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Revalidation: Lessons and Progress from across the Tasman.

John Kolbe

Outline.



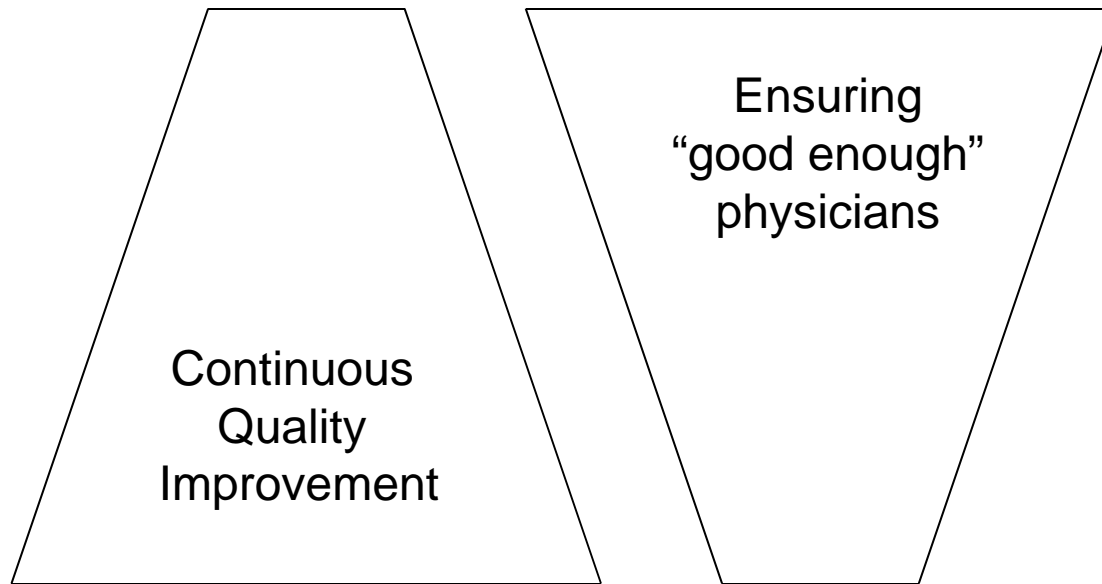
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- Revalidation and CPD
- Rationale for revalidation/ CPD
- Next generation (“strengthened”) CPD for RACP
- NZ initiatives.

Revalidation and CPD.



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Regulator - Revalidation
(Community)

College - CPD

Better Performing Physicians
Safe, Quality Health Care.
Community Accountability and Assurance.

The RACP Approach



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- Focus is on continuous quality improvement in performance
 - “Better” – Atul Gawande
- Not primarily to detect underperformance
- There is not a “problem to be fixed”
- Common recommendations from UK enquiries
 - improvements in leadership
 - a positive culture and **professionalism**
 - **promotion of quality of care**
 - **pro-active structured peer review**

UK community and regulators clearly not satisfied: Revalidation introduced in 2012



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General
Medical
Council

Regulating doctors, ensuring good medical practice

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Revalidation



Revalidation started on 3 December 2012 and we expect to revalidate the majority of licensed doctors in the UK for the first time by March 2016.

Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis 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.

Licensed doctors have to revalidate, usually every five years, by having regular appraisals with their employer that are based on our core guidance for doctors, *Good medical practice*. Patients can help their doctors improve their practice by providing them with regular feedback about the care they have received.

Only doctors who have a [licence to practise](#) will need to revalidate.

Quick links to our guidance

GMP framework for appraisal and revalidation
(PDF, 120.16Kb)

Supporting information for appraisal and revalidation
(PDF, 178.27Kb)

Summary revalidation guidance
(PDF, 103.57Kb)

Meeting our requirements in the first cycle
(PDF, 78.00Kb)

Responsible officer protocol
(PDF, 679.76Kb)

Governance handbook
(PDF, 664.22Kb)

Detrimental effect of an early unsatisfactory experience.



- “What good physicians do”
 - take personal responsibility to be up to date
 - practice safe and high quality medicine
 - undertake continuous quality improvement
 - are accountable!
- Responsibility to the community
 - Core business for Collegesand for physicians
 - “To serve the health of our people” – RACP
 - “Demonstrable professionalism”
 - Set standards, adhere, and “assure performance” (accountability)
 - Address community expectations





Perhaps the culture of accountability that we are relentlessly building for ourselves actually damages trust rather than supporting it. Plants don't flourish when we pull them up too often to check how their roots are growing: political institutional and professional life too may not go well if we constantly uproot them to demonstrate that everything is transparent and trustworthy.

Onera O'Neill

Reith Lecturer 2002

A Natural Evolution within RACP.



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“Once in, good for life”

CME (MOPS)

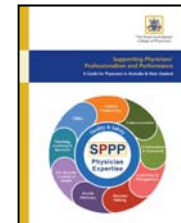
myCPD

Professional Qualities
Curriculum

Tripartite Statement on
Professionalism

SPPP: Supporting Physician
Performance and Professionalism

Other



Next Generation (“strengthened”) CPD
(Enhancing Physician Performance and Professionalism)

Concepts of an “strengthened” CPD/Revalidation Program



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- Emphasises “life-long” learning
- Involves all domains of physician activity
- Supportive/formative
- Evidence-based
- Focus on (self-)reflection
- Reflects current/future professional practice (setting and scope)
- Meaningful (to the physician who derives personal benefit)
- Achievable, without undue “cost”
- Integrates with existing systems and is scalable and sustainable.

Next Generation of RACP CPD.

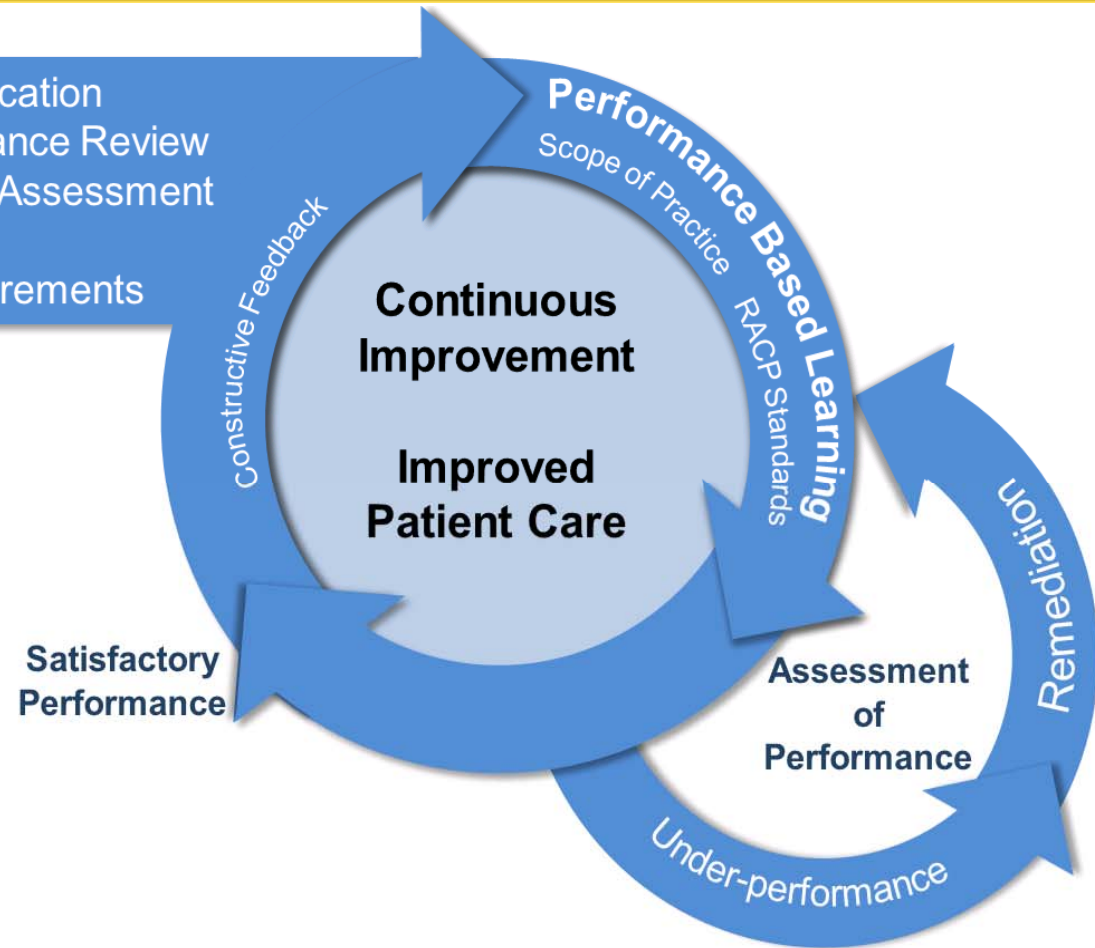


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CPD Portfolio

- Physician Qualification
- Annual Performance Review
- Learning Needs Assessment
- Learning Plan
- Other CPD requirements

- based on professional practice
- involve all domains (of SPPP)
- include components
 - **continuous quality improvement**
 - **appraisal of performance**
 - **provision of feedback**
 - **professional development plan**



Components of an “strengthened” CPD (&Revalidation) Program.



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- Components
 -+ CME + Audit +Appraisal
 - all domains of SPPP
 - continuous quality improvement – irrespective of starting point
 - **appraisal** of performance...by feedback
 - from peers (MSF)
 - from patients
 - (from external reviewers)
 - provision of feedback; crucial component
 - “professional development needs assessment”
 - development of professional development plan
 - engagement in cycles of performance-driven learning.



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Current Activities in New Zealand



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- “What good physicians are already doing”
 - (Multiple) innovators and early adopters
- DHB stock takes ...harmonisation of activity
- Other specialties

- Stakeholder engagement
- Formal trials of MSF and the “framework”
- Informal “trials” of instruments
- RACP Workshops
- Current discussions with MCNZ.

Stakeholder Consensus: Performance Review Framework



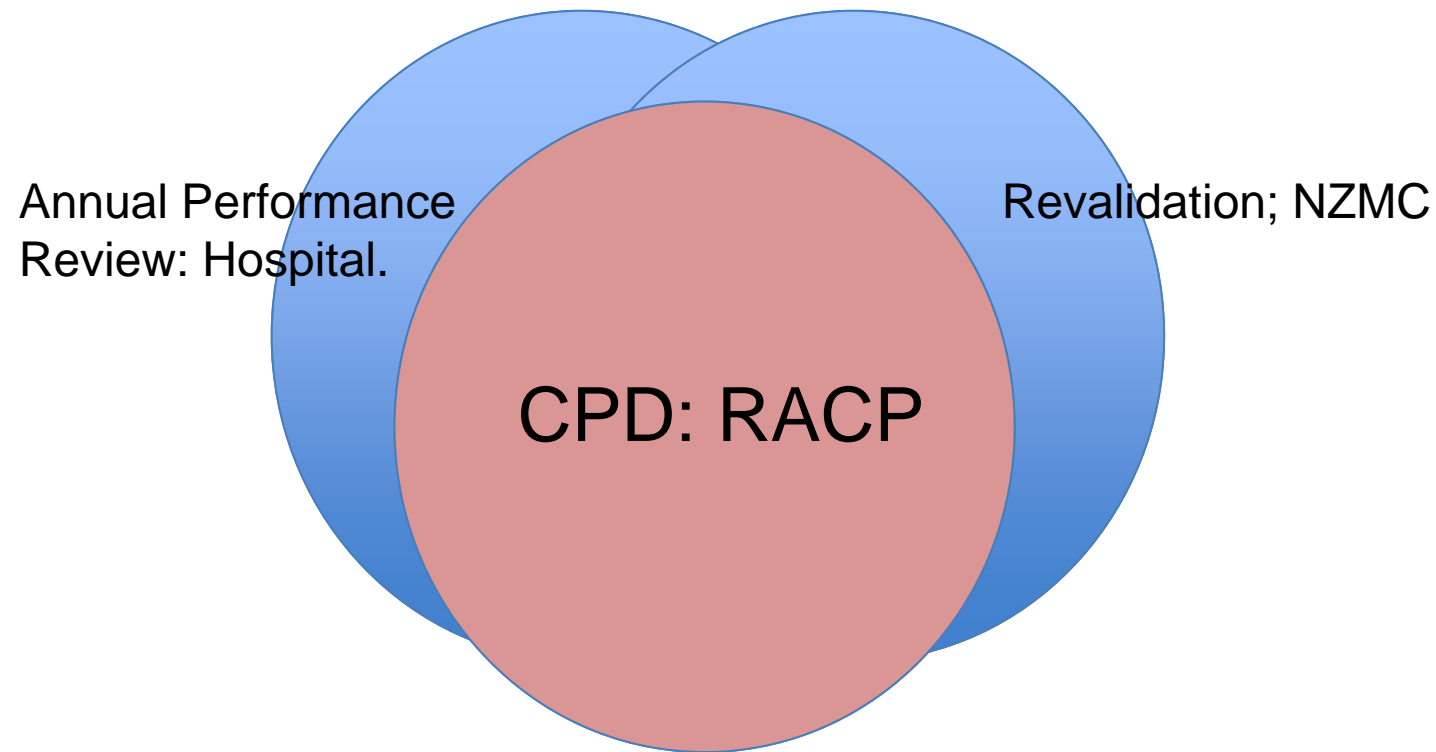
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- Meeting of Stakeholders; RACP, MCNZ, DHB CEOs, Chairs of DHB, Office of H&DC, Health Workforce NZ, National IT committee (and MBA)

“Do it once, do it right”.



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(Advantages > Disadvantages.)

Stakeholder Consensus: Performance Review Framework



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- Meeting of Stakeholders; RACP, MCNZ, DHB CEOs, Chairs of DHB, Office of H&DC, Health Workforce NZ, National IT committee (and MBA)
- Agreed on a collaborative approach; an integrated, efficient, consistent, system-wide approach would serve most of the needs of the parties
- Led by the profession
- Support for generic structure of the proposed process
- Embedded in the workplace
- That RACP should proceed with current plans for “augmented” CPD.



- Meeting with CEOs of “central” DHBs
- Very keen to introduce a standardised performance framework for all SMOs
- Based on RACP framework
- Engagement of CMOs
- Enquiries from other DHBs
- “an idea whose time has come”.

Patient Feedback Questionnaire; a Pilot Study.



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- Modified from RCP Questionnaire
- Generic
- Addresses non-medical expert domains; especially communication, attitudes and behaviour
- Short : 9 questions.
- Pilot Study
 - Good face validity
 - Highly acceptable to patients
 - Administration feasible in out-patient setting
- Unforeseen benefits.

Integrated Performance Framework Pilot.



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- Undertaken in Cardiology Dept, Waitemata DHB (Dr Tony Scott)
- Comprehensive programme; multiple methods and multiple exposures
- Use of externally-sourced MSF; (UK) bench-marked
- Use of experienced “peers” for feed-back

- Employer-based program is feasible and well received
- ?Scalable and sustainable.



- Rationale
 - Evidence that the feedback, and how it is delivered is crucial
 - UK experience of “appraisers”
 - “Evidence-informed Facilitated Feedback” – SAFeR Research Team.
- RACP has developed workshops to up-skill in areas of
 - Provision of feedback
 - Support the reflective process
 - Identification of professional development “needs”
 - Development of professional development plan
- To be trialed in NZ centers; regional and metro



- **Requirement of MCNZ:** “Participation in audit of medical practice (at least one audit per year). This is a systematic critical analysis of the quality of the doctor’s own practice that is used to improve clinical and/or health outcomes, or to confirm that current management is consistent with current available evidence or accepted consensus guidelines.....it involves a cycle of continuous improvement of care, based on explicit and measurable indicators of quality. It has a statistical basis.”
- **Specific expectations unclear**
- **Focus should be on reflection and action, rather than collection**
- **Need effective data collection/IT systems in institutions to support audit**

MCNZ Proposals re External Appraisal



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- MCNZ: “.....feedback from review undertaken by peers external to the doctor’s usual practice setting”
- Range from yearly “structured conversation with designated senior colleague” to Regular Practice Review every 3 years
- Previously proposed but generated opposition
- Activities of other specialties; O&G, Orthopedics
- Issues of;
 - Resources; human and financial
 - Feasibility; availability of reviewers
 - Training of reviewers
 - Standard setting

Final general comments.



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- Nothing new: “I shall in an open and verifiable way...” Hippocratic Oath.
- Culture change...from CME.
- Buy-in; based on factors such as experience with the processes, validity of tools/processes, quality of feedback, perceived benefit etc
- Need for leadership; champions, role models,
 - “The Fish Rots from the Head”, Bob Garrett.
- Focus on the important aspects
 - “Don’t sweat the small stuff”, Richard Carlson.
- “Go low, go slow, but GO.”



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	Yes Definitely	Yes to some extent	Not Really	Definitely Not	Doe- not appl
1. Was the doctor polite and considerate?	100%				
2. Did the doctor give you enough opportunity to ask questions?	91 %	9%			
3. Did the doctor answer all your questions?	94%	5%			1%
4. Did the doctor explain things in a way you could understand?	100%				
5. Are you involved as much as you want to be in the decisions about your care and treatment?	88%	8%			4%
6. Did you have confidence in the doctor?	96%	4%			
7. Did the doctor respect your views?	94%	6%			
8. If the doctor examined you, did he or she respect your privacy and dignity?	94%				6%
9. By the end of the consultation did you feel better able to understand and/or manage your condition?	82%	12%			2%
	Very Easy	Somewhat Easy	Neutral	Difficult	Very Difficu
Was the questionnaire quick and easy to complete?	96%	2%	2%		
Were the questions easy to understand?	92%	6%			
Did the questionnaire address the issues that you consider important in a doctor?	96%	2%	2%		
What is most important to you in the doctor you see in the clinic?					

Example of MSF Questionnaire.



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I have concerns

Below expectations

Meets expectations

Consistently above
expectations

Unable to comment

1. Diagnostic skill.
2. Management of complex clinical problems.
3. Makes well reasoned and consistent clinical decisions.
4. Appropriate use of resources.
5. Conscientious and reliable.
6. Availability for advice and help when needed.
7. Time Management.
8. Commitment to improving quality of service.
9. Keeps up-to-date with knowledge and skills.
10. Contribution to the education and supervision of students and junior colleagues.
11. Spoken English - clear and understandable; no risk of significant misunderstandings by colleagues or patients.
12. Actively listens and answers questions, appropriately and succinctly.
13. Written records are clear, legible and appropriate.
14. Is polite, considerate and respectful to patients; shows respect for patients' opinions, privacy, dignity and confidentiality.
15. Compassion and empathy towards patients and their relatives.
16. Is polite, considerate and respectful to Colleagues of all levels; encourages their input/opinions.
17. Values the skills and contributions of multi-disciplinary team members.
18. Respectful of different views and responds in a non defensive way when others disagree with his/her views.
19. Praises and constructively guides colleagues appropriately.
20. Easy to approach to discuss any problems.
21. Facilitates development of good working relationships with other members of the team engendering cooperation rather than competition.
22. Takes the leadership role when circumstances require.
23. Delegates appropriately.

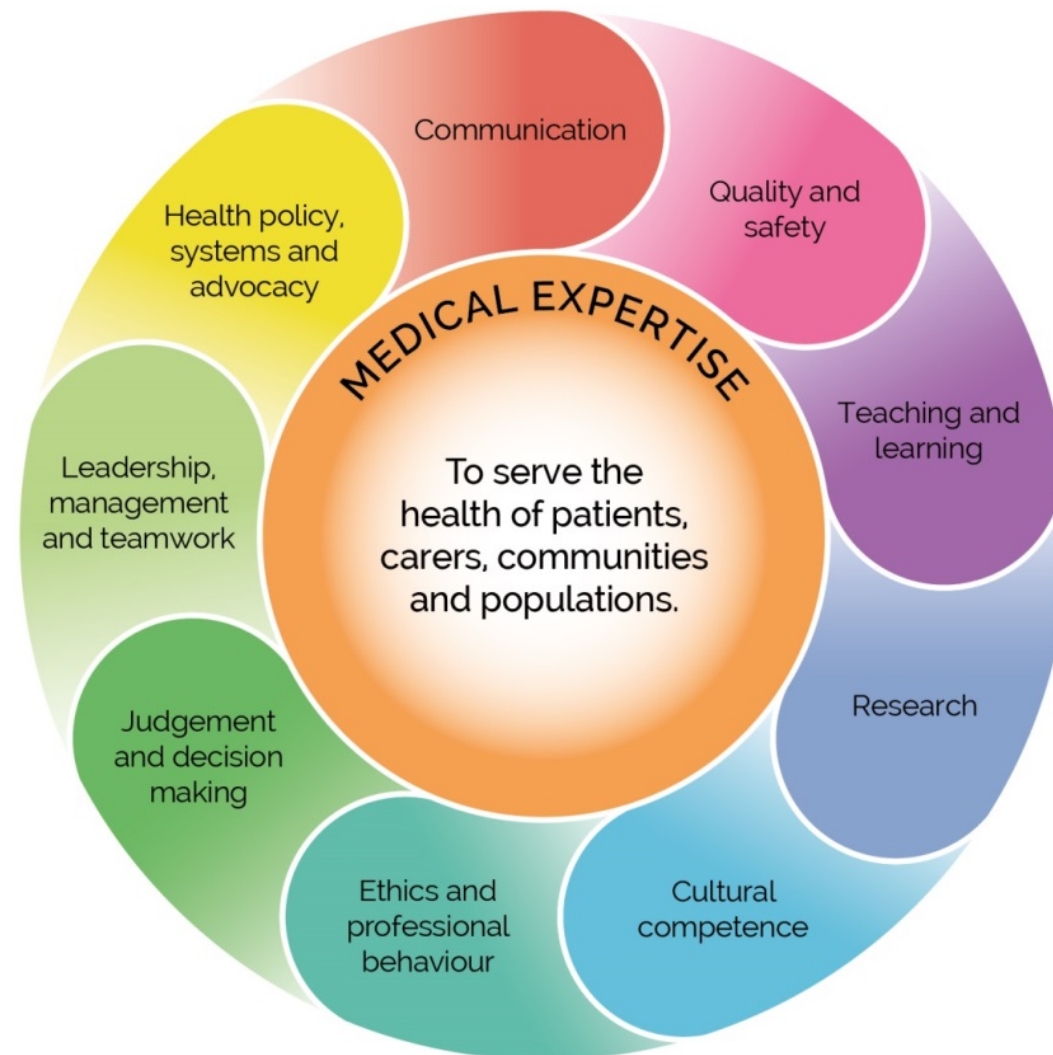
Do you have any concerns about the Probity or Health (physical or mental) of this doctor that may impact on patient care?

SPPP: Supporting Physicians' Professionalism and Performance.



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“Demonstrable professionalism”



Remediation.



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- Need a plan to address this issue ! – 5% “just good enough”
- Needs to be
 - anticipatory and “preventive”
 - non-punitive
 - individualised
 - educational
 - aimed at returning doctor to full practice ASAP
- But.....
 - Time-consuming
 - Who sets “consistent” standards?
 - Who designs the program? Scalability of current processes
 - What does the interaction between the DHB, College and MCNZ look like?
 - Who “signs off”?and on what?

A Natural Evolution within RACP.



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Enhancing Physician Performance and Professionalism

Roles of the College(s).



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- Core business for Colleges
 - “To serve the health of our people” – RACP
 - improved, affordable health outcomes for patients and communities
- Setting of standards
- “What good physicians do”
- Natural evolution
- “Demonstrable professionalism” to meet community expectations
- “Assuring performance” – standard setting and appraising performance including input of colleagues (and patients)
- Remediation of under-performance



- Begins process towards next generation of CPD
- Allows the “road testing” of “new” CPD components
- Engagement of (the remaining) Fellows (and other stakeholders) in a “cultural change”; continuous quality improvement, (various) forms of appraisals, feed-back etc.
- College seen to “value add” in a practical manner on important issues



- **Overall improved, affordable health outcomes for patients and communities**
- **Enhanced professionalism of all physicians**
- **Enhanced performance of all physicians**
- CPD meets needs of physicians and emphasizes continuous quality improvement, appraisals, feed-back etc.
- College role in setting of standards is enhanced
- College reputation is enhanced and its role is secure.
- Profession retains degree of self-regulation
- College produces “great clinical leaders” (3rd generation CME/CPD)



- Single Process
 - “**Do it once and do it right**”
 - Similar objectives
 - Efficiency
 - Integration with professional activities
 - Disadvantagesbut outweighed by advantages
- Resource allocation
- Whole of system approach; all health professionals – managers and clinicians
- Remediation
 - of the “just good enough”

Revalidation & CPD; What's in a name?



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....all areas of professional practice....

.....fit to practise....

..remain up to date..

...new knowledge, skills and behaviors...

...scope of practice...

..in accordance with standards...

remediation of poor practice.....

....quality improvement....

...assessment of an individual...

...maintain and improve performance...

....keep up to date and competent...

...address areas requiring improvement...

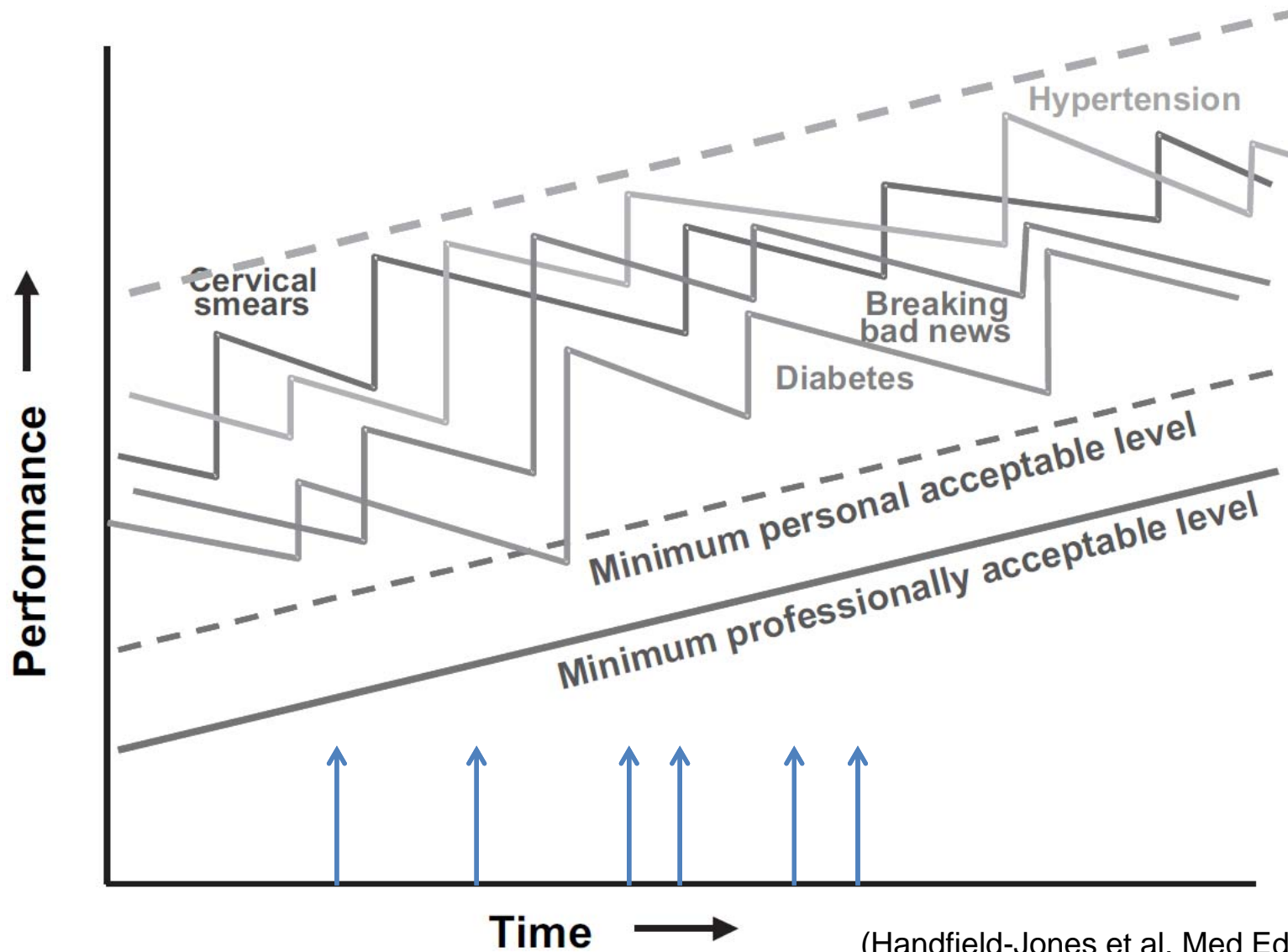
.....response to need...

Role of the College in “the Process”



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- Standard Setting
- Provision of a framework for CPD
- Provision of educational resource
- Engage and support Fellowship
- Establish collaborative partnerships
- Develop framework to address under-performance
- Avoid quasi-regulatory role
- Monitoring and evaluation



(Handfield-Jones et al. Med Ed 2002; 36: 949-58.)



Early

- Begins process towards next generation of CPD
- Engagement of Fellows in the “cultural change” to continuous quality improvement, (various) forms of appraisals, feed-back etc.
- College seen to “value add” in a practical manner on important issues
- Able to “road test” important components of next generation of CPD

Late

- meets needs of physicians and emphasizes continuous quality improvement, appraisals, feed-back etc.
- Enhanced “professionalism” of all physicians
- Enhanced performance of all physicians
- College role in setting of standards for physicians is enhanced
- College reputation is enhanced and role is secure. Profession retains degree of self-regulation
- College produces “great clinical leaders” (3rd generation CME/CPD)