Preamble

The GMC and NHS have recognised the scale and challenges ahead in developing an effective National Standards quality assurance framework for revalidation, which will ensure that doctors are fit to practice and patients and the public are protected.

The NHS Revalidation Support Team (RST) have designed a 2-stage Organisational Readiness Self-Assessment Tool (ORST) - Report 2010-2011 to help designated bodies in England to develop their systems and processes in preparation for the implementation of revalidation and to inform the Secretary of State’s decision regarding the commencement of revalidation (late 2012).

However, whilst there has clearly been a considerable amount of work and effort put into the ORST self-assessment exercise, administrative functions and progress made in clinical governance and appraisals there are still many gaps in aspiring to a National framework of quality assurance, and in how these existing arrangements and a doctor’s working practice are going to be effectively and efficiently incorporated into these standard quality systems.

If the program of revalidation is to be successful and achieve its desired outcomes and gain the confidence of both the public and profession, it will be vital that organisations and clinical/local governance are provided with the necessary support mechanisms and in helping them better understand and implement these quality systems dynamics.

The leadership and management of any quality assurance system against (robust) national standards and codes of practices can and may present for many organisations a very complex and daunting prospect, this may be indicative of the apparent current difficulty and trepidation in grasping the meaning or realise the real benefits and rewards.

The aim of any research evidence base must be to complement the current foundations and progress of revalidation and strengthen the smooth transition towards achieving future effective quality systems of clinical governance which will be vital in improving the quality of patient care.

Statement of Intent

The intention of what follows is the result of a series of independent critical analysis into the GMC’s proposed system of revalidation. The first in this sequence of assessments begins with the NHS Revalidation Support Team Organisational Readiness Self-Assessment Tool (ORST) - Report 2010-2011.

It should be noted that the GMC’s programme of revalidation, or appraisal made pursuant to the medical profession (responsible officer) regulations 2010, and the GMC’s (licence to practise and revalidation) regulations order of council 2012 is quite unusual and in contrast to the current National Standards quality assurance framework for learning and development, the benchmark for this study of preliminary findings.

For any organisation embarking on such as the programme of revalidation of doctors to deliver high quality service and that meets the needs of consumers, learners, educational and training providers and employers is a considerable task, this undertaking by the NHS and GMC, enormous.

In the national sphere of education and learning and development regulatory authorities are responsible for criteria and codes of practice for accredited bodies to ensure compliance and good practice of quality assurance systems.
The first step towards establishing these internal and external functions is to recognize roles and responsibilities, however the NHS and GMC’s protocol and in the case of an integrated quality assurance policy or framework is currently scant and vague; the collaboration between the Royal Colleges, NHS (and human resources), NHS Revalidation Support Team (RST) and GMC has proved especially difficult to comprehend.

In the absence of more clearly defined structures it will likely become increasingly more problematic to identify and minimise risk or to effectively measure whether efficient and robust quality assurance systems are in place, either at NHS designated bodies or at local governance level.

As a consequence appropriate and early measures will need to be taken to address any shortcomings of TQM (total quality management) elements, which if successfully implemented will be crucial for the concentration of and eradication of waste and inefficiency, but in due and productive process interacts favourably with the ethics and principles of national and occupational standards of learning and development.

On first inspection of the NHS RST’s organisational readiness self-assessment tool there is cloudiness and misunderstanding in the relationship between the appraisal interview (cause and effect) and conventionally initial diagnosis, formal > summative assessment, the latter in judging evidence, performance, knowledge, understanding and measuring competence in a workaday or vocational setting.

The differentiation between these two components needs to be crystallised so as to get a clearer and wider sense of direction in the revalidation process.

The Responsible Officer (RO) role and its responsibilities is weakly opaque, but in any episode this position cannot (assumingly) effectively or ethically undertake both internal and external quality assurance functions.

The RO’s role will be at the ‘heart’ of the system of revalidation and central to the success of this operation, but somewhat surprisingly given this high level of significance there appears currently little clarity attached to this innermost factor, or in any visible linkage between this role and appraisers/managerial and trainer’s skills.

This will now necessitate the system of revalidation outlining more lucidly if and how the RO will go about interacting with and supporting and developing the appraisal interviewers and trainers both at NHS designated and local governance level.

In returning to grassroots the system of revalidation appears to be largely inflated with boards, committees, other group memberships and functionaries, this along with the NHS RST’s administrative function currently leaving a lack of rigour or indecisive crater in the key quality assurance and internal mechanism at local governance level.

With no immediate suggestion of how in particular these professional and board functions are going to be holistically or practically integrated into revalidation or learning and development there is an ongoing risk of disintegration, hence cost and operation inefficiency.

Within the medical profession, Royal Colleges, NHS and clinical research there seems an ocean and bewildering dispersal of information which could be more substantially fed into the revalidation system, this breakdown or in making better utilisation of feedback moreover is a waste and ineffective use of taxpayer’s money and in valuable, scarce and ultimately healthcare, and revalidation resources.

Subsequently there needs to be shown much greater and closer collaboration within the medical profession and implementation of revalidation, as well as the engagement of patients and consumers of public (and private partnership) healthcare services. In this parliament and allied to health and social care reforms at present gives the impression of remoteness.

As has been signalled earlier the programme of revalidation displays no clear qualifications, attributes strategy or framework for the roles of e.g. medical teachers, trainers, instructors,
assessors or appraisal interviewers or this approach concisely outlined in quality assurance policy.

Until these important ground rules are determined it will not be easy to give confidence to the public (or medical profession) how Responsible Officers will be able to fulfil their statutory obligations in making safe and fair recommendations as to a doctor’s fitness to practice.

The NHS is under severe strain and growing threat. And in this like-for-like financial sustainability the GMC, its statutory function, and revalidation is a critical link to the maintaining and future of this public health and social service.

These vital links will call for strong leadership and cream of talent to confront this major threat to the public’s well-being and to prevent social inequalities in healthcare services.

However, in order to gain the public’s confidence and in preparing to move forward with this huge responsibility and undertaking that is revalidation the GMC must first establish whether they are a campaigner for doctors, a representative for the medical profession or more importantly a protector and defender of the public. This current distinction between these two but conflicting roles is momentarily blurred and has steadily become vague.

The current scale of the problem with the NHS, as is ultimately always the case a question of money and lies with financial soundability; but so too in discovering why so many hospitals are failing or underperforming and in delivering quality of care. For this inevitably the focus must switch to the skills and competence of the workforce, hence operational efficiency - performance analysis.

In glancing across the GMC’s ‘state of medical education and practice in the UK’ and especially in these hard times it might also take into account whether the many diverse medical and academic institutions concerned in learning and development, and if these publicly-funded institutions are performing efficiently in the direct provision of healthcare at ground level, or if these various establishments merit better fiscal integration into a single national quality assurance framework of education and training.

So then how best can the NHS RST or GMC identify and prioritise areas for development towards assessment for revalidation?

In carrying out this crucial function of initial assessment this is inadequately defined, but in the current ambience of healthcare triggers significant and overlapping factors. Namely there currently appears no stated or comprehensive policy on how and in this proposal it is going to ensure fair access to revalidation for doctors or those with special needs.

As has been indicated the NHS/GMC’s and parliamentary programme of revalidation (or appraisal) is not conventionally administered and so with no nationally accredited standards benchmark or external scrutiny leaves the NHS, GMC (taxpayer and limited health resources) vulnerable to legal action and when it comes to the determination or disagreement of a doctors’ fitness to practice.

Such lack of quality rigor also highlights three more crucial and relevant issues.

One, medicines errors account for, if not a highest contributor in clinical negligence and fatalities, medicines prescribing also. Many errors and in hospital settings have come about by simple misinterpretation of words, or letters. Typically it is not specifically documented how a doctor with a learning disability, or say dyslexia will be fairly managed or this situation safely dealt with in protecting the public.

Two, it is generally accepted that bullying takes place in medicine and of junior doctors. How this situation would be approached and given now at a time of high expectations in care and with little margin for error is not immediately evident or in terms of fair access to revalidation.
Three, what has been described at this point may often permeate from similar behaviour in childhood or adolescence as well as by abuse of power by peers or at medical school, which in turn has a tendency to manifest itself into the behavioural disruptive physician.

In depth global studies have shown both the very real risk that can be posed to patients as well as the financial impact borne because of adverse incidents, outbursts and conflict within medical teams. Appropriate documentation, code of conduct or for those unfairly disadvantaged is not apparent in revalidation policy.

Either way this situation may be a sign of much earlier and more stringent diagnostic screening of potential problems at the start of a doctor’s career, consequently helping alleviate end-loaded revalidation and remediation, the upshot of which both adds to already expensive healthcare costs, more on medical schools and revalidation later.

Moving towards the implementation phase of revalidation identifies some immediate gaps and in how the individual designated NHS bodies, local governance and GMC will be supported and throughout the revalidation approval stage.

In addition to this demonstrating by policy and criteria how a designated body or organisation would have had to have met compliance and in the event of this not happening a tariff of sanctions issued.

At this particular conjecture in the RST’s revalidation readiness apparatus the administration function and the internal quality assurance function at designated and local level is becoming muddled and this between the senior/management function of the GMC and the RO. These three overarching responsibilities and functions could be more simply and easier defined.

A further factor observed is the lack of detail or in mitigating risk, namely how internal quality assurance assessment processes, at local level are conducted, both at operational level and at implementation phase.

The changing role of medicine, healthcare, society, consumer attitudes and global economy will rouse the need to reassess the way clinical performance, expertise and technical skills are measured.

Where this shift in emphasis may compound on revalidation and in the appointment of responsible officers is considered.

Really, the first serious concept of revalidation came to life around 2000 under the Labour government and has continued for two years under the coalition government. This exceptionally slow pace of reform however has meant that throughout this long passage of time there have undergone major challenges for the global agenda, an international economic crisis and domestically unarguably the biggest reform of the NHS (or health service) since its creation in 1948.

To add to these tremendous challenges that lie ahead consumer expectation is at the top of this world agenda, where in a recent global poll (excluding the UK) peaked quality and price and this factor being by far the most important consideration when buying a product, with, and during production, the ethical value of the producer, its impact on human well-being and the environment, strikingly and distinctly below (World Economic Forum).

These worldwide demographical changes, economic pressures, healthcare reforms and controlling costs is likely to have significant implications for postgraduate, surgical and medical education - societal change prompting a well-timed evaluation and cultural shift in the way e.g. that learning is taught, where, for how long - who should pay?

The main logic is that medical education (and manpower) will have to be more clearly defined, better all-round, relevant, meaningful and auditable measures of clinical outcomes to increase, and as surgical and medical education becomes shorter, and less funded.
Drawing on the views, both within the medical profession and distinguished academic and educational research are given thought provoking suggestions in effectively and efficiently assessing professional performance and in resource, and quality management.

In synthesising revalidation the search for solutions for learning and development in a volatile and world economic crisis has taken on a cosmopolitan analysis. In health, medicine and welfare how other countries are facing the same problems as the UK and in pooling whereabouts and ideas for developing and raising educational standards, quality assurance and healthcare outcomes.

Applying longitudinal, historical and contemporary studies attempts to establish the future impact on medical education is conceptualised and with traditional values, technological advances, societal change and post modernity.

The system of revalidation identifies two fundamental questions, the interrelationship between the appraisal (interview (360°) and competence-based model, where in both mechanisms there displays little, if any clear policy as to how performance and learning outcomes will be measured, likewise the skills, expertise and aptitude of e.g. responsible officers, appraisers, teachers, trainers, assessors, or this hierarchy and in the support and development of both matrix markedly opaque, and absent.

In addition to this there appears vagueness, and lack of knowledge within the medical profession itself over the range of appraisal mechanisms that will be applied and in determining fitness to practice and re-certification. The application of ‘portfolio-based performance’ appraisal ‘within medicine’ is a ‘grey area’ and it critical that this is more clearly defined in policy.

The implementing phase of revalidation has displayed insufficient indication of risk assessment having been undertaken, either by case study or piloting - implementation of local governance TQM mechanisms imprecise, in the advancement of revalidation the involvement and consultation with patients and the public has been conspicuously lacking.

Many countries, e.g. Canada, Singapore, Japan, British Columbia and the US are building on progress, and national initiatives for strengthening public health and health service programs within university education and medical deaneries - this ethos of bringing together of the country, students, practitioners and patients is seen as fundamental in achieving greater cohesion and for improving community, social structures and health. Though it must be said that from the history of our own NHS patients, and society have not always been best served by the aloofness and decision making of medical dean(eries) and ‘bioethicists’ - what are ‘bioethicists’?

The firmly embedding of these structures and principles into the medical curriculum, CPD and with a strong research base in this area of development and expertise is becoming very much an integrated and direct team-based part of medical learning and development, and culture - putting inter-professionalism and education into practice to enhance health and social care and the lives of patients, families and community.

“The social understanding of science considers obtaining a PhD as the end of the reading and research process. The degree rather than the research record is what determines an individual’s status, both outside and inside the university.” (Al-Husban, 2008).

“While the scale and range of social science research in the country (India) have been expanding, the nature, scope and quality of research output, as well as its contribution to a better understanding of socio-economic processes and shaping public policy is widely perceived to have fallen short of expectations and also not commensurate with the resources spent on them”. (ICSSR Report, 2007).

Real benefits have been and are being garnished by giving the patient a more potent voice and in the development of medical education programs which is greatly espoused as a prerequisite for this success, and for linking this epithet across all healthcare disciplines and to people living with e.g. cancer, diabetes, epilepsy, arthritis and mental health. Getting to
learn the ‘whole story’ behind the illness and ‘stereotypical’ patient, by continual quality improvement joining up this amalgamation of knowledge and experience into clinical settings.

Building on these foundations and success stories these initiatives are being formed into National Quality Forums, such as those encouraged by the US, and by Government sponsorship handing over the ownership to main (public) membership or committees to set priorities and to evaluate an ever-evolving quality measurement of health and social care.

Working alongside a wide variety of stakeholders, consumer organisations, public and private purchasers of healthcare, physicians, nurses, hospitals, supporting industries, health and scientific research, patients and patient groups craft together cross-cutting solutions to drive up continual efficiency and quality improvement.

From this diverse breadth and depth of expertise this roadmap for quality improvement is reported directly to the public and main committee(s) - the vision - joining in and reaching out to all people to promote the ideals of public health, including compassion and social justice.

These types of local symposia wholeheartedly embracing the sterling work of UNESCO, of socio and scientific culture and with the co-ordination of knowledge responding to global and environmental challenges.

Although these are major steps forward in realising human capital there emerges new homespun enlightenment and exploring education in clinical and surgical practice.

This human capital is becoming universally accepted as being the main driver in confronting and overcoming the challenges of the 21st Century and these tests of today and tomorrow, but moreover in this perspective, innovation and inspirations coming from the heart of governments - being open and communicative to people.

For some years now countries across the world have been preparing for changes of the future, as challenges grow more complex, what disciplines and skills will be needed, how big is the question?

What is for sure is that because many problems are so complex, the only way to solve these problems is by working collaboratively, and so sharing a common understanding. “A problem aired is a problem shared.”

Healthcare, and medicine over the centuries has held a unique and autonomous place in society but like other professions and businesses it now has to discover how to deal with unexpected situations, rapid pace of change and in bringing about best possible solutions to help instil confidence, trustworthiness and pride in the profession, while at the same time recognising people as people.

Today there is ever greater cultural transformation and diversity in public health services, how this is being more successfully and internationally implemented and integrated in medical education is briefly considered.

Critical appraisal, evidence-based medicine and epidemiology is already happening but by greater collaboration of patients and families and introducing their engagement of this exercise much earlier into medical education, post graduate studies and learning and development can result in all-round and real benefits in public health and practice.

As complexities grow so more fields of medicine will stress the need for these specialities to be signposted to medical curricular.

The embedding of human capital in medical education and healthcare has found to be particularly effective, and therapeutic for patients in areas like schools of medicine and health science; clinical skills and data management, research and trials in practice; health trends; market dynamics; humanising medicine; healthcare innovation; clinical studies; pharmacy; tort; transforming the nation’s health and workforce development.
The Future of Medical Education

Appropriately the future of medical education leads off with the official announcement of revalidation lift-off by the Health Secretary, Jeremy Hunt, 19th October 2012.

Revalidation since its inception has been shrouded with controversy and criticism, but most notably for the lack of patient and public voice afforded during its long passage of implementation – in likeness to panic-driven legislation a potential recipe for catastrophe.

The parliamentary Health Select Committee, both in its legislative duty mediocre and displaying a distinct presence of aloofness in the 21st Century, and medicine. At a considerable cost to the taxpayer for instance legislative pilots, and risk assessment kept conspicuously absent from the public domain.

Looking back over the 62-year history of the NHS the almost monolithic dominance, and persuasiveness of this ‘social ideology’ by the medical profession, government and ‘free-riders’ of this publicly-funded service has been seen to be a main contributor towards it’s threat, and steady decline.

This situation also typically remonstrates one of many questions being asked of the future regulation of law, private law and regulation in the new millennia. In this convolution and ambiguity it is likely to further merge and fuel lobby from support of medical negligence, but moreover this in the previous form of the GMC’s fitness to practice decision making process, and public confidence in their ‘ultimate determination’ of a doctor’s ‘competence’ to practice.

Had the RCS (Royal College of Surgeons) not been so complacent and taken the opportunity in the early days to carry out quality system audits today’s picture may have been very different. Likewise had the medical profession been more open and transparent in its function of some 150 years ago the GMC may not have needed to be formed, but instead them and the Royal Colleges, all-round better self-regulating themselves.

But as a country we are where we are and in health terms have to look to the best way ahead for the economy and society and based on the most favourable research and evidence available.

Logically revalidation performance appraisal and CPD programme may have proven more cost effective, less complex and fragmented if a doctor’s employer fully conducted this process or/and with their human resources department, and especially given the nature and ‘flexibility’ of the Good Medical Practice values and principles.

Revalidation appears to fall somewhat short of what would normally be nationally acceptable and in offering a wide breadth of assessment for determining surgical competency and vocational standards - CPD, or as a standalone tool generally tends not to get thoroughly evaluated nor it emphasised why this is fundamental in learning and development.

Measuring surgical competency in medicine outside of the profession is not understandably always readily and fully understood. The reason why there is such an absence of documentation though in revalidation policy for this purpose is because it may simply not exist, or rather by this mechanism for testing surgical proficiency and/or dexterity, both physical and mental.

Even by its own admittance the medical profession’s assessment for determining surgical judgment is not easy to explain, other than this body of skill and knowledge is gained by years of practice and observational practice.

Given that this body of skill and knowledge is gained over many years it may not sit comfortably or within a rigid 5-year revalidation cycle, and it more suited to experiential, community and a multidisciplinary team environment.

Abstract Updated 20 October 2012
What comes across as also uppermost in the newly published report into the tragic consequences of the Mid-Staffs healthcare scandal is the inducement, and evident cataclysmical failure in evidence based medicine. Evidence based medicine is constantly at the centre point of healthcare and quality of care - it is both subject to much contention as it is professionally accepted as the best available method of clinical decision making.

However, science, both in society and medicine is moving forward, but at a basic level of surgical management it must also be critically examined as to the front line value, or in value of life of evidence based medicine and if this support line is not made available to junior doctors at crucial point of diagnosis, as was overwhelmingly evident at Stafford.

Throughout this paper a re-examination has been carried out into the route of revalidation and in the perspective of other high profile healthcare tragedies. These earlier studies and datasets contrast with the present implementation of revalidation, the two strands evaluating the current healthcare environment, medical education and quality assurance.

As the debate continues on evidence based medicine a brief outline is considered on this team-based approach in medical practice and also how this may work, or is working in the GMC’s programme of revalidation, healthcare and the doctor-patient relationship.

Of course the problem with the scientific and journalistic approach of evidence based medicine is that ........

7th February 2013
About Us

Solu'te Macadamia have a long tradition and passion of delivering a wide range of community skills in higher education, training and development.

Our history and alliance of achievement are drawn from nationally recognised, accredited qualifications and competences within the areas of teaching in adult education, commercial and public sectors and training and development, as follows:

- teaching of adult students, including a-level students
- examinations approved moderation and examinations marking in Oxford and Cambridge accredited qualifications
- qualified and in the practised delivery of vocational and educational assessment and internal verification and quality assurance and management processes
- experienced lecturing and in the practised and accredited criteria of key skills
- across curriculum, including skills mapping of science and health syllabus and other programme of study
- qualified mentoring and monitoring of learners progress in the workplace
- consultation in skills analysis and adults returning to learn

Added Factor

Our specific generic teacher training qualified status allows this specialism to be mapped in the mandatory units of the new portfolio of FE (further education) teacher training qualification; these units that have been met in full are given as follows:

- (P&EL) Planning and enabling learning
- (P&PA) Principles and practice of assessment
- (EL&A) Enabling learning and assessment
- (T&PP&EL) Theories and principles of planning and enabling learning
- (CP&PD) Continuing personal and professional development
- (CDIP) Curriculum development for inclusive practice
- (WPP) Wider professional practice
- (PTLLS) Preparing to teach in the lifelong learning sector
- (CTLLS) Certificate in teaching in the lifelong learning sector

As part of The World Skills London 2011 we have recently attained recognition of the Qualified Teacher Framework (QTF) and can establish Licensed Practitioner Status.

In addition to this accolade we are also entitled to claim additional recognition of FENTO Standards, which endorse and approve qualifications for further education, post-compulsory learning and skills sector.

We can also establish recognition against this basis agreed by the Department for Innovation, Universities and Skills.

As part of our ongoing commitment towards our own continual professional development we are currently undertaking research into the proposed system of revalidation for healthcare professionals.