THE PREVENTION, DETECTION AND MANAGEMENT OF UNDERPERFORMANCE IN GENERAL PRACTICE

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THE PREVENTION, DETECTION AND MANAGEMENT OF UNDERPERFORMANCE IN GENERAL PRACTICE

CHAPTER 1

1.1 INTRODUCTION

General practitioners provide general medical services to the whole population. Patients register with a general practitioner and that registration forms the basis of a contract between doctor and patient. However, in most cases, this relationship goes beyond a formal contract. The relationship itself is defined in terms of trust, and the commitment of the practitioner is one of continuity of responsibility to the "individual as a whole" rather than to " the person with a certain disease". Mutual trust and respect is built through commitment, with the patient trusting the doctor to do his or her best for them as a patient. Patients often remain registered with one doctor for many years enabling a very strong partnership to be established. Most patients are very content with the service that their family doctor provides and this is reflected in the relatively low number of complaints. The majority of general practitioners work hard at maintaining their standards of care by investing in their practice, by enhancing and developing their services and by participating in ongoing education.

However, as in all walks of life there are occasions when people and systems do not work as well as they ought to. GPs are no different, and there are occasions when for a variety of reasons the care delivered by individual GPs falls short of that which we would normally expect. When this happens it has the potential to adversely affect the well being of the patient and has the capacity to erode the mutual trust, which has been built over many years. It can also impact on professional and contractual relationships.

The recommendations in this document are designed to help prevent individual doctors from falling below the accepted standards, and when standards do drop, to ensure that there are systems and procedures in place to enable appropriate action to begin, to help address the issues.

1.2 WORKING GROUP

The working Group was established to look at the current regulations and procedures, and to draw up guidance on possible changes, which could be introduced immediately prior to the full implementation of major policy initiatives including the CMO's report "Confidence in the Future", "Best Practice, Best Care", new GMC requirements for revalidation of GPs and new service arrangements for primary care in Northern Ireland.

It is generally agreed that current regulatory, statutory and disciplinary processes are not very effective in preventing and managing underperformance.

It is hoped that the recommendations that this document proposes will help clarify the procedures that could be put in place to help prevent, detect and manage potential issues of performance. Appendix A contains remit and membership of the Group.

1.3 BACKGROUND

Our first aim must be to ensure that we put in place the necessary structures and processes to prevent performance problems developing. This may require a significant change in culture both within organisations and within individual practitioners. There needs to be change of culture within the HPSS to ensure that GPs are fully supported by investing in practice infrastructure and professional development. There also needs to be a change of culture within the GP community so that there is a sense of corporate responsibility and accountability.

We need to ensure that there are robust systems of clinical and social care governance embedded into general practice and primary care. This needs to be supported by systems of Continued Professional Development (CPD) and regular appraisal and revalidation. There also needs to be some consideration given to protecting and supporting doctors suffering from illness, by putting in place an occupational health system for GPs.

In spite of having such systems to help prevent performance problems, it is however inevitable that on occasions the performance of an individual GP may give cause for concern. In line with the spirit of the recommendations contained in Confidence in the Future, the Group recommends that procedures be put in place to enable the appropriate authorities to take action to ensure that patient safety is not compromised.

1.4 RECOGNISING POSSIBLE PERFORMANCE ISSUES

Underperformance can manifest itself as problems with health, performance, discipline or conduct or can present with combinations of these elements.

The nature of general practice makes it very difficult to give a concise definition of what constitutes an unacceptable standard of care delivered by an individual GP. Each consultation is unique and indeed confidential between doctor and patient. Measurement of quality of care depends on a whole variety of factors, not all of which are easily influenced by the GP.

However, considerable work has been carried out by RCGP and GPC nationally to draw together a wide range of opinion, and this has resulted in the publication of "Good Medical Practice for GPs". This is based on the GMCs publication Good Medical Practice, and makes it applicable to general practice. The document clearly sets out standards of care, which would be regarded as excellent and standards of care, which are unacceptable. It is now generally accepted that this document provides a tool against which the performance of GPs can be assessed.

It can, therefore, now be stated that there "may be a performance issue when a GPs performance is repeatedly falling within the unacceptable standards as defined in Good Medical Practice for General Practice".

1.5 PERFORMANCE

The potential causes of, and factors associated with under-performance may include any of the following:-

- Poor training for general practice;
- Lack of continuing education;
- Isolation from colleagues;
- Physical health problems;
- Mental health problems including alcohol and drug abuse;
- Stress related to work or domestic situations;
- Low morale;
- Excessive workload;
- Poor practice infrastructure;
- Poor relationships within a practice;
- Poor premises and facilities; and
- Poor communication and relationship with Health Board.

Clearly from the above list the situation can often be complex. This highlights the need to have proper procedures in place to discover the reasons behind potential performance problems. Such procedures need to be able to not only detect where there may be problems but also what may be the root cause of the problems.

1.6 CONDUCT

Underperformance can be caused by and manifest itself as misconduct. This could include personal and professional misconduct including, for example:-

- Inappropriate attitude and behaviour to patients and colleagues;
- Corrupt or criminal behaviour including committing fraud;
- Professional misconduct, for example, serious neglect or disregard of professional responsibilities to patients or any abuse by the doctor of his/her position;

1.7 DISCLIPINARY

These include breaches in statutory terms of service (Disciplinary Committee); serious allegations that a practitioner has put at risk the efficiency of the service (HPSS Tribunal); serious concerns that a doctor is not fit to practise (GMC procedures). Appendix B provides further detail on the disciplinary arrangements.

CHAPTER 2

THE CURRENT SYSTEM FOR MANAGEMENT OF UNDERPERFORMANCE OF GPS IN NORTHERN IRELAND

2.1 INTRODUCTION

Recent events at national level, which have highlighted underperformance by individual doctors and systems' failures, have eroded patient confidence in the processes, which are devised to protect patients. The service itself has also lost confidence in its ability to effectively protect patients and manage underperformance problems and GPs too have lost confidence that new policies will assist the prevention of underperformance.

This chapter expands on the reasons why that confidence may have been eroded and provides a local context to the scale of the problem highlighting some of the strengths and weaknesses in the current system for the management of underperformance.

2.2 PATIENT CONFIDENCE

The public appear to have low confidence in the profession regulating itself, e.g. patients' representatives believe that within primary care local resolution of complaints performs poorly or very poorly in meeting the reasonable expectations of complainants. A majority of Health Council respondents to the national evaluation of the NHS complaints procedure (March 2001) also believed that local resolution at practice level performs poorly or very poorly in ensuring that services improve as a result of a complaint or in identifying serious clinical problems and professional misconduct.

2.3 SERVICE CONFIDENCE

The final report of a national evaluation of Primary Care Groups and Trusts in England (September 2001) stated that while "Primary Care Groups and Trusts have made good progress in implementing clinical governance strategies it appears that they still have more to do in relation to dealing with poor performance".

2.4 GP CONFIDENCE

The results of the national survey of GP opinion carried out by the BMA (October 2001) showed that less than 40% of Northern Ireland GPs believe that clinical governance will lead to general improvement in patient care in general practice. Less than 50% of Northern Ireland GPs believe that clinical governance will improve patient care in the practices of doctors who give cause for concern and only just over half were committed to the concept of clinical governance. Similarly about 50% of Northern Ireland GPs appear to believe that either appraisal or revalidation will improve patient care in the practices of doctors who give cause for concern.

2.5 THE LOCAL PICTURE - STRENGTHS AND WEAKNESSES IN THE CURRENT SYSTEM FOR THE MANAGEMENT OF UNDERPERFORMANCE

The general weaknesses in the current system for the management of underperformance of GPs in Northern Ireland are well known and have been discussed in other documents such as the CMO's report "Confidence in the Future".

In a recent review of new cases, giving rise to serious concern, over a 5-year period (36 GPs) by one Health and Social Services Board, all were managed by the relevant Board. The Board was the body by and to whom the concerns were identified. In most cases reported below the serious concern related to potential risks for patients.

In one third of cases recorded other organisations or bodies contributed significantly or provided input to the assessment and management of cases over a period of time. Such organisations include the Department of Health and Social Services and Public Safety, the Local Medical Committee and the Royal College of General Practitioners. In no cases were organisations external to the Board involved throughout the entire process involving any individual GP.

The major sources of concern regarding GP performance arose from Board monitoring processes and from patient complaints made to the Board (66%). The management of some cases reviewed extended over a number of years.

The numbers and percentages of cases by nature of allegation are as follows (note that 50% of cases contain more than one allegation).

Nature of Allegation	Number of Cases (% of Total Number Cases)*
Clinical underperformance	19 (52%)
Professional misconduct	11 (30%)
Terms of service	9 (25%)
Fraud	9 (25%)
Sickness	8 (22%)
Partnership issues	5 (13%)
Criminal	1 (2%)

*Total number of cases reviewed = 36

There were also large numbers of contacts made with the Board about 'routine' complaints or allegations, which were dealt with by the Board, and these were not reported on in this review.

2.6 SUPPORT TO GPS AND THEIR PRACTICES

In 25% of cases where serious concern was identified, specific support was offered or provided to underperforming GPs. Examples of support included private treatment for the GP out of local area, occupational health service provision, and offers of individual or practice mentoring, and offer of educational support. These examples were tailored to individual circumstances and often had a cost associated with them. Costs were met by the Board. GPs did not necessarily accept offers of support.

2.7 OUTCOMES OF BOARD ACTIONS

In half of the 36 cases reviewed the Board's initial action was informal involving assessment by the Board and appropriate remedial action.

Out of the 36 cases reviewed by the Board:

- 18 were initially dealt with informally;
- 4 were managed through established Board assessment processes and proceeded to further investigation;
- 5 were referred on for disciplinary investigation by another body, eg the General Medical Council; and
- the remaining 9 had formal assessments but did not proceed to any disciplinary investigation.

Surprisingly the lack of management, contractual or regulatory levers within a Board's relationship with GPs can facilitate case sensitive processes of performance assessment and management. This is because a Board has no powers to require GPs to cooperate with a management process, nor does it have powers to immediately suspend GPs. It can only obtain such cooperation or sanction eventually in some cases at the stage when serious concerns have been evidenced sufficiently to allow disciplinary action to be taken, including referral to the GMC. The GMC has previously had lengthy and legislatively bound processes that took a long time. This has enabled Boards to develop differing approaches over time to assist under performing GPs. Unfortunately this has also mitigated against the earlier patient protection, as an under performing GP can choose to take up such offers of support and assistance at will.

Case Study

3 GP Practice. The doctors do not have formal practice meetings. Serious concerns about a range of clinical prescribing issues over time were identified by the Board.

The concerns included the following:-

- High level of prescribing of minor opiates;
- Poor recording of prescriptions;
- Poor monitoring of long term treatment.

Board input since then included:

- Assistance from a locality pharmacist working directly in the practice for 2 years.
- Training for practice staff.
- Development of repeat prescribing systems for the first time.
- New clinical computer system.
- New practice staff.

Case Review

- Practice organisational and staffing issues addressed.
- GPs 'override' practice systems and computer system in response to patient demand.
- Serious prescribing concerns remain.

2.8 THE FUTURE

Most commentators regard some form of external validation and/or testing of performance concerns as essential for quality improvement. Yet how can this be achieved at this point in Northern Ireland given the confidence issues that exist for patients and GPs? Major reforms described in chapter 3 will eventually be implemented in Northern Ireland to ensure improved monitoring and accountability of doctors including:

- the introduction of clinical and social care governance;
- regular revalidation of all doctors by the GMC;
- annual appraisal of doctors and a system to address poor performance;
- mechanisms to enable the health service to detect and learn from adverse events.

Some of these reforms are developing faster elsewhere in the United Kingdom but there are already practical difficulties with the timescale for implementation. There is a need, in Northern Ireland, to improve the current way the service manages those

cases where concerns relating to potential underperformance by GPs are identified, or will continue to be identified in the short to medium term future.

Recommendations should build quickly on current structures in the interim whilst the new reforms are developed and implemented in Northern Ireland. These recommendations should focus on enhancing current Board processes and should include, for the first time, the provision of advice by peer GPs at earlier stages with the aims of quality assuring Board views and action plans about performance concerns. The early and regular involvement of peer GPs in current Board processes should help to influence under performing GPs to improve the quality of their performance and thereby protect patients at the earliest possible stage. Early identification may also be of benefit to the individual practitioner and his professional colleagues. There is need to have greater transparency and consistency of approach in current processes in Boards. Lay involvement should be an integral part of those processes.

Given the current numbers of GPs, who are identified without the use of formal performance screening procedures, it is anticipated that there could be 12 cases per annum in Northern Ireland where serious concerns about performance are expressed. These cases will require the active involvement of the HSS Board, peer GPs, the particular GP concerned and lay people in a structured approach to the assessment and management of the case.

2.9 SUMMARY RECOMMENDATION

Pending implementation of major reforms (chapter 3) to improve quality of care and individual and corporate accountability, current HSS Board processes for dealing with potential underperformance of GPs should be enhanced. These processes have been identified in Chapter 4.

CHAPTER 3

THE PREVENTION OF UNDERPERFORMANCE

3.1 INTRODUCTION

It is a professional duty of all medical practitioners to keep up to date and to provide the best possible care for their patients.

3.2 PERSONAL MOTIVATION

The most important force to maintain that drive for quality is internal personal motivation.

General practitioners should be able to take pride in their work, be recognised by their patients for a job well done and be valued by society for their contribution to the healthcare of their community with acknowledgement that core tasks have intrinsic value.

In order to maintain that essential personal motivation they need to feel empowered, knowing that individuals can contribute to and influence the organisation governing their work. In addition, in order to maintain motivation it is important that individuals are appropriately financially rewarded for their work.

3.3 OCCUPATIONAL HEALTH SERVICE

It is accepted that poor health is a significant factor in many cases of underperformance. The extent of health problems amongst general practitioners is not known as GP's are known to be poor at recognising and reporting health problems in themselves and very often take inappropriate action when ill health does occur. Recent research carried out in Northern Ireland has highlighted the cultural and behavioural changes that need to take place, at undergraduate and postgraduate level, to ensure that GPs develop a positive approach to self care. Where problems arise they should be encouraged to access Health and Social Services, and where appropriate, an occupational health service.

In order to minimise the effect of poor health and thereby reduce the potential for underperformance it will be of great importance to introduce an occupational health service for GP's in Northern Ireland. Where health concerns are identified as a cause of underperformance, during the local assessment process, the GP should be offered a specialist occupational health assessment – carried out by a designated consultant occupational health physician. Problems identified should lead, where appropriate, to referral for treatment and if possible, should include the support of the GPs own GP – who should not be a member of his own practice.

3.4 CLINICAL AND SOCIAL CARE GOVERNANCE

It is proposed that Clinical and Social Care Governance (CSCG) should apply to the recently announced Local Health and Social Care Groups in primary care, which are to commence their activities in April 2002. GPs will, therefore, not only have to work within their contractual obligations but also within this framework.

CSCG is an organisational concept and is defined as "*a framework through which ...organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in care will flourish"*

Implementation of CSCG will support GPs and primary care teams and will provide data about individuals and team performance. Variations in performance will be identified and mechanisms to ensure that all are performing to their full potential will be made available. However, it is recognised that Local Health and Social Care Groups will take some time to become established and to develop governance arrangements. It is, therefore, important that strategies to support CSCG are identified and introduced as soon as possible.

It is the professional responsibility of an individual GP to keep up to date, and to provide the best possible care to their patients. It will be essential that Local Health and Social Care Group have an infrastructure to monitor activity and where an individual's performance gives cause for concern, to provide support or remedial action when necessary. Various sources of data relating to an individual GP and GP practice exist including GP practice generated data, HSS Board, and data from the Central Services Agency. The content of the data available will be different depending on its source. Clinical audit should be promoted as an integral part of GP practice and Local Health and Social Care Group, and should be made available to HSS Boards, if appropriate.

3.5 APPRAISAL

Currently, the culture in the HPSS does not encourage doctors to come forward to seek help when concerned about their performance. The introduction of appraisal and personal development plans in a confidential and supportive environment should ensure that prevention is the solution to underperformance in the long term.

Appraisal is a process whereby an individual general practitioner has a regular review of their professional development and recommendations for further actions are planned. It is a valuable tool for supporting an individual in their professional development; it may identify areas of need and enable an individual to further develop. It is acknowledged that appraisal will require additional resources but, wherever possible, it should be built on existing data sources. In order to avoid duplication of effort and to minimise demands on clinical time, it should complement the activity required for revalidation. There are 4 possible outcomes from an annual appraisal: -

1) Satisfactory outcome with an agreed development plan, to be undertaken and reviewed within the year;

2) Specific development needs identified relating to performance, where specific action is required;

3) Further advice and assessment is required; or

4) Public safety issues are identified; the appraisal process is deferred and the case is referred to GMC or other disciplinary body for further investigation.

Whilst annual appraisal is a tool whereby all doctors can improve their performance, quality of care also is determined by many other factors. Underperformance may not be the fault of the individual practitioner but of systems' failures. Where these are highlighted during the course of the appraisal process, there is a need to have a communication pathway in place to enable action to take place.

Professional appraisal will be supported by the process of Clinical and Social Care Governance, which should provide one of the data sources to enable the appraiser and appraisee to come to their conclusions.

There is now agreement, in principle, with the profession that appraisal should be introduced here. However, in order to progress this further in Northern Ireland it will be necessary to agree a process of appraisal within the profession. Detailed discussions are currently taking place. Agreeing structure and process will be of importance. This will include the identification and training of potential appraisers in addition to all parties coming to an agreement regarding the costs of the process.

It is evident that the appraisal model will have to evolve over time, taking account of CSCG activities, local developments in structure and processes in the HPSS and the evolving needs of revalidation.

3.6 PERSONAL DEVELOPMENT PLAN

Each individual practitioner is required to keep up to date, and should review their performance, identify their learning needs and produce an individual Personal Development Plan (PDP). This personal development plan should provide the basis of that individual's educational activity.

Expertise is needed to facilitate the production of and regular review of a PDP by a GP Tutor. In order that an individual GP maintains his/her performance and matches educational needs to individual requirements, all GPs should be required to produce a PDP. There is, therefore, a need to identify and provide an adequate number of trained GP tutors to carry out this task.

3.7 REVALIDATION

This is a process whereby an individual practitioner is required to demonstrate that they remain fit to practise. It is part of professional self-regulation. This process is currently being developed by the General Medical Council, which has identified that appraisal will be a key element of revalidation.

The GMC is nearing the final stages of agreeing the model for revalidation. This will require legislative change and dependent on this, the first practitioners may expect to be revalidated in 2004. It will be essential that GPs here will have had the opportunity to develop a folder consistent with revalidation requirements and experience the appraisal process prior to the introduction of revalidation. It will, therefore, be necessary to agree and provide support for appraisal to match that time frame.

3.8 VOCATIONAL TRAINING FOR GENERAL PRACTITIONERS

The current regulations governing vocational training are Medical Practitioners (Vocational Training) Regulations (Northern Ireland) 1998. However, the content of these Regulations has not changed significantly in recent decades. During that time the work of general practice has changed significantly. GPs spend more time looking after complex medical problems. They have taken on a greater range of tasks. They now work in a very different multidisciplinary environment. It was the opinion of the Group that the current interpretation of the Vocational Training Regulation is too rigid to meet the demands on new practitioners.

There is a need to ensure that current arrangements for vocational training equip a new GP for the tasks to be encountered in the modern health service. It is vital that they receive necessary clinical skills and management training in the appropriate areas and that they acquire the skills and knowledge required to maintain a process of "lifelong learning".

It is acknowledged that the general practice component of vocational training is too short and that programmes of training should match an individual's learning needs.

Appropriate investment in these critical formative years in a new professional's life will help provide the tools that will avoid underperformance in later life.

NON PRINCIPALS

All quality initiatives identified in this chapter should be accessible to the range of non-principals who might work in general practice. These initiatives include structures and processes at local level for the introduction of appraisal, clinical and social care governance and personal development. As processes for revalidation and appraisal are put in place, GPs, as employers should ensure that non-principals can demonstrate evidence of successful participation in both revalidation and annual appraisal. Where serious cause for concern has been identified, the non principal, as any other GP, should be the subject of assessment procedures as outlined in Chapter 4.

It is recognised that the introduction of Supplementary Lists would require legislative changes. However, the introduction of such lists would provide another quality assurance mechanism for general practice.

3.9 RECOMMENDATIONS

Positive approaches to self care should be actively encouraged through existing undergraduate and postgraduate programmes.

Where health concerns have been identified as a cause of underperformance the GP should have access to a specialist occupational health assessment.

A collaborative approach to the development of an appraisal process, which meets the needs of all GPs in Northern Ireland, is urgently required. This process should complement revalidation requirements.

Enhancement of educational provision of vocational trainees and principals should be considered.

As soon as the legislative programme permits, the opportunity for the introduction of Supplementary Lists for non principals should be investigated.

CHAPTER 4

THE LOCAL PROCESSES FOR THE RECOGNITION, ASSESSMENT AND MANAGEMENT OF UNDERPERFORMANCE

4.1 INTRODUCTION

Underperformance can be defined as the repeated failure to meet acceptable standards over a period of time as expressed in the document "Good Medical Practice".

It is important to have an agreed and transparent process, based on clearly defined principles, to promote a supportive environment for the early detection and management of underperformance. Central to this process is ensuring patient safety and improving the quality of patient care. Given that many cases of underperformance arise from systems' failures, investigation, assessment and management of underperformance are likely to be multifaceted.

Rather than await crisis intervention, developing a framework in advance, which clearly identifies roles and responsibilities, and one, which is seen to be fair, is in the interests of practitioners, the public and the wider HPSS. This chapter aims to set out the principles and processes for the identification and management of underperformance, taking account of:-

- Existing processes already developed at local level;

- St Paul's Toolkit for managing doctors whose performance gives rise to concern (RCGP);

- Confidence in the Future and Best Practice, Best Care (DHSSPS);

- Prevention Better than Cure- Ensuring safer patients and better doctors (Scottish Executive); and

- National developments including the development of National Clinical Assessment Authority, the National Patient Safety Agency and forthcoming GMC revalidation procedures.

4.2 THE PRINCIPLES UNDERPINNING THE MANAGEMENT OF UNDERPERFORMANCE

It is recommended that, when dealing with a doctor whose performance gives rise to concern, the following principles should be adopted at local level in order to provide consistency of approach across the 4 HSS Boards:-

- The overall aim is to ensure patient safety;
- There should be a clear definition of unacceptable practice, based on Good Medical Practice for General Practice;
- Fairness, openness and objectivity should underpin any assessment of the identified concern;

- The principles of confidentiality in relation to doctors, informants and patients should be documented;
- The lines of responsibility should be clearly defined;
- The aims, objectives and responsibilities of a group that assesses a situation should be clearly defined;
- Except in certain circumstances (see below) local resolution should be the norm;
- Independent advice and performance assessment should be available and utilised, when necessary; and
- The decision making process should be clearly documented.

4.3 LINES OF RESPONSIBILITY

Under current structures and arrangements, HSS Boards are responsible for ensuring adherence to GP contractual arrangements, and for probity arrangements in relation to payments made through the Statement of Fees and Allowances.

Whilst arrangements may change following introduction of Local Health and Social Care Groups and the Review of Public Administration, at present, HSS Boards, together with key stakeholders, are best placed to facilitate the development of mechanisms which encourage staff, colleagues and the public to bring forward legitimate concerns and for having local procedures in place which will provide clarity and consistency in the decision making process.

In the meantime, Boards should develop their role in collaboration with local professional bodies.

4.4 WHO ARE THE KEY STAKEHOLDERS?

Any local process should have local support of the profession and the public. It will only be successful if it is widely known and is seen to be fair. In any local process the following might be seen as key stakeholders:-

- Senior HSS Board staff e.g. Director of Primary Care/ GP medical Adviser;
- Representation from LMC and RCGP;
- As LHSCGs develop, input from those identified as leaders in the promotion of quality, and performance development and review processes;
- Local representation of the NICPGMDE; and
- Lay representation.

4.5 THE PROCESSES FOR THE RECOGNITION AND ASSESSMENT OF UNDERPERFORMANCE

It is recognised that underperformance may come to light through proactive monitoring, or by reacting to concerns expressed through complaints procedures, staff and professionals' concerns, anonymised reports, and through self referral. Once problems have been identified it is vitally important that GPs should recognise their responsibilities in the process of identifying, assessing and coming to terms with their

own performance. It is also important that within a partnership, the partners jointly have a responsibility to be involved.

HSS Boards already collect information relating to specific GP practices including information of list size and practice profiles, premises and staff, access to services, prescribing details, immunisation rates, cervical screening uptake, sustained quality scheme, annual reports, complaints and some audit data. But, routine performance indicators are not used.

It is recognised that performance indicators may be used as a tool for screening and improving performance; however, the Group considered that caution should be used in the interpretation of the data. In particular it was considered that performance indicators could only be interpreted in light of knowledge of the working environment of the practitioner. It was considered that they might be best used in the future at local level, perhaps in the context of a LHSCG, to support change and enhance performance.

4.6 ASSESSMENT PROCESS

The general principles outlined in the St Paul's document should provide a template for the consistent approach to dealing with concerns. There should be a protocol in place, which sets out procedures to be followed including how to respond to informants, and the documentation and handling of isolated complaints. The system should be able to distinguish between genuine concerns and rumours by using a consistent approach to the criteria for assessment (see below). Each Board should have processes endorsed by the LMC, Health and Social Services Council and the Management Board of the LHSCG. It should take account of developments in relation to any changes in complaints procedures, appraisal and revalidation processes.

A primary care medical advisor in each HSS Board should be the lead individual for co-ordinating activity regarding procedures for the assessment of a practitioner's performance, where concerns have been raised. The aim should be for local resolution except where there are concerns about patient safety, statutory requirements or probity. In such circumstances, consideration should be given to referral to the GMC and/or other statutory bodies.

This assessment and decision-making processes should be in three stages. Every effort should be made to resolve the problem locally. Participation should be voluntary; however, consideration would have to be given to the reasons why the practitioner did not wish to participate and further action taken, if necessary, e.g. referral to an independent assessment group such as NCAA, or referral to GMC, suspension, or referral to local statutory committees.

4.7 SUGGESTED MODEL FOR LOCAL PROCESSES

It is envisaged that ultimately there will be three stages in the processes in identifying and dealing with possible underperformance. This is in keeping with arrangements described in "Confidence in the Future".

Stage 1- Local processes and procedures
Stage 2 – Professional Performance Advisory Panel
Stage 3 – Further Action

This process is outlined below. A diagrammatic representation is contained in Appendix C.

Stage 1

The structure and process of stage 1 is represented in Appendix D. Each Health Board should set up a Local Advisory and Investigative Panel.

The composition may vary but should include a range of professionals and lay persons eg:-

Senior Primary Care Manager from HSSB
Primary Care Medical Adviser HSSB
Senior LMC Representative
Representative from RCGP
Representative from NICPMDE
Representative from LHSCGs
Lay representation, e.g. Health and Social Services Council or lay representatives from LHSCGs

The panel should meet on a regular basis perhaps quarterly, but may need to be convened at short notice to deal with any urgent problems.

The panel's composition, constitution and remit must be clearly stated. The issues of confidentiality must be clarified by each panel. Where appropriate legal advice should be sought; panel members should be familiar with relevant legislation (see Appendix E).

The role of this panel will be to consider expressions of serious concern. These concerns may come from many sources such as patient complaints, professional concerns expressed by other doctors, nurses or other professionals, Health Board staff, practice staff, or other sources. The concerns should generally be in writing and be carefully documented. The HSSB should have a policy of informing appropriate professional and practice staff as to how and to whom concerns should be addressed.

It is likely that the Medical Adviser to the Board may already have taken some action regarding concerns while a Panel is convened. However it is recommended that all concerns and actions are documented and brought before the Panel even if resolution has been achieved or is in process of being achieved. Appendix F provides one example of defined criteria used by the Manchester Performance Panel to decide whether there is significant cause for concern about a GP's performance. Further information is available in the St Paul's Toolkit. Also included in this appendix are two flow charts " When things Go Wrong in Primary Care " (BAMM –October 2001). These outline the work of an assessment panel in the determination of risk to patients, possible causes and actions.

The panel's role will be to assess these concerns and establish their degree of seriousness. The Panel should decide if further investigation or action is required, and ensure that appropriate action is taken and followed through.

The Panel will always aim for local resolution when that is appropriate.

It will be important that the Panel's decision and recommended actions are carefully documented so that the process can be reviewed over time.

Possible Outcomes at local level have been developed into a 3 stage process, summarised at Appendix C. These outcomes include:-

1. The panel may decide there is currently no substantial evidence for concern and may make no recommendations for action.

2. The panel may decide on current information to monitor and review the situation.

3. The panel may decide there is an area of concern and may initiate local action. This will almost always require further investigation in which case an interview with the practitioner by at least two members of the panel may be appropriate to gather further information on the issues. The results of this interview would be reported back to the Panel.

4. Based on the results of an investigative visit to the practice, the Panel may decide a local action plan to address the issues. This could involve:

   - support for the practice infrastructure,
   - re-training in some specific area
   - clinical supervision / mentoring,
   - referral for health assessment and/or treatment of the practitioner,
   - some other action.

   In individual cases the Northern Ireland Council for Postgraduate Medical and Dental Education should lead on educational issues – in the staged assessment process and in the development and delivery of targeted training and mentored supervision. The Director of Postgraduate General Practice Education may, in addition, offer review and support to the GP.

5. The panel may decide that the risk to patients is high requiring immediate action. The major issue may involve performance, conduct, health or discipline. Immediate action could include referral to GMC or local disciplinary procedures or referral for further formal assessment for example to a body such as the National Clinical Assessment Authority.

The financial considerations of this local action both to the individual and to the Board will need to be clarified as part of this process.

If however either local resolution fails or if a practitioner fails to co-operate then referral to stage 2 will be necessary.

Possible Outcomes Stage 1

- No action
- Monitor and review after specific time
- Referral for health assessment / treatment
- Referral to NICPGMDE
- Retraining / clinical supervision / educational plan
- Support for practice infrastructure
- Other – referral for further investigation via existing disciplinary procedures, or consider suspension

Stage 2 – Professional Performance Advisory Panel

This regional expert group will be set up by the CMO and will assist the HSSB in resolving difficulties arising from the possible poor performance of doctors. (see Confidence in the Future p 20).

The PPAP, after examining the evidence, may advise the HSSB to continue with attempts at local resolution or may advise referral on to stage 3. The referral will be the responsibility of the Health Board.

Possible Outcomes Stage 2

- Refer back to Health and Social Services Board
- Recommend referral to eg NCAA, GMC, or other disciplinary procedures
- Recommend suspension pending further action (currently not available except through GMC or HPSS Tribunal);

Stage 3 - Referral

This stage involves referral to other agencies. The referral will be the responsibility of the Health and Social Services Board.

This may be to the NCAA or it's equivalent, GMC or other disciplinary body. This stage may also involve suspension of the doctor until further investigation is completed and a management strategy is determined.

The Assessment Process recommended in this chapter is a voluntary process and every effort should be made to ensure active participation by the GP involved. However, should a GP not wish to participate in this procedure, it may pose a significant risk for patients. At present, only a local HPSS Tribunal has the power to suspend. A new power of interim suspension has been granted to the GMC via the Interim Orders Committee. The principal criterion is in the public interest in stopping a doctor who represents a danger to patients from practising until their fitness to practise has been determined.

It was the view of the Working Group that current procedures are lengthy and where there are serious issues which may put the public at risk, HSS Boards should have the power to suspend, without prejudice, where the Assessment Panel and/or the Professional Performance Advisory Panel considers it to be appropriate.

4.8 RECOMMENDATIONS

Health and Social Services Boards, in collaboration with professionals and others, should develop a consistent, transparent approach to the identification of potential problems, and supportive interventions.

The Group recommends the formation of Local Advisory and Investigative Panels, which should use agreed tools of assessment.

There should be local mechanisms in place to ensure that staff working in general practice know the structure and process of the above procedures.

Pending full assessment, where serious concerns are raised regarding a doctor's performance, the Working Group recommends that HSS Boards should have to power to suspend, without prejudice. This recommendation is in keeping with those outlined in " Confidence in the Future". It will require legislative change.

APPENDIX A

REMIT AND MEMBERSHIP OF THE GROUP

Remit

The Remit of the Group is set out as follows –

- to review current formal and informal arrangements when concerns are expressed about underperformance in general practice;

- to make recommendations for fair and open arrangements for dealing with such concerns;

- to make recommendations to strengthen and support the prevention of underperformance; and

- to recommend a process for dealing with any training issues which may emerge.

Membership

Dr W R Thompson (Chair) (SHSSB)

Mr D Baker (DHSSPS)

Mr D Bingham (DHSSPS)

Dr K Booth (EHSSB)

Dr M Briscoe (DHSSPS)

Dr I Carson (RGH)

Dr P Colvin (RCGP (NI))

Dr B Dunn (GPC (NI))

Mr Seamus Magee (SHSSC)

Dr A McKnight (NICPGMDE)

Professor P Reilly (RCGP (NI))

Dr Tony Stevens (Consultant, Occupational Health, RGH)

Dr B Sweeney (GPC (NI))

APPENDIX B

The current disciplinary and regulatory arrangements are in 3 parts:

1. Disciplinary Committees;
2. HPSS Tribunal
3. GMC Fitness to Practise procedures.

Disciplinary procedures

In considering action, following an allegation that a practitioner has breached his terms of service, a Board may consider referring the matter to:

- A discipline committee;
- A tribunal;
- The GMC; and/or
- The police.

A case may be referred by a Board to a Disciplinary Committee of another Health and Social Services Board if it considers that a individual GP is in breach of his Terms of Service. It is a matter for this committee to determine whether a breach of Terms of Service has taken place. These committees have no powers of suspension but will make recommendations as to the action to be taken against the GP. The referring Board has to accept the findings of the Disciplinary Committee. Outcomes include a formal warning to the GP, financial penalties, limiting the number of patients that a GP may treat or referral to a Tribunal or GMC. Appeal of the decision of the Committee is to the Department of Health, Social Services and Public Safety

The Tribunal

Referral to a Tribunal is exceptional and only takes place when serious allegations are made against a GP. The Tribunal Regulations 1995 (and amendments) determine the composition and procedures of the Tribunal. The chairman is appointed by the Lord Chief Justice and other members are determined by the Department. The Tribunal has the powers of suspension from the Medical List if it is considered necessary to protect patients and efficiency and effectiveness of the service. Appeals against a Tribunal's findings are made to the Supreme Court.

General Medical Council

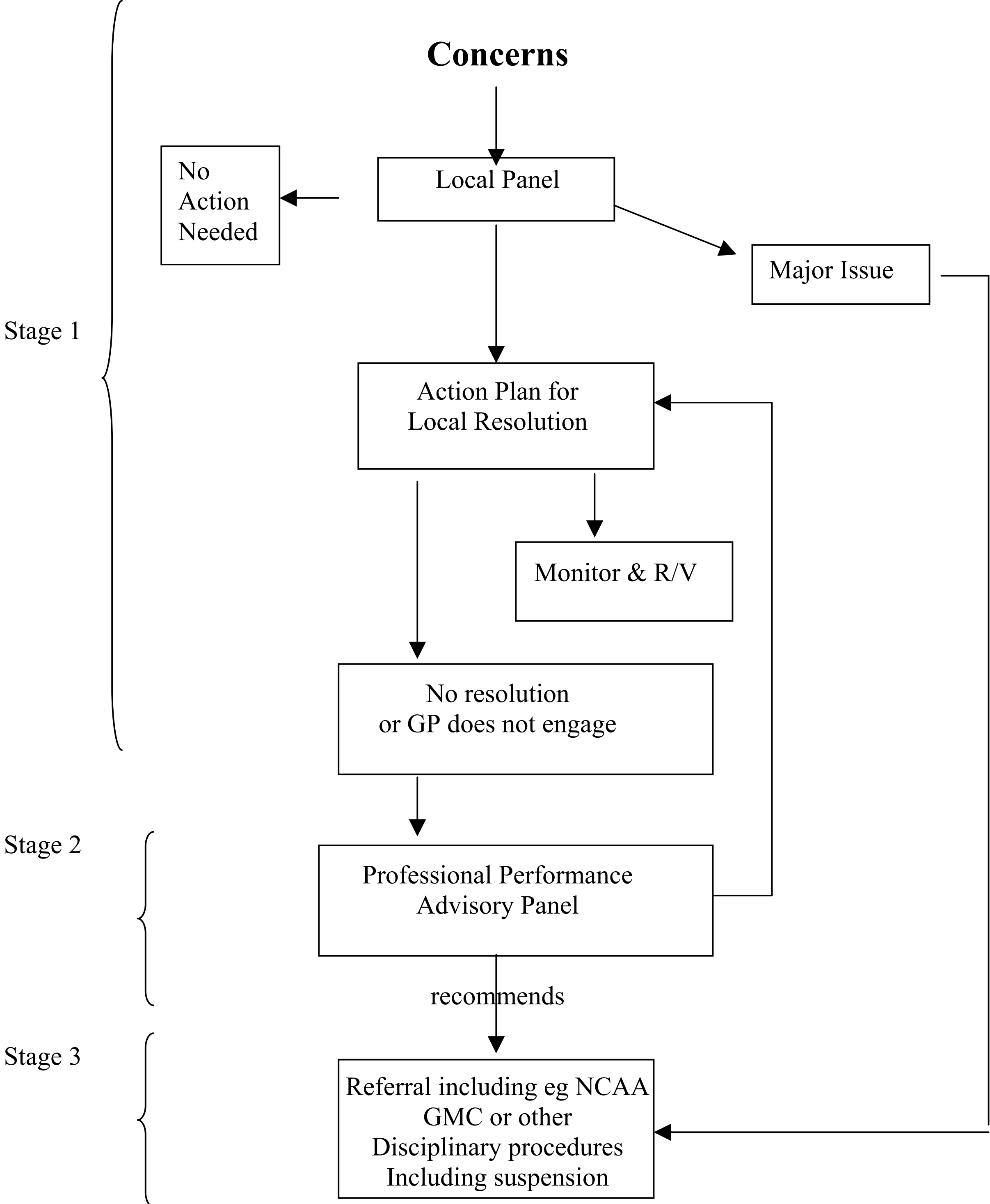
The General Medical Council is a statutory body, which is responsible for maintaining a register of all doctors who are licensed to practice as medical practitioners in the United Kingdom. Ensuring safe care of patient by doctors is a key function of the GMC. It is the responsible body for assessing whether a doctor's conduct, health or performance brings a doctor's registration into question.

Referral to the GMC should only be used when concerns about a doctor are so serious that they call into question whether a doctor should be allowed to continue to practise at all or whether the scope of their professional practice should be limited. New powers of interim

suspension have been granted to the GMC pending full assessment of a doctor’s fitness to practise where it is considered that there is a significant risk to the public.

APPENDIX C

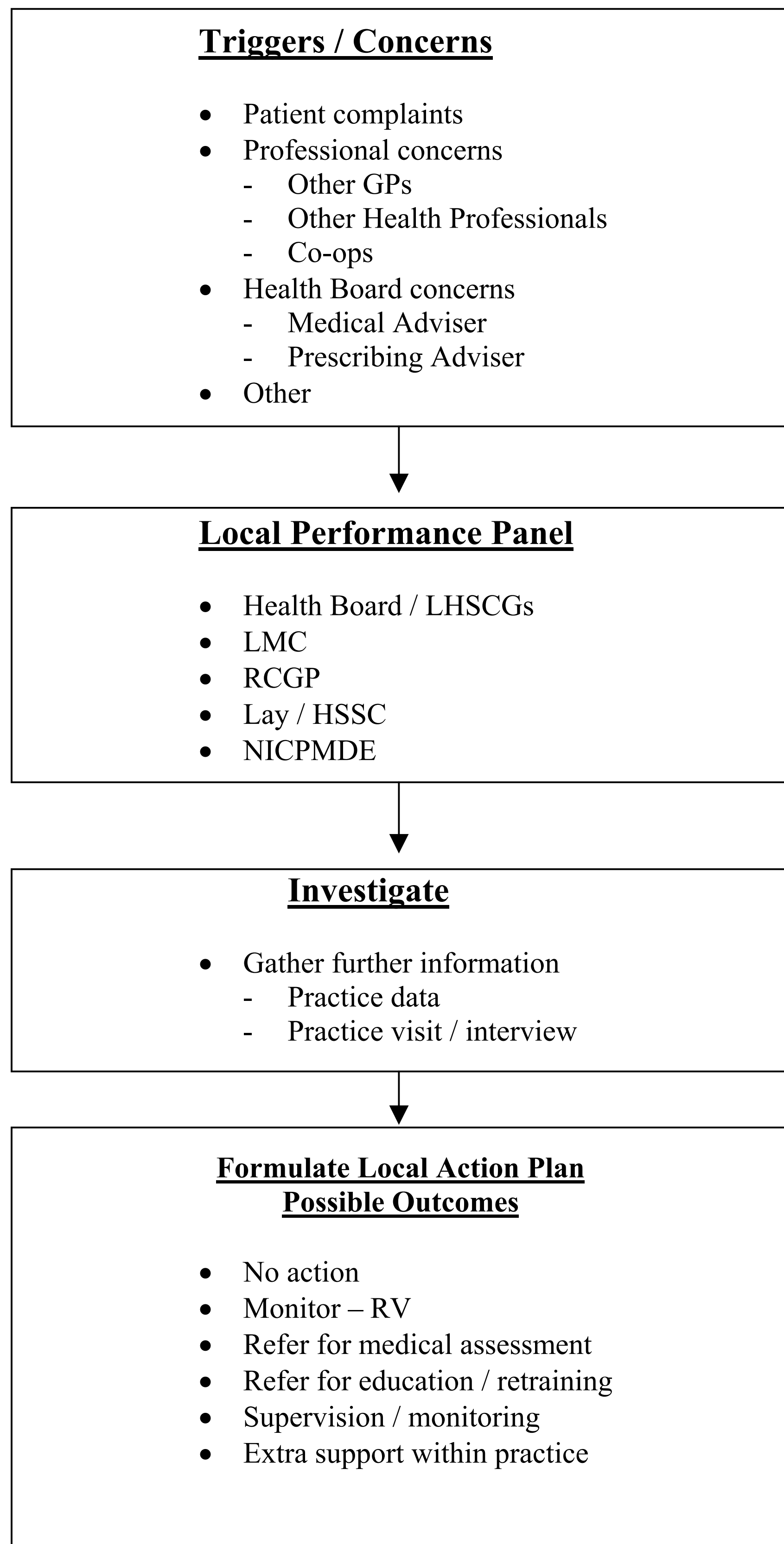
3 Stage process for dealing with performance problems of General Practitioners



APPENDIX D

STAGE 1 – Process for dealing with performance problems in GPs

Stage 1



APPENDIX E

Legal Considerations

Each case of underperformance under investigation should be considered on its own merits, and where there are any legal concerns, appropriate legal advice should be sought. The following issues should be considered. Systems should be in place for maintaining confidentiality and auditing procedures.

Confidentiality

The rules on confidentiality affect both the doctor under investigation, Panel participants and patients. The Panel has the responsibility of keeping information in such a way that is legal, so that the doctor does not suffer an infringement of his/ her rights.

The Data Protection Act is very detailed and complex. Therefore, those involved in the assessment and management of underperformance at Board level should familiarise themselves with the obligations and restrictions placed upon them by the Data Protection Act. Where appropriate legal advice should be sought.

Human Rights Act 1998

The Human Rights Act applies to all public authorities and renders it unlawful for a body, such as a Board to act in a way that is incompatible with " Convention Rights". Again, this is a complex piece of legislation which is beyond the scope of this documents but Panel members should ensure that they familiarise themselves with the fundamental principles and should seek legal advice where appropriate.

Among the Convention Rights of particular note are Article 8 and Article 1 of Protocol no. 1. Article 8 contains the right to respect for private and family life, a person's home and correspondence. It provides that there should be no interference by a public authority with the exercise of this right though it is subject to certain exceptions including public safety grounds and the protection of health and morals.

Article 1 of Protocol1 of the Convention provides that every natural or legal person is entitled to the peaceful enjoyment of his possessions. This extends far beyond physical possessions and may include other things such as the rights accrued under a contract. Removal of registration could interfere with such a right. Again there are exceptions, which allow interference with this right.

(Source: Prevention Better than Cure,

Scottish Executive July 2001)

General

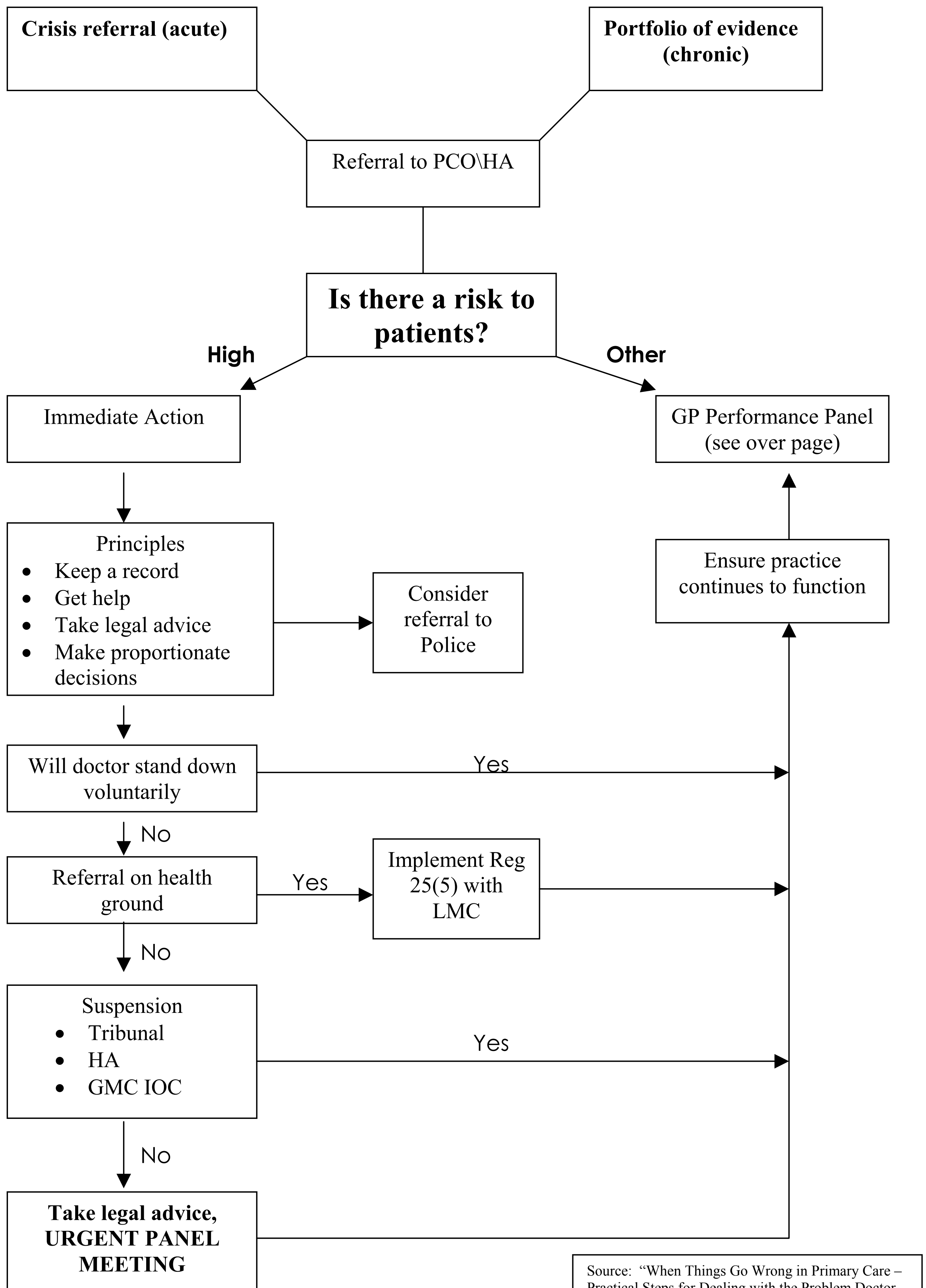
Practitioners retain any rights, which they may have under common law and, in appropriate cases, under employment legislation.

APPENDIX F

The Manchester Performance Panel has a series of criteria and definitions to decide whether there is significant cause for concern about a GP's performance:

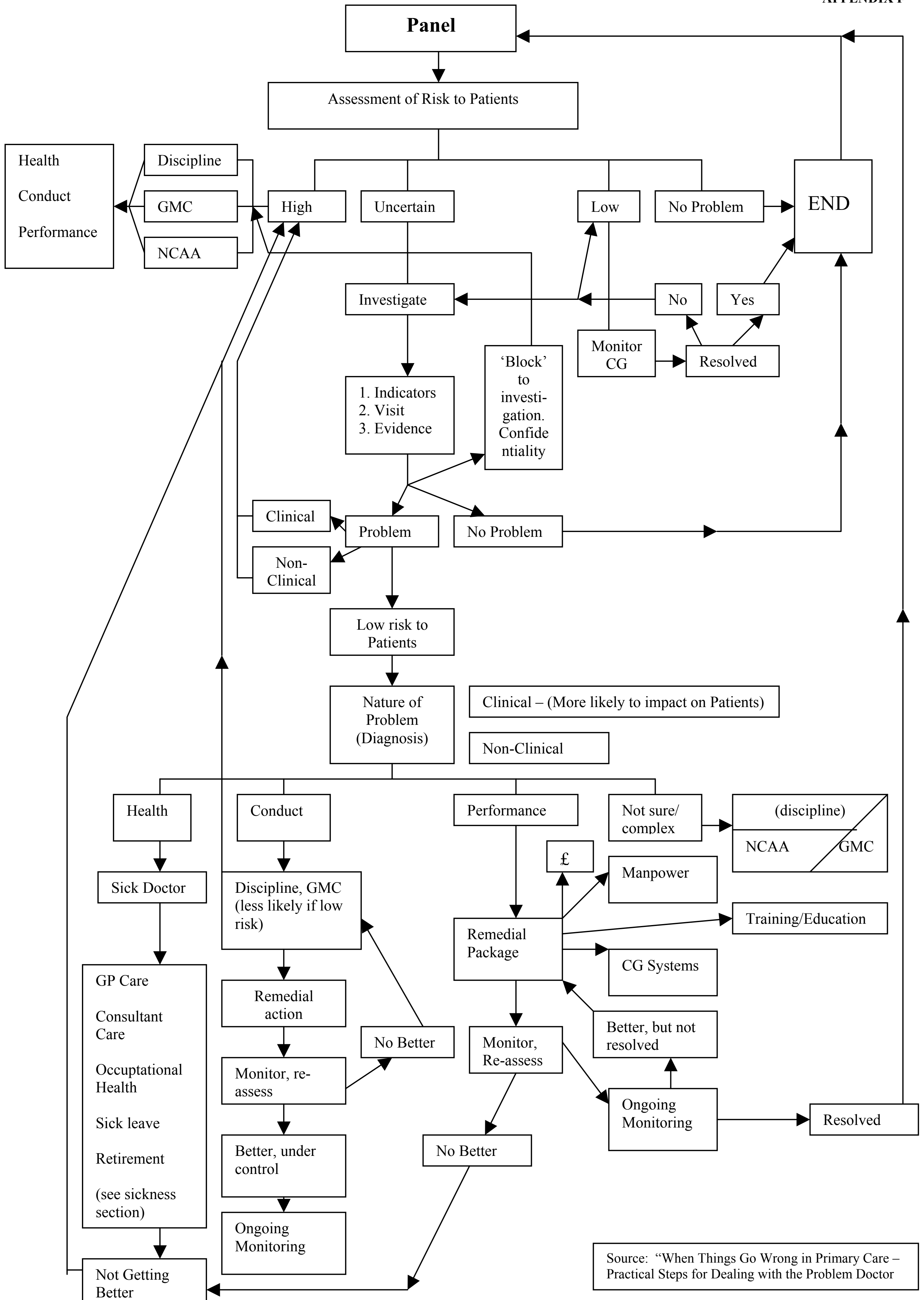
CRITERIA	DEFINITION
Service provision	Is there alleged poor performance in one or more of the following: Inappropriate treatment or medication Poor clinical performance Poor behaviour or attitude Poor administration or management
Severity	It is acknowledged that if the expressed concerns are substantiated, at the very least they represent sufficiently sub-standard performance to the point that they cannot be ignored and demand some form of action.
Repetitious	Has the alleged poor performance been on going over a period of time or occurred on at least two separate occasions?[1]
Substantiated	On the evidence available (preferably written) do the expressed concerns appear to be accurate and factual statements?
Inexcusable/indefensible action	Do the actions about which concerns are expressed fall well short of what a doctor would be expected to do in similar circumstances?
If all the above criteria are met the basis for defining poor performance has been established	
If poor performance has been established, the Panel considers the following to assist the decision for further action:	
Are there mitigating circumstances which are now resolved?	Were there temporary circumstances inside or outside the practice that might reasonably have been expected to affect the doctor's performance?
Is the doctor aware and addressing the concerns?	The doctor has acknowledged areas of poor performance and is addressing them.

[1] Whether the group decide on one or two expressions of concern will depend on the level of specificity or sensitivity they feel is acceptable.



Source: "When Things Go Wrong in Primary Care – Practical Steps for Dealing with the Problem Doctor

APPENDIX F



APPENDIX G

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