Clinical governance and revalidation

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The quality agenda in the NHS has many parts. For the medical profession the means of enhancing standards and consistency will be revalidation. This article outlines progress to date in defining how doctors will demonstrate they are 'up to date' and 'fit to practice'.

There can be little doubt that the government has a new agenda for the NHS: quality. Outlined in *A First Class Service* (Department of Health, 1998) and fleshed out in *Clinical Governance: Quality in the New NHS* (Department of Health, 1999), it is now something of which every doctor working in the NHS should be aware. It can only be achieved with a fundamental culture change. A change where perhaps the public are ahead of the medical profession, but one which is linked to a new culture of openness and transparency.

The climate change has been underway for some time: the publication in 1995 of the General Medical Council (GMC)'s *Good Medical Practice*, with its explicit standards of good care, showed that the profession recognized the demands for quality assurance and partnership. The GMC's Performance Procedures were another step in that direction. Events such as the Bristol case at the GMC, and subsequent government enquiry have added impetus to the process (Irvine, 1997a,b).

The government is ensuring that the momentum is maintained through the establishment of bodies such as the National Institute for Clinical Effectiveness (NICE) and the Commission for Health Improvement. For the medical profession, and the guardian of its register — the GMC, we cannot afford to remain recumbent and reactive. We too must roll up our sleeves and put our house in order.

We may well feel that the vast majority of doctors are already delivering a good standard of care, and that it is unfair to lumber them with the blame for a small minority of poor performers. However, it is clear that our traditional system of exception reporting is not sufficient, and has failed patients in a number of high-profile examples: we cannot expect to qualify and sit happily on the medical register for the next 30 years as long as no misdemeanour has come to light.

In February 1999 the GMC made the decision that all doctors should be 'up-to-date' and 'fit to practise'. The ability to demonstrate those two assets of any practising doctor would then be linked to their remaining on the medical register.

It is the quality of the NHS as a whole on which we must now focus, not simply the management of poorly performing doctors (Chantler, 1999; Irvine, 1999). The objective must be to raise the overall standard. There will still be a small minority beyond the pale and it is through the fitness to practise procedures of the GMC that their registration will be restricted or removed. But revalidation is about the achievements, and the continuous improvement, of those doctors remaining on the register (more than 100 000 in active practice), and the GMC has already agreed that revalidation will be based on its document *Good Medical Practice*.

RELATIONSHIP BETWEEN CLINICAL GOVERNANCE AND REVALIDATION

There are four components of clinical governance:

1. The creation of clear lines of accountability for the overall quality of clinical care
2. 'A comprehensive programme of quality improvement activities'. These might include the participation of doctors in audit, national confidential inquiries, support for and use of evidence-based practice, and implementation of both national service framework and NICE recommendations
3. Systems to assess and reduce clinical risk should be in place
4. All professional groups should identify and remedy poor performance.

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This may entail the reporting of adverse incidents so that lessons can be learnt before the situation is irredeemable (Hopkinson, 1999). Many of the fundamental ingredients are common with those which will be required for the development and implementation of revalidation — audit, appraisal and a constructive approach to teamwork such as that needed to implement evidence.

WHERE IS THE GMC AT?

Currently it is reasonable to say that revalidation is in its developmental phase. There is a matrix of work to be undertaken, which entails a wide consultative process with extensive lay involvement at each stage both in the development and the implementation. The GMC is beginning to define the kinds of evidence which each doctor will need to produce in order to be revalidated.

While implementation per se may not be as important an issue for the GMC as development, it is important that the position at which the GMC arrives by May 2001 is consistent with local processes and capable of implementation: revalidation must not entail new bureaucratic systems, it should draw upon data generated under clinical governance. There is a very important exercise with hearts and minds so that the majority of the profession and the public are brought with the process not dragged kicking and screaming. On the ground the Oxford Local Medical Regulation Project is taking place in parallel, under the auspices of a group entitled Maintaining Good Medical Practice. An external steering group includes the relevant players (Royal Colleges, UKCC, British Association of Medical Managers (BAMM), postgraduate deans, deans, Association of Community Health Councils of England and Wales).

The objective of the Oxford project is to ensure that there are good local systems in place for implementing the two documents *Good Medical Practice* and *Maintaining Good Medical Practice* (GMC, 1998). This will be possible by defining how those with responsibility for local systems could monitor the implementation of these documents. While the Oxford project is not about revalidation or clinical governance in its entirety, it is about interrogating the processes and ensuring that they are robust and fit for purpose.

The project is valid in its own right. But it has been developed at the same time as the discussions about revalidation have been taking place and the government has been establishing its quality framework. It aims to provide assistance to professional (medical) self-regulation. It may also contribute to the delivery of revalidation processes.

The Oxford project has taken a number of doctors as case studies — mapping the doctor's journey through the career pathway and asking a series of questions about the processes of appointment, development and departure as well as enquiring about remediation.

Much of what will be required by chief executives to demonstrate that clinical governance is being implemented within their own organizations will represent the component parts of the 'revalidation process'. It is very important that this process is not onerous and does not reinvent an entirely new tier of processes for those who cause concern.

The GMC is also tapping into other examples of good local medical regulation. Great Ormond Street has developed processes for appraisal, which were implemented from the medical director down — true management by walking about. The process to date has shown the paucity of public involvement in medical regulation at local level. This involvement will be more explicit than before by examining a matrix of factors involved in practice. The other important factor is not to alarm the public by seeking their involvement without their understanding of its importance. There is no doubt that public expectation has risen — the medical profession now needs to grasp the nettle and make it clear that they actively seek public involvement and hence public ownership of the result.

The Chief Medical Officers have been consulted as part of an attempt to be explicit, to ensure the involvement of the NHS and to check that there is no duplication or dissonance with other initiatives. Effective implementation will need both local and NHS Executive support. One clear message is that revalidation and clinical governance must not result in duplication but should mesh in such a way that Trusts and the individual doctors can achieve their objectives — bearing in mind that a high proportion of doctors on the medical register, particularly GPs, will not be involved in clinical governance.

I am enough of an optimist to believe that no competent, reasonable doctor should have anything to fear from revalidation. Indeed if the initial objectives set out are fulfilled we should all benefit, and have a medical workforce of which we can be justly proud. Much hard work is still to be done before we achieve that end, but the more we get our hands dirty at this stage the more likely we are to be able to live with the consequences. There is no mileage in carping

from the sidelines — the world has moved on — openness, transparency and public accountability are here to stay. Better that we work in partnership with patients, management and others, using our professional ethics — to the benefit of patients, the public and the service we provide — than that we find ourselves imposed with an ugly chimaera of others' demands. HM

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KEY POINTS

- The new agenda for the NHS is quality.
- Revalidation and clinical governance are important components of that agenda and its delivery.
- Revalidation is about being 'up to date' and 'fit to practice'.
- Revalidation must be straightforward and implementable. It must not reinvent or duplicate existing frameworks but incorporate them.
- Revalidation should not be feared by the vast majority of doctors who are competent and reasonable.