



Department of
**Health, Social Services
and Public Safety**

www.dhsspsni.gov.uk

AN ROINN

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

MÄNNYSTRIE O

**Poustie, Resydènter Heisin
an Fowk Siccar**

Confidence in Care Tackling Concerns Locally Baseline Assessment of Readiness Final Report

17 June 2009

CONTENTS

1	INTRODUCTION	3
2	PURPOSE OF THIS DOCUMENT	4
3	TACKLING CONCERNS THEMES AND READINESS	6
3.1	WHAT IS TACKLING CONCERNS LOCALLY?	6
3.2	CLINICAL GOVERNANCE ARRANGEMENTS	6
3.3	IDENTIFYING AREAS OF CONCERN	8
3.4	INVESTIGATION, REMEDIATION AND RE-SKILLING	10
3.5	INFORMATION MANAGEMENT	11
3.6	RESPONSIBLE OFFICER AND GMC AFFILIATES	13
4	SUMMARY OF MAIN THEMES/GAPS/KEY AREAS OF WORK	15
4.1	GAPS/KEY AREAS OF WORK	15
4.2	NEXT STEPS	16

APPENDICES

Appendix 1 - DH Tackling Concerns Recommendations

1 INTRODUCTION

The *White Paper Trust, Assurance and Safety : The Regulation of Health Professionals* sets out a programme of reform to the United Kingdom's system for the regulation of health professionals, based on consultation on the two reviews of professional regulation published in July 2006: *Good doctors, Safer Patients* by the Chief Medical Officer (CMO) for England and the Department of Health's *The Regulation of the Non-Medical Healthcare Professions*. It is complemented by the Government's response to the recommendations of the Fifth Report of the Shipman Inquiry and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, *Safeguarding Patients*, which sets out a range of measures to improve and enhance clinical governance in the NHS.

The Department of Health (UK) programme of reform of the regulation of health professionals is structured across seven working groups, each with a number of sub-groups focusing on particular areas. The seven working groups are:

- 1. Enhancing confidence in the health professional regulators** – including the size and composition of their councils, the strategic role of the councils, and accountability to patients, the general public and Parliament.
- 2. Extending professional regulation** – advising on the criteria to determine whether emerging health care roles should be regulated, and making recommendations about existing non-regulated healthcare roles.
- 3. Medical revalidation** – the principles and next steps for implementing the revalidation of doctors in the UK.
- 4. Non-medical revalidation** – developing general principles, applicable to all professions other than doctors, for a new system of appraisal and revalidation.
- 5. Tackling concerns nationally** – advising on the establishment of an independent body to adjudicate on medical fitness to practise cases brought before the General Medical Council.
- 6. Tackling concerns locally** – coordinating a series of reforms which will strengthen local arrangements for identifying poor practice among healthcare workers and taking effective action to protect patients and the public.
- 7. Health for health professionals** – piloting and evaluation of referral services for doctors, dentists, and development of an integrated strategy for the health of all health professionals.

DHSSPS have translated this programme of work for Northern Ireland into the Confidence in Care Programme (and also integrated some outstanding work from *Safety First*). The Confidence in Care Programme has four workstreams encompassing the work emanating from the seven national working groups. The four workstreams are:

- Professional Regulation
- Tackling Concerns (Locally and Nationally)
- Medical and Non-Medical Revalidation
- Pharmacy

2 PURPOSE OF THIS DOCUMENT

The purpose of this document is to provide an assessment of the current state of readiness in Northern Ireland to implement the recommendations from Tackling Concerns Locally.

The assessment contained in this document was informed by consultation with key HPSS stakeholders during quarter one of 2009. As such the analysis contained in this document reflects the HSC structures in place at that time. The findings of the consultation were reviewed and updated in April 2009, following the publication of the Department of Health Tackling Concerns Reports (March 2009).

Those consulted during the baseline assessment included:

- HSC Trust Medical Director's
- HSC Trust Directors of Nursing
- HSC Trust Allied Health Professional Leads
- HSC Trust Directors of Human Resources
- HSC Trust and HSC Board Governance Leads
- Health and Social Care Board Primary Care Advisors
- Health and Social Care Board Ophthalmic Advisors
- Health and Social Care Board Pharmacy Advisors

The DH Tackling Concerns report proposes a possible 4-stage framework to tackling concerns: (i) Identifying potential concerns (ii) Investigation (iii) Local action/remediation and (iv) Referral to the national regulator.

The DH Tackling Concerns Locally Group established a series of working groups to take forward the work: These are:

- Clinical Governance
- Information Management
- Death Certification
- Performers List
- Responsible Officer
- GMC Affiliate

The DH working groups released their final reports in March 2009 in respect of Clinical Governance, Information Management and Performers List. The DHSSPS Tackling Concerns Working Group are currently bringing together a draft plan to address the implementation of the recommendations. Nationally legislation and guidance is developing on the Responsible Officer role, and this will be mirrored by NI specific regulations and guidance. The outcomes are awaited on the GMC affiliate pilots in GB, prior to any decision being taken with regard to implementation of GMC affiliates in NI. A separate but linked DHSSPS project is progressing work associated with new death certification assurance processes in NI.

The output of this baseline assessment will inform the programme of work to be taken forward to address the recommendations of *Tackling Concerns Locally*, and specifically the implementation plan referred to above.

The structure of this document is as follows:

Section 3: Identifies the main themes associated with *Tackling Concerns Locally* and summaries the current state of readiness of the HPSS against same

Section 4: Summarises the main themes which have emerged as a result of the baseline assessment and identifies the gaps/key areas of work to be taken forward to support the implementation of recommendations associated with *Tackling Concerns*.

3 TACKLING CONCERNS THEMES AND READINESS

This section outlines the main themes from *Tackling Concerns Locally* and provides an assessment of the state of readiness of the HPSS against same. Appendix 1 outlines the recommendations made by the DH Tackling Concerns Group in April 2009.

3.1 What is Tackling Concerns Locally?

Tackling Concerns Locally is concerned with:

- Strengthening the local processes for identifying and dealing with concerns over performance, conduct and health of healthcare professionals; and
- Improving coordination between local healthcare organisations and the national regulators.

The Tackling Concerns report proposes a possible 4-stage framework to tackling concerns: (i) Identifying potential concerns (ii) Investigation (iii) Local action/remediation and (iv) Referral to the national regulator.

The DH Tackling Concerns Locally Group established a series of working groups to take forward the work: These are:

- Clinical Governance
- Information Management
- Death Certification
- Performers List
- Responsible Officer
- GMC Affiliate

This document does not seek to assess the baseline status of the HPSS against the outputs of each of the above sub-groups, as these are addressed elsewhere. However, during the consultation processes with key stakeholders to inform this baseline assessment views were sought on the relevant aspects related to the areas of clinical governance, information management, responsible officer and GMC affiliate. The output of this assessment is reflected in this document.

The next sub-sections outline the main themes from DH Tackling Concerns Locally and provide an assessment of readiness of HPSS bodies to absorb same.

3.2 Clinical Governance Arrangements

For the purposes of Tackling Concerns Locally clinical governance is defined as:

A framework through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care.

This framework includes not only a number of specific processes and structures but more generally an organisational culture in which every member of the

organisation (managers and administrative staff as well as healthcare professionals) take joint responsibility for the quality and safety of the healthcare services provided. *Tackling Concerns Locally* focuses specifically on issues of poor performance, conduct and health in individual healthcare professionals (covering only a small part of the broader issues associated with clinical governance). *Tackling Concerns Locally* also emphasises the role of Boards of individual healthcare organisations in taking responsibility for ensuring that the organisation has appropriate structures, processes and resources associated with identifying issues for concern, investigating concerns, deciding on what action should be taken and access (where appropriate) to remediation, reskilling and rehabilitation.

The baseline assessment discussions with stakeholders sought information on the current arrangements in place both organisationally and for individual professionals in respect of clinical governance. The main findings of this were:

- All the organisations consulted have organisational clinical governance systems and process in place – though the precise nature and form of these arrangements differ by organisation. Generically, each Trust/Board has a Governance Committee reporting directly to the Board of the organisation. Governance Committees are constituted of executive and non-executive directors of the organisation. Below this level a range of governance structures are in place – the format of which is aligned with the broader organisational structures of each body. For example, in some organisations clinical governance leads employed within the medical directorate of Trusts are aligned to individual service directorates, in other organisations clinical governance leads are directly employed within service directorates/groups with links to the medical directorate. There are also examples of organisations which in addition to clinical governance leads have professional governance leads (specifically in respect of nursing, AHPs and social work). Governance systems are underpinned by a range of processes associated with incident reporting and management, complaints management, claims management, assurance frameworks, risk management, user views, patient safety programmes, implementation of standards and guidelines, audit etc.
- The general consensus of views by Trust representatives was that clinical governance arrangements have taken some time to bed down within the context of RPA. This is a particular challenge given the increased size of organisations and the need to embed clinical governance processes at all levels of the organisation. Limitations on capacity and resources for clinical governance in the current financial climate were also seen as a particular challenge. It was also highlighted that clinical governance was not traditionally a well resourced function in legacy Trusts (often posts associated with this function did not have substantive funding). These issues were compounded by the need to then make further financial savings in a traditionally under resourced function. However, the majority of those consulted felt that good progress in this area had been made, but accepted there was still much to do. In respect of Boards the clinical governance arrangements have been established within existing structures for some time and so have not recently suffered the same transitional issues as those in Trusts.

- On an individual profession basis there were differing views in respect of the robustness of clinical governance systems for different healthcare professional groups. The most mature clinical governance systems were viewed to be associated with nursing and medical staff, and to a lesser extent AHP's. Those consulted felt that recent developments in the changes to contracts for both consultants and GP's have increased the robustness of clinical governance systems for medical staff. However, Boards commented that clinical governance is still developmental at GP practice level (though the implementation of practice governance leads, the regionally standardised practice plans and QoF have supported the development of clinical governance in general practice). Particular concerns were raised in respect of the robustness of clinical governance systems and processes for community pharmacy and optometry practitioners. For each of these three groups new contracts are at various stages of negotiation. The view was expressed that significant opportunities exist to improve the clinical governance systems and processes for these groups via the leverage of a new contractual arrangement.
- The consultation process indicated that the culture of clinical governance and continuous quality improvement is more mature in some settings than others. In particular it was felt that the culture of clinical governance is less well developed in those groups which were identified as having less robust clinical governance systems and processes (community pharmacists and optometrists).
- Patient/client/public involvement with regard to continuous quality improvement and clinical governance was recognised by most to be functioning at an organisational and service level. All those consulted agreed that patient/client involvement with regard to quality improvement and clinical governance at an individual practitioner level was not well developed, and required robust tools for multi-source feedback to facilitate this. It was noted that one Trust has piloted 360 degree feedback for medical staff in conjunction with the Beeches Management Centre.

3.3 Identifying Areas of Concern

As identified under Section 3.2 *Tackling Concerns* emphasises the role of Boards of individual healthcare organisations in taking responsibility for ensuring that the organisation has appropriate structures, processes and resources associated with identifying issues for concern. The baseline assessment identified that the main existing systems and process via which concerns may be identified are; complaints, adverse incidents, claims, clinical audit, appraisal (for some staff groups), supervision, and staff, public/patients/clients and colleagues.

The general consensus was that whilst discrete information existed in respect of concerns raised through one of the above sources, information was generally not integrated. Stakeholders raised concerns that identifying any patterns with regard to concerns associated with an individual professional is compounded by the lack of information integration.

The management of 'soft' information in respect of concerns about an individual practitioner can be problematic. Often such information is derived informally and

the basis of the information has not been evidenced so careful handling of such information is required.

With regard to medical and dental professionals (and pharmacists from April 2009) stakeholders referred to the use of the National Clinical Assessment Service (NCAS). NCAS work with health organisations and individual practitioners where there is a concern about a dentist, doctor or pharmacist (from April 2009). However, many stakeholders indicated that whilst the advisory service from NCAS was helpful up to a point there was a gap in capacity in Northern Ireland to appropriately resource the skills and access the mechanisms needed in the case of remediation of re-skilling of healthcare professionals.

Medical Directors identified that the uptake of medical staff appraisal in secondary care had suffered in recent years due to the focus on the introduction of the new consultant contract and then RPA. However, the consensus was the appraisal uptake was now increasing, and that this improvement is essential to support the new processes of revalidation. A higher level of appraisal uptake was noted amongst consultant medical staff than for doctors in training and locums. It was noted that there is no standard quality assurance process in operation for medical staff appraisal in secondary care (though some Trusts have applied a QA process on a sampling basis).

A higher level of appraisal uptake has been maintained with GPs in primary care and the appraisal system for GPs which is run by NIMDTA is viewed as robust (though it was noted that the current system does not include summative elements). It was also noted that a quality assurance process exists within the GP appraisal scheme.

Mixed views were expressed with regard to AHP appraisal, with some Trusts indicating a high level of appraisal and others less so. Appraisal was generally reported to well embedded in nursing, with some stakeholders indicating that they have, or are introducing mechanisms to more effectively integrate nursing appraisal, KSF and supervision.

On a general point Trusts highlighted that the uptake and quality of appraisal has traditionally been variable across Trusts. With the merging of Trusts under RPA this has created a variable baseline of uptake and quality of appraisal across the organisations which have merged.

Local Advisory and Investigatory Panels (LAIP) are in operation in some of the Boards. Panel membership typically includes, lay representatives, LMC, RCGP, NIMDTA and medical advisors. Though the specific remit of these panels differs by organisation, typically they review information indicating concerns about GP's (and in some cases other practitioners) and provide advice/direction with regard to action.

Currently no formal appraisal systems exist in community dentistry, community pharmacy or optometry.

Some stakeholders raised concerns about the co-ordination and sharing of information in respect of concerns. Particular examples were quoted in respect of pharmacy where on occasions concerns can be raised with more than one organisation in parallel (i.e. Directors of pharmacy, regulatory body etc.), but

neither party involved may be aware of the concern raised with the other. In nursing a process for the management of alerts operates. However, information on concerns is not shared well across services until formal action has been taken by the NMC. This creates a potential risk, which is magnified in the independent sector.

3.4 Investigation, Remediation and Re-skilling

As identified under Section 3.2 *Tackling Concerns* emphasises the role of Boards of individual healthcare organisations in taking responsibility for ensuring that the organisation has appropriate structures, processes and resources associated with investigating concerns, deciding on what action should be taken and access (where appropriate) to remediation, reskilling and rehabilitation. In addition, the Clinical Governance Sub-group of Tackling Concerns has summarised 10 key principles for good practice in carrying out investigations. These are:

- The overriding objective should be to protect the safety of patients and the public
- Clear policies for local investigation
- A fair, consistent and objective investigation process
- A clear definition at the outset of the scope and context of the investigation
- Investigations should be properly resourced
- Work to agreed timescales
- People raising concerns or making complaints should be supported and keep informed
- The healthcare organisation under investigation should be supported and informed
- Healthcare organisations need to decide who else, in the organisation or outside, needs to be informed about the investigation and its progress
- Healthcare organisations should seek expert external advice when appropriate

The Clinical Governance Sub-group of Tackling Concerns also recommend key principles for good practice associated with decision making and remediation, reskilling and rehabilitation.

Section 3.3 identified that the NCAS service is viewed as valuable by stakeholders (though the service does not currently extend to all healthcare professions). Though investigations of serious concerns are generally the exception, such investigations are resource intensive and require particular skills. There was a consensus amongst all stakeholders that there are capacity constraints and limited skills locally associated with investigating concerns. In addition, culturally in some sectors (more notably primary and community care services) there is not a cultural acceptance of investigation. Secondly, on completion of an investigation were the recommendations include actions associated with re-skilling it was indicated that there is limited capacity to support this within current arrangements. In addition, it was noted that it is more difficult to source appropriate mechanisms to support behavioural change than re-skilling.

It was noted that a joint NIMDTA/ four HSC Board bid had been submitted to DHSSPS for resources to support retraining of GP's who wish to rejoin the

Performers List, those who have never worked before in the NHS and under performing GP's. The outcome of this bid is currently awaited.

3.5 Information Management

Tackling Concerns highlights that in order to maximise the chance of early identification of performance issues the information from appraisals, adverse incidents, routine performance data, complaints and concerns must be brought together in a structured way which enables clinical management to take an informed view.

The recommendations of the DH Information Management sub-group have been endorsed by the DH Tackling Concerns Locally group. The Information Management sub-group was tasked with considering the information needed to investigate concerns about health professionals. The terms of reference of the sub-group were:

“To design and implement systems to capture, share and interpret information which could lead to the early identification of issues of poor performance and conduct in health professionals, both to protect patients and to help the individual where possible to get their career back on track.”

In the first instance the conclusions and recommendations relate only to England, although broadly similar approaches would be appropriate in Northern Ireland.

The Information Management sub-group outlined categories of information which are relevant to the identifying concerns and which should be held locally. During the baseline assessment stakeholders were asked to comment on the availability and completeness of such information in its current form. A summary of this analysis is tabulated below:

Information Category	Comment
Information obtained or verified at the time of initial recruitment including references and CRB checks	This information is available for all healthcare professionals
Clinical audits undertaken (broad nature, outcomes and learning)	Information may be available via clinical audit departments in Trusts or held by the health professional themselves. For those professionals who undertake appraisal such information is normally included in their appraisal folder.
Any clinical quality indicators agreed by the relevant professional body to give a fair indication of the performance of the individual or clinical team	Some clinical team indicators are available for medical staff in secondary care and by GP practice via QoF. Individual practitioner indicators are not well developed by organisations, though professionals may hold this information themselves (sourced from their professional body) and include in their appraisal folder.
Summary of outputs of annual appraisals	Available for those professionals who undertake annual appraisal.
Complaints and concerns from patients,	Complaints information is available if a

Information Category	Comment
carers, fellow professionals and trainees (nature of complaint or concern, outcome and learning)	complaint is recorded on the Datix system (the regional IT systems for the management of complaints information). 'Softer' information (not in the form of a formal complaint) is not normally readily accessible as such information is not recorded systematically in most cases. Current appraisal systems focus on the 'absence of concerns' – not affirming practice.
Adverse events where performance on the part of the professional was a contributory factor (nature, current status and final outcome)	Adverse event information is available for those adverse events reported and recorded on the Datix system. There is a recognised under reporting of adverse events and amongst some healthcare professionals there is not a well developed culture of reporting adverse events (i.e. in the case of community pharmacists).
Clinical negligence claims (nature, current status, final outcome)	Information is available for secondary care via the Datix system which manages claims. Information is not readily available for independent practitioners (i.e. GPs) who maintain this information themselves and are not obliged to disclose same to HSS Boards.
Health issues which may affect professional performance	Information is available in the case were such issues are known to the line manager/appraiser – this is not always the case.
Learning needs and training undertaken, in particular any remedial training	Information is available for those professionals who undertake annual appraisal or who are subject to any remedial or re-skilling actions.
Investigations of internal disciplinary processes (nature of allegation, status, outcomes)	This information may not be readily available for all independent practitioners.
Informal and formal warnings, including (for doctors) recorded concerns (subject to the outcome of further discussion on this issue)	This information may not be readily available for all independent practitioners.
Local agreements on conditions of practice	Information should be available.
Referrals to the regulator (nature of allegation, status, outcomes including any voluntary undertakings or condictions imposed by the regulator)	This information is available for all healthcare professionals

The analysis of the information categories suggested by the Information Management sub-group indicate that whilst the information may be available it may not currently be readily accessible to all those who require access to such information in order to identify concerns. Currently no formal appraisal systems exist in community dentistry, community pharmacy or optometry. For these groups some of the information suggested above is not therefore routinely captured or available. As identified earlier the lack of contractual leverage for

these groups in respect of clinical governance compounds the issue of access to the information suggested above.

For those stakeholders who do have mechanisms to capture the majority of the information suggested there is as fundamental issue with accessibility of the information and information integration. Currently, the information tends to be held in a number of discrete places (manual or IT systems). The information systems of Trusts/Boards (in their current form) would not have the capacity to access the information suggested without directing a significant resource to this task. In addition tracking and trending of information is limited by the lack of information integration.

The Information Management sub-group also considered the extent to which “soft” information should be part of the above dataset of information. “Soft” information was defined as – *a statement of concern about an identifiable healthcare professional which has not been articulated as a formal complaint or as part of a formal process such as the summary record of an appraisal interview.* The recommendation of the sub-group is that “soft” information, which if true, implied a threat to patient safety, should be taken seriously and acted upon. Acting upon means a thorough investigation, a record on the database, and the opportunity for the healthcare professional involved to comment. Information not confirmed after investigation should be reviewed in 5 years with a presumption of removal from the database if no similar concerns had subsequently been raised.

The Information Management sub-group also considered that sometimes it may be necessary to confirm to patients and the public that an investigation is underway, and in the case of any conditions on the healthcare professional they should be made aware of the nature of such conditions. Patients and public should also be told about the outcome of investigations where the investigation was public knowledge or the outcome results in a finding that requires some remedial action on the part of the individual professional. DH also intend to develop regulations and guidance in respect of sharing information between organisations where information indicates that a healthcare worker may be a threat to the public; in responses to requests for information about healthcare workers; and to agree on any action needed to protect patients and the public.

3.6 Responsible Officer and GMC Affiliates

The Responsible Officer and GMC Affiliate subgroups of Tackling Concerns make the following recommendations in respect of Responsible Officers:

- Every healthcare organisation employing doctors as doctors should have an RO (an organisation can “hire in” a senior doctor from another organisation to act as its RO);
- PCT’s should provide the RO function for all doctors on their Performers List, including locum GPs; and
- Federations or self-employed doctors are encouraged to apply to provide an RO function for their members, subject to demonstrating appropriate clinical governance capability.

The sub-groups were unable to reach a firm conclusion on the appropriate arrangements for locum doctors in secondary care. The sub-group did agree

that if a locum doctor was unable to find an RO through a locum agency or other route, in the last resort they should be able to look to the PCT of their GMC-registered address for the RO function. The sub-group also outlined the resources, including support staff and IT systems on which the RO should be able to draw.

The sub-groups were unable to reach consensus with regard to “recorded concerns”, and have recommended that the concept be modelled as part of the GMC affiliate pilots. Following the outcome of the pilots a final decision will be made on whether to proceed with the concept of recorded concerns.

During the consultations Trust Medical Directors expressed some particular views in respect of the responsible officer role and GMC affiliates. The main issues expressed were:

- There is a broad consensus on the concept of the Responsible Officer
- Clarity is required with regard to responsible officer arrangements for locum agencies and how their clinical governance systems will be assessed as sufficiently robust.
- Particular concerns were expressed with regard to locum doctors who ‘move around the system’ – how will locum agencies share relevant information on these individuals with Trusts?
- Concerns with regard to acting as a Responsible Officer for locums who are employed by the Trust on a short-term basis (for those locums viewed as ‘longer-term’ medical directors were broadly comfortable with the concept of acting as a responsible officer for this group.
- The need for clarity with regard to responsible officers for those medical staff practising independently (i.e. outside primary or secondary care services).
- Consensus that the responsible officer should be able to delegate some responsibilities whilst retaining overall accountability.
- Broad agreement that the responsible officer role can only function effectively if the systems and processes which support it are robust.
- Concerns were expressed about the capacity of the medical management structures and their limited support mechanisms to respond to the requirements of a future model which will seek to address tackling concerns and underpin revalidation.
- Consensus on a need for capacity building to support the introduction of the responsible officer role. This is required not just with medical directors, but also the medical management tiers below who will operate the systems and processes which will support appraisal and revalidation.
- A general lack of clarity was expressed with regard to the GMC affiliate role (this in part is due to a lack of feedback yet from the national GMC pilots). Concerns were expressed about how GMC affiliates would be appointed and the type of skills required for this role. Stakeholders also identified a potential issue were the responsible officer and GMC affiliate may not agree on a particular course of action with regard to a doctor – how will such a conflict be resolved?

4 SUMMARY OF MAIN THEMES/GAPS/KEY AREAS OF WORK

This section summarises the main gaps which have emerged as a result of the assessment of the current state of readiness of the HPSS to absorb the recommendations emerging from the DH Tackling Concerns Group.

4.1 Gaps/Key Areas of Work

- The culture of clinical governance requires further development generally in the HPSS. This is particularly more relevant with some professional groups than other (i.e. independent practitioners).
- There are capacity constraints in respect of general clinical governance systems across the HPSS. In moving forward it will be essential to consider a future model to support Tackling Concerns which minimises impact on the existing limited resources, whilst at the same time providing a robust mechanism to support early identification and appropriate action in respect of concerns about healthcare professionals.
- There is variability in the robustness of the clinical governance systems which support different healthcare professions. In particular community pharmacy, community dentistry and optometry were identified as professions in which clinical governance systems were not mature. The clinical governance systems for these groups will need to be enhanced to absorb the recommendations emerging from Tackling Concerns. The new contracts currently being negotiated for these groups may provide an opportunity to help address this issue.
- There is little evidence of patient/client/public involvement or feedback in respect of quality improvement at an individual practitioner level. Developmental work in respect of multi-source feedback is required to support this.
- For those healthcare professionals who undertake annual appraisal the uptake of appraisal needs to be increased in order to meet the requirements of revalidation. Additionally, the appraisal systems need to be more robust and include a quality assurance mechanism. The GMC revalidation pilots in operation across the five Trusts should test the proposed process for medical staff more fully.
- Routine appraisal is not undertaken for some staff groups – community pharmacists and optometrists. Appraisal for these groups will need to be developed to underpin any future proposals for revalidation. In addition, appraisal also acts as a mechanism for identifying and acting upon concerns.
- The lack of integrated information systems makes identifying trends and tracking concerns difficult. The information systems which support clinical governance in their current state are unlikely to be able to address this problem without some development.
- Analysis of the proposed information categories of the Management Information sub-group identified some gaps in respect of the accessibility and

availability of information for all healthcare professionals. An assessment of the potential to bridge the gaps identified will be required if the proposed categories are to be adopted in Northern Ireland.

- 'Soft' information regarding concerns is not routinely captured by a formal system. The difficulties associated with this are well recognised. However, further consideration is required with regard to how 'soft' information should be managed and shared in any future model of Tackling Concerns.
- The sharing of information regarding concerns with other appropriate stakeholders/organisations needs further consideration. The Information Management sub-group have made a series of recommendations associated with information sharing re; concerns (both with other healthcare organisations and patients/public). The appropriateness of these recommendations should be considered from a Northern Ireland perspective.
- Stakeholders expressed the consensus view that more support locally was required in respect of investigation skills and remediation and re-skilling resources following an investigation. Consideration should be given to how this might be best addressed.
- Clarity is required on the outstanding questions associated with the Responsible Officer role (though it is noted that this is dependant upon national guidance re; same). In particular the issues associated with responsible officers for locums and healthcare practitioners outside the HPSS are the most relevant.
- Further clarity is required on the role of GMC affiliates. It is recognised that this is dependent upon the outcome of the national pilots.
- Capacity building is required to support the introduction of the responsible officer role. In particular with key stakeholders in medical management structures.
- Whilst the focus of this baseline assessment has been directed at healthcare practitioners (as is the focus of the DH working groups) the integrated model of health and social care in Northern Ireland presents additional challenges. Consideration should be given the extension of a Tackling Concerns model to social care in order to ensure an equitable approach to tackling concerns across the integrated health and social care system in Northern Ireland.

4.2 Next Steps

The content of this report will be considered by the DHSSPS Tackling Concerns Working Group on 20th February 2009, following which the report will be forwarded to the Confidence in Care Programme Board for consideration. The output of this baseline assessment will help inform the programme of work to be taken forward to support the implementation of Tackling Concerns in Northern Ireland.

APPENDIX 1 – DRAFT RECOMMENDATIONS DH TACKLING CONCERNS WORKING GROUP

EXTRACT FROM CHAPTER 9 – TACKLING CONCERNS DRAFT REPORT, OCTOBER 2008

The recommendations and conclusions of this working group are summarised below. In addition, **we endorse** the recommendations in the separate reports of the clinical governance, information management, and Performers List subgroups.

Key messages for healthcare organisations

One of our key recommendations is that the Department of Health should commission a refresh of existing guidance on clinical governance, in particular those aspects which relate to identifying and handling concerns over the performance, conduct and health of healthcare professionals. We expect this guidance to be published and disseminated in the course of 2009. In the meanwhile, the key messages for healthcare organisations can be summarised as follows:

General principles

1. Boards of healthcare organisations should take responsibility for developing a culture of continuous quality improvement and for maintaining effective clinical governance structures and processes, including identifying and handling concerns over professional performance, conduct and health.
2. These processes should actively encourage the participation of patients and the general public.
3. Healthcare organisations should aim to identify concerns about health, conduct or professional performance at the earliest possible stage and to intervene quickly to safeguard patients and, where possible, help the professional to get their career back on track
4. Healthcare organisations should be alert to the possibility that apparently poor individual performance could be the result of wider systems problems.

Processes for identifying problems with performance, conduct or health

5. People who wish to raise concerns – whether patients, carers or other members of staff – should be encouraged to do so and supported throughout the process; organisations should act swiftly on concerns and provide regular feedback to those raising the concern.
6. Healthcare organisations should establish systems for collating and analysing information from a variety of sources relating to potential early signs of poor performance, conduct and health and should regularly review this data in order to identify clusters and trends.

Processes for investigating and acting on concerns

7. Healthcare organisations should ensure that they have clear processes and the capacity and skills to investigate concerns over professional performance, conduct and health. This may involve pooling resources or bringing in external expertise, especially for smaller organisations.
8. Following an investigation, a clear decision must be taken by a transparent and fair process which protects patients while respecting the rights and needs of the healthcare professional. Healthcare organisations should ensure that they have the structures, processes and capacity to achieve this.
9. Healthcare organisations should develop a robust, quality assured and resourced strategy for remediation, reskilling and rehabilitation where this is appropriate. Remediation plans should be tailored to the needs of the individual with integral arrangements for clinical placements, supervision, monitoring and return to normal clinical practice.

Supportive strategies

10. Subject to Parliament, healthcare organisations will be required to nominate or appoint “Responsible officers” with specific responsibilities for the local clinical governance arrangements relating to the performance, conduct and health of doctors. We expect to introduce this requirement in the final quarter of 2009. In the meanwhile, healthcare organisations should consider what further support is needed to medical directors or other senior officers who are already carrying similar responsibilities.
11. Subject to the result of pilots now underway, the GMC will establish a network of “GMC affiliates” to support responsible officers, to help them to improve the fairness and consistency of local decisions, and to improve the liaison between local and national processes.
12. Reforms to death certification will improve the quality and accuracy of certification, provide greater protection for the public, and improve public health surveillance.

Recommendations for the Department and other national organisations

Recommendation 1: we endorse the proposal in *Good doctors, safer patients* that the Department should work with the Royal Colleges and professional organisations to develop and disseminate clinical indicators relating to individual healthcare professionals for use both in secondary and primary care.

Recommendation 2: we recommend that the Department should take forward with the national regulators and with NHS bodies, including the SHAs, the further steps needed to support patients and colleagues in raising concerns about a healthcare professional.

Recommendation 3: we recommend that the Department should commission a review of analytical tools for collating and analysing information on the

performance and conduct of healthcare professionals and should consider whether further steps are needed to stimulate the market.

Recommendation 4: We recommend that the modified version of the “Recorded Concern” should be modelled as part of the GMC affiliate pilots.

Recommendation 5: We recommend that the Department of Health should commission and disseminate an update of the guidance on identifying and handling concerns about healthcare professionals, consulting relevant stakeholders and authors of existing guidance. The aim should be to generate a coherent and accessible body of guidance in this area.

Recommendation 6: We recommend that DH should set up or commission a web portal on which all relevant guidance (any newly-commissioned guidance and existing guidance from bodies such as NCAS) can be readily found.

Recommendation 7: We recommend that DH should consider the use of the new PCT assurance framework to ensure that all PCTs have appropriate capacity and capability in this area.

Recommendation 8: We recommend that DH should make an early decision on the options for developing a centralised database to hold information on concerns about performance, conduct and health, following the scoping study which the Department is commissioning. If the decision is taken that this is not feasible or would pose too much risk, then we recommend that the Department should discuss with the national regulators the alternative model of holding a core of information on the national register for each profession.