REVALIDATION

Special report editor
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DOCTORS' ORDERS

WORKFORCE

The GMC register says nothing about doctors' current competence. Ingrid Torjesen reports on how a panel at the NHS Confederation conference saw the revolution in performance management

"Medicine used to be simple, ineffective and relatively safe. It is now complex, effective and potentially dangerous," wrote the medical academic Professor Sir Cyril Chantler in *The Lancet* in 1999.

That sentiment is even more true today, Niall Dickson, chief executive of the General Medical Council, told a panel discussion of revalidation at this summer's NHS Confederation conference. "In simple terms the capacity for doctors to do good and harm is greater than it ever was."

To illustrate this he gave the example of a GP presented with a woman with a breast lump. "Forty years ago, it didn't really make a difference whether they got it right [and referred the patient]. Today it could be an absolutely critical decision that they are making over the prognosis and the life chances of that patient," he said.

He added that until the 1990s the consensus was that: "If enough well qualified professionals could be educated and trained, they could then be relied upon to provide services of high quality ... Indeed there was a prevailing wisdom that policy makers and managers should be kept out of matters involving professional judgement."

Not unsurprisingly medicine is considered to have lagged behind other safety-critical industries, such as aviation and nuclear, in embracing quality and assessing the performance of personnel.

While the roles and responsibilities of doctors have changed since the GMC began publishing the medical register in 1859, the register itself is fundamentally the same. Mr Dickson said: "It's really an historic record about qualification and actions taken, not an indicator of current or contemporary competence." Yet a record of current competence is increasingly what patients want and need in the consumer-driven 21st century.

Although the medical profession still scores top marks in comparison to other professions in surveys about trust, Mr Dickson added: "It isn't an esteemed trust in perhaps the way it was a generation ago."

And that is where revalidation comes in, although Sir Keith Pearson, who chairs the UK Revalidation Programme Board and Health Education England, said revalidation is as much about reassurance for the patients and the public as it is about ensuring doctors are fit to practise and up to speed.

Ann Lloyd, a trustee of the Patients Association and former chief executive for NHS Wales, agreed. "It is vitally important that the trust and confidence that patients in the main have in their health professional is protected and enhanced, and revalidation is part of the growing conjoining of the experience of patients and practitioners in delivering a much better service," she said.

'Most patients believe that doctors already go through some form of revalidation'

Most patients believe that doctors already go through some form of revalidation process to demonstrate their competence, Ms Lloyd added. "I think it will come as a bit of a shock to them to find that this isn't the case."

But Mr Dickson says the role of revalidation is not just about individual doctors, it is about improving quality, achieving excellence and getting overall improvement across health providers. In the past the focus has been on volume and throughput rather than quality, he explains, there has been a disconnection between medical staff and management and critically, organisations have not had effective clinical governance systems in place.

The inquiry into the more than 400 excess deaths at Mid Staffordshire Foundation Trust had seen good governance as key to ensuring patient safety, Mr Dickson said. "Without good governance it is quite impossible for the board to be effective.

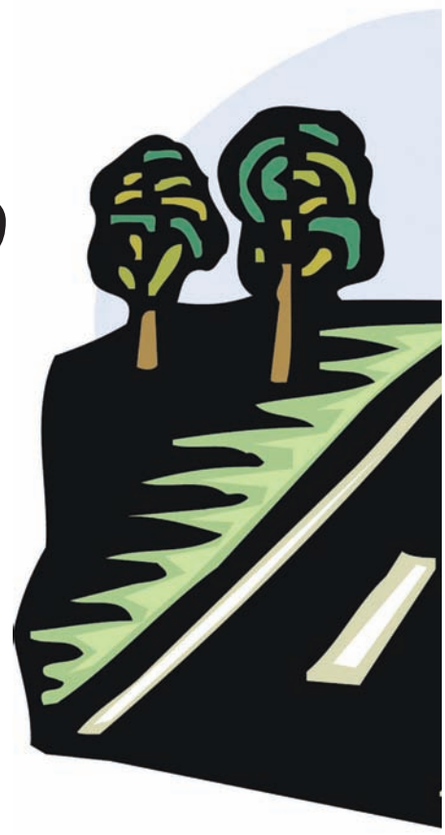
"Every other major business throughout the world uses performance management, it uses appraisal. They don't do this because it is something fluffy and odd and different, they do it because it makes business sense. You have got to be supporting the human resource in the same way that you would support any other resource."

Since the mid-1990s there has been a greater emphasis on improving quality of care through initiatives to reduce healthcare acquired infections and in-patient mortality. In the future the quality agenda will be strengthened. The National Quality Board is taking a leadership role on quality and the new NHS Commissioning Board will have a duty to maintain and improve quality.

At last the leaders of healthcare providers were beginning to see quality and safety as central to their core business, said Mr Dickson. ●

PERFORMANCE MANAGEMENT

'LIGHT THE FIRE OF ENTHUSIASM'



The road to full revalidation of doctors will take five years. The panel heard how, in that time, it is vital that they and employers take ownership of the process and see it as useful, rather than as a burden

"We've been on the journey towards the implementation of revalidation for some time and we are really very close. We are in a state now that by the end of this year we expect to be getting underway," Sir Keith Pearson told the NHS Confederation conference revalidation panel.

"The UK Revalidation Programme Board is reaching that position where we are ready to recommend to the Secretary of State for Health that we are ready enough to move forward."

Niall Dickson agreed revalidation was "good enough to go". Good progress had been made in building the policy model and the IT systems and processes required were being put in place.

"We already know the connections between 192,000 doctors and their designated bodies," he said. "So far 785 designated bodies have been identified throughout the UK and 720 of them have responsible officers in post."

In England organisational readiness has reached 82 per cent. In primary care appraisal rates are 90 per cent, for hospital consultants 74 per cent, and for staff and associated specialist doctors 53 per cent.

The expectation is that revalidation will start in early December this year, following a decision by the health secretary around the end of this month. If all goes to plan, responsible officers and other medical leaders will be revalidated first, by March 2013.

As revalidation is rolled out over five years, the target will be to revalidate 20 per cent of doctors in the first year (between April 2013 and March 2014); the majority of doctors by March 2016; and every doctor by March 2018. "That is not an overambitious timetable," Mr Dickson stated.

Appraisal time

In the first cycle of revalidation, doctors will need to have at least one appraisal based on the GMC's core guidance, *Good Medical Practice*. They will also need to collect a range of supporting information that demonstrates their professionalism including patient and colleague feedback.

Mr Dickson said that this "suite of supporting information should not be over burdensome but should support and provide a robust and interesting discussion between the doctor and their appraiser".

It should include evidence showing that they are keeping up to date in their learning through professional development, that they are engaging in quality improvement such as clinical audit, and that they are identifying, flagging up and reflecting on significant events.

Ann Lloyd welcomed the inclusion of patients' views in the appraisal process. This would include information about care provided by the doctor and how the doctor had communicated with the patient. Although patients and carers liked giving feedback, she warned many were concerned that, if negative, it might impact adversely on their ongoing care. Nevertheless, she said: "It is a big step forward in retaining and growing further the confidence in which they hold the professions and it will allow them to take ownership and help improve the quality of service for the whole community."

Any regulatory methodology, particularly the Care Quality Commission's, could only function if patients and carers, and managers and clinical staff at the frontline were its "eyes and ears" and drew attention to significant events and problems that could cause them, said Professor David Haslam, national clinical adviser to the CQC and member of the National Quality Board.

He predicted the upcoming Francis report on Mid Staffs would highlight how cultural issues had deterred staff from raising significant events and quality issues with management.

"This entire culture needs to change. Clinicians need to be able to raise concerns and managers and boards need to be in a position to respond. I see this as an integral part of the appraisals that form such a central part of revalidation. I can't believe that anyone in the health service goes through a year without seeing anything that should be flagged up as a concern. I'm not talking about major scandals, just what could be done a bit better. It should be the norm, it shouldn't be a mark of failure, it should be a mark of caring. If whistles come to be blown, the system has failed."

Quality needed to be endemic in the NHS, he emphasised, and appraisals should therefore focus on quality development, improvement, safety and raising concerns. "For the first time there will be an ongoing focus on whether doctors are up to the mark and with this comes a real culture shift. Quality won't be assumed, it will be demonstrated," he said.

Focus on quality

Professor Haslam predicted that the NHS would struggle to offer more than two out of quality, access and affordability in the next few years as the squeeze tightened on finances. That is why it was important that regulators such as the GMC and the CQC worked together on quality and had good local mechanisms for sharing concerns. "There is a real need for a whole system focus on quality. The more that we have numerous regulators looking at

PANEL MEMBERS

Niall Dickson chief executive of the General Medical Council

Ann Lloyd trustee of the Patients Association

Dr Penny Dash principal at McKinsey & Company

Professor David Haslam national clinical adviser to the Care Quality Commission

Sir Keith Pearson chair of UK Revalidation Programme Board, chair of Health Education England and chair of NHS Confederation

quality, the more there is a risk that there is a lack of clarity as to who is responsible for any given issue. Revalidation is such a core central plank to the whole system approach."

As well as there being a responsibility on doctors to prepare for and go through revalidation, the responsible officer regulations, introduced by the DH in early 2011, also place responsibilities on employers as designated organisations. "Everyone on a board should read those regulations and be aware what a designated organisation must be doing," Mr Dickson said.

The role of responsible officers is to ensure there are systems in place to support doctors to deliver quality care and encourage improvement, and that the organisation has robust, reliable and efficient clinical governance systems. Responsible officers will have to ensure that the organisation has an effective appraisal system – an integrated system for monitoring a doctor's performance that recognises good practice and encourages and supports learning and development – and will need to take appropriate actions to remedy any concerns about a doctor's practice.

Mr Dickson emphasised that revalidation had to be part of a wider drive to push up quality across UK healthcare through improving the governance of medical practice.

It was not just about finding and addressing potential problems early, but also encouraging doctors to strive to be better, he explained. "It has to be about mainstream practice and encouraging self-reflective practice and about supporting the good doctor in the middle and giving them the opportunity to be better."

For revalidation to be truly successful, the medical professions and their employers would have to take ownership of it, Mr Dickson asserted. "If it becomes a burdensome, tick-box exercise, people won't see the value of it, and then of course it won't work."

Revalidation needed to be done in a way that "lights a fire of enthusiasm", so that the doctors who went through it felt the benefit by getting objectives that they considered useful to them, so that they were inspired.

"The boards of NHS organisations need to feel that this is an important thing that they are doing, not something strange that the medical director is up to. It has to be absolutely central to the core mission – as important as safety," he added.

The GMC is working with the CQC, Monitor and the other UK systems regulators to develop a framework that will lay out the regulators' shared expectations of what healthcare providers should have in terms of quality governance to support high quality care. The framework, which is expected to be published later this year, will help organisations to evaluate the robustness and effectiveness of the systems they have in place to support revalidation.

Mr Dickson predicted that if the UK gets revalidation right "we will lead the world". "There isn't another nation that I know of that is building as robust or comprehensive system as this," he said. "And we are being watched by others."

"The start of revalidation [in early December] is only the beginning," he added. "Then we need to have a discussion about how we make this process better. Not how we make it more burdensome or more difficult, but how we make it more pointed, more outcome driven, more relevant, more attuned to different specialties, so it seems most relevant to the individual doctor." ●

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RESOURCES

- General Medical Council website www.gmc-uk.org/revalidation
- NHS Revalidation Support Team website www.revalidationsupport.nhs.uk
- NHS Employers website nhsemployers.org/revalidation
- Listen to the podcasts from the GMC's panel discussion audioboo.fm/GMC-UK
- Revalidation case studies www.gmc-uk.org/revalcasestudies

ALAMY

SERVICE IMPROVEMENT

STANDARD BEARERS

Revalidation can do much more than just check doctors' skills and knowledge, the panel heard – it can also encourage them in the role of team leader, helping their organisations to function better

From the outset, revalidation will ensure that doctors have the knowledge and skills they need, that they are keeping specialist knowledge up to date and are practising core skills frequently enough – but it has the potential to go much further.

Dr Penny Dash, a principal at McKinsey and vice chair of the King's Fund, told the NHS Confederation conference panel on revalidation that many of the quality issues the NHS faced were not related to the performance of individuals but of organisations and teams.

"We know that we need to redesign care across pathways and that we need to be much better at delivering much better quality care outside of hospitals so we don't have the boomerang effect of people going in and out of hospital," she explained. "We also need to deliver significant efficiency gains at the same time.

"If healthcare hasn't kept up with other organisations on a quality perspective, it also hasn't kept up on efficiency," she added. For example, supermarkets and banks had introduced processes which had reduced costs and allowed staff to focus on dealing with the customer more effectively. Achieving this required the development of people both as individuals and within teams, and appraisal and revalidation had to play a role in this, she said.

When working as an NHS doctor, Dr Dash's performance had not really been tested, but since she had moved to the consulting world she had been assessed regularly against a number of metrics, prompting her to wonder what would happen if a similar process were applied to doctors' performance.

Such an approach would involve ensuring doctors were able to form a relationship with their patients and assess how they interacted with patients and conveyed key messages in much greater depth than revalidation would do initially.

The NHS Future Forum report on information acknowledged there was much greater potential within the NHS for systematic feedback from patients. Professor David Haslam, who was one of the report's co-authors, said there was real potential for engaging the entire population through text messaging or email and that normalising feedback in this way would alleviate patients' concerns about the repercussions of negative feedback.

When you went on holiday and parked your car at the airport, you were sent a car parking feedback form on your return, he said. But the same did not happen after a heart transplant. "That's extraordinary."

Dr Dash's vision for the evolution of revalidation would also involve looking at how the doctor helped support their organisation develop and work more effectively in terms of: "Am I really making sure that my organisation is continually striving to improve?"

Finally it would consider the doctor's role in terms of leadership and developing people, critically: "Am I working as part of a team and how do we as different types of people collectively ensure that we deliver fantastic results?"

'If you look at the leading edge primary care organisations around the world, the doctors see relatively few patients'

Dr Dash said the NHS needed to look at how other organisations were assessing staff to determine the criteria doctors should be assessed against.

"Many people now are starting to write about the role of doctors, not as the practitioner not as a caregiver but actually as a team leader. If you look at the leading edge primary care organisations around the world, the doctors see relatively few patients. The key thing is about how we are going to increasingly assess doctors as part of the team."

She pointed out that doctors were increasingly working as part of integrated teams that crossed organisational boundaries and that the increased use of technology such as the internet to deliver care meant that in future doctors would see patients face to face less frequently and be encouraging and supporting self care. "The doctor is no longer an information gatherer, the doctor is interpreting information. How do we reflect that?" Dr Dash asked.

However, there was a danger that revalidation might lead employers to think that they did not have to take responsibility for assessing doctors' performance themselves, Dr Dash warned. "If I were a chief executive or a chair or a non-exec on a hospital board I would actually want to know far more about the quality that was being produced in my hospital, about the quality of the individuals, than I think will ever come out of any revalidation process." ●