STRIVING FOR CONTINUING COMPETENCE
Participants

- Grady Barnhill – Sr. Assessment Advisor, National Commission on Certification of Physician Assistants
- Kym Ayscough – Executive Director, Regulatory Operations, Australian Health Practitioner Regulation Agency
- Niall Dickson – Registrar, United Kingdom General Medical Council
- Sean McKinley – Chief Executive/Registrar, New Zealand Social Workers Board
CC
Tree-nalogy
Foundational Elements
Structural Elements
Branches or Options

- Patient Questionnaires
- Peer Evaluations
- Certifications
- Lectures
- Online Courses
- Badges
- Continuing Education
- Practice Im.
- Self-Assessment
- Mentoring
- Rounds
Program Design: Consider Practitioner Types
What are the barriers to meaningful Continuing Competence?

• Public Apathy/Ignorance- “I thought you were already doing that...”

• Anti-regulatory – “Do more with less”

• Professional Pushback – “You’re just a cash cow. You’re not up-to-date – I’m a specialist”
Effective Continuing Competence in 3 Easy Steps:

• Find and publicize a “Black Bart” practitioner

• Trust but verify (using new tools) - Help the Public by helping the practitioner

• Make it mandatory
Program Considerations...

• Is the program individualized for the practitioner or is it of the “one size fits all” type?

• Does the program take into account progression from entry-level to beyond entry-level practice?
Program Considerations...

• Does the program accommodate specialization?

• How do Politics/Publicity/Purses affect your program?
So as we roll into the future...
Future Assessment Modalities (i-Human – Virtual SPs)
USC – Standard Patient Hospital (communications)
ANZASW
Historical
1964 onwards
Mix of Unqualified and Qualified

Social Workers Registration Act
2003

Contracted ANZASW and Te Ara Aramatawai

TAA drop out SWRB enters

Future: Competent until Competence Questioned.
Still requirement for CPD and Critical Reflection

Still ‘Incompetent’ until proven ‘Competent’

Move from 10 Core Competence Assessment to Structured CPD and Critical Reflection

Face to Face changed to Paper-based. Included Graduate Competence
Striving for Continuing Competence: Revalidation in the UK
CLEAR Fourth International Congress

Niall Dickson
Chief Executive and Registrar
Chair International Association of Medical Authorities
Friday 26th June 2015

Working with doctors Working for patients
A safety critical industry?

- Institute of Medicine in the US estimates that Healthcare is 10 years behind other safety critical industries (2000)
- Errors difficult to detect
- Poor history of reporting serious incidents
- High levels of litigation – individuals and institutions defensive
- Poor history of reporting incompetent colleagues
- Blame culture
- Management focus on volume
- High levels of trust among consumers but major asymmetry in knowledge and understanding
Managing risk - citizens expect regulators to be:

**Vigilant** - spot emerging threats early and act before much harm is done

**Nimble** - flexible enough to organise quickly and appropriately to emerging risk, rather than being locked into patterns of practice linked to former risks

**Skilful** - masters of the intervention toolkit, adept at creating new approaches when existing methods are irrelevant or insufficient

1. The Sabotage of Harms: An Emerging Art Form for Public Managers
   Professor Malcolm K. Sparrow  John F. Kennedy School of Government  Harvard University
Risk based regulation in a high risk profession

- Doctors have a greater capacity to do good
- But their capacity to do harm is greater than ever
- Patient expectations are greater than ever and appetite/tolerance for poor experience and harm lower
- Media and political appetite for risk and failure feels lower than ever...“something must be done”
- Era of “zero harm”? False expectation?

‘Medicine used to be simple, ineffective and relatively safe. It is now complex, effective and potentially dangerous’

Lancet 1999

SIR CYRIL CHANTLER
Julia Fullerton Batten
National Portrait Gallery 2006
Revalidation has three clear aims

- Bring all doctors into a governed system – specialist doctors, locums
- Help to identify problems earlier
- Encourage self reflection

How does Revalidation drive improvement?
Medical Revalidation – background

- Medical revalidation introduced December 2012 (1)
- Revalidation is a statutory requirement that builds on:
  - development of clinical governance since 1998
  - introduction of annual appraisals for consultants + GPs in 2001-02
  - Responsible Officer introduced in 2011.
- All doctors licensed to practise in the UK are required to demonstrate every 5 years that they are up-to-date and fit to practise
- Regular participation in medical appraisal and Responsible Officers making revalidation recommendations to the GMC

1 GMC: The Early Benefits and Impact of Medical Revalidation: Report on research findings in year one
Revalidation – the process

- Each year

- Doctor
  - Appraiser
  - Cycle of appraisal & review

- Responsible Officer
- Revalidation recommendation

- General Medical Council
- Revalidation decision

Each 5 years
Where are we now? The numbers

- Doctors subject to revalidation in the UK: 225,420
- Recommendations received by the GMC: 126,585
- Number of doctors revalidated: 100,027
- Number of deferrals: 22,234

GMC figures, as at 19 May 2015
Engaged doctors leads to greater patient safety

In England

GP appraisal rates have increased from 79% (2011) to 92% (2014).

Consultant rates have increased from 64% to 86%.

GMC Perceptions Study and Revalidation 2014 (1)

- More than 2700 doctors asked about their experiences of revalidation
- Of the more than 800 respondents who had been revalidated, 37% said they were collecting more information about their practice than a year ago
- 34% said they were reflecting more on their practice

“As at 16 June 2015, 104,489 doctors have been revalidated” ¹

¹ GMC Perceptions Study, 17 October 2014
² GMC latest figures, Reval Data Team
Impact of Revalidation

- Increased focus on the quality of appraisers and the appraisal process
- Earlier identification of concerns
- Strong support for the system among ROs and appraisers
- 50% increase in doctors giving up their licence to practise since 2012
- 773 deferred due to local processes
- We have suspended approval of revalidation recommendations in three organisations after concerns about the robustness of the process
- We have removed 577 licences due to failure to engage with the process as a whole (e.g. providing no information to GMC)
How will we know it is working?

UK Medical Revalidation Evaluation Collaboration (UMbRELLA)

- How are GMC guidelines on appraisal being applied in practice and how might they be improved?
- Has the process of collecting the supporting information and the appraisal process increased doctors’ levels of reflection?
- Does revalidation help identify potential concerns earlier?
- What level of involvement do patients want in the revalidation process?

Department of Health Evaluation

Audits by Healthcare Improvement Scotland, Health Inspectorate Wales

Benefits of Revalidation

- Moving towards Revalidation must be seen as part of the wider quality movement within healthcare in the UK
- Not just a tick box exercise for doctors
- Data collection and critical analysis for ongoing improvement

Revalidation can:
- lead to better support for doctors to engage in PDP
- foster belief in doctor’s own development
- give greater transparency and assurance for patients
- deliver safer and better care
- be a driver for quality improvement
Thank you

www.gmc-uk.org/revalidation

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Contact Centre 0161 923 6602

Working with doctors Working for patients
Thanks for your attention & participation...

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