# Editorial comment: Determining doctors' views on performance measurement and management of their clinical practice

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OVERVIEW

**Editorial comment on 'Determining doctors' views on performance measurement and management of their clinical practice' by Timothy M Trebble, Charles Carder, Maureen Paul *et al***

The aim of every doctor is surely to provide the best possible care to their patients – but how do we know we are doing this? In the 'future' era of quality improvement and system change that *Future Hospital Journal* promotes, we should be aiming to demonstrate to ourselves, to colleagues, to patients and to commissioners that we are providing the best possible care. The aim of performance measurement is to evaluate both the quality of clinical care and productivity. Most would argue that these concepts go hand in hand, because poor quality of care is not productive when complications increase length of stay and the cost of treatment. Productivity may be easier to measure than quality, which involves measures of clinical competence and clinical outcomes, as well as patient satisfaction. These are all complex metrics, and for many years clinicians have argued that available data are not robust enough to provide adequate comparison at the level of individual clinicians or even departments. However, some specialties have embraced the challenge and cardiac surgeons, for example, routinely collect outcome data which are published publically and transparently.[1]

Most doctors will already have experienced the process of revalidation, and by 2016 all doctors should have been revalidated by the General Medial Council. The aim of revalidation is for doctors to demonstrate that they are up to date, fit to practice and provide a good level of care, meeting professional standards set by the royal colleges and specialist societies.[2] The current system of revalidation relies on appraisal and patient and colleague feedback. However, the authors of this article argue that appraisal is an ineffective way to measure performance and does not improve productivity. If this is not the way forward, then clinicians, and in particular clinical leaders, need to engage with the process to improve it and to make it fit for purpose. It is our responsibility to work out how to measure performance, what data to collect and to ensure the data are appropriate and accurate. A commitment to measurement and improvement is enshrined in the GMC good medical practice guidelines.[3]

Measuring performance and managing it are different; however, in order to manage performance we have to know whether it meets the standards we have set or falls short. Measurement is fundamental to management. Good performance management involves continuous improvement in clinical practice through feedback, setting goals for improvement and monitoring progress. The standards are being set by royal colleges and specialist societies – we have a moral obligation to engage in this process to ensure that we are responsible for and have ownership of the standards to which we will be compared.

For surgical specialties, the Royal College of Surgeons of England[4] is working towards improved methods of ensuring high standards through public reporting of operation outcomes. The aim for clinicians is to provide a basis for judging and improving practice, to provide evidence for service improvement and quality assurance; for patients, to improve public transparency and accountability and enable them to make informed choices about their care and for health service commissioners to have data to support funding decisions. The College aims to integrate existing statistics and audits with clinical registers and patient feedback to underpin these standards. Other royal colleges and specialist societies are working on appropriate methods to support clinicians in their fields.

The authors of the paper in this edition of the journal state that performance measurement and management may improve productivity and quality of patient care and examine doctors' attitudes to the process. Reassuringly, they found that clinicians support the use of data to measure and manage performance, but overall the feeling was that current methods were inadequate and not always well managed. Strikingly, in a single hospital trust there were a large variety of methods used and there did not seem to be a trust policy or methodology in place to ensure consistency. The authors report that a barrier to good performance management is resistance by clinicians, and they cite fear, vulnerability, scepticism and suspicion as reasons for this resistance. Sadly, they found that only 49% of respondents

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found it useful and only 23% had changed their practice as a result. This implies that the process is not as effective as it could be. Standardisation may improve the quality of performance management but will not address the issue of engagement. This highlights the importance of clinical leadership to engage clinicians in the process and motivate them to participate openly and fully in the process. There is also a responsibility for the leaders and managers involved in designing the process to make it efficient and effective – which should help to improve engagement. Medical engagement needs to be part of an organisational approach, it requires clear leadership and for doctors to assume greater responsibility for improving quality in partnership with colleagues and patients.[5]

Another barrier highlighted in the study was lack of good quality data, and the problem of measuring performance in specialties without procedures that can be counted and evaluated, or where easy to count outcomes such as mortality may be very low (paediatrics) or very high (elderly care). These are certainly issues to be taken into account, but could be seen as challenges rather than barriers – an opportunity for clinicians to take ownership of the issue and work out, with their patients, what constitutes excellent care and how to measure it. In this study only 15% respondents mentioned patient surveys or feedback, so there is certainly scope for increased patient involvement and co-production of care.

Only one-third of respondents in this study felt that performance data should be widely shared. This may reflect the lack of confidence in the process, but goes against the principles of transparency and openness recommended by the Francis report[6] and encouraged by the government transparency agenda.[7] A recent King's Fund report recommends a greater emphasis on peer review and peer pressure to improve performance, and notes that leadership continuity and organisational stability is essential.[8]

One note of caution that we should bear in mind as we approach performance measurement with open hearts and minds is that an individual's clinical performance may not necessarily reflect the overall care experienced by patients. Healthcare is a complex, 'wicked' system and patients experience the whole system and its processes. Don Berwick argues that despite its complexity the NHS can become the safest healthcare system in the world:

> *That will require unified will, optimism, investment, and change. Everyone can and should help. And, it will require a culture firmly rooted in continual improvement. Rules, standards, regulations and enforcement have a place in the pursuit of quality, but they pale in potential compared to the power of pervasive and constant learning.*[9]

In the spirit of a learning culture, healthcare leaders must embrace the measurement and management of performance of clinicians and healthcare systems. It is time to stop claiming that it is too difficult and engage with the process to make it as meaningful and effective as possible. Leaders must set the example to their colleagues and engage openly and transparently in the process. ■

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