

***PREVENTION BETTER THAN CURE -
ENSURING SAFER PATIENTS AND BETTER DOCTORS***

**REPORT OF SHORT LIFE WORKING GROUP ON IDENTIFYING AND
PREVENTING UNDER PERFORMANCE AMONGST
GENERAL MEDICAL PRACTITIONERS**

**SCOTTISH EXECUTIVE
July 2001**



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Making it work together

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FOREWORD

The Scottish Health Plan, “Our National Health: A Plan for Action, A Plan for Change”, commits the NHS to improving health and the quality of health services in Scotland.

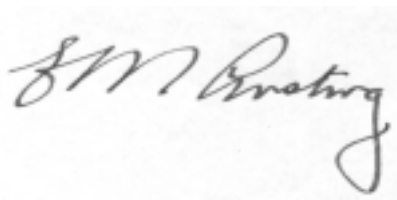
One of the prime concerns of NHSScotland is that patients should receive the best possible treatment and advice. In achieving this, it is essential that individual general practitioners should not put them at risk by inadequate performance or wilful failure. In Scotland, we are fortunate that patient care is usually of a very high standard but, inevitably, lapses sometimes occur.

This report, together with the parallel report on Doctors and Dentists in Training and the 1999 report for consultants “Suspensions – A New Perspective”, provides a strong platform on which to build. It makes a series of recommendations to ensure that the occasional general practitioner whose performance is causing concern is identified as early as possible and dealt with fairly and sympathetically; both to avoid potential harm to patients, and to "prevent" rather than "cure" problems. It will also ensure that the mechanisms to deal with potential problem general practitioners are consistent across Scotland.

We are grateful to the Working Group Members for their time and effort, and thank them for their work in producing this report, which we commend. We expect the recommendations to be implemented across Scotland. This will make a significant contribution and help to reduce to an absolute minimum any harm to patients because of under performance by general practitioners.



MR T JONES
Chief Executive



DR E M ARMSTRONG
Chief Medical Officer

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SUMMARY AND RECOMMENDATIONS

The Short-Life Working Group on under performance among general medical practitioners, and the similar Group which looked in parallel at doctors and dentists in training, were set up at the request of Ms Susan Deacon, Minister for Health and Community Care. This followed consideration by the then Chief Medical Officer, Sir David Carter, which pointed to the need to review the two groups concerned.

The Group met on 5 occasions from October 2000 to February 2001. The remit of the Group is set out in Chapter 2 and the membership is at Annex A.

The Group considered that it is important that there are clear guidelines in place across Scotland to ensure that concerns which arise about performance are dealt with in a fair and consistent manner. It considered also that it is crucial that there is clarity as to where accountability and responsibility lie for taking decisions. In this report, the Group offers guidance on how to define under performance and on the roles and responsibilities of the wide range of individuals and bodies which have a part to play in identifying and dealing with under performance.

This report outlines a four stage Assessment Process which the Group considers should be introduced across Scotland to investigate and resolve concerns about under performance. This is summarised in the flow chart at Annex F.

The Group makes 24 recommendations, designed to ensure that concerns about under performance among GPs in Scotland are dealt with in a proactive, fair and consistent manner across Scotland. The recommendations are set out below. (The term 'Trust' should be taken to mean a Primary Care Trust or an Island Health Board.)

1. The following key principles - adapted from the report "Suspensions - A New Perspective" - should be applied when dealing with GPs about whom concerns of under performance have been raised, with immediate effect:

- Patient safety ensured
- Caution before embarking on any formal action
- Fairness and openness with the practitioner
- Objectivity on the part of the Trust
- Independent advice when necessary
- Probity in the use of NHS funds
- The need to identify whether the problem lies with the individual in the context of his or her practice or whether it lies with relationships within the practice or the wider primary care team (paragraph 2.3).

2. Trusts should establish systems for early identification and investigation of potential problems and supportive, rehabilitative intervention, by 31 March 2002 (paragraph 4.1).

3. Practices should have mechanisms in place for identifying potential problems concerning partners or non principals, including locums, by 31 March 2002 (paragraph 4.1).

4. Trusts should have mechanisms in place through clinical governance and audit as outlined in paragraphs 5.24-5.31 to investigate and resolve any concerns which raise possible instances of under performance. The mechanisms, in due course, should take account of the finalised arrangements for revalidation, annual appraisal, the NHS Tribunal and other NHS disciplinary procedures. They should be in place by 31 March 2002 (paragraph 4.2).
5. In order to minimise the requirements for administration and data collection and the demand on clinical time, the Scottish Executive Health Department (SEHD), Trusts and the profession should work together to ensure that the systems introduced to underpin revalidation and annual appraisal are standardised as far as possible (paragraph 4.7).
6. SEHD should implement the proposals on supplementary lists across Scotland. The arrangements should include explicit procedures for identification of cause for concern and clinical governance arrangements for non principals including locums. The arrangements for supplementary lists should be introduced as soon as Parliamentary time permits (paragraph 4.9).
7. All employers of GPs should already be fully aware of their responsibilities. This should include references being obtained from a recent post, preferably the last post in which the locum or non principal was employed (paragraph 4.10).
8. Every GP who is subject to the Assessment Process recommended in Chapter 5 should be offered a specialist occupational health assessment (paragraph 4.16).
9. The process by which occupational health assessments are offered to GPs entering the Assessment Process should be as set out in Annex D. The occupational health assessments should be carried out by designated Consultant Occupational Physicians. These arrangements should be introduced by 31 March 2002 (paragraph 4.16).
10. SEHD should establish a network of Consultant Occupational Physicians available to undertake occupational health assessments on GPs undergoing the Assessment Process for doctors whose performance or health is causing concern, by 31 March 2002 (paragraph 4.20)
11. The Consultant Occupational Physicians should subject their anonymised case records and reports to peer review and audit by other participating Occupational Physicians (paragraph 4.21).
12. The Consultant Occupational Physicians should submit an annual report to the Chief Medical Officer, within six months of the end of each calendar year (paragraph 4.22).
13. Proposals in "Towards a Safer, Healthier Workplace" for the establishment of common minimum occupational health, immunisation and health surveillance employment records for transfer between OHSS in Scotland should also include a GP's personal occupational health record. The minimum standard should be ready for implementation by 31 March 2002 (paragraph 4.25).

14. SEHD should introduce a power of suspension, in specific circumstances and without prejudice, for Trusts to protect patients, GPs and/or NHS funds and to allow a more detailed investigation of concerns of under performance raised about GPs. This power should be introduced as soon as Parliamentary time permits (paragraph 4.27). As the suspension is without prejudice it should not result in financial disadvantage to the suspended GP or the practice.

15. Trusts and practices should work towards a culture which leads to the creation of the appropriately supportive environment required to encourage GPs to seek help when needed (paragraph 5.4).

16. GPs should recognise their role and responsibilities in the process of identifying, assessing and coming to terms with their own performance and conduct (paragraph 5.5).

17. Trusts should review their existing arrangements for effective and efficient clinical governance and clinical audit for all practices and ensure that these are adequately supported and monitored, by 31 March 2002. The arrangements could include independent death rate monitoring and critical incident monitoring (paragraph 5.8).

18. Practices should be prepared to identify under performance among non principals - and to address the issues, whatever they may be (paragraph 5.9).

19. Trusts should continue to develop mechanisms which encourage staff to bring forward legitimate concerns about performance (paragraph 5.15).

20. SCPMDE should establish a national network of expert independent educational assessors and a range of comprehensive assessment tools by 31 March 2002 (paragraph 5.16).

21. GPs should belong to an appropriate professional group and a medical defence union (paragraph 5.21).

22. SEHD should review the existing powers of the NHS Tribunal with a view to effecting changes when Parliamentary time permits (paragraph 5.23).

23. To investigate and resolve concerns about under performance, Trusts should introduce the four stage Assessment Process set out in paragraphs 5.24-5.31 by 31 March 2002. The stages are:

- Initial Screening - to determine if there is a 'prima facie' case
- Assessment at Local Health Care System Level - to gather information further to define the problem and an appropriate course of action, including OHSS assessment if indicated
- Assessment by the Expert Independent Educational Assessment Network - to provide expert independent assessment of performance based on an in-depth educational needs assessment and an individually tailored programme of targeted training

- Mentored Supervision - to ensure that the targeted training has been successful and the individual can return to unsupervised practice (paragraph 5.24).

24. SCPMDE should submit a confidential annual report on the Network's activity to the Chief Medical Officer within six months of the end of each calendar year (paragraph 5.30).

1. INTRODUCTION AND BACKGROUND

1.1 The Short-Life Working Group on under performance among general medical practitioners, and the similar Group which looked in parallel at doctors and dentists in training, were set up at the request of Ms Susan Deacon, Minister for Health and Community Care. The Group met on 5 occasions from October 2000 to February 2001.

1.2 While general medical practitioners (GPs) as a rule provide high quality care to their patients, for a small number, problems may arise with their performance. It is important that there are clear guidelines in place across Scotland to ensure that concerns which arise are dealt with in a fair and consistent manner. It is crucial that there is clarity as to where accountability and responsibility lie for taking decisions and when, for example, to refer the individual to the NHSScotland Disciplinary Procedures (Discipline Committees), the NHS Tribunal or the General Medical Council (GMC) - or to more than one of these bodies. The aim of this report is to describe the systems that should be in place to ensure that serious problems are minimised by early detection and supportive intervention.

1.3 Throughout the report, the term 'Trust' should be taken to mean a Primary Care Trust or an Island Health Board.

1.4 Consultation documents on under performance of doctors were issued in late 1999 and 2000 by the Department of Health in England, the National Assembly for Wales and the Department of Health, Social Services and Public Safety in Northern Ireland. The documents were titled "Supporting Doctors, Protecting Patients", "Maximising Clinical Performance" and "Confidence in the Future". While the principles identified in these documents were very similar, the suggested ways of tackling the issues varied reflecting different national and local organisational structures and processes. The Department of Health in England has now set up a National Clinical Assessment Authority (NCAA) to supervise problems of under performance in England. There are no plans to set up a similar body in Scotland.

1.5 Consideration of the position in Scotland by the then Chief Medical Officer, Sir David Carter, in conjunction with leaders of the profession in Scotland, pointed to the need to review two particular groups - doctors and dentists in training and GPs. Accordingly, two Short-Life Working Groups were set up to consider under performance arising within these groups.

1.6 Unlike hospital doctors most GPs are not employees of NHSScotland. GPs are doctors vocationally qualified to work in general practice (or suitably experienced as defined in the National Health Service (Scotland) Act 1978). They are:

- independent contractors (GP principals) who contract with Trusts to provide general medical services (GMS) or personal medical services (PMS);
- non principal GPs - employed by a GP principal (assistants, associates, locums and retainees); or
- PMS practitioners directly employed by PMS practices or Trusts.

This report covers all these categories. GP registrars as doctors in training are included in the report by the Working Group on doctors and dentists in training. While the principles in this report apply to PMS practitioners directly employed by Trusts, the mechanisms for addressing disciplinary issues relating to them will depend on the appraisal and disciplinary procedures within the Trust.

1.7 Responsibility for, and involvement in, helping GPs with problems rests with a number of individuals and organisations. These include the GPs themselves, other medical practitioners, other members of the primary care team, professional and support staff with whom the GP comes into contact, Trust Management (and in particular the Medical Director), the Local Medical Committee (General Practice) (LMC), the GP Sub Committee of the Area Medical Committee (AMC), the local Occupational Health and Safety Service (OHSS), the Royal College of General Practitioners, the Scottish Council for Postgraduate Medical and Dental Education (SCPMDE), the British Medical Association (BMA), Medical Defence Organisations and the GMC.

1.8 Under performance for the purpose of this report is defined as practice by a GP which fails to meet the standards usually expected of doctors in general practice in the areas defined in the GMC's Good Medical Practice.

1.9 The membership of the Group is set out at Annex A.

2. REMIT OF THE WORKING GROUP

2.1 The remit of the Working Group was agreed as:

To consider and identify best practice in taking forward the assessment of any general medical practitioner in Scotland about whom concerns about under performance are raised. Concerns can encompass problems with health, performance, discipline or conduct;

To clarify the roles and responsibilities of the different parties involved; and

To consider organisational aspects of remedial training for general medical practitioners.

Method of Working

2.2 In order to draw on the considerable breadth and depth of experience represented on the Working Group, members of the Group submitted papers on specific topics within their expertise. Members drew on experience from outside the Group in the production of these papers. The papers, along with the discussions at the meetings of the Group, underpin this report. Members also had the benefit of the consultation papers issued by the other Health Departments (see paragraph 1.4), the March 1999 Report of the Short-Life Working Group on Suspension of Medical and Dental Staff entitled "Suspensions - A New Perspective" and the September 1997 report by the University of Sheffield's School of Health and Related Research on "Measures to Assist GPs whose Performance Gives Cause for Concern".

2.3 The Group believes that implementation of the recommendations in this report will be a significant step forward in addressing the problems of under performance amongst GPs. Consistency, fairness, equity and rigour of approach across Trusts will maximise efficiency and effectiveness in detecting and dealing with under performance. This is particularly important for GPs who may move frequently between practices, and sometimes Trusts.

- **Recommendation - the following key principles - adapted from the Report "Suspensions - A New Perspective" - should be applied when dealing with GPs about whom concerns of under performance have been raised, with immediate effect:**

- **Patient safety ensured**
- **Caution before embarking on any formal action**
- **Fairness and openness with the practitioner**
- **Objectivity on the part of the Trust**
- **Independent advice when necessary**
- **Probity in the use of NHS funds**
- **The need to identify whether the problem lies with the individual in the context of his or her practice or whether it lies with relationships within the practice or the wider primary care team.**

3. UNDER PERFORMANCE

Identifying the problem

3.1 A large number of individuals and groups may have a role in the identification process. These include many of the same individuals and organisations identified in paragraph 1.7 as having a role in helping GPs with performance problems. The role and responsibility of the Trust and in particular the Medical Director, is crucial. There can be a complex interaction between individuals and organisations who have roles firstly in identifying under performance and secondly in providing support and help to the under performing doctor. In addition, there are important roles in identifying under performance for patients; for organisational procedures such as the complaints process, clinical governance, clinical effectiveness and clinical audit; for revalidation; for annual appraisal; and for external mechanisms such as Fatal Accident Inquiries.

Defining the problem

3.2 Once a potential problem has been identified, it is essential to define the underlying cause of any under performance.

3.3 As indicated at paragraph 1.8, an under performing GP is one whose personal practice fails to meet the standards usually expected of doctors in general practice in the areas defined in the GMC's Good Medical Practice. Under performance can manifest itself as problems with health, performance, discipline or conduct; or can arise through any combination of these elements.

3.4 Defining the root cause of under performance is not an easy task. Identification of under performing doctors requires robust systems and well trained individuals. Systems should be aimed at recognising early warning signs and providing a supportive environment, rather than crisis intervention. It is important to consider the individual's performance in the context of the practice or organisation. Individual under performance may be part of a systems problem which may also need to be addressed.

3.5 The Group identified the following problem areas:

- Health: contributing factors include stress, workload and isolation. Specific health issues include areas of mental illness, drug and alcohol abuse and physical conditions which may lead to under performance. Access to OHSS is essential in deciding how best to assess health related problems.
- Performance: contributing factors include errors or delays in diagnosis, use of outmoded tests or treatment, failure to act on the results of tests and technical errors in the performance of a procedure. Whether the under performance is a single mistake, or a continuing pattern, needs to be considered. Competence can be defined as what a GP is *capable of doing* while performance can be defined as what a physician *actually does in practice*. Under performance may arise from:

- failure to keep professional skills and knowledge up-to-date;
 - failure to work effectively and efficiently with colleagues;
 - failure to recognise the limits of professional competence and consult colleagues as appropriate;
 - attempting to practice techniques in which the practitioner has not been appropriately trained;
 - inability to communicate effectively with colleagues, patients or their relatives;
 - decline in technical proficiency and/or physical ability.
- Disciplinary: problems concern behaviour or activity which can lead to action by an NHS Medical Discipline Committee, the NHS Tribunal or the Discipline Committee of the GMC. They relate to breach of the statutory terms of service (Discipline Committee); serious allegations that a practitioner has put at risk the efficiency of the service (NHS Tribunal); circumstances where a practitioner has been convicted of a criminal offence (GMC); or circumstances where there is evidence of serious misconduct, evidence that a doctor is not fit to practice or evidence of seriously deficient performance (GMC). Annex B describes the disciplinary arrangements in more detail.
 - Conduct: concerns attitude, behaviour towards and communication with patients and colleagues and the ability to work as a member of a team. Problems with conduct include inappropriate conduct towards patients and colleagues, and inappropriate behaviour such as that arising from the misuse of alcohol or drugs. It is not always clear how problems should be dealt with or followed-up, or what remedial action should be taken. Standards not only encompass knowledge and technical skills, but also include demonstration of acceptable professional and personal standards of behaviour. Conduct also includes corrupt or criminal behaviour including internet and pornographic issues and committing or attempting to commit fraud.

3.6 NHS Circular No 1990(PCS)8 relates to disciplinary procedures for hospital medical and dental staff, community medicine staff and doctors in public health medicine. It gives definitions of personal and professional conduct and professional competence.

3.7 The Group expanded the definitions of conduct in the Circular as follows, essentially adding specific examples and covering situations where problems arise.

- Personal Misconduct covers deficient or unacceptable performance or behaviour due to factors other than those associated with the exercise of medical skills and may include:
 - sexual or racial harassment ;

- lack of probity;
 - lack of reliability and poor timekeeping;
 - acting on duty under the influence of drugs or alcohol;
 - inappropriate or criminal behaviour;
 - inappropriate use of NHS facilities.
- Professional Misconduct covers under performance or behaviour arising from the exercise of medical skills and may include –
 - serious neglect or disregard of professional responsibilities to patients;
 - any abuse by the doctor of his or her position of trust, including a breach of professional confidence, or any form of indecency towards a patient;
 - inappropriate or unacceptable attitudes and behaviour towards patients and relatives, and colleagues;
 - unprofessional and inappropriate attitudes and approach to work.

3.8 The Group recognised that the differentiation between "personal" and "professional" misconduct was difficult. Under current disciplinary procedures, the Group's attention was drawn to the recent agreement developed in 2000 between the BMA and employers in Scotland, to resolve differences as quickly as possible as to whether allegations should be considered as "personal" or "professional" misconduct.

3.9 The Group supported the view that it would be helpful to remove the distinction between "personal" and "professional" misconduct, and that a new and simplified category of "misconduct" be introduced.

3.10 It was also recognised that, where there were particular professional issues involving doctors, any investigatory or disciplinary hearing should have doctors on the panel.

4. INVESTIGATING AND TACKLING DIFFICULTIES

Prevention of problems if possible

4.1. For all concerned, the aim should be early identification, investigation and intervention, followed by appropriate, supportive rehabilitation measures. Local resolution should be the norm except where concerns about patient safety, statutory requirements or the commission or attempted commission of fraud cannot be resolved; in such circumstances there should be automatic reference to the GMC, the NHS Tribunal or the Medical Discipline Committee - or to more than one of these bodies. As under performance can manifest in different ways, all those with whom GPs come into contact as they carry out their professional duties can have a role to play in bringing forward questions about under performance.

- **Recommendation - Trusts should establish systems for early identification and investigation of potential problems and supportive, rehabilitative intervention, by 31 March 2002.**
- **Recommendation - Practices should have mechanisms in place for identifying potential problems concerning partners or non principals, including locums, by 31 March 2002.**

4.2 The differing roles of the Trust, usually through the Medical Director, and the GP Sub-Committee of the AMC are crucial. The Trust must ensure that effective and efficient clinical governance and clinical audit are in place for all practices and that these are adequately supported and monitored.

- **Recommendation - Trusts should have mechanisms in place through clinical governance and audit as outlined in paragraphs 5.24-5.31 to investigate and resolve any concerns which raise possible instances of under performance. The mechanisms, in due course, should take account of the finalised arrangements for revalidation, annual appraisal, the NHS Tribunal and other NHS disciplinary procedures. They should be in place by 31 March 2002.**

Links to GMC Revalidation

4.3 The key elements of the GMC's Guidance on Good Medical Practice are set out below.

- Good clinical care
- Maintaining good medical practice
- Keeping up to date
- Maintaining performance
- Maintaining trust
- Professional relationships with patients
- If things go wrong
- Abuse of professional position
- Duty to protect all patients

- If the doctor's health may put patients at risk
- Working with colleagues
- Working in teams
- Arranging cover
- Central role of the GP
- Delegation and referral
- Providing information about services
- Probity in professional practice
- Financial and commercial dealings
- Conflicts of interest
- Research

4.4 Following wide consultation leading to agreement by the GMC in May 2001 to proceed with revalidation, the GMC are working on detailed mechanisms for introduction. The Group saw it as essential that GPs should have a continuous career folder consistent with the expected requirements of revalidation, and retained by the GP.

Links to Annual Appraisal

4.5 The GMC has agreed that annual appraisal will be a key element in underpinning revalidation. Annual appraisal will require every GP to establish performance objectives. The outcome of the appraisal should be recorded in the revalidation folder. Under the GMC's proposals, the folder will hold all documented evidence of the GP's educational and clinical competence, his/her achievements and any concerns expressed.

4.6 There is now national agreement, in principle, between the Health Administrations and the profession for the introduction of annual appraisal for all doctors in Scotland and throughout Great Britain. Detailed arrangements for GPs are currently under discussion. The purpose of annual appraisal is to improve the personal development and the performance of the individual doctor and thus the quality of care provided by the practice. It will, inevitably, on occasion identify concerns about an individual doctor's performance.

4.7 The Group recognised that GPs will have to comply with the requirements of revalidation and annual appraisal as introduced in due course. While that is not their main purpose, these initiatives will provide further mechanisms to ensure that underperformance is identified wherever it occurs. The Group took the view that the processes underpinning revalidation and annual appraisal should be aligned as closely as possible. This will minimise the requirements for administration and data collection and the demand on clinical time.

- **Recommendation - in order to minimise the requirements for administration and data collection and the demand on clinical time, the Scottish Executive Health Department (SEHD), Trusts and the profession should work together to ensure that the systems introduced to underpin revalidation and annual appraisal are standardised as far as possible.**

Non principals

4.8 Particular issues arise with GPs practising as non principals including locums on short term contracts. The Group regarded the development of robust systems to ensure identification of under performance in these groups as a key issue which must be dealt with on a Scotland wide basis.

4.9 The Group welcomed proposals by SEHD to introduce supplementary medical lists for all categories of GP who are not currently required to be on a list regulated at Trust level, before they can practice. SEHD explained to the Group that full implementation will require primary legislation. The policy intention is that, if a GP is not on a list regulated locally, he or she will not be able to work as a GP in NHSScotland. The proposals will link locum and other non principal GPs directly into quality assurance systems. The introduction of supplementary lists together with the introduction of annual appraisal for all GPs including non principal GPs will greatly assist in relation to dealing with under performance.

- **Recommendation - SEHD should implement the proposals on supplementary lists across Scotland. The arrangements should include explicit procedures for identification of cause for concern and clinical governance arrangements for non principals including locums. The arrangements for supplementary lists should be introduced as soon as Parliamentary time permits.**

4.10 In the meantime, action should be taken at a local level by a more careful use of taking up references. The purpose is to ensure that GPs whose performance gives cause for concern do not move around from post to post without proper checks being carried out. When engaging a locum or other non principal GP, GPs as employers should be fully aware of their responsibilities. A reference should be obtained from a recent post, preferably the last post in which the doctor had been employed and the reason for any gaps in employment should be clear, understood and acceptable. Employment should not be offered "subject to satisfactory references"; and Trusts and practices should work towards a culture where references are open and structured round the person specification for the post and where references given are honest and objective.

- **Recommendation - all employers of GPs should already be fully aware of their responsibilities. This should include references being obtained from a recent post, preferably the last post in which the locum or non principal was employed.**

4.11 A locum should be engaged by a practice only after having displayed to that practice evidence of competence, including in due course evidence of revalidation, and after having submitted suitable references. Practices should also ask the practitioner to provide the folder which is expected to be required as part of revalidation. Practices should take steps as far as possible to ascertain whether or not the practitioner is the subject of any legal or disciplinary process arising by reason of any conduct on the part of that practitioner as a medical practitioner. Where the performance of a non principal raises concerns, the employing practice should report those concerns under the procedure in Chapter 5.

4.12 Particular issues arise concerning the transfer of information between practices and regarding the continuity of legal and disciplinary processes. These are particularly relevant in the case of GPs practising as locums or otherwise on short-term contracts. It is not yet clear to whom the information contained in the folder will have to be declared. The individual practitioner should have responsibility for ensuring that the folder is kept up to date. Failure to disclose the folder could be taken into account when deciding whether or not to engage that person. Trusts should consider how best to monitor the folder, eg by conducting sampling checks of the folders.

Health Issues

4.13 A proportion of under performing doctors will have health problems which may contribute to their under performance. It is crucial that issues of health are considered very early on in the Assessment Process to allow any underlying problems to be addressed. GPs need to be made aware of and encouraged to use counselling services as the need arises. The profile of Occupational Health and Safety Services (OHSS) should be raised significantly. The GMC recommends that all doctors should be registered with a GP and also advises that wherever possible GPs should not be registered as patients in their own practice. Useful addresses and information on where to find help and support for GPs with health-related problems are contained at Annex C.

4.14 The Group endorsed the support for occupational health services in "Towards a Safer, Healthier Workplace", the Report of the Occupational Health and Safety Service Short Life Working Group. The report states:

"The OHSS must provide a confidential service to staff. Management must demonstrate a clear commitment to protecting the confidentiality of employee information obtained through the OHSS. OHSS policies and procedures must give staff confidence that the service exists to assist the individual and is not a tool of management. All staff should have access to confidential advice from an OHSS from outwith their immediate area if necessary".

4.15 The Group welcomed the recent establishment of the Occupational Health and Safety Strategy Implementation Group (OHSSIG) to implement "Towards a Safer, Healthier Workplace". The Implementation Group will report to the Scottish Partnership Forum. Its remit is to produce a fully integrated occupational health service for NHS staff within three years. The Group also welcomed the commitment in "Our National Health: a plan for action, a plan for change" to the extension of occupational health services to staff working in general practice, including GPs.

4.16 The role of occupational health is first of all to identify health problems caused by work or health problems impacting on an individual's ability to do the job.

- **Recommendation - every GP who is subject to the Assessment Process recommended in Chapter 5 should be offered a specialist occupational health assessment.**

- **Recommendation - the process by which occupational health assessments are offered to GPs entering the Assessment Process should be as set out in Annex D. The occupational health assessments should be carried out by designated Consultant Occupational Physicians. These arrangements should be introduced by 31 March 2002.**

4.17 The assessment should consider the current health of the GP and any relevant past medical history. It would normally consist of a full occupational health evaluation, including evaluation of the medical, social and occupational history. Problems identified should lead where appropriate to referral for treatment and, when possible, engagement of the GP's own GP. Significant relationship or organisational factors should be highlighted in the occupational health report.

4.18 Participation should be voluntary. However, refusal to participate in some circumstances could be grounds for reference to the GMC Health Committee.

4.19 Alternatively, should circumstances arise where the nature of the health problem was such that the GP was unable to recognise the existence of the problem, it would - depending on the circumstances of the case - be open to the Trust to take the view and produce evidence that the GP might be unfit to practice. Under the National Health Service (General Medical Services) (Scotland) Regulations 1995, the Trust may make arrangements for the temporary provision of general medical services for a GP's patients if satisfied that the GP's obligations are not being carried out adequately because of his or her physical or mental condition. This power can be used only after consultation with the AMC and with the consent of Scottish Ministers. Under the Regulations the Trust may, after consultation with the AMC, also require a GP to submit for medical examination. Subsequently, again depending on the circumstances of the case, it would be open to the Trust to regard the GP as unfit to practice until he or she could produce a report from health advisers and the OHSS confirming that they were fit to practice.

4.20 To ensure consistency and quality of service and to provide national coverage, a network of designated Consultant Occupational Physicians should be created. All occupational health assessments for the under performing procedures should be conducted by a physician from the network.

- **Recommendation - SEHD should establish a network of Consultant Occupational Physicians available to undertake occupational health assessments on GPs undergoing the Assessment Process for doctors whose performance or health is causing concern, by 31 March 2002.**

4.21 The output from the assessment must be regarded as strictly confidential and should be sent to (a) the Medical Director of the responsible authority which commissioned the occupational health opinion as well as (b) the doctor who was being assessed. The doctor being assessed should have the option of choosing an out-of-area Consultant if he/she does not wish to attend the locally based Occupational Physician. The assessment, its elements and format of the report should be to a predetermined standard agreed by participating Consultant Occupational Physicians. The Consultant Occupational Physicians should be subject to peer review and audit by other participating Occupational Physicians.

- **Recommendation - the Consultant Occupational Physicians should subject their anonymised case records and reports to peer review and audit by other participating Occupational Physicians.**

4.22 Participating Occupational Physicians should collate anonymised data on doctor demographics and the health problems identified.

- **Recommendation - the Consultant Occupational Physicians should submit an annual report to the Chief Medical Officer, within six months of the end of each calendar year.**

4.23 Problems can arise as doctors move from one post to another. A new appointment can involve a different Trust whose occupational health is provided by a different service. At present, occupational health records do not follow NHS employees and as a consequence, all information collected about a doctor is in effect lost. OHSS records are highly confidential and while it would be open to a GP to offer OHSS records to a new Trust or to a prospective employer, this could not be insisted upon.

4.24 The Group endorsed the action point in "Towards a Safer, Healthier Workplace" that 'OHSS must identify minimum occupational health, immunisation and health surveillance employment records for transfer between OHSS in Scotland'. It endorsed also the recommendation in the report "Needlestick Injuries: Sharpen Your Awareness" that 'the Scottish Executive Health Department with the OHSSIG should investigate the use of a smart card and/or electronic employment record for staff which will include occupational health information, including vaccination information, as a priority'.

4.25 Transfer of OHSS information, with the doctor's consent, is currently being piloted in England by the use of smart cards. This will contain essential health information relating to pre-employment health checks such as the doctor's current immunisation status. The OHSSIG is following the smart card pilots in England with a view to adopting a similar arrangement in Scotland. The Group supports the action of the OHSSIG and commends the evaluation of smart cards, with the GP's consent, as a possible way of addressing occupational health information transfer in this context.

- **Recommendation - proposals in "Towards a Safer, Healthier Workplace" for the establishment of common minimum occupational health, immunisation and health surveillance employment records for transfer between OHSS in Scotland should also include a GP's personal occupational health record. The minimum standard should be ready for implementation by 31 March 2002.**

Performance

4.26 Performance can be assessed by a range of mechanisms which include clinical effectiveness or audit; clinical governance; practice visits; prescribing patterns; OHSS assessment; local knowledge (peers and colleagues); and practice-specific

information. The Trust has a key role to play in ensuring that effective arrangements are in place to assess performance and identify under performance.

Discipline and Conduct

4.27 These are issues for the current statutory disciplinary procedures which are described in Annex B. Each of the disciplinary mechanisms has the capacity to resolve in one form or other cases of under performance. However, none of them currently provides the opportunity for the local health care system to ensure that a GP is suspended from duty pending full examination of the circumstances of a case. Only the NHS Tribunal may direct the suspension of a GP pending disposal of his or her case. Early suspension could, however, be important in particular circumstances - for example where serious misconduct was alleged. At present, an informal process operates whereby a GP may be persuaded by three colleagues appointed from among his or her peers ('three wise men' approach) to cease practice while an investigation takes place. That approach will be replaced by the Assessment Process set out in Chapter 5. The voluntary nature of these procedures will be the key to their success - but they are insufficient in themselves. While in appropriate circumstances GPs should continue to be encouraged to cease practice voluntarily pending investigation, a power of suspension by the Trust should be introduced to ensure protection of patients, GPs and/or NHS funds in exceptional circumstances.

- **Recommendation - SEHD should introduce a power of suspension, in specific circumstances and without prejudice, for Trusts to protect patients, GPs and/or NHS funds and to allow a more detailed investigation of concerns of under performance raised about GPs. This power should be introduced as soon as Parliamentary time permits. As the suspension is without prejudice it should not result in financial disadvantage to the suspended GP or the practice.**

Criminal Misconduct

4.28 Where there are allegations of criminal misconduct or fraud it is clear that such allegations should be a matter for the police and the Procurator Fiscal to investigate. Advice on how and when this is done must be taken from those who have experience of legal affairs, eg the Central Legal Office or the Fraud Investigation Unit of the Common Services Agency for Scotland or a Medical Defence Organisation. It is important to emphasise that anyone so accused is entitled to a presumption of innocence until proven guilty. It is therefore important to ensure that no action in respect of under performance in such circumstances prejudices any criminal enquiries. The Trust should be notified, however, so that it can consider what action, if any, it should take. The Trust should always take advice on how to proceed before taking any action. All criminal convictions are automatically reported to the GMC.

5. ROLES AND RESPONSIBILITIES

5.1 As stressed in the Introduction, it is crucial that there is clarity about who should take the lead and be responsible for dealing with under performing GPs. This Chapter sets out the procedure which should be followed when concerns about under performance are raised.

5.2 The responsibilities need to be agreed by all stakeholders and be clearly defined, so that the whole system deals with under performance in a supportive and fair manner and the procedure is consistently applied throughout Scotland.

5.3 The Group was aware of the principles outlined in the report of the short-life Working Group on Suspension of Medical and Dental Staff published by the Scottish Office Department of Health in 1999 entitled "Suspensions - a new perspective". In the report, it was recognised that NHSScotland has a duty of care to patients and to their employees. While the report related to suspensions in the hospital sector, the Group accepted that the general principles set out apply equally to independent contractors to the NHS such as general practitioners. The principles should therefore be considered carefully when investigating and tackling under performance. The relevant extract of the report is at Annex E.

Key stakeholders

Role of the Trust and GPs

5.4 Currently the culture in the NHS does not encourage doctors to come forward to seek help when concerned about their performance or health. The introduction of an OHSS for GPs will undoubtedly help.

- **Recommendation - Trusts and practices should work towards a culture which leads to the creation of the appropriately supportive environment required to encourage GPs to seek help when needed.**

5.5 The Assessment Process set out in this Chapter covers GP principals (GMS and PMS); GP non principals (except GP registrars who are included in the report by the Working Group on doctors and dentists in training); and PMS practitioners directly employed by practices or Trusts. The procedures should operate in the same way for each of those categories of GPs.

- **Recommendation - GPs should recognise their role and responsibilities in the process of identifying, assessing and coming to terms with their own performance and conduct.**

5.6 Some suggestions as to how GPs could deal with these issues include:

- by being aware of the responsibilities described in GMC publications including 'Good Medical Practice', which sets out the duties of a doctor;
- by understanding and complying with the terms of service Regulations;
- by participating and co-operating in the annual appraisal process;

- by engaging in continuing professional development;
- by ensuring their revalidation folder is kept up to date;
- by being prepared to ask for help from other colleagues;
- by joining the appropriate professional bodies;
- by registering (and their families also registering) with a GP from another practice, preferably a practice outwith their local area, and looking after their health needs;
- by being willing when appropriate to make use of the Trust's OHSS.

5.7 Most GP principals operate in partnership with one or more fellow principals while some operate single handedly. In a partnership, the partners jointly have a responsibility for identifying and addressing under performance.

5.8 As the holder of the contract the Trust is responsible for operating pro-actively to ensure that under performance is identified and addressed.

- **Recommendation - Trusts should review their existing arrangements for effective and efficient clinical governance and clinical audit for all practices and ensure that these are adequately supported and monitored, by 31 March 2002. The arrangements could include independent death rate monitoring and critical incident monitoring.**

5.9 For GP non principals, the employing principal (or principals) is/are responsible for addressing under performance. Particular issues arise as regards locums who by the nature of their employment are peripatetic. It is not sufficient simply to release a locum or to avoid employing a particular individual in future.

- **Recommendation - Practices should be prepared to identify under performance among non principals - and to address the issues, whatever they may be.**

5.10 Generally as regards non principals, again the Trust will be responsible for ensuring that practices address under performance and for supporting practices in doing so.

5.11 GP principals and the Trust should ensure that the folder and annual appraisal systems are developed and used in an honest and constructive manner.

Other stakeholders

Role of colleagues

5.12 Colleagues in all healthcare professions have a responsibility for patient safety and for probity in the use of NHS funds. All practices/Trusts should have efficient systems in place for staff to raise their concerns without fear. These should be a core component of local policies and procedures.

5.13 Anonymity may make it easier for individuals to raise concerns. However, from the point of view of the person against whom concerns have been raised, anonymity of a complainant can only be tenable at the very earliest stages of

investigation. The principle that an individual has the right to know his or her accuser and the nature of the accusation must be upheld.

5.14 The need for openness could lead to reluctance on the part of one doctor (or other member of the primary care team) to criticise a colleague who could influence his or her future career. Trusts should develop mechanisms to deal with this specific issue.

5.15 The bringing forward of legitimate concerns by colleagues should be encouraged. All NHSScotland employers should have efficient systems in place for staff to raise their concerns without fear (NHS Circular No GEN(1993)10). These should be a core component of local employment policies and procedures. Practices should adopt a culture whereby staff feel able to speak freely about any concerns they may have about their own performance or that of others.

- **Recommendation - Trusts should continue to develop mechanisms which encourage staff to bring forward legitimate concerns about performance.**

Role of Scottish Council for Postgraduate Medical and Dental Education (SCPMDE) and Director of Postgraduate GP Education

5.16 In individual cases the Director of Postgraduate General Practice Education (DPGPE) will be expected to lead on behalf of SCPMDE in educational issues, in the assessment process and in assisting in the development and delivery of targeted training and mentored supervision. The Director will advise on the identified educational needs and on appropriate educational interventions. In addition, the Director may offer periodic review and support to the GP.

- **Recommendation - SCPMDE should establish a national network of expert independent educational assessors and a range of comprehensive assessment tools by 31 March 2002.**

5.17 Following expert independent educational needs assessment SCPMDE will co-ordinate targeted training or re-training (if indicated) through the local DPGPE. Following the period of targeted training a further assessment should be conducted to ensure that the previously identified deficiencies have been addressed and resolved.

5.18 The intensity and requirement for close expert supervision of doctors undertaking a period of targeted training cannot be overestimated. This will require the identification of a number of practices willing to participate in this exercise within which there are at least two practitioners with the high level skills required to supervise a period of targeted training. It is important that these practices are adequately resourced to undertake this task and that support and training are available from the trainers.

5.19 Practical suggestions for organising targeted training follow. These should be adapted for the different individual circumstances of the training required.

- Targeted training periods should be clearly identified and agreed with the GP at the outset and should end with a formal assessment, also agreed at the outset.

Success in the latter should be followed by a return to normal working (but supervised and audited).

- Targeted training periods should have clearly defined time limits and be specifically targeted to the GP's identified problem areas. If the GP wishes training in other areas, this would be at the individual GP's own expense.
- Prior agreement would need to be reached between the Trust and the Postgraduate Dean on the timing, duration and content of the targeted training programme. If serious problems of clinical competence arise during the targeted training, the Trust can, at its sole discretion, terminate the training agreement.
- Appraisal of the GP's performance, following a return to work, should be undertaken at regular intervals.
- Not all under performing GPs are capable of successful return to practice and re-training may have to be considered.
- Patient safety is paramount and the Trust must ensure that GPs undergoing targeted training are adequately supervised and given clear feedback on their performance throughout.
- Any training programmes should be notified to the Trust's Clinical Governance Committee, who should ensure that the quality of patient care is not compromised by these arrangements.
- All agreements should be confirmed in writing, and signed by all relevant parties before targeted training begins.

Role of statutory Regulatory Bodies

5.20 The role of all the statutory Regulatory Bodies is under review and evolving. The arrangements for assessing under performance of GPs will need in due course to be consistent with the outcome of these reviews.

Role of the BMA and medical defence unions

5.21 The BMA and the medical defence unions play a valuable role in advising individual doctors about terms and conditions matters and about their rights. They also give help in how to deal with allegations of misconduct and performance, and support the individual doctor in any disciplinary hearing.

- **Recommendation - GPs should belong to an appropriate professional group and a medical defence union.**

Role of GMC

5.22 The GMC is the appropriate point of referral for cases of under performance, health and conduct which have not been resolved by any other route; which are of a serious nature; or, in criminal cases, which result in a referral to the GMC on

conviction. In a number of cases, it will be appropriate for a simultaneous referral to take place to an NHS Discipline Committee or the NHS Tribunal. A new Interim Orders Committee now enables the GMC to act quickly to place restrictions on a doctor's registration where it is considered to be in the interests of patient safety, in the public interest or in the interest of the doctor pending fuller investigation of the individual. The Fitness to Practise Directorate of the GMC is willing to advise Trust Medical Directors whenever formal referral to the GMC is being considered.

Role of statutory disciplinary bodies

5.23 The outcome of the GMC's current review of its procedures and processes and the impending introduction of revalidation will have consequences for the conduct of the Assessment Process, including questions about referral to statutory bodies. In addition, there are a number of factors that are likely to impact on the current powers of the NHS Tribunal which are likely to require a review of its powers and functions.

- **Recommendation - SEHD should review the existing powers of the NHS Tribunal with a view to effecting changes when Parliamentary time permits.**

Assessment Process

5.24 As indicated at paragraph 4.1, local resolution should be the norm except where concerns about patient safety, statutory requirements or the commission or attempted commission of fraud cannot be resolved; in such circumstances there should be automatic reference to the GMC and/or other statutory body. As necessary, in order to deal with cases where neither of those options apply, the Trust should establish a formal voluntary process to consider and advise on problems relating to individual GPs. In essence, the process should replace the traditional 'three wise men' approach. The Medical Director of the Trust in consultation with the GP Sub Committee of the AMC should have the key role of ensuring the development and effective operation of the arrangements. The process should be as set out below and as illustrated in Annex F.

- **Recommendation - To investigate and resolve concerns about under performance, Trusts should introduce the four stage Assessment Process set out in paragraphs 5.24-5.31 by 31 March 2002. The stages are:**
 - **Initial Screening - to determine if there is a 'prima facie' case**
 - **Assessment at Local Health Care System Level - to gather information further to define the problem and an appropriate course of action, including OHSS assessment if indicated**
 - **Assessment by the Expert Independent Educational Assessment Network - to provide expert independent assessment of performance based on an in-depth educational needs assessment and an individually tailored programme of targeted training**
 - **Mentored Supervision - to ensure that the targeted training has been successful and the individual can return to unsupervised practice.**

5.25 The detailed arrangements for the process should be agreed locally between the Trust and the GP Sub Committee of the AMC but should include:

- Open method of referral
- Supportive and informative communications to GP practices by the GP Sub Committee of the AMC and the Trust
- GPs going through the process should have the right to be involved and to respond to concerns raised at every stage
- Assessments should be carried out in confidence, subject to ensuring patient safety
- Any patient information should be anonymised wherever possible. This may not be possible in fraud cases
- Assessment of the problem
- A range of options to resolve a problem
- The outcome at each stage should be fully recorded in all cases
- After each stage in the process, the recommended option should be submitted to the Trust for formal endorsement and action as required.

5.26 As discussed at paragraph 3.1, concerns about a doctor's performance may arise in a number of ways, both formal and informal, and a range of individuals and organisations have the responsibility to raise any concerns which they may have about the performance of a GP. Such concerns are likely to be raised with the Trust/Medical Director, the LMC or the GP Sub Committee of the AMC. Once a concern has been raised, the following process should be adopted. At any stage when information comes to light that patient safety may be at risk swift and decisive formal action must be taken.

5.27 Participation in the assessment process by a GP should be voluntary. However, if a GP about whom concerns have been raised refuses to take part in the process, the Trust will have to consider formal referral of the case to an NHS Discipline Committee, the NHS Tribunal or the GMC - or to more than one of these bodies. In due course, if the Group's recommendation that Trusts be given a power of suspension is accepted, the Trust will have the alternative, depending on the circumstances of the case, of suspending the GP.

Stage 1 - Initial Screening

5.28 An initial inquiry needs to be made to determine if there is a 'prima facie' case, and whether immediate action needs to be taken to protect patients from harm.

Process

This screening should be undertaken by a Co-ordinating Group involving the Medical Director in conjunction with the Chairman of the GP Sub Committee, Senior Trust Management and with lay involvement through a non-executive Board member. The Medical Director and the Chairman of the GP Sub Committee should contact the doctor involved to inform him or her of the concerns raised and any proposed actions and to provide the opportunity for the doctor to respond. The screening should focus on the concerns raised and

the evidence provided. It is important to consider routinely available local information on the GP and practice.

Outcome

The options are:

- no case or cause for concern;
- prima facie evidence of serious under-performance, health, discipline or misconduct problems requiring formal referral to statutory bodies (GMC, NHS Tribunal, Disciplinary Committee processes). For GPs salaried to the Trust under PMS arrangements, this includes referral to Trust disciplinary procedures;
- local remedial action; or
- needs further detailed local investigation and assessment via Stage 2.

Stage 2 - Assessment at Local Health Care System Level

5.29 This stage involves gathering further information which is then used to enable the Co-ordinating Group further to define the problem and an appropriate course of action.

Process

Information may be requested from a variety of sources and will be dependent on the nature of the concerns. If, for example, there is a suspected health issue there will be a requirement for involvement of OHSS (local or external).

Confidential inquiry may be made to:

- The LMC; GP Sub Committee of the AMC; Human Resources; OHSS (local or external); Local Associate Adviser; LHCC clinical governance lead; Prescribing Adviser; Local Health Council; and the Trust, usually through the Medical Director.

The process should involve more detailed evaluation of local routinely available information such as:

- clinical effectiveness or audit; clinical governance; practice visits; practice development plans; complaints; prescribing patterns; any other Trust-held information including performance indicators; the revalidation folder; self-identification of under performance; Out of Hours Co-operatives; OHSS assessment; local knowledge (peers and colleagues); and practice-specific information.

Outcome

The options open to the Co-ordinating Group are:

- no case or cause for concern;

- prima facie evidence of serious under-performance, health, discipline or misconduct problems requiring formal referral to statutory bodies (GMC, NHS Tribunal, Disciplinary Committee processes). For GPs salaried to the Trust under PMS arrangements, this includes referral to Trust disciplinary procedures;
- local remedial action; or
- outstanding concerns about under-performance requiring referral to the Expert Independent Educational Assessment Network.

Stage 3 - Assessment by the Expert Independent Educational Assessment Network

5.30 This stage involves commissioning the Expert Independent Educational Assessment Network to provide expert independent assessment of performance based on an in-depth educational needs assessment. The Network should be nationally co-ordinated by SCPMDE.

Process

The Trust (usually the Medical Director) should commission and receive the assessment. The process should be developed by SCPMDE, through the DGPPEs. Close liaison between the Trust Medical Director and the Network is essential.

Outcome

The options from the expert independent assessment are:

- no case or cause for concern;
 - individually tailored programme for targeted training;
 - prima facie evidence of serious under-performance, health, discipline or misconduct problems requiring formal referral to statutory bodies (GMC, NHS Tribunal, Disciplinary Committee processes). For GPs salaried to the Trust under PMS arrangements, this includes referral to Trust disciplinary procedures; or
 - re-training.
- **Recommendation - SCPMDE should submit a confidential annual report on the Network's activity to the Chief Medical Officer within six months of the end of each calendar year.**

Stage 4 - Mentored Supervision

5.31 For GPs who have undergone targeted training, there should be a period of mentored supervision to ensure that the educational interventions have had the desired impact on the individual's day to day practice. The supervision should include regular reporting to the Medical Director.

Finance

5.32 The operation of the Assessment Process will have resource implications for NHSScotland. Some of these are identified below. In a given case, however, these costs will almost certainly be less than the costs arising from serious failure by a GP.

There will be costs for SCPMDE in relation to:

- Development of assessment tools
- Selection and training of individuals to be part of the Expert Independent Educational Assessment Network
- On going support and evaluation of the Network activity
- Support for individuals undertaking remedial work
- Re-training including support.

The following costs should be set against the costs of any disciplinary or legal procedures which may be averted by a robust support system for GPs.

- Costs for practices and Trusts to allow time for proper educational supervision.
- Costs of any necessary practice support and locum costs.
- Any recurring additional practice resources identified.
- Costs of OHSS and any treatment.

6. LEGAL CONSIDERATIONS

Data Protection Act 1998

6.1 The Data Protection Act 1998 contains numerous conditions and restrictions concerning the holding and distribution of data and concerning access to that data by the person who is the subject of that data. This is a very detailed and complex piece of legislation and consideration of its application is beyond the scope of this report. Trusts and practitioners should nevertheless familiarise themselves with the obligations and restrictions placed upon them by the Data Protection Act 1998.

Human Rights Act 1998

6.2 The Human Rights Act 1998 applies to all public authorities, which includes Trusts and renders it unlawful for such a body to act in a way that is incompatible with a “Convention right”. The term Convention rights incorporated many of the rights and freedoms contained in the Convention for the Protection of Human Rights and Fundamental Freedoms, otherwise known as the European Convention on Human Rights. Again consideration of the application of this legislation is beyond the scope of this report but Trusts should ensure that they familiarise themselves with the fundamental principles and should seek legal advice where appropriate.

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

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

General

6.5 In addition to the matters outlined above, it should be remembered that practitioners retain any rights which they may have under common law and, in appropriate cases, under employment legislation.

6.6 Each case should be considered on its own merits and where there are any legal concerns, appropriate legal advice should be obtained.

**UNDER PERFORMING DOCTORS GROUP: GENERAL MEDICAL
PRACTITIONERS**

MEMBERSHIP LIST

Dr H Whyte, Scottish Executive Health Department (Chairman)

Dr D Alexander, Scottish General Practitioners Committee

Dr D Blaney, Director of Postgraduate GP Education, Lister Postgraduate Institute,
Edinburgh

Mr T Davison, Chief Executive, Greater Glasgow Primary Care NHS Trust

Dr F Elliot, Medical Director, Fife Primary Care Trust

Dr K Harden, Chairman, Scottish General Practitioners Committee

Dr C Hunter, immediate past Chairman, Royal College of General Practitioners
Scottish Council; National GP Co-ordinator, Primary Care, SCPMDE

Mrs H Kelly, Human Resources Director, Forth Valley Primary Care Trust

Dr E B Macdonald, Senior Lecturer in Occupational Health, University of Glasgow;
Director of Salus Occupational Health and Safety Service

Professor G Needham, Dean of Postgraduate Medicine, Aberdeen

Dr J Rodger, Medical and Dental Defence Union of Scotland

Dr A Short, Assistant Director, Department of Postgraduate Medicine (GP); West of
Scotland Board for Postgraduate Medical Education

Dr M Winter, Medical Director, Lothian Primary Care NHS Trust

The Very Reverend Dr H Wyllie, lay member

Mr C Walker, Observer, Department of Health

Mr M Richards, Scottish Executive Solicitor's Office

Mr T R Macdonald, Scottish Executive Health Department

Mr J W Davidson, Scottish Executive Health Department (Secretary)

DISCIPLINARY PROCEDURES

The current disciplinary and regulatory arrangements for GPs are in three parts: Discipline Committees, the NHS Tribunal and the GMC. The criteria for referral of any doctor to the Discipline Committee, the Tribunal and the GMC are set out in NHS Circular No PCA(M)(1997)5.

Discipline Committees

When a Trust considers that a GP may have breached the statutory terms of service it may refer the matter to the Medical Discipline Committee of another Health Board or of a consortium of Boards of which it is not a member. Consideration by a separate Committee ensures a degree of impartiality. The decision to refer may come about by examination of the report into a patient complaint or information received from some other source. It is for the Committee to reach a decision on whether the terms of service have been breached. The Committee should also make a recommendation as to the action to be taken against the GP. The referring Trust must accept its findings and decide on the appropriate sanction: to warn the GP to comply more closely with the terms of service or to recover an amount from their remuneration. In addition, a special limit may be imposed on the number of patients for whom the GP can provide treatment. Discipline Committees have no power of suspension.

NHS Tribunal

The NHS Tribunal considers serious allegations where a practitioner has put at risk the efficiency of the NHS. It may direct their exclusion. Cases are very rare. The Chairman of the Tribunal is appointed by the Lord President of the Court of Session while the other members, one lay and one professional, are drawn from lists appointed by the Scottish Ministers. Cases referred to the Tribunal by Trusts must be examined while those referred by any other person or body may be examined at the Tribunal's discretion. The Tribunal has a power of interim suspension if that is necessary for patients to be protected. Hearings must be held into any call for suspension and also into the full case unless the grounds of the case are that the GP has been convicted of a criminal offence, or admits the allegation, and agrees to dispense with a hearing. Appeals against directions of the Tribunal may be made through the Court of Session on a point of law.

General Medical Council

The Council can restrict or remove a doctor's registration if one of the Fitness to Practice Committees decides this is necessary. The Council will investigate if a doctor has been convicted of a criminal offence - or there is evidence of serious professional misconduct, that a doctor is not fit to practice or of seriously deficient performance. Cases are taken forward by the Conduct, Health or Performance Committees. The sanctions available to the Council are to cancel, suspend (immediately if necessary) or place conditions on a doctor's registration. Through the new Interim Orders Committee the GMC can act quickly to place restrictions on a

doctor's registration where it is considered to be in the interests of patient safety, in the public interest or in the interest of the doctor, pending a fuller investigation of the charge.

ADDRESSES AND INFORMATION ON HELP AND SUPPORT FOR GPs WITH HEALTH RELATED PROBLEMS

The BMA 24-Hour Stress Counselling Service for Doctors – 08459 200169

Callers are able to speak to trained non-medical counsellors. Direct ongoing support or referral to specialised addiction services is offered.

The National Counselling Service for Sick Doctors (NCSSD) (Mon-Fri 9.00am-5.00pm) – 0870 2410535

This service provides general information and advice. Callers can be given the name and number of one of the NCSSD medical advisers (including Scottish based advisers) to whom they can talk in confidence. NCSSD advisers are also available to talk to groups and the media about doctors' health issues.

GMC's Fitness to Practise Division – 0207 580 7642

Can provide informal advice and guidance about involving the GMC's health procedures.

The Sick Doctor's Trust - 01252 345163

A proactive service for addicted physicians. 24-hour advice and intervention service. Facilitates admission to appropriate treatment centres and introduction to support groups.

The British Doctors' and Dentists' Group (accessed via the Medical Council on Alcoholism) – 0207 487 4445. 24-hour helpline - 01252 345163

A support group of recovering medical and dental drug and alcohol misusers. Local groups meet throughout Scotland and the British Isles. Medical students also welcomed.

The Overseas Doctors' Association – 0161 456 7828

Health counselling panel can be helpful for doctors where cultural or linguistic factors are prominent.

Samaritans – 0845 790 9090*

Alcoholics Anonymous - 0845 769 7555*

Scottish Council on Alcohol – 0141 572 6700*

* See telephone directory for local contacts.

THE ROLE OF OCCUPATIONAL HEALTH IN THE EVALUATION AND SUPPORT OF THE UNDER PERFORMING DOCTOR

PROPOSED PROCESS FOR OCCUPATIONAL HEALTH ADVICE TO THE UNDER PERFORMING DOCTOR

A doctor entering the under performing procedures should be offered specialist occupational medicine assessment. This would normally consist of a full occupational health evaluation, including evaluation of the medical, social and occupational history and the current health of the doctor. Reports would normally be sought from the doctor's GP or any other doctors attended by the doctor (with consent). Measures of mental well-being such as the Hospital Anxiety and Depression Score should be used routinely.

All doctors should be registered with a GP. GPs wherever possible should register with a GP from another practice, preferably a practice outwith their local area.

Participation in the occupational health assessment must be voluntary. Output from the assessment would:

- protect clinical confidentiality and would identify only whether or not there was a health problem and whether this health problem could have an impact on performance;
- identify whether or not, from an occupational health perspective, there were organisational or other factors which were having an adverse effect on the individual's performance;
- confirm whether or not the Occupational Physician had initiated any therapeutic interventions via the doctor's GP or other specialists;
- identify whether or not the doctor was fit to continue practising as a doctor in the short-term and by implication participate in the under performing processes;
- identify whether the doctor required ongoing occupational health support and how this was to be provided.

The output from this assessment must be regarded as strictly confidential and should be sent to (a) the responsible Medical Director and (b) the doctor who is being assessed.

The doctor being assessed would be asked to approve the draft report before it was sent. Where the doctor being assessed disagreed with the report and agreement with the Occupational Physician could not be reached, then the Occupational Physician could communicate that report to others without consent, only in situations approved by the Ethical Guidelines of the Faculty of Occupational Medicine, ie where there was a significant risk to patient or public safety or where there was a statutory obligation to inform a responsible authority, eg in case of suspects' criminal activity or child abuse etc.

The output from the assessment must be regarded as strictly confidential and should be sent to (a) the Medical Director of the responsible authority which commissioned the occupational health opinion as well as (b) the doctor who was being assessed.

Ongoing support and treatment for the doctor going through the processes may be from the assessing physician, from an alternative Occupational Physician, the individual's GP or other specialist services as clinically indicated. The point of the process would be to ensure that adequate support and treatment from an appropriate service was in place for the doctor.

ORGANISATION OF THE SERVICE

Selection

Only designated Consultant Occupational Physicians should be involved in the assessment.

The doctor being assessed would have the option of choosing an out-of-area Consultant if they did not want to attend the local Occupational Physician.

Quality and Audit

The assessment, its elements and format of the report would be to a predetermined standard agreed by participating Consultant Occupational Physicians.

Annual Report

Participating Occupational Physicians would collate anonymised data on doctor demographics and the health problems identified.

EXTRACT FROM SUSPENSIONS - A NEW PERSPECTIVE, REPORT OF THE SHORT-LIFE WORKING GROUP ON SUSPENSION OF MEDICAL AND DENTAL STAFF

Key principles

4.3 *The employer's prime concern has to be the maintenance of safety for patients and the public. When evidence is such that patient's safety is in jeopardy, the employer should consider the immediate use of suspension. The most frequent reasons for suspending staff are:*

- *when continuation of work by a practitioner would cause a direct threat to patient safety;*
- *when the practitioner has to be removed from the employing body's premises to ensure that the practitioner's interests are protected;*
- *when the employer considers it necessary to resolve an acutely tense situation;*
- *when the investigation into allegations of misconduct may be hindered by the presence of the person under investigation;*
- *when the practitioner refuses to co-operate with voluntary restriction of practice.*

4.5 *The [Short-Life Working Group on Suspension] Group considered that employers should adopt the following principles to steer them through the pre-suspension process:*

- *patients should not be put at risk;*
- *caution before embarking on suspension;*
- *fairness and openness with the practitioner;*
- *detachment and objectivity by the employer;*
- *independent advice if necessary;*
- *consider whether the problem is confined to the individual or part of a wider problem within a clinical team;*
- *keep an open mind.*

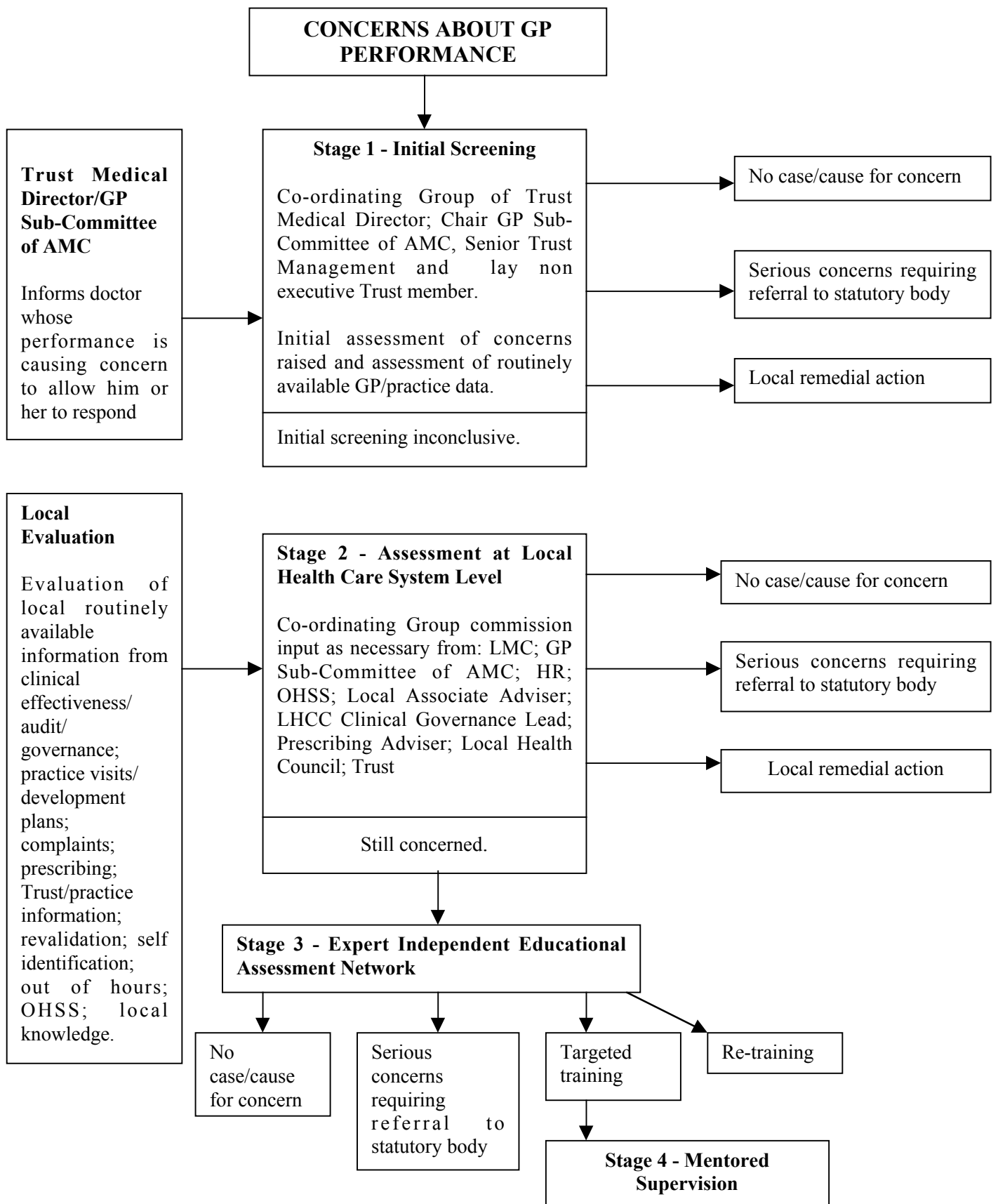
Stages in dealing with a practitioner with a problem

4.6 The [Short-Life Working Group on Suspension] Group suggested that there were four distinct stages which employers should consider when they are faced with a practitioner with perceived difficulties of performance or when they have received allegations of professional or personal misconduct. These can be defined as follows:

- *Substantiating or refuting concerns about a practitioner*
- *Identifying the cause of the problem. For example, is the problem attributable to functioning of the individual, a clinical team or unit, or are there wider implications?*
- *Defining the type of problem*
- *Dealing with the problem.*

FLOW CHART OF ASSESSMENT PROCESS

**Annex F
(paragraphs 5.24-31)**



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Glossary

BMA	British Medical Association
DPGPE	Director of Postgraduate General Practice Education
GMC	General Medical Council
GMS	General Medical Services
GP	General Medical Practitioner
AMC	Area Medical Committee
LHCC	Local Health Care Co-operative
LMC	Local Medical Committee (General Practice)
NHSScotland	National Health Service in Scotland
OHSS	Occupational Health and Safety Services
OHSSIG	Occupational Health and Safety Strategy Implementation Group
PMS	Personal Medical Services
SCPMDE	Scottish Council for Postgraduate Medical and Dental Education
SEHD	Scottish Executive Health Department
Trust	Primary Care Trust or Island Health Board

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