

Guest editorial

Professional regulation in primary care: improving quality and safety ... we hope

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Introduction

There was a lot of discussion about strengthening professional regulation five or so years ago – but now it really does seem to be happening. So far so good. There seems to be a general confidence that revalidation will be about improving and maintaining individual practitioners' performance rather than focusing on specific faults.^{1–3} It will hopefully be about enhancing the quality of care and safety of patients, rather than a bureaucratic exercise for health professionals that takes yet more time and energy away from patient care.

The primary purpose of professional regulation is to ensure patient safety. Box 1 describes the various purposes of revalidation for general practitioners (GPs). So the clinical governance framework in all healthcare settings must ensure that individual practitioners provide minimally acceptable standards of care in terms of the safety and quality of care.

Progress with pilots

The seven revalidation working groups are producing their initial reports, so that the Chief Medical Officer of England can agree the pilots of the new system. The other three countries of the UK are observing progress so that they can adopt or adapt the English system, all being well. The Medical Royal Colleges are all working hard to anticipate the systems and processes that will be required for recertification of their specialist members or, in the case of the Royal College of General Practitioners (RCGP), all GPs. Many of the deliberations about the way forward are drawn from the experiences of appraisal and tackling underperformance of doctors and dentists, but also from how the work of practitioners such as independent midwives is overseen.

Box 1 The purposes of revalidation for GPs (recertification and relicensure)⁴

Primary purpose

- To demonstrate that doctors on the GP register continue to meet the standards that apply to the discipline of general practice

Secondary purposes

- To promote continuous professional development among GPs
- To encourage improvement in the quality of care, patient safety, team working, communications and appropriate behaviour of GPs
- To identify GPs, as far as is practicable, for whom there are significant concerns about their fitness to practise and to alert for early signs of deteriorating performance
- To reassure, as far as is possible, individual patients, the public, colleagues and the NHS that individual GPs are up to date and fit to practise

The thinking seems to be to launch revalidation for doctors before that of other health professionals. The medical system will be more complicated than that for other professionals, with its twin components of recertification by the Medical Royal College, and relicensing by the responsible officer of a trust/primary care organisation (PCO) affirming a doctor's fitness to practise to the General Medical Council (GMC) regionally based affiliate.

We need pilots of how the responsible officer role will work out in trusts and PCOs, receiving information about individual practitioners' performance and affirming that they are fit to practise. Figure 1 illustrates how the responsible officer role might work for operating the relicensing process for doctors employed in their trust or on the performers' list of the PCO.⁵

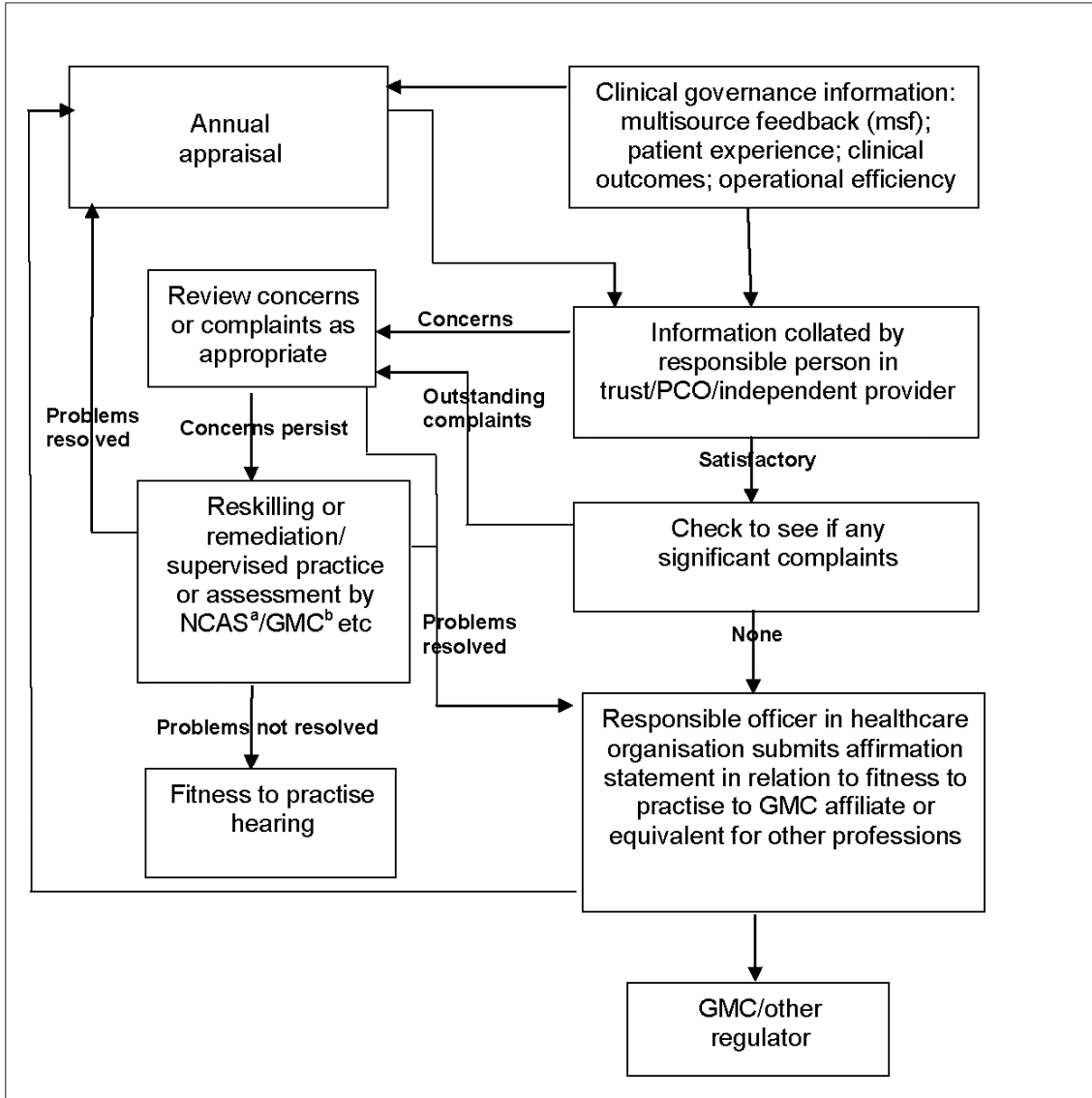


Figure 1 Illustration of how the clinical governance framework fits with the relicensing process for doctors;⁵
^aNational Clinical Assessment Service; ^bGeneral Medical Council

Clinical governance

It can be seen in Figure 1 that clinical governance is going to be central to professional regulation, that is, the framework through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care. The investment in clinical governance should engender provision of clinical services focused on:

- continuous quality improvement
- assurance of safety
- reduction of risk

- minimisation of costs (without detriment to the other objectives).

So this means systems will be created so that information about a practitioner's performance will be generated through multisource feedback exercises with colleagues and patients: through comparing their performance with peers and adhering to best practice, via local audits or patient complaints. An appraiser will receive that information from the trust/PCO for the annual appraisal, as well as information prepared by the doctor or other health professional being appraised about the continuing professional development (CPD) they have undertaken, or other personally collected evidence of their performance, such as practice-based clinical audits.

There will need to be good leadership in the trust/PCO to make the flow of information work and develop good communication systems between the various people in roles relevant to clinical governance and revalidation.

Clinical governance will grow in importance with the increasing emphasis on accrediting primary care providers and the services they deliver. The RCGP is piloting a scheme with 40 general medical practices, which should be ready as a voluntary accreditation scheme when revalidation is in full swing. The body replacing the Healthcare Commission, the Commission for Social Care, and the Mental Health Act Commissioner will also have a remit for inspecting the quality of primary care providers.

Appraisal will be key⁶

The RCGP has successfully agreed a common policy on GP appraisal with leads from all four countries of the UK.⁷ At present the four countries differ substantially in the way they run GP appraisal, with Wales leading on integration of appraisal with clinical governance information systems.⁸ Appraisers will form a judgement about whether the quality and extent of CPD a doctor has undertaken in the previous year matches the learning plan previously agreed, whether any variation is justified, and if it is equivalent to at least 50 learning 'credits'.

Quality assured CPD will be more common

The RCGP is setting up a managed CPD scheme for GPs.⁹ This will be a process- and outcome-based 'credit' system, which will serve as a framework for the quality assurance of CPD for GPs. GPs will be expected to complete a minimum of 50 credits from a learning-based credit system (with credits matching the impact of learning) each year, with a good balance of CPD reflecting the doctor's range of practice within the 250 credits of a five-year cycle. The 'credits' will be based on the process and outcomes of learning rather than just being present when CPD is delivered – encouraging GPs in reflective learning. Many other Medical Royal Colleges already have such schemes. It is likely that other health professions will follow suit or adapt their CPD requirements to fit with requirements for revalidation.

The RCGP already has a system for quality assuring educational providers other than higher education

institutions in Scotland, and plans to pilot a similar scheme in England soon.

Tackling concerns locally

We can expect that the extra focus on health professionals' performance through enhanced clinical governance will reveal more concerns about an individual's performance or fitness to practise. The revalidation working groups are considering what sort of information systems and governance arrangements we need in place to be able to record concerns about individual practitioners. There should be ways to collate any 'soft' or relatively minor concerns where there are no apparent risks to patient safety, so that someone in a position of responsibility becomes aware that a picture is building of substantial numbers of minor concerns, which by themselves would not trigger an enquiry or referral. There may be more significant concerns about performance generated too, which will require sufficient resources and expertise to be available for detection, diagnosis and assessment of an individual's performance, and remediation, reskilling and rehabilitation as appropriate. The tools used for diagnosis and assessment should also be viable for monitoring progress to obviate the need for re-assessment before a practitioner is allowed to practise in an unsupervised way again.¹⁰

There are many challenges to resolve: the matter of who pays for this expensive resource – the practitioner themselves or the responsible trust/PCO – and how we support patients so that they feel able to make a complaint about a practitioner's performance. Trusts/PCOs need an educational and supportive ethos. It is important to create a culture in which healthcare professionals should feel able to self-report their learning needs, or their concerns about colleagues – knowing that these concerns will be dealt with fairly and with the aim, wherever possible, of remediation, reskilling or rehabilitation.

Learning lessons

It is time to turn rhetoric into reality (oh dear, is using that sentence more of the same?). Any investigation into concerns about a practitioner's performance will usually reveal weaknesses in the trust/PCO or practice systems. It's rare for the individual to be underperforming without there being other factors involved too – poor communication, a dysfunctional team, unrealistic targets, inadequate resources, etc. So if the systems and processes involved in operating revalidation

at a local level are to be fit for purpose, then trusts/PCOs/practices will have to establish a sound clinical governance structure, and provide sufficient resources to allow consistent best practice.

They will have to be prepared to learn lessons from all the information generated to monitor practitioners' performance and investigate poor performance – to improve quality and safety of services in sustainable ways.

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