Confidence in the Future

for patients, and for doctors

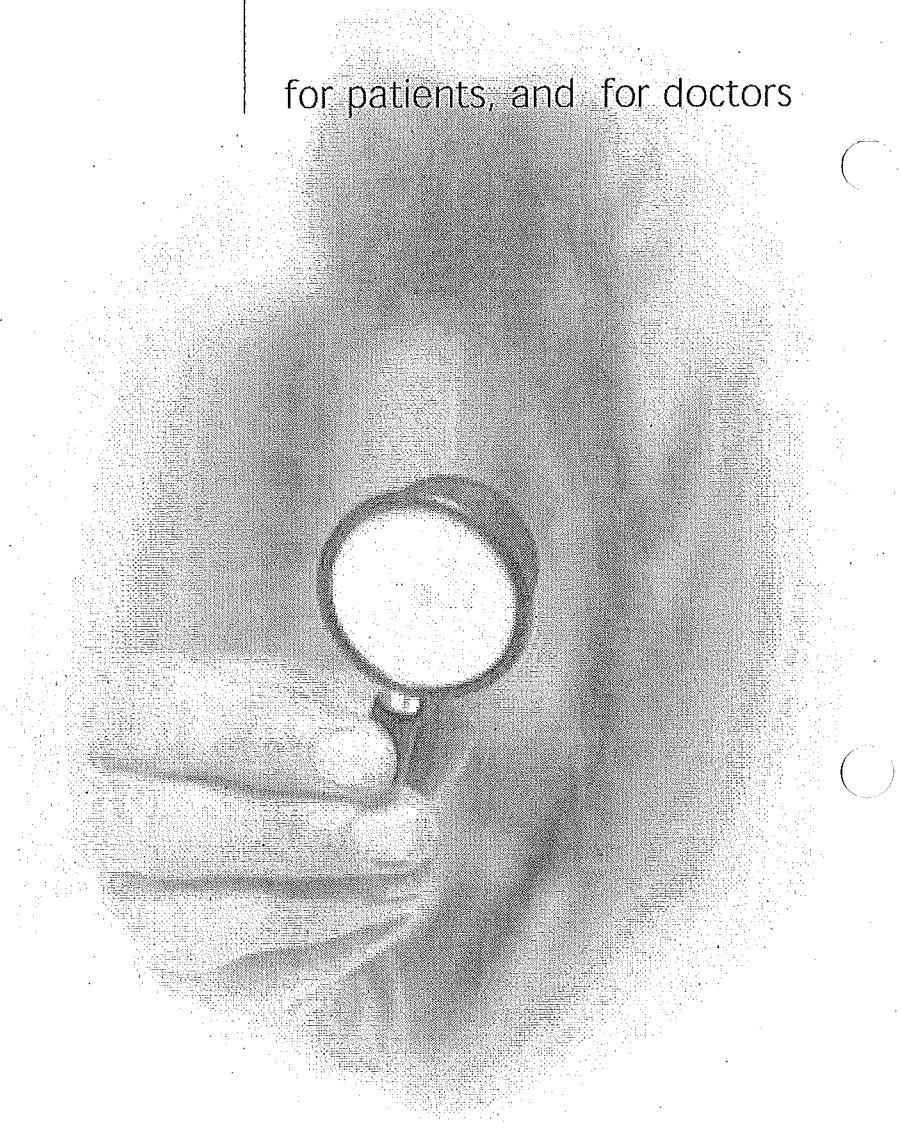
A consultation document on the prevention, recognition and management of poor performance of doctors in Northern Ireland

DHSSPS

333-184-001

Confidence in the **Future**

for patients, and for doctors

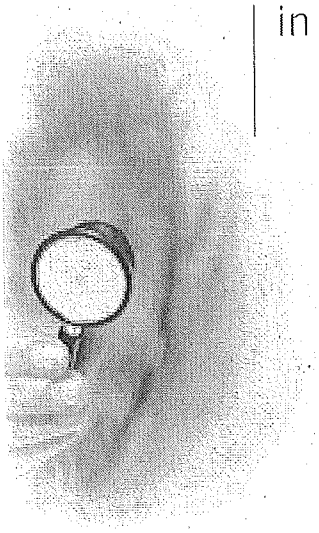


A consultation document on the prevention, recognition and management of poor performance of doctors in Northern Ireland

Department of Health, Social Services & Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteacht Phoiblí

DHSSPS 333-184-002

Confidence in the **Future**



FOREWORD

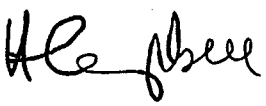
We have been rightly proud of the achievements in the Health and Personal Social Services (HPSS). In particular, we acknowledge the dedication, skill and hard work of all our staff, often in very difficult and demanding circumstances.

There is little that is more important to us and to our families than our health. However, society does not stand still, nor do the developments and achievements within health care. The consequent demands and expectations placed on the health service have increased enormously in recent years.

Our doctors make a significant contribution to the development of new treatments, new services and new patterns of care. Never before has their personal and professional performance come under more public scrutiny than at the present time. They are very conscious that the public reputation of the profession as a whole has been damaged by the poor performance of a few. To this end the profession have taken steps through their professional bodies, including the General Medical Council, to modernise their procedures for the prevention, detection and management of under-performance.

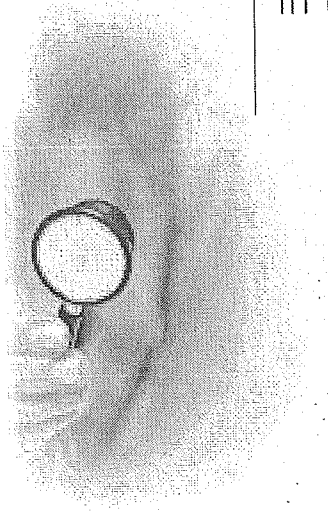
Although the problem is very small in Northern Ireland, it is necessary to modernise the processes in the HPSS to reduce this further. These should reflect the needs of patients and all doctors throughout their careers wherever they practice.

This document reflects similar publications which have been prepared recently to address the small minority of problem doctors working within the NHS.[1-2] It sets out proposals for the prevention, recognition and management of poor performance of doctors. Its primary aim is to ensure patient safety. In line with this aim, the Group is seeking a wide spectrum of views. I believe that this document proposes an approach in which the public, together with the medical profession, can be justifiably confident.



Dr. Henrietta Campbell
Chief Medical Officer

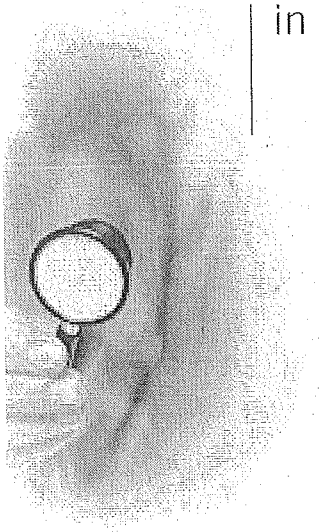
Confidence in the **Future**



CONTENTS

	Page
Introduction	6
What we are trying to achieve	8
Current approach to poor clinical performance in the HPSS	9
Professional self-regulation	11
Prevention and recognition of poor clinical performance	13
Management of poor performance	19
Arrangements for doctors in training	24
Arrangements for doctors in general practice	26
Summary of Recommendations	28
References	30
Appendices:	
1. Membership of Working Group	31
2. Support services	32
3. Royal College Rapid Response or Service Review Teams	33
4. Glossary of Terms	35
5. Implications for other clinical professionals, including dentists	37
How to respond	38

Confidence in the **Future**



INTRODUCTION

Recent publications have highlighted the need for modernisation in the Health Service. A key element in ensuring the quality of Health Services lies in the maintenance of the standards of performance of individual practitioners. Increasingly, doctors, together with other healthcare staff, have had to maintain their quality of practice against a background of:

- evergrowing workload;
- ongoing technological developments;
- rising public expectation; and
- ever widening range of explicit standards set by a variety of bodies.

At the same time, however, there have been a number of highly publicised instances where standards of practice have clearly fallen short of those considered acceptable. These events have given rise to public concern, undermined public confidence in the health service and damaged morale amongst staff. These incidents have exhibited some common themes:

- whilst a single incident has brought the case to light, investigation has tended to reveal a background pattern of poor practice;
- this level of performance was often known about informally; or
- formal mechanisms for addressing poor practice were not activated at an early stage.

One reason which may account for these problems is confusion about the respective roles and responsibilities of those charged with ensuring protection for patients. This requires greater clarity in the quality assurance activities undertaken by medical bodies as part of professional self-regulation and similar responsibilities discharged by the HPSS.

On the professional regulatory front, the GMC has been developing its procedures for ensuring competent clinical practice over the past decade. The initial stage was the introduction of fitness to practice procedures and the most recent is the proposed introduction of revalidation.

At the same time, it is recognised that health service arrangements for dealing with unsatisfactory performance are weak in a number of key areas: -

- in their provision of protection for patients;
- in their fairness to doctors;
- in their cumbersome, costly and legalistic nature; and
- in their inability to support the provision of high quality healthcare.

With a view to addressing these deficiencies and ensuring that medical practitioners in Northern Ireland are in a position to comply with the GMC's requirements for revalidation, the Chief Medical Officer established a working group with the following remit.

The Working Group has been established to -

- **Consider**

  procedures currently in place for the assessment of clinical performance and management of poor performance;

  proposed developments elsewhere in the UK; both within the Health Service and within the profession;

- **Advise**

  the DHSS & PS on guidance for new procedures in Northern Ireland, taking account of local administrative structures; and to

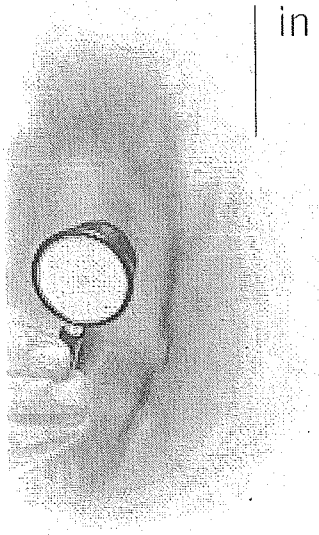
- **Consult**

  on proposed arrangements with a view to having procedures in place by April 2001.

The Working Group was established in March 2000 and the membership of the Group is included as Appendix 1.

In recognition of specific issues relevant to general practice, a sub-group representing wide interests was established. Their views are taken into account in this report.

Confidence in the Future



'WHAT WE ARE TRYING TO ACHIEVE'

The ultimate aim is that the public is assured that the doctor who treats them is well trained, highly competent and up-to-date in his or her practice.

In order to achieve this we need:

- widely accepted statements on standards of conduct, performance and ethics primarily aimed at the protection of patients;
- regulatory bodies working to explicit criteria, which are easily understood and widely publicised;
- better structures, particularly in primary care, and working environments which enable all doctors to provide a high level of care;
- a strong effective partnership between the HPSS and medical professional bodies to prevent, recognise and deal with poor clinical performance;
- well targeted continuing professional development for all doctors; and
- appropriate support systems for the small number of doctors who present with performance problems.

This should result in:

- doctors working in teams where adequate resources and support enable them to achieve and maintain a satisfactory standard of care;
- doctors with competency, conduct or ill health problems recognised at a much earlier stage than at present;
- doctors willing to report concerns about their colleagues;
- far fewer cases, than at present, of patients experiencing harm or sub-optimal outcomes of care due to poor practitioner performance;
- patients not put at risk or denied a response because the system fails to adequately resolve problems with a doctor's practice; and
- alternatives to the protracted, expensive procedures in place to address serious problems in performance.

CURRENT APPROACH TO POOR CLINICAL PERFORMANCE IN THE HPSS

Deficiencies in clinical performance may become apparent in a number of ways, such as:

- errors or delays in diagnosis,
- use of outmoded tests or treatment,
- failure to act on the results of tests,
- technical errors in the performance of a procedure,
- poor attitude in behaviour,
- inability to work as a member of a team, or
- poor communication with patients.

However, practitioners rarely work in isolation and individual problems may be a symptom of organisational deficiencies. Alternatively, an individual's performance may deteriorate as a result of health or personal problems. Information quantifying such problems is not readily available.

There are generally accepted weaknesses within the current system for managing deficient performance. These include:

- processes initiated as a result of a single serious incident which itself may only be the culmination of a pattern of deficient or deteriorating practice;
- the current system exhibits an over reliance on disciplinary action,[3] rather than prevention in the first place, early identification and remediation;
- the legalistic nature of current procedures acts as a deterrent towards early action;
- there is a lack of clarity between the roles of the GMC and the HPSS in ensuring satisfactory performance;
- processes for the identification and support of sick doctors are poor;
- there is a tendency to allow problem doctors to change employer and thus become someone else's problem; and
- the protracted timescales for dealing with problem.

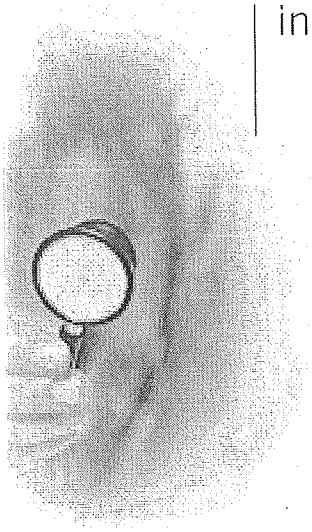
Suspension of Hospital Doctors

Concern has been growing about inadequacies in the current procedures which provide for hospital doctors to be suspended[4] pending investigation of allegations of professional and personal misconduct.

Alert Letter System

A formalised system of alert notification exists within the HPSS[5], which should ensure that employers are informed of doctors or dentists who have been dismissed or suspended. The system is activated when the prospect of their continuation in practice gives rise to concerns for patients' safety. An alert letter may be issued where there is reason to believe that such

Confidence in the Future



practitioners may seek work elsewhere. Although, generally, the system seems to operate effectively, it is not possible to guarantee that serious concerns are automatically shared with all parties with a legitimate interest.

Doctors in Private Practice

Given that the majority of doctors working in the private sector also practice in the HPSS, the issue of poor performance is a shared concern. As there may be more than one employer involved in these cases, problems can be exacerbated by poor communication between the two sectors.

Sick Doctors

Doctors at any stage of their career can be more prone to psychological disturbance than those in other occupations[6]. Some doctors have conditions that are unrecognised or concealed until their clinical performance is affected.

There are a number of options currently available to deal with this problem. These include:

- local HPSS procedures; including
- referral to the occupational health service, where this is available;
- a number of special national schemes [see Appendix 2]; and
- the GMC's health procedures.

In addition, the Postgraduate Dean provides a confidential counselling service for doctors in training.

HPSS Health Procedures

These procedures[7] were introduced in 1984 to assist the management of the 'sick doctor or dentist' whose clinical performance was below accepted standards. They were designed to function within the HPSS management arrangements prior to the establishment of Trusts. Often referred to as the "Three Wise Men", the procedures were not well understood, nor were they always effective. In the absence of other mechanisms, they were inappropriately used to deal with non-health related performance problems.

Summary

At present, the management of poor performance concentrates on the aftermath of serious events rather than their prevention. Currently, prevention is reliant on doctors maintaining a high standard of practice on an individual basis. There are no formal mechanisms to ensure this is effective. Available procedures are aimed at addressing serious deficiencies. They are often introduced at a relatively late stage when punitive action may be the only option. It is recognised that current procedures fail to ensure the continued maintenance of acceptable practice or address minor deficiencies that could be dealt with in a more constructive manner.

PROFESSIONAL SELF-REGULATION

The present system of professional regulation in medicine can be traced back to the mid-19th century when it was enshrined in the Medical Act of 1858. With this, came the establishment of the General Medical Council (GMC). The essential elements of self-regulation were the determination of standards of practice, the control of entry to the profession (through the medical register), and removal of a doctor from the register in specific defined circumstances. For over 100 years the Council's role changed little.

However, in recent years there has been a significant widening of that role as part of a process of modernisation. This has been supported by:

- standards for medical student education published in *Tomorrow's Doctors*[8];
- the publication of explicit standards for practicing doctors in *Good Medical Practice*[9]; and
- the establishment of new performance procedures to address a broader range of substandard practice as an extension of the GMC's traditional fitness to practice powers concerning conduct and health.

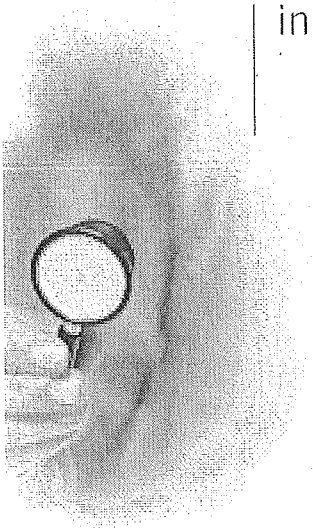
A related aspect of professional self-regulation is the management of postgraduate medical education. Following graduation, all doctors undertake a pre-registration year in designated heath service posts. They are assessed at the end of this year before they can become eligible for full registration. Doctors intending to pursue a career in general practice will spend a minimum of three further years before completing training. For those pursuing specialist practice, a further 6-10 years training can be anticipated following full registration. In all cases, assessment occurs at regular intervals particularly towards the end of the training period.

Thus, by the time doctors in training are in a position to practice independently, they have undergone a prolonged period of regular assessment. However, it is recognised that this situation is not universal.

The most recent development in medical regulation is the proposed introduction of **revalidation**. The aim of this process is the demonstration that doctors meet the standards of *Good Medical Practice* throughout their careers. Essentially, the burden of proof in future will be placed on individual practitioners who will regularly provide evidence that supports their continued registration. A consultation process on the GMC's proposals contained in *Revalidating Doctors - Ensuring Standards, Securing the Future*,[10] has been completed recently.

It is essential that all doctors have the opportunity to maintain their registration in line with the GMC's requirements. Arrangements within the HPSS must facilitate this process to ensure the quality of service.

Confidence in the **Future**



The Duties of a Doctor registered with the General Medical Council

Patients must be able to trust doctors with their lives and well-being. To justify that trust, we as a profession have a duty to maintain a good standard of practice and care and to show respect for human life. In particular as a doctor you must:

- make the care of your patient your first concern
- treat every patient politely and considerately
- respect patients' dignity and privacy
- listen to patients and respect their views
- give patients information in a way they can understand
- respect the rights of patients to be fully involved in decisions about their care
- keep your professional knowledge and skills up to date
- recognise the limits of your professional competence
- be honest and trustworthy
- respect and protect confidential information
- make sure that your personal beliefs do not prejudice your patients' care
- act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practice
- avoid abusing your position as a doctor
- work with colleagues in the ways that best serve patients' interests.

In all these matters you must never discriminate unfairly against your patients or colleagues. And you must always be prepared to justify your actions to them.

DHSSPS 333-184-013

PREVENTION AND RECOGNITION OF POOR CLINICAL PERFORMANCE

It is evident that the current system is heavily reliant on the occurrence of serious incidents or complaints to trigger an assessment of a doctor's performance. There is an obvious need to replace this reactive approach with one that ensures maintenance of satisfactory clinical performance throughout a practitioner's career. This can only be achieved through regular assessment of all aspects of every doctor's practice. A key element of such an assessment is **appraisal**. Individual appraisal is one method whereby achievement and progress can be recognised and acknowledged, and weaknesses or shortcomings identified[11]. This, together with other assessment tools will provide a measure of individual performance and an opportunity to identify development needs. The motivation provided by annual appraisal would, in itself, be a preventative tool.

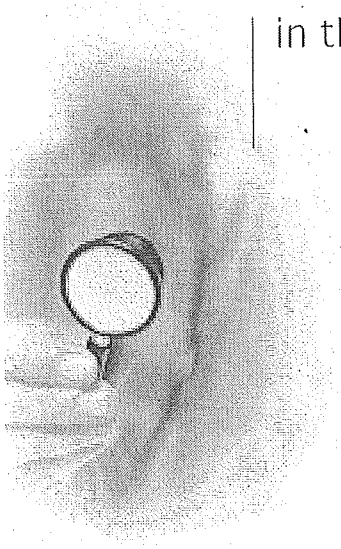
Consequently, it is recommended that:

- **a compulsory and comprehensive appraisal system which will meet the needs of the GMC for revalidation, the medical Royal Colleges for accreditation and the HPSS, be introduced for all doctors;**
- **everyone involved in the appraisal process should be adequately trained;**
- **participation in clinical audit be compulsory for all doctors;**
- **participation in programmes of continuing medical education (CME), and continuing professional development (CPD) be mandatory; and**
- **the early preparation of 'personal folders' for revalidation purposes, and to facilitate annual appraisal, be commenced.**

Further work is needed on the detail of the appraisal process:

- who will conduct appraisal;
- what information will be used to support the appraisal process; and
- what happens if the appraisal process does not lead to an agreed outcome.

Confidence in the **Future**



Appraisal in General Practice

Currently, there are management structures within the hospital and community sector which could provide the framework for the appraisal process. This is not the case in general practice.

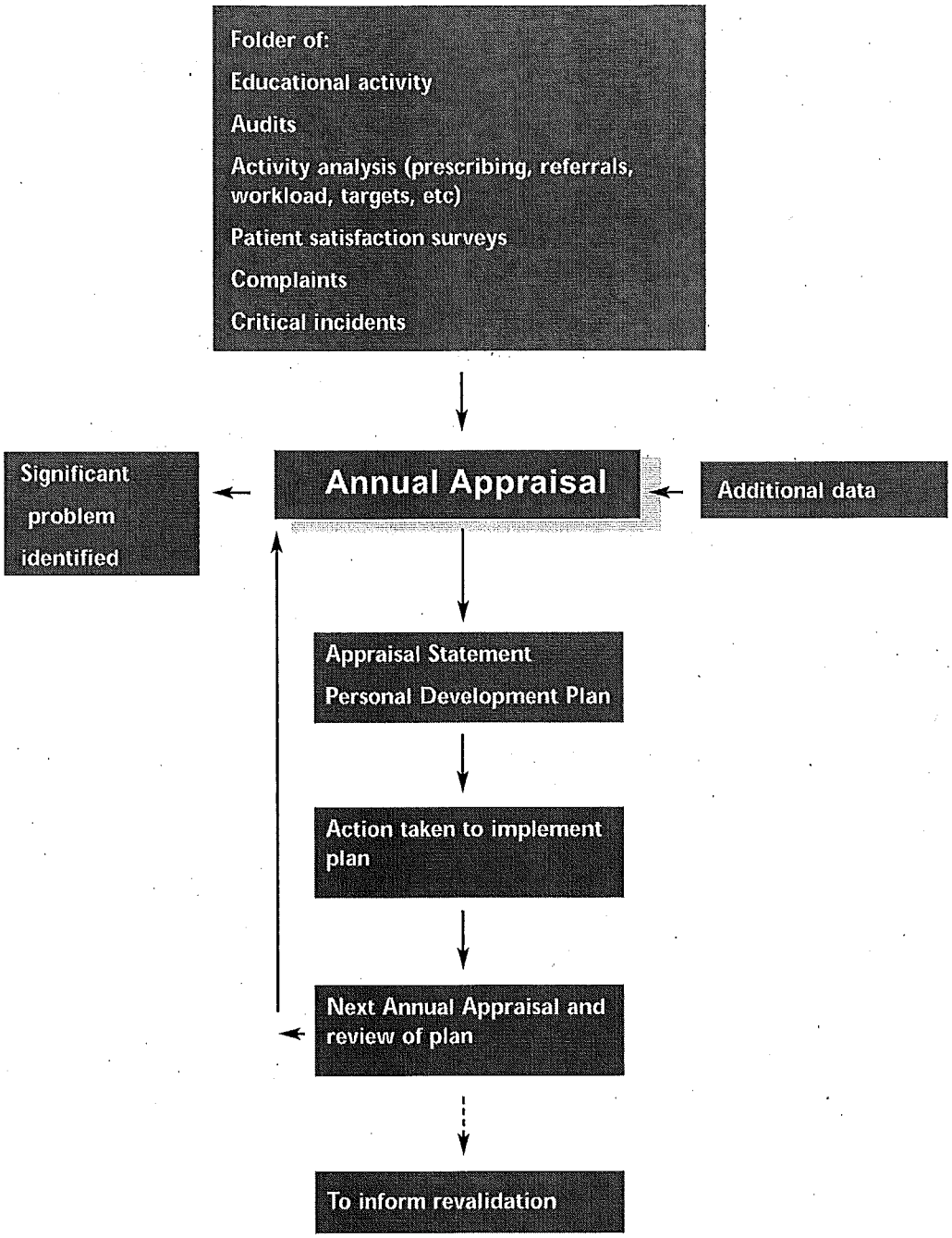
Within the current organisational framework of primary care, resources need to be identified to put suitable structures in place as a matter of urgency.

Under current arrangements, H&SS Boards have a responsibility to ensure that GPs meet their contractual obligations. However it would be inappropriate for the appraisal to be carried out solely by a H&SS Board Manager, as appraisal will address issues beyond contractual matters. Annual appraisal should be undertaken by a designated General Practitioner, with clear authority, who works within the locality.

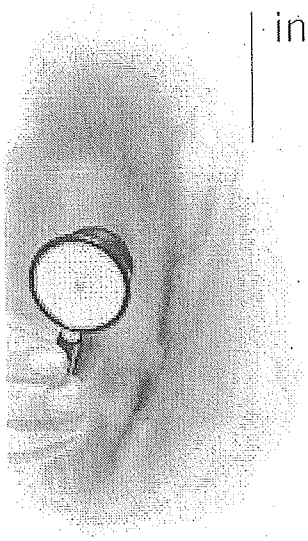
There has been work aimed at setting standards for general practitioners[12]. This could form the basis for appraisal. There are specific issues which need to be considered to enable the introduction of appraisal in general practice. It is recommended that:

- **an independent Appraisal Body be established to co-ordinate appraisal in general practice.**

Suggested model for Annual Appraisal and Revalidation



Confidence in the **Future**



Doctors in Training

During training, junior doctors may change employer many times. Potential problems can be prevented by time spent at the beginning of each period of employment clarifying the expectations of trainer and trainee. It is recommended that:

- **thorough induction programmes should be in place, with clear explanation of departmental procedures and policies.**

This is the most effective way of ensuring satisfactory performance following a new posting.

It is important to remember that trainees' competencies will be limited. The extent of their responsibilities is dependent upon their experience which must be carefully assessed by the supervising consultant or GP. The expectations of their employer with regard to their attendance at educational meetings must also be made explicit, ideally through the training agreement.

It is recommended that:

- **clear guidance from senior doctors, along with appropriate supervision, is required when delegating clinical tasks to doctors in training.**

Locum Practitioners

Another group with specific issues relevant to good clinical practice are locum practitioners. These doctors are not in regular employment with a health service body but are frequently engaged to cover the absence of permanent staff. Good practice guidance on the employment of locums exists[13] but there is no current process to ensure the competence or continuing development of such practitioners. In recognition of the need for arrangements to remedy the current position, it is recommended that:

- **a Regional Register of all locum doctors be established.**

Doctors in training should have:-

- A written training agreement
- A full and proper induction programme
- Regular appraisal
- Regular assessment of competence and performance
- Clearly defined supervisory arrangements
- Responsibility tailored to competence
- Written policies and protocols

Health related Performance Problems

As stated earlier, health problems can underline poor clinical performance. Currently, the availability of occupational health services is limited, particularly for general practitioners. Traditionally, doctors have been reluctant to use such services, even when they are available. Consequently, it is recommended that:

- **regular health assessment be introduced for all doctors; and**
- **occupational health services be reviewed and strengthened for all doctors, particularly general practitioners.**

Organisational Problems

However, it is recognised that the finding of poor clinical performance in an individual may be a symptom of wider organisational problems. It is therefore necessary that HPSS organisations adopt procedures aimed at addressing problems and learning from them[14]. It is therefore recommended that:

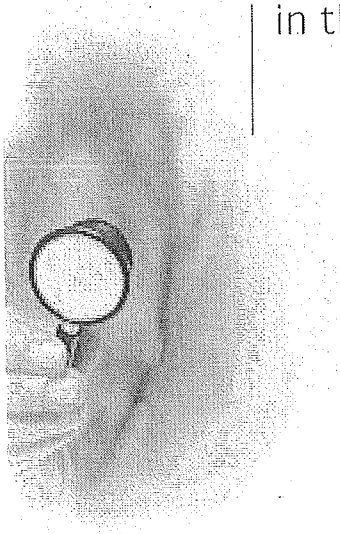
- **a framework for clinical governance in the HPSS, including primary care, be established as a matter of urgency;**
- **clinical teams with clear leadership roles and responsibilities be identified and established in every appropriate setting;**
- **methods of recording adverse events be put in place in every organisation, and a regional register established; and**
- **a regional database of performance case studies be established.**

These latter two proposals would contribute to a new basis for learning from mistakes or errors in the HPSS, either at a personal level or at a system level. The regional database of case experience would enable the HPSS to:

- monitor the incidence of underperformance;
- identify the factors which contribute to underperformance; and
- review the outcomes of investigation and resolution.

A new culture which sees the advantage of openness, rather than the current tendency towards secrecy and blame, is more likely to provide reassurance to patients and encouragement and support to doctors.

Confidence in the **Future**



It is recognised that there is a need to provide resources and facilities to ensure the development and maintenance of clinical skills. These would be available for all doctors, not just practitioners identified as underperforming. The following are recommended:

- **facilities for general skills training, e.g. in advanced life support, and other forms of emergency care, be established in appropriate locations; and**

- **a Regional Centre to provide advanced training in new methodologies, e.g. endoscopic interventions, be established and linked to a Regional Simulation Laboratory where competence and performance may be assessed.**

Summary

It is envisaged that the introduction of these arrangements will lead to a number of benefits:

1) Those doctors whose practice is satisfactory will have this explicitly demonstrated.

2) Professional development will be based on the results of appraisal and therefore directly related to the individual's ongoing needs.

3) Weak areas can be identified at an early stage and dealt with in a supportive manner with confidence that patient wellbeing is not compromised.

4) A register of locum practitioners should facilitate the new arrangements for revalidation in this group of doctors.

These measures are primarily preventative and will hopefully uncover problems at a much earlier stage than at present.

However, the system may still identify doctors with more serious difficulties. These may require further detailed investigation and formal steps to ensure patient safety.

MANAGEMENT OF POOR PERFORMANCE

This section sets out arrangements for managing poor performance, once it is identified. When problems arise, it is apparent from past experience that:

- there is a variable approach to local investigation;
- there can be considerable delay in taking action when patients might be at risk; and
- there are occasions when the use of suspension is both inappropriate and unnecessarily protracted.

It is therefore recommended that:

- **Trusts and H&SS Boards adopt the following "Three Stage" approach to management of problems; and**
- **a Professional Performance Advisory Panel be established.**

Stage one:

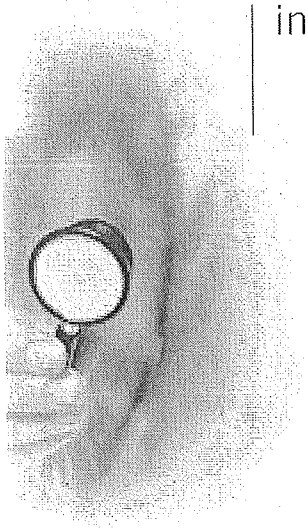
Local Investigation and Resolution

When a problem occurs, an early view should be determined as to which category it belongs - personal misconduct, failure to fulfil contractual commitment, or concerns about clinical performance. In a hospital or community trust setting this will usually be undertaken by the Medical Director and Human Resource Director, and in primary care by the H&SS Board's Primary Care Medical Adviser.

Misconduct of a personal nature (e.g. theft, violence, deception, and sexual or racial harassment). This should be dealt with under the employer's internal disciplinary procedure or through contractor mechanisms; this is no different to the present situation.

Failure to fulfil contractual commitments (e.g. not turning up for clinics, undertaking private practice to the detriment of HPSS duties). This is also dealt with under the employer's internal disciplinary procedure or contractor mechanisms; this would simplify the present arrangements where there is often confusion about what is contractual and what is professional misconduct.

Doubts or concerns about clinical performance or professional conduct. This would lead to a new approach to investigation, with a more thorough review at a local level. In addition, external assistance or advice may be called



on when appropriate. This is a new element and is a particularly important feature of what is proposed. It is a departure from the present where employers address professional performance using the existing disciplinary procedures.

Clinical dysfunction which is so serious as to warrant immediate referral to the regulatory body. There will be occasionally serious cases where such referral would be immediate. A decision whether to refer to the GMC would usually be taken after initial local evaluation or following receipt of external advice.

As part of this first stage, local procedures will require that the employer undertake an initial investigation to ascertain the facts relating to the situation. This should be carried out quickly, but it must also be comprehensive. The service would benefit from the development of good practice guidelines and training for clinical and medical directors and human resource staff in this important area. If this initial investigation indicates that the issues are too difficult to resolve internally, the employer should consider engaging the assistance of the appropriate medical Royal College 'rapid response team' (See Appendix 3).

Arrangements should be devised to ensure analogous procedures for primary care. Under current arrangements, these must involve the relevant H & SS Board.

Stage two:

Professional Performance Advisory Panel

If the employer is unable to resolve the difficulties following stage one, or is unclear as to what steps to follow, they may refer the case to the 'Professional Performance Advisory Panel'. This new body will be commissioned by the Chief Medical Officer to assist the service in resolving difficulties arising from the poor performance of doctors. The Panel may advise the employer to:

- continue to resolve the issues at a local level;
- refer the doctor to an appropriate 'professional assessment and support service'(see stage three below); or
- refer the doctor to the GMC.

Stage three:

Further Action

The Professional Performance Advisory Panel will have powers to commission services from an appropriate 'professional assessment and support service'. These services should be delivered within Northern Ireland, where possible. However, there will be occasions when it will be necessary for the assessment to take place in another region.

Referal to a 'professional assessment and support service' would provide:

- a diagnosis of the problem;
- a full impartial written assessment of its nature and seriousness; and
- recommendations for action.

This would be based on review of records, documentation, clinical audits, interviews with the doctor concerned and other staff as well as site visits. Other assessment methodologies would be used as appropriate.

The findings and recommendations following assessment would be made available to both the doctor concerned and the Trust or H & SS Board.

Doctors involved in a serious professional dispute which was jeopardising the functioning of a service could also be referred to the 'professional assessment and support service' if they were unwilling or unable to resolve their dispute.

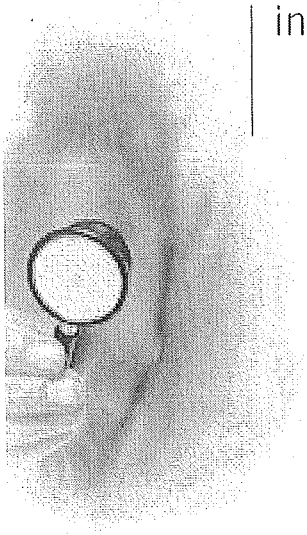
It would be for the local employer or H & SS Board to implement the findings of the 'professional assessment and support service' in each case.

Any retraining or reskilling of the doctor could be co-ordinated by the 'professional assessment and support service' in close liaison with the employer and using services designated as suitable for this purpose. The 'professional assessment and support service' would have to reassess the doctor as fit for return to practice at the end of this period. Similar liaison and reassessment could apply in cases of ill-health.

In a small number of cases there may be no prospect for remedial action within the scope of the doctor's current employment. Thus, where the report from the 'professional assessment and support service' concluded that the problem was "serious and intractable" the employer may decide to seek to terminate the doctor's contract or agree his or her retirement within its local procedures. These procedures would enable such cases to be fast tracked to deal fairly and quickly with the matter.

Where the problem is considered to have implications for the doctor's registration, parallel referral to the GMC must be made.

Confidence in the **Future**



Summary of possible outcomes following referral to a 'professional assessment and support service' :-

- The doctor could continue to practice. The report would give reassurance to the employer that there were no major problems and would give recommendations on criteria for monitoring if this is deemed appropriate.
- The doctor could continue to practice, but be monitored according to specified criteria. There were specific concerns identified but not sufficient to pose a significant risk to patients.
- A period of re-education and retraining followed by further reassessment.
- Re-skilling in another area of medical practice followed by further reassessment.
- Referral to formal GMC procedures (because the problem is so serious or complex that it could affect the doctor's registration or because there are implications for patients being treated outside the HPSS).
- Referral for medical treatment (under new procedures for sick doctors).
- Referral back to the employer with a report that assessed the problem as serious and intractable.

It is recognised that occasions will arise when the employing authority or H&SS Board will have to exercise their disciplinary powers. The current guidance is unwieldy, legalistic and slow. It is recommended that:

- **the current disciplinary procedures be abolished and replaced by fairer, quicker and more effective local procedures which integrate processes involving the HPSS and professional bodies.**

Protection of Patients by the Suspension of Doctors

The new system would retain the power of suspension for hospital doctors and it is proposed that such powers be extended to H&SS Boards in respect of general practitioners.

With the introduction of the 'Professional Performance Advisory Panel' and 'professional assessment and support services', suspension would only need to be considered when:

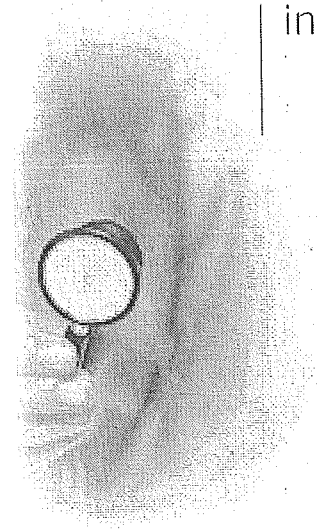
- there is an imminent danger to patients and a need to ensure that they are immediately protected;
- an employer or H&SS Board is investigating a matter of serious concern or taking action under its internal disciplinary procedures because of alleged personal misconduct or failure to fulfil contractual responsibilities;
- a doctor refused to be referred to a 'professional assessment and support service'; and
- an employer is dealing with a doctor who is referred back from the 'professional assessment and support service' with a report concluding that their problem is "serious and intractable".

Any doctor who is suspended would be required to give an undertaking not to practice in any capacity (including the private sector) until their position is resolved.

Summary

The present procedures used by the HPSS to deal with poor clinical performance need to be reformed along the lines outlined above.

They need to be simpler to utilise in practice and they need to be able to deal with the full spectrum of underperformance. This will necessitate a revision of current guidance.



ARRANGEMENTS FOR DOCTORS IN TRAINING

Doctors in training are employed by Trusts, in the main, and as such are subject to the Trust's disciplinary procedures. The Postgraduate Dean has responsibility for the doctor's education throughout the programme of training. The Dean, as the commissioner of training, has a legitimate interest in knowing that an investigation involving a doctor in training is taking place. As a general rule the Postgraduate Dean will not wish to be directly involved, but should be satisfied that matters are being handled in a fair and appropriate manner. The Dean will need to know the result of any investigation when it is completed.

Change of Employer during an Inquiry

Junior doctors are usually appointed to training programmes which involve a change of employer at frequent intervals. Often a disciplinary procedure will not be completed before it is time for the trainee to take up a new post. The trainee will be encouraged to continue to co-operate from the new post, if necessary by personal counselling from the Postgraduate Dean. It is recommended that:

- **the recipient Trust should be informed of the ongoing action and be required to facilitate the conclusion of the inquiry; and**
- **on conclusion of the inquiry the recipient trust, as the contract holder, will implement the findings.**

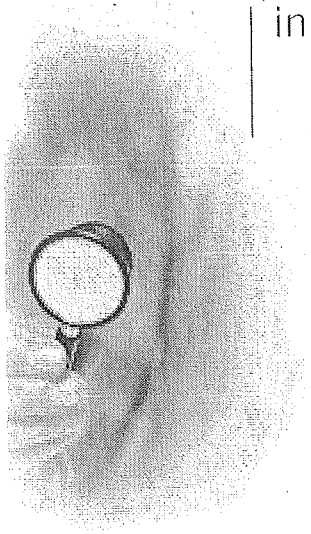
Patient safety takes precedence over an employee's right to confidentiality. The trainee has a right to know what information is being transferred and have an opportunity to challenge the accuracy, but not to prevent information being transferred. The information shared should be written and factual.

If there is no identified new employer, and the trainee does not agree to co-operate, it may be appropriate to contact the Chief Medical Officer about issuing an alert letter.

Remedial training

Where a trainee is moved for educational reasons, it is appropriate for the receiving trainer to have information about the areas of practice that gave rise to concern. This information may be necessary to protect patient safety, and is certainly necessary to ensure optimum educational supervision. This information should be transferred in writing through the Postgraduate Dean.

A distinction should be made between disciplinary procedures, which are rightly expunged from the employment record after a given time, and a training history. Subsequent trainers may have a legitimate interest in the training history, in the interests of safeguarding patient care as well as tailoring future training to the needs of the trainee.



ARRANGEMENTS FOR DOCTORS IN GENERAL PRACTICE

The proposals on management of poor performance put forward are relevant to those employed by the HPSS. These proposals do not easily translate to the contractual arrangements under which General Practitioners provide services.

Currently, H & SS Boards have responsibility to ensure:

- that there is proper adherence by all practitioners to their obligations under regulations. This includes the terms and conditions of service for GPs; and

- that adequate arrangements are put in place to ensure the probity of claims by GPs for payment through the Statement of Fees and Allowances.

In effect, however, H&SS Boards' statutory powers are very limited.

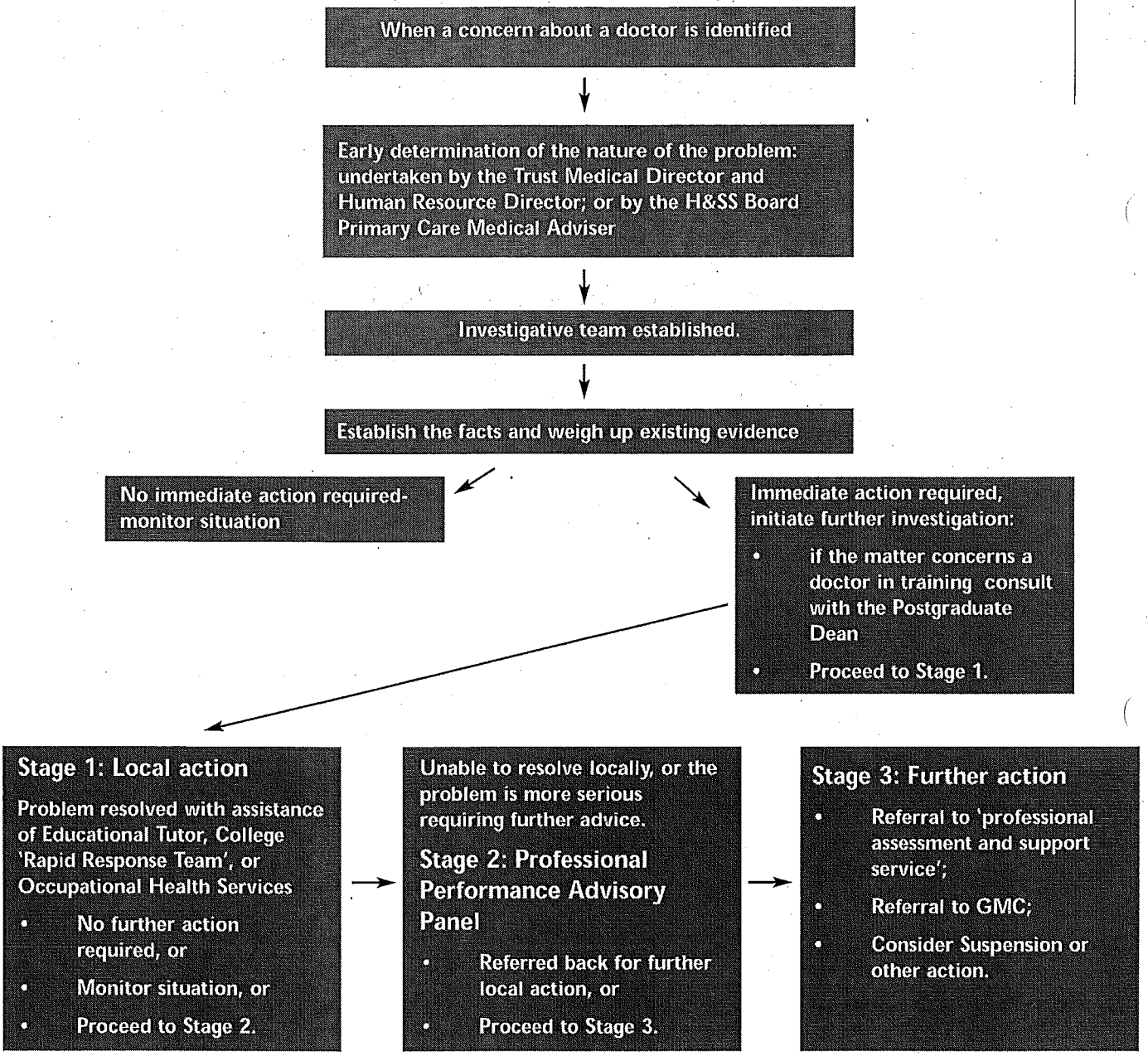
It is recommended that:

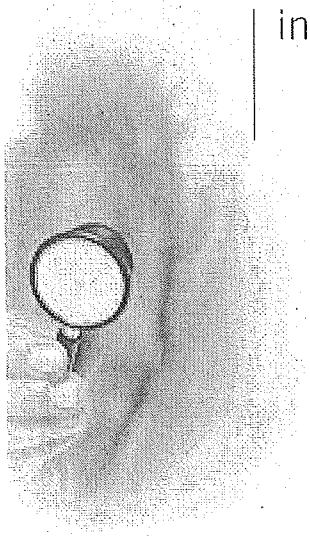
- **new powers must be granted so that concerns regarding performance of GPs can be investigated.**

Under current structures this would be facilitated by the relevant H&SS Board, and would involves setting up a small team to carry out an investigation of a GP, following the three stage approach recommended earlier. This would involve examining practice data and interviewing the practitioner and practice staff if appropriate.

Referral to this investigative process could be initiated by the appraisal process or as a consequence of complaints from patients, or other health care workers.

Model for Management of Poor Performance





SUMMARY OF RECOMMENDATIONS

Prevention and Recognition of Poor Performance

1. A compulsory and comprehensive appraisal system which meets the needs of the GMC for revalidation, the medical Royal Colleges for accreditation and the HPSS, be introduced for all doctors.

2. Everyone involved in the appraisal process should be adequately trained.

3. Participation in clinical audit be compulsory for all doctors.

4. Participation in programmes of continuing medical education (CME), and continuing professional development (CPD) be mandatory.

5. The early preparation of 'personal folders' for revalidation purposes, and to facilitate annual appraisal, be commenced.

6. An independent Appraisal Body be established to co-ordinate appraisal in general practice.

7. Thorough induction programmes should be in place for all new staff, with clear explanation of departmental procedures and policies.

8. Clear guidance from senior doctors, along with appropriate supervision, is required when delegating clinical tasks to doctors in training.

9. A Regional Register of all locum doctors be established.

10. Regular health assessments be introduced for all doctors.

11. Review and strengthen occupational health services for all doctors, particularly general practitioners.

12. A framework for clinical governance in the HPSS, including Primary Care, be established as a matter of urgency.

13. Clinical teams, with clear leadership roles and responsibilities, be identified and established in every appropriate setting.

14. Methods of recording adverse events be put in place in every organisation, and a regional register established.

15. A regional database of performance case studies be established.

16. Facilities for general skills training, e.g. in advanced life support, and other forms of emergency care, be established in appropriate locations.

17. A Regional Centre to provide advanced training in new methodologies, e.g. endoscopic interventions, be established and linked with a Regional Simulation Laboratory where competence and performance may be assessed.

Management of Poor Performance

18. Trusts and H & SS Boards adopt the proposed 'Three Stage' approach to management of problems.

19. A Professional Performance Advisory Panel be established.

20. The current disciplinary procedures be abolished and replaced by fairer, quicker and more effective local procedures which integrate processes involving the HPSS and professional bodies.

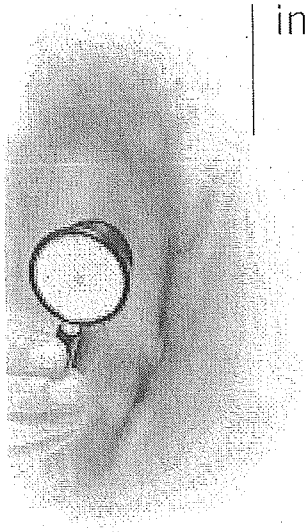
Recommendations for Doctors in Training

21. When a doctor in training transfers to a new employer before an inquiry or disciplinary process is complete, the recipient Trust should be informed of any ongoing action, and be required to facilitate the conclusion of the inquiry.

22. On conclusion of the inquiry, the recipient Trust, as the contract holder, will implement the findings.

Recommendations for General Practitioners

23. New powers be granted so that concerns regarding performance of GPs can be investigated.



REFERENCES

1 The Scottish Office Department of Health. *Suspensions – A new perspective.* The Scottish Office: Edinburgh, 1999.

2 Department of Health. *Supporting doctors, protecting patients.* DoH: London, 1999.

3 DHSS (NI). *Disciplinary procedures for hospital and community medical and dental staff.* [HSS (TC8) 15/91]

4 DHSS (NI). *Disciplinary procedures for hospital and community medical and dental staff-suspension.* [HSS (TC8) 3/95]

5 DHSS (NI). *Issue of alert letters about hospital and community medical and dental staff under investigation by the HPSS.* [HSS (TC8) 6/98]

6 *Weinberg A, Creed F. Stress and psychiatric disorder in healthcare professionals and hospital staff. Lancet* 2000; 355: 533-37.

7 DHSS (NI). *Prevention of harm to patients resulting from physical or mental disability of hospital and community medical and dental staff.* [HSS (TC8) 1/84]

8 General Medical Council. *Tomorrow's Doctors: Recommendations on Undergraduate Medical Education.* GMC: London, 1993.

9 General Medical Council. *Good Medical Practice.* GMC: London, 1998.

10 General Medical Council. *Revalidating Doctors – Ensuring Standards, Securing the Future.* GMC: London, 2000.

11 British Association of Medical Managers. *Appraisal in Action.* BAMM: Stockport, 1999.

12 Royal College of General Practitioners/General Practice Committee. *Good Medical Practice for General Practioners - a draft document for consultation.* RCGP/GPC: London,1999.

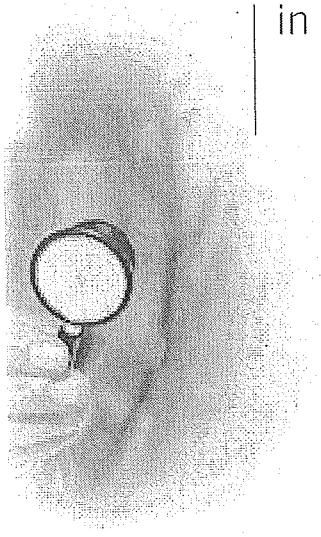
13 DHSS(NI). *A code of practice in HCHS Locum Doctors' Appointment and Employment.* (HSS (TC8) 2/98)

14 Department of Health. *An organisation with a memory – report of an expert group on learning from adverse events in the NHS.* DoH: London, 2000.

APPENDIX 1

Membership of Working Party

Dr Ian Carson (Chairman)	Special Adviser to DHSS&PS on Clinical Governance. Medical Director, Royal Group of Hospitals HSS Trust.
Mrs Stella Burnside	Chief Executive, Altnagelvin HSS Trust.
Dr John Jenkins	Chairman, Hospital Services Sub-Committee of the Central Medical Advisory Committee (CMAC). Senior lecturer in Child Health, QUB and Consultant Paediatrician, United Hospitals Trust.
Mr Seamus Magee	Chief Officer, Southern Health & Social Services Council.
Dr Jack McCluggage	Post-graduate Dean, N.I. Council for Postgraduate Medical & Dental Education.
Dr Jim McFarland	Consultant Physician, Medical Director, Ulster Hospital & Community HSS Trust.
Mr John McGrath	Director of Planning and Performance Management, DHSS&PS.
Miss Therese McKernan	Director of Human Resources, Greenpark HSS Trust.
Dr Anne Marie Telford	Director of Public Health, Southern Health & Social Services Board.
Dr Robert Thompson	General Practitioner, Chairman of the General Medical Care Sub-Committee of CMAC.
Mr Herbie Vance	Deputy Director of Human Resources, DHSS&PS.
Mrs Doreen Wilson	Chief Dental Officer, DHSS&PS.
Dr Paddy Woods	Medical Officer, DHSS&PS.



APPENDIX 2

Support Services

BMA Counselling Service:

This service is available to doctors and their families on a 24 hour basis. It provides a confidential facility for discussing personal, emotional and work related problems. Tel: 0645 200 169

The National Counselling Service for Sick Doctors:

This service is supported by the medical Royal Colleges, the Joint Consultant Committee and the BMA. It can be accessed by individual doctors or their colleagues or relatives. The service is confidential and is not linked to the GMC or any other statutory authority. Tel: 0645 200 169

Other Confidential Help Lines

The Sick Doctor Scheme, Association of Anaesthetists of Great Britain and Ireland.

Tel: 0207 631 1650

Doctors Support Network.

Tel: 01306 880 347

Sick Doctor's Trust (Helpline for addicted physicians).

Tel: 01252 345163

BMA Stress Counselling Service for Doctors.

Tel: 0645 200169

APPENDIX 3

Royal College Rapid Response or Service Review Teams

Telephone numbers for the initial contact point in the respective College or faculty:-

Royal College of Anaesthetists

The Chief Executive

Tel: 020 7813 1900

Royal College of General Practitioners

The Head of Corporate Affairs

Tel: 020 7581 3232 or 020 7584 2678

Royal College of Obstetricians & Gynaecologists

The President or a Vice-President

Tel: 020 7772 6228

Royal College of Ophthalmologists

The Chief Executive

Tel: 020 7935 0702

Royal College of Paediatrics and Child Health

The College Secretary

Tel: 020 7307 5600

Royal College of Pathologists

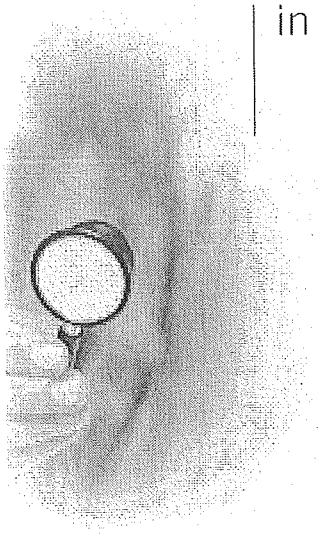
The Registrar

Tel: 020 7451 6700

The Royal College of Psychiatrists

The Vice-President

Tel: 020 7201 2601



APPENDIX 3 (continued)

Royal College of Physicians (London)

The Vice-President

Tel: 020 7935 1174

Faculty of Public Health Medicine of the Royal College of Physicians

The Vice-President

Tel: 010 7935 0243

Faculty of Occupational Medicine of the Royal College of Physicians

The President

Tel: 020 7317 5890

Royal Colleges of Radiologists

The Registrar

Tel: 020 7636 4432

Royal College of Surgeons of England (RCSE)

The College Secretary or Assistant Secretary

Tel: 020 7405 3474

Faculty of Dental Surgeons, RCSE

The Secretary to the Faculty

Tel: 020 7312 6667

APPENDIX 4

Glossary of Terms

Appraisal

A positive process to provide feedback on performance, chart continuing progress and identify development needs.

Accreditation

Formal recognition or approval of a clinical service or training programme from a recognised authority e.g. A medical royal college.

Assessment and support service

Structured service which aims to help those individuals who, for whatever reason, may need assistance in improving their performance.

BMA

British Medical Association.

Clinical Audit

A quality assessment and improvement mechanism in which health professionals peer review their practice, compare it to best practice and introduce improvements in line with their findings.

Clinical Dysfunction

A serious deviance from acceptable practice or failure to provide the service required by anyone in a clinical position.

Clinical Governance

A framework through which local organisations are accountable for the quality of service they provide.

CME

Continuing medical education

CPD

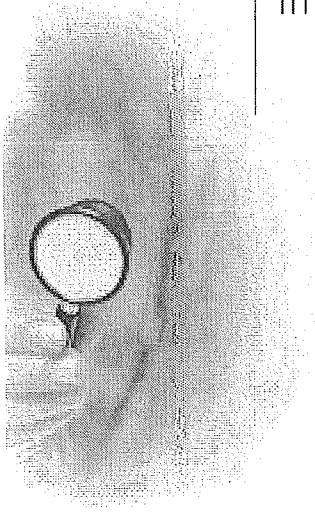
Continuing professional development.

Endoscopic Interventions

Surgical or other procedures conducted through instruments which are designed to be as minimally invasive as possible.

Fitness to practice procedures

The GMC's procedures for assessing whether a doctor's performance has fallen below the standards for registration.



APPENDIX 4 (continued)

General Medical Council (GMC)

The body responsible for maintaining a register of those suitably qualified to practice medicine.

Locum Practitioner

One who works on a temporary basis, usually taking the place of another doctor or filling a vacancy for a finite period of time.

Misconduct

Improper or unprofessional behaviour, such as theft, violence, and sexual or racial harrassment.

Personal Folder

A folder of information containing the doctor's relevant personal details; a description of what the doctor does; information on performance assessment; and evidence of continuing development.

Postgraduate Dean

A senior professional in a Region who is responsible for the organisation of doctors in training.

Primary Care

Those services, based in the community, which an individual can access on his/her own behalf. These cover a wide range of health professionals as well as social services.

Professional self-regulation

A system to control entry to and maintenance within a given profession.

Rapid response teams

Teams developed by Royal colleges to provide advice and assisstance where problems have been identified within a local service.

Revalidation

The regular demonstration by registered doctors that they remain fit to practice in their chosen field(s).

Simulation laboratory

A facility designed to replicate the working environment.

Underperformance

The repeated failure to meet acceptable standards over a period of time.

DHSSPS 333-184-037

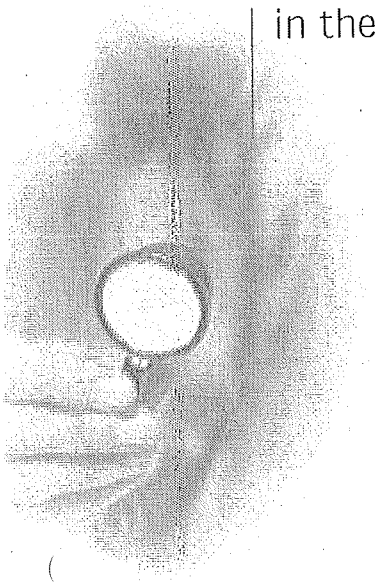
APPENDIX 5

Implications for other Clinical Professionals, including Dentists

In May 2000 the General Dental Council considered a document setting out the framework for the Council's Performance Review Scheme and Fitness to Practice. Traditionally, the General Dental Council has operated a system of reactive regulations founded on the presumption that all registered dentists are fit to practice. Performance Review will allow preventive action in the interests of public protection. It will serve this purpose through procedures for preventing, recognising and dealing with poor clinical performance.

A successful Performance Review Scheme will protect patients from poorly performing dentists by restricting or suspending their right to practice when necessary.

It will also provide a framework for their re-education and restoration to safe and acceptable practice.



HOW TO RESPOND

The consultation period will end on 12th January 2001. Written responses may be sent by post or by electronic mail to the addresses shown below.

Mrs I Wilkinson
DHSS & PS
Room C4.22
Castle Buildings
Belfast BT4 3SJ

confidence@dhsspsni.gov.uk

If you have a query about any of the issues raised in this document you may telephone 028 9052 0723 or write to / e-mail the above addresses.

In keeping with policy on openness, responses to this document may be made available to the public on request. If you do not wish your response to be used in this way, or if you would prefer it used anonymously, please let us know when responding.

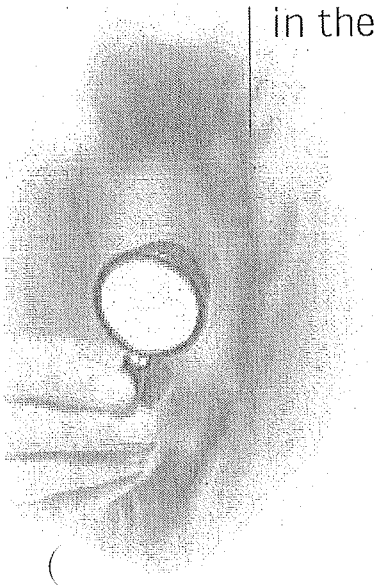
Further copies of this paper can be obtained by writing to the address above, or by telephoning 028 9052 2820, or through the e-mail address shown.

An electronic version is available at:

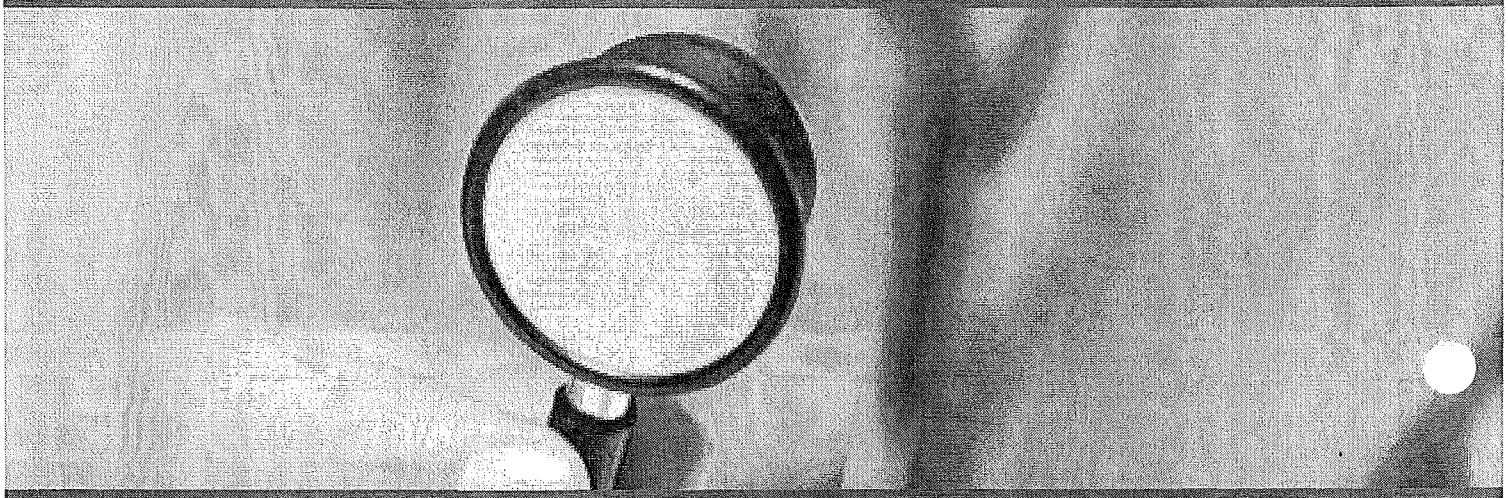
http://www.dhssni.gov.uk

Versions of the paper in Chinese, large type, Braille and audio cassette may be obtained through the contact points listed above.

Confidence in the **Future**



Department of Health, Social Services & Public Safety



An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteacht Phoiblí