Performance management, appraisals, and revalidation: quantity analysis and quality control for UK GPs

THE INFORMATION AVAILABLE ABOUT GPs

A huge amount of information about GPs is available now. It is not all of great quality, but it is serviceable, and it needs to be acknowledged, and acted upon. The information is both qualitative and quantitative and it partially measures our performance as GPs. Some of the information is held at the level of the local area[1] by primary care trusts (and increasingly by commissioning consortia) and some is held by us within our practices. It needs to be brought together.

VARIATION

What we do know about UK GPs is that our performance is variable with a range from good to poor.[2] We know that in the UK there are unmet health needs and wants. We also know that our systems are slow to change, and culture even slower.[3]

In a farsighted article Marshall described some major changes he anticipates coming to general practice in the next 30 years or so.[4] He sees the role of the GP moving from its traditional focus on treating individual patients in our consulting rooms to our becoming much more explicitly accountable for our performance both in terms of its quality (patient perception and outcome measured) and its quantity (our commissioning role and use of resources). We will become as concerned with making the system work well as with actually being the product delivered by the system and this will mean making much use of our knowledge, and, as a profession, contributing much more actively to its development. He foresees the consultation sometimes becoming a more fluid, asynchronous interaction with a lot of information being acted on remotely (for example, patients send in their blood pressure readings, and receive our recommendations about them later.) This will not diminish the role of consultations; if anything it may free up some time for proper consulting when a full face-to-face meeting is needed, and the consultation may well be better for prior preparation by both sides.

We can see some of the early steps towards Marshall's predictions coming into place now. In the past there has been a tendency for GPs to be very private, a bit shy, and ruggedly autonomous. Even within partnerships there has often been the partner who avoids practice meetings on the pretext of, 'something's cropped up, another patient to see ... while you lot are talking'. In the future the collective conversation is going to become ever more important and there will always be another patient to see.

HOW THE INFORMATION WILL BE ANALYSED

The analysis of performance information about GPs is going to happen at two levels. First, with the advent of commissioning consortia and with membership of a consortium becoming a prerequisite for a practice to take on NHS GPs, there will be area-wide analysis at this practice level. Currently, area-wide data are not wholly accurate and measure costs and transactions rather than clinical value achieved.[5] That said, the data will still need to be reviewed and outliers on the figures are likely to be shepherded back towards the mean. Hopefully commissioning consortia will be alert to the limits of their data accuracy, and will interpret it sensitively and tactfully and in line with clinical good sense. However, the very act of showing the variation[6] across an area will raise the question of whether that variation is an acceptable or unacceptable spread. In the background the consortia will have powers to act if the variation turns out to be unjustifiable.

IMPLICATIONS FOR PRACTICES

At the practice level, practices are going to have to make a number of adjustments. The days of practices being solely a means to run a building, share staff, and run the appointment system are over. Modern practices are going to need to do all those functions, but also move into becoming learning organisations[7] that analyse their inputs and outputs (and associated costs), and work collectively to ensure a good service to patients and effective use of resources. This will put pressure on the partners within a practice to look at their own contribution to the whole, which will be uncomfortable for many of us. Hopefully this will all be done in educational and reflective manner, with opportunity for learning, development, and change. Practice meetings are going to need better, and maybe external, facilitation.

Box 1. Four-layer model of medical regulation[8]

- Personal regulation
- Team-based regulation
- Workplace regulation
- National regulation

The General Medical Council (GMC) has proposed a four-layer model of medical regulation (Box 1).[8] The layers are the individual doctor's conscience, the local accountability to colleagues, then moving up to area and national levels. The hope is that if the first two levels work well then we are keeping each other on track and working well, so that the higher, more disciplinary, levels are needed less. It fits well alongside the relationship between the doctor, the practice, and the consortium.

IMPACT ON INDIVIDUAL DOCTORS

For individual doctors these changes are partially threatening and partially exciting. The days of the unsupported practitioner ploughing a lonely furrow in their consulting room, making the same mistake year after year until burn out, a complaint, ill health, or the GMC forces them out, should be over. The new systems mark a much more collaborative approach to our careers, and have the potential within them for a more supportive environment, focused on collective and individual learning and improvement. The days of doctors being

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'good despite the system' should be going, and instead we should be able to say that doctors are good because of the system they work in. We are moving from the cottage-industry model to postindustrial care; from unexplained and probably unjustified variations[6] to consistent and planned care with measured outcomes.[9]

IMPLICATIONS FOR APPRAISAL

For individual doctors the appraisal and revalidation processes will basically confirm that they are taking part in the discussions described above: analysing input and output data, looking for how their practice compares with others and why the variation is present, and making some contribution to system improvement. The main questions appraisal and revalidation ask can be boiled down to:

- Is my clinical care good enough?
- Do I respond to signals of the unusual?
- Do I keep up to date?
- How do I come across to my colleagues?
- How do I come across to my patients?
- What I have done about what I have learned?

WHAT THE NEW SYSTEM WILL LOOK LIKE

So we see a new world of performance management emerging for GPs. It will involve active reflection on both qualitative and quantitative data. It will involve much discussion, collaboration, and learning with colleagues. The spurs to our discussions will be our own observations and the consortium's perspective of our practice, and seeing and explaining how these match or mismatch each other.

All this demands participation. It is not optional, and a failure to keep up with these educational and performance reviewing processes will be seen as a failure to keep up with the norms of our profession,[10,11] and as a failure to manage the care and maintenance of your medical career. But surely as an intelligent GP you are not going to let yourself run foul[12] of simple processes such as revalidation, are you?

Overall these changes should be an improvement for GPs giving us a more supportive and protective environment, provided that we stay within the learning envelope of our organisations. We will lose some individual idiosyncrasy, but we should be moving towards less variable, more consistent, and better audited care for patients.

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