Revalidation: an evidence-based intervention? (A personal view)

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In 1982, Donald Schön noted that between 1963 and the time of his writing, an increasing public and professional awareness of the flaws and limitations of medical professions had developed. Schön further noted that the professions themselves were suffering from what he termed a crisis of legitimacy, which was rooted in their perceived failure to live up to their own standards with professionals, including doctors, misusing their autonomy for private gain, and a visible failure of professional action.[1]

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Public confidence in the professions in the UK has been similarly undermined in recent years due, in part, to a number of high-profile cases.

In 2000, Dr Harold Shipman was convicted of murdering 15 of his patients over a 20-year period, beginning with his first victim in 1975 and ending with his arrest in 1998. Shipman is believed to have killed up to 250 victims[2].

In 2001, Sir Ian Kennedy reported on his investigation of excess deaths in paediatric cardiac surgery cases in Bristol between 1991 and 1995 and found that between 30 and 35 more children under the age of one, died at the Bristol unit, than would have been expected in a "typical" unit. Professor Kennedy was highly critical of the "club culture" evident in the behaviour of the professionals involved in the care of these children.[3]

In 2013, Sir Robert Francis reported on his investigation into the poor care delivered to patients at the Mid Staffordshire NHS Foundation Trust between 2005 and 2009.[4]

Revalidation

All doctors working in the UK must hold a licence to practise and must participate in revalidation to retain that licence. Revalidation, the process by which the General Medical Council (GMC) confirms the continuation of a doctor's licence, was introduced in December 2012. Revalidation provides assurance to the GMC, the public, employers and the profession that licensed doctors are up-to-date and fit to practise.[5]

In June 2000, the General Medical Council's consultation document *Revalidating doctors: ensuring standards, securing the future*[6] introduced the concept of revalidation for health care professionals in the United Kingdom.

In February 2007, the Government published a White Paper: *Trust, assurance and safety: the regulation of health professionals in the 21st century* setting out proposals for future legislation on revalidation.[7]

In 2010, *The Medical Profession (Responsible Officers) Regulations 2010*[8] introduced the role of the responsible officer under the *Medical Act (1983)*[9].

On 3rd December 2012, *The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012*[10] mandated the implementation of revalidation as a statutory obligation for all employers in the UK.

Revalidation is often equated with appraisal. Although the two are related they are distinct: the annual appraisal process provides much of the evidence used to make a revalidation recommendation, but appraisal itself pre-dated revalidation.

Appraisal

In 1999, the introduction of appraisal for doctors was first mooted in the Department of Health consultation document: *Supporting doctors, protecting patients: A consultation paper on preventing, recognising and dealing with poor clinical performance of doctors in the NHS in England.*[11] The document defined appraisal and differentiated it from assessment:

"Appraisal is a positive process to give someone feedback on their performance, to chart their continuing progress and to identify development needs. It is a forward-looking process essential for the developmental and educational planning needs of an individual. Assessment is the process of measuring progress against defined criteria. For example, trainees may have to meet an agreed standard, as specified by a curriculum, to assure their progression or completion of a course or programme. It's essential purpose is to validate training and development achievement."

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The report proposed that appraisal be made compulsory for doctors working in the NHS.

In 2001, Advanced Letter (MD) 5/01 provided advice and documentation for NHS organisations to support the implementation of appraisal[12].

In 2003, appraisal became a contractual requirement for consultants under the new consultant contract.[13]

The evidence base for revalidation

In 2013, the NHS Revalidation Support Team commissioned the King's Fund to undertake a review of the impact of medical revalidation on the behaviour of doctors and organisational culture[14]. The study was undertaken within seven case study sites across England. The report, published in March 2014, noted that revalidation is a regulatory process which complements clinical governance: each process strengthening the other. The study found that it was still early days for revalidation and that designated bodies, appraisers and appraisees were focusing on implementing the process of revalidation. There was no evidence provided to suggest that revalidation was having any positive impact. This is not surprising as at the time the report was published only medical leaders, responsible officers and 20% of doctors had been revalidated.

In 2016, the GMC commissioned Sir Keith Pearson to undertake an independent review of revalidation over the first cycle[15]. Pearson investigated revalidation across the four countries of the United Kingdom. He met with responsible officers, appraisers, doctors' representatives and system leaders, the Chief Medical Officers, employers and patient representatives. His report was published in January 2017. Pearson noted that revalidation was progressing as expected.

Pearson highlighted that revalidation has already delivered significant benefits by ensuring that annual appraisal was taking place and changing doctors' practise through reflection upon specified types of information. Pearson also highlighted that revalidation had enhanced clinical governance within healthcare organisations by identifying poorly performing doctors and providing support to them to improve.

Pearson expressed confidence that these developments would lead to safer and better care for patients.

Pearson made sixteen recommendations for the GMC, healthcare organisations and their boards, and for the government health departments.

In July 2017, The GMC published its action plan in response to the Pearson report and identified six priority areas[16]:

1. Making revalidation more accessible to patients and the public.
2. Reducing burdens and improving the appraisal experience for doctors.
3. Strengthening assurance where doctors work in multiple locations.
4. Reducing the number of doctors without a connection.
5. Tracking the impact of revalidation.
6. Supporting improved local governance.

In 2014, the GMC commissioned an independent UK wide long-term evaluation of revalidation to explore its impact and consider ways to shape it in the future by a collaboration of researchers, UMbRELLA (UK Medical Revalidation Evaluation coLLAboration), led by Plymouth University. The study was undertaken between 2014 – 2017 and the final report was published in February 2018.[17]

The UMbRELLA study consists of seven work packages, organised by research methods and designed to collect and analyse quantitative and qualitative data across revalidation's component activities.

The completed study involved nine literature reviews, analysis of pseudonymised GMC data relating to 281,000 doctors, 8 surveys with over 85,000 participants, the recording and analysis of 44 appraisals, interviews with 156 doctors and patient representatives and reviews of 24 doctors' portfolios.

The study addressed six research questions:

- Is the GMC's objective of bringing all doctors into a governed system that evaluates their fitness to practise on a regular basis being consistently achieved?
- How is the requirement for all doctors to collect and reflect upon supporting information about their whole practice through appraisal being experienced by revalidation stakeholders?
- Is engagement in revalidation promoting medical professionalism by increasing doctors' awareness and adoption of the principles and values set out in good medical practice?
- Are revalidation mechanisms facilitating the identification and remedy of potential concerns before they become safety issues or fitness to practise referrals?
- How do responsible officers fulfil their statutory function of advising the GMC about doctors' fitness to practise and what support do they have in this role?
- Are patients being effectively and meaningfully engaged in revalidation processes?

There were 28 key findings. One of the report's authors summarised the findings[18]:

- Most doctors have been brought into a governed system, with a rise in engagement in annual appraisal.
- There is a variation in revalidation outcomes and experience of revalidation for some groups of doctors.
- While reflection in appraisal is key for generating change, reflection is often seen as just a product of appraisal, and not necessarily translated into ongoing reflective practice.
- Both doctors' and patients' engagement with patient feedback is inconsistent, and current patient feedback tools require refinement. >>

In April 2018, The GMC responded to the publication of the UMbRELLA report and noted that[19]:

- Most doctors now had a regular appraisal.
- Appraisals were helping to address local concerns.
- Most doctors were collecting the supporting information required for appraisal.
- Some doctors found the process of data collection to be difficult.
- Appraisal was challenging for locum doctors.
- Deferral rates were higher for younger doctors, females and those from BME backgrounds.

In March 2018, in the GMC issued an update to *Guidance on supporting information for appraisal and revalidation.*[20] The GMC stated that there would be no change to the information to be collected and reflected on, but in response to one of Pearson's key recommendations, they would clarify what is mandatory for appraisal and revalidation from the GMC's perspective and how that may differ from any requirements set by employers, royal colleges or faculties.

The GMC's key improvements include:

- More guidance on the balance between the quality and quantity of supporting information needed for appraisal for revalidation so you don't feel pressured to gather too much evidence.
- Explaining that we do not set either a minimum or a maximum quantity of supporting information that you need to collect.
- Emphasising that, although you must participate in a whole practice appraisal every year unless there are mitigating circumstances preventing you from doing so (for example if you were on long term sick or maternity leave), it should be a developmental experience as appraisal and revalidation are not pass or fail exercises.
- More information about how you should collect feedback from colleagues, including how colleagues should be selected.
- Reinforcing the importance of doctors, who have multiple roles, gathering and reflecting on information that covers the whole of their practice.
- A new section to provide clearer guidance on our requirements for doctors in training and more direction for doctors who may find collecting certain aspects of supporting information difficult.

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In May 2018, the GMC published *Revalidation: data from the first five years* which summarised the key statistics about the first five years of revalidation (between December 2012 and 31 March 2018). In total, 258,570 recommendations were made for 198,142 doctors: 96,748 (76%) recommendations were to revalidate; 61,180 (24%) were to defer and 642 (0.2%) were recommendations of non-engagement.[21]

Over the same period, 3,984 doctors had their licences withdrawn for failure to engage with revalidation.

Of the 45,401 doctors who relinquished their licence, only 5% gave revalidation as their reason, in comparison with 61% giving going overseas as the reason for relinquishing their licence.

Of the 18,276 doctors who applied to voluntarily erase their names from the register, only 1% gave revalidation as their reason, in comparison with 62% giving retirement as the reason for relinquishing their licence.

	Total number of recommendations	% Revalidate	% Defer	% Non-engagement
England	221,122	76%	24%	0.3%
Scotland	20,482	78%	22%	0.04%
Northern Ireland	6,658	77%	23%	0.1%
Wales	10,308	81%	19%	0.2%

Table 1: Revalidation recommendations between December 2012 and March 2018 (GMC).

Conclusion

More than a decade has elapsed since the first proposals for revalidation and its implementation. Over that period, there were two major re-organisations of the NHS and significant changes in the regulatory environment. Trying to tease out the impact of revalidation from these other changes that occurred in the same period would be difficult.

The qualitative data published by the GMC provides some evidence for the effectiveness of revalidation. Most doctors (76%) who had a recommendation submitted in the first five years had a positive recommendation. The fact that a proportion of doctors were deferred (24%) and a small number had their licence withdrawn for failure to engage (0.2%) provides evidence that revalidation acts as a filter, although it is not possible to state whether the thresholds are set at the correct levels. These figures would suggest that revalidation has been successful in providing assurance that doctors with a licence are up to date and fit to practise, which was the main intention for introducing it.

In terms of appraisal, the qualitative data from the studies reported suggest that the majority of doctors find the appraisal process to be a valuable one.

It is still early days for revalidation and appraisal, but the indications are that it is having, and will continue to have, a positive benefit on the professional development of individual doctors practising in the UK and on improvements in patient safety.

Getting specific evidence that isolates the impact of revalidation and appraisal from other changes in the organisation and provision of healthcare will continue to be challenging. ■

References

References can be found online at www.boa.ac.uk/publications/JTO