scenario 2 - Investigation Reveals:

Further investigation reveals the doctor:

- Is a single handed GP working in a deprived area, who employs a salaried assistant. The list size is above average
- The practice struggles to meet QOF targets. No complaints or significant event reviews have been reported to the PCT
- The doctor has had appraisals at intervals of approximately 13-16 months meaning he has had 4 appraisals over the last 5 years. The current gap is 15 months, your systems now highlight this as a missed appraisal
- There have been two appraisers in this period who have made brief summaries and agreed annual PDPs

Scenario 2 - Investigation Reveals:

- 1-2 PDP items have been carried forward on each occasion with explanations such as ‘needed more time to complete this item’ and ‘this became a lower priority through the year’.
- Comments about the portfolio include ‘CPD records patchy’, ‘should review how the practice level prescribing information relates to his personal practice’ and ‘more consideration on what to include in the portfolio’
- The doctor defends their statement and describes in vivid terms how busy he is. He adds that he doesn’t feel he needs to do any more appraisals as he is retiring in a couple of years.

What should your plan be now?

Scenario 3

A surgeon has lost his temper with a trainee on a ward round and the senior nurse has asked that something is done to stop this happening as it has been a regular occurrence recently

What action should you take?

Scenario 3 - Investigation Reveals:

Further investigation reveals that the doctor:

- Has a reputation for losing his temper and can react unpredictably
- 2 complaints have been received in the last 2 years from patients and relatives about him being ‘rude’, ‘angry’ and ‘seemed to fly off the handle’
- The complaints were handled by the Head of service and they remember ‘having a word with him’ about it. It seems that no record was kept of any discussion that occurred.
- The Head of service says ‘it’s just the way he is, we know to keep out of his way when he’s in one of those moods’

Scenario 3 - Investigation Reveals:

- Generally his performance is very good with low complication rates and activity data which compares favourably with colleagues
- Appraisers make no mention of this tendency, it is unclear whether the complaints have been discussed
- It is known informally through colleagues that he has recently been divorced
- At a meeting he apologises for his loss of temper but then gives a strong defence of the reasons for it including the lack of attention to detail of the trainee and the number of times he has had to tell this trainee to ensure things are done the right way. The debate becomes heated when he is challenged.

What are your options now?

Scenario 4

A female consultant radiologist recently returned from maternity has lost her temper with a radiographer and the senior radiographer has asked that something is done to stop this happening as it has been a regular occurrence recently

What further information do you need? What should you do now?

Scenario 4 - Investigation Reveals:

Further investigation reveals:

- This is her first baby, she had a short period of maternity leave and there were no apparent complications. She is a private person and not much is known by colleagues about her home life
- Colleagues mention her being more short tempered and appearing tired. She is at work early as has always been her habit and her volume and quality of work do not seem to have suffered
- Her explanation for the episode is that she has been very tired recently. She apologised to the radiographer involved and felt that was an end to the matter.
- She doesn't feel this is a recurrent issue, it was a 'one-off'. She closes the discussion by saying she needs to get back to work

What are your options? What should you do?

Scenario 5

A locum in Accident and Emergency is reported by the nursing staff to have managed several emergency situations in a way which was contrary to agreed protocols. The situations were potentially serious though no patients were harmed as senior medical staff were available and corrected the situation in time. They were concerned that if this continued it would only be a matter of time before a patient was seriously harmed

What action should you take now?

Scenario 5 - Investigation Reveals:

Further investigation reveals:

- The doctor has done a number of weekend night-time locums in the department over the last 6 months. He does regular locums in several departments in the region
- No previous formal concerns have been expressed though some staff say they are ‘surprised he is continuing to be employed by the department as everyone knows’ and he is ‘an accident waiting to happen’
- He is registered with a locum agency which is not on the government’s purchasing framework and his contact address is in the area of a local Area Team

Scenario 5 - Investigation Reveals:

- His records show he was trained as a Consultant in Emergency Medicine in Eastern Europe and is hoping to get onto a training programme in the UK.
- It was not possible to contact him to discuss these issues and someone recalls him saying he was going home for a month or so to see his family
- During one of the situations a Consultant told the locum that there was a protocol for the management of these situations, he said he didn't know there was one and promised to read it

What are your options now? What should you do?

Our Challenges?

- To ensure that the governance remains watertight, given the strain that the system faces
- To ensure that we exploit the potential afforded by the information flows, underpinning revalidation, to the full
- To develop the processes of revalidation on the basis of experience of implementation, without losing any of the integrity of the system



NHS England work programme

- Appraisal – ensuring that appraisals are consistent
- Responsible officer decision-making – setting up and running peer review networks for responsible officers of every discipline, every sector in every part of the country
- Responding to concerns – ensuring standardised processes and thresholds for intervention
- Ensuring that every doctor is included in the system
- Ensuring that responsible officers have the leadership skills they need to drive the culture change for which revalidation could be a major catalyst

What can we share – and learn ?

- What are other countries doing about revalidation/quality assurance of doctors' performance?
- Does anyone have a more targeted approach?
- How do other systems assure patients and the public that their doctors are up to date and fit to practise?
- Do other countries anticipate that a system similar to the UK's medical revalidation will be introduced?
- If so, will it be led by the profession, the regulator, the government – or who?