The new NHS framework for handling performance concerns

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There have recently been important changes in the procedures for handling performance issues among medical and dental employees. The author explains the background, explores the practicalities, and discusses the challenges and unresolved issues for medical managers.

BACKGROUND

The successful handling of performance matters to all doctors. A recent unpublished survey of the training needs of consultants in London found that their greatest current concern as trainers was managing poor performance in trainees.

As part of the new consultant contract agreed in October 2003 there was an agreement in principle to reform the current framework for handling concerns about the conduct and performance of medical (and dental) employees. The new framework will eventually be in five parts, the first two parts of which have now been published as a Health Service Circular (Department of Health, 2003). These are:

1. Action when a concern arises
2. Restriction of practice and exclusion of practitioners from work.

In technical terms these have replaced HSG (94)49.

In due course, the framework will replace HSG (90)9 and paragraph 190 appeals, so will also cover:

3. Conduct hearings and dismissals
4. Procedures for dealing with issues of capability
5. Handling concerns about a practitioner's health.

This article will review some of the background to these changes, explain the practicalities, and discuss the challenges and unresolved issues which make handling of concerns such a challenge for medical managers.

The Bristol Inquiry has been one of the seminal events that have changed the face of UK medical practice in the last few years (The Stationery Office, 2001). Despite that, out of the 198 recommendations only three are of any direct relevance to the processes for handling concerns. In particular the inquiry stated:

> **'Trusts should be able to deal as employers with breaches of the relevant professional code by health care professional, independently of any action which the relevant professional body may take.'**

It also encourages professional regulatory bodies to be more flexible towards that which constitutes misconduct and encourages them to deal with cases at a local level. Finally, and slightly controversially, it suggests that members of staff in the NHS should receive immunity from disciplinary action if they report a sentinel event to a trust or a national database within 48 hours except when they themselves have committed a criminal offence (recommendations 47, 104, 114).

More relevant has been the recent National Audit Office report on *The Management of Suspensions of Clinical Staff in NHS Hospitals and Ambulance Trusts in England* (National Audit Office, 2003). This was particularly interested in the problem of exclusion from work ('suspension' or 'gardening leave'). The annual additional cost of exclusion to the NHS is £29 million, doctors make up 20% of all exclusions and account for 75% of all costs. In large part this is because exclusions average 47 weeks for doctors and 19 weeks for other clinical staff. The average cost of excluding a doctor is £188 000.

Professional competence, where there were concerns about clinical performance, made up 44% of doctor cases, while personal conduct made up 33%. Of particular importance is the outcome of exclusions: 36% resign or retire, 24% are dismissed and only 40% return to work. Of these half have no restriction, a quarter have personal development and training plans and a quarter receive a final or written warning. Not surprisingly the National Audit Office made very firm proposals for the management of exclusion and much of their advice seems to have been taken on board in the latest guidance.

ACTION WHEN CONCERN ARISES

The new framework sets out the common ways in which concerns about a doctor's conduct or capability can come to light (*Table 1*).

The new process has three key players within the trust: the case manager, the case investigator and the designated board member. The medical director acts as case manager in all cases involving clinical directors and consultants, although they may delegate this role to a senior manager to investigate other cases.

The case manager must then appoint (after discussion with the chief executive and director of human resources) an appropriately experienced or trained person as a case investigator. The guidance states 'several clinical managers should be appropriately trained to enable them to carry out this role when required'. The case investigator is then responsible for leading the investigation into all the allegations, including collecting written statements and ensuring confidentiality. Where clinical judgment issues are raised then either a senior member of the medical staff or possibly an independent practitioner from another NHS body can be involved. The case investigator has to

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TABLE 1.
Ways in which concerns about a doctor's conduct or capability can come to light

Concerns expressed by other NHS professionals, health care managers, students and non-clinical staff
Review of performance against job plan, annual appraisal, revalidation
Monitoring of data on performance and quality of care
Clinical governance, clinical audit and other quality improvement activities
Complaints about care by patients or relatives of patients
Information from regulatory bodies
Litigation following allegations of negligence
Information from the police or coroner
Court judgments

complete the investigation within 4 weeks and then submit their report to the case manager within a further 5 days. It is then for the case manager to make a decision as to whether:

- There is a case of misconduct, in which case it goes to a conduct panel
- There are concerns about health, which need to be considered by the occupational health service
- There are concerns about performance that should be explored with the National Clinical Assessment Authority (NCAA)
- Restrictions on practice or exclusion from work should be considered
- There are serious concerns that should be referred to the General Medical Council (GMC)
- There are intractable problems that should be put before the capability panel
- No further action is needed.

The framework discusses in detail the role of the NCAA and points out that the NCAA can provide immediate telephone advice 24 hours a day, advice to support local care management or clinical performance assessment, but are likely to be most involved when performance is falling well short of what would be expected, or if repeated would put patients seriously at risk. Although referral to the NCAA requires a doctor's agreement, the guidance makes clear that if a practitioner chooses not to cooperate with such a referral it may necessitate disciplinary action or referral to the GMC.

EXCLUSION FROM WORK

This part of the framework has received most publicity and interest. There appear to be two drivers, first a genuine wish to prevent unnecessary exclusions but also an attempt to put in place processes that will reduce the length of time (and of course the cost) of long and often highly publicized exclusions in the past.

The framework makes it clear that the purpose of exclusion is:

- To protect the interest of patients or other staff and/or
- To assist the investigative process where there is a clear risk that the practitioner's presence would impede the gathering of evidence.

There is an emphasis on alternative ways of managing risk, particularly patient risk, to avoid exclusion, such as:

- Medical management supervision of normal contractual clinical duties
- Restricting the practitioner to certain forms of clinical duties
- Restricting activities to administrative, research, audit, teaching or other educational duties
- Sick leave for the investigation of specific health problems.

In the exclusion process an immediate exclusion, if warranted, can only be for up to 2 weeks. This is to allow more measured consideration to take place. The manager making the exclusion must explain why the exclusion is being made in broad terms and at the start agree a date at which the practitioner should return to the workplace for the formal meeting. During those 2 weeks there must be a case conference including the chief executive, medical director, the director of human resources, the NCAA and other interested parties (e.g. fraud or the police). In the case of consultants or clinical directors, the medical director acts as case manager and appoints a case investigator.

A new role in this process is appointment of a non-executive member of the trust as 'designated board member' whose job it is to have an overview of all cases being formally investigated against medical practitioners within the trust and ensure the momentum is maintained. They have a particular remit to ensure that the timeframes for investigation of cases with exclusion are consistent with the European Convention on Human Rights and the right to a fair trial.

A formal exclusion can only occur after the case conference, with the involvement of the NCAA and where all consideration has been given to using the practitioner in other capacities, pending the resolution of the case. If the doctor is to be formally excluded then they have the right to be told of the reasons for the exclusion with a witness present and the doctor must be given the opportunity to state their case and to propose alternatives. The excluded doctor may also make representations to the designated board member at any time after receiving a letter confirming a formal exclusion. Thereafter exclusions may continue for 4-week renewable periods.

However, the case manager must review the exclusion before the end of each 4-week period and report to the chief executive and to the board. After three exclusions the NCAA must again be called in and the chief executive must report the strategic health authority. The NCAA will review the case with the strategic health authority and then advice the NHS body on the handling of the case until it is concluded. Should a case last for 6 months, the chief executive must again report to the strategic health authority giving the reasons, the anticipated timescales and the actual antici-

pated cost of the exclusion. The strategic health authority may then also wish to offer advice. Except for cases involving criminal investigations there should be a normal maximum limit of 6-month exclusion.

Finally at the end of the framework there is a short paragraph stating that there must be formal arrangements for the return to work of the practitioner, and details of whether duties and responsibilities remain unchanged or if any restrictions on monitoring arrangements are to be put in place.

COMMENT

Early on the document states say that it wishes to abandon the 'suspension culture' of the NHS, tackle the blame culture (recognizing that most failures in the standard of care are caused by the system's weaknesses not individuals per se), and encourage the use of the NCAA, as well as building on the changes of appraisal and revalidation. At first sight it is pragmatic, builds on some examples of good practice and has been welcomed as a way forward.

Real life problems

However, it certainly will not resolve all the problems faced by medical managers. In reality many issues are ill defined, present as rumour and hearsay, and very commonly can be difficult to identify absolute facts or get people to stand by written statements. Some allegations are gossip or reflect power battles or subtle bullying. No medical director could put this formal process into place for every issue brought to their attention by the mechanism set out in *Table 1*. It is particularly difficult for a medical director who cannot 'unknow what they have heard' but equally can not proceed if people are not prepared to give hard evidence (despite the advice of the GMC). Thus there has to be a screening or sifting process to decide which incidents are serious enough, or potentially resolvable with the processes suggested above.

Some people believe that anonymity is guaranteed under 'whistleblowing policies' but it would appear that the most that can ever be guaranteed is that you will tell the informant when information is going to be released. One method of screening may be to involve an associate medical director and chairman of department before initiating the type of investigation set out in this framework (Black, 2002).

One outcome of this new guidance is the need to train both case investigators and the designated non-executive board members. Non-executive directors have had no experience in this area and the guidance clearly states that 'several clinical managers should be appropriately trained'. Although clinical managers could well be doctors it seems likely that most of the trained clinical managers will be general managers working in the clinical field. The importance point is they must be trained; if they are not, this would likely be grounds for an appeal in the future.

Trainee doctors

Trainee doctors in the NHS are treated the same way as consultants except the medical director may now delegate the role of case manager to another senior manager, who would appear to not have to be a doctor. The framework does say that the appropriate postgraduate dean should be involved as soon as possible. There do seem to be more opportunities for trainee doctors to be kept working without having to be excluded. Possibilities include clinical audit and some forms of research, or direct supervision in a different role. Importantly it does state that capability issues for doctors in training should be considered initially as a training issue, with the involvement of the postgraduate dean.

The guidance is certainly very strong on timescales; if these are genuinely met it will significantly improve the processes in many organizations.

It is also good that the new guidance makes clear when and what information must be given to the doctor who is being investigated or excluded. Previous cases described by the National Audit Office have not had this important communication. It cannot be emphasized enough how difficult it is to meet timescales. The investigating officer needs to be single-minded to get accurate and thorough statements taken, as the evidence gathered will inevitably be thoroughly tested. If adequate time is not released for the case investigator, timescales will slip. It is also not clear what real influence the designated board member can have on the process.

Another suggestion is that a mentor might be offered for the doctor being investigated. This is an important and potentially growing role to provide support during a very stressful time. The Royal College of Obstetricians and Gynaecologists (2003) have taken a lead in this and now have a panel of trained mentors who can externally support doctors in difficulty. This does seem to be a particularly difficult mentoring job and it would certainly be helpful if other colleges followed the example of the obstetricians and trained people to be available rather than relying on ad hoc, one off experiences.

The single clinical incident

An issue which often causes significant concern is the single clinical incident. Most people are aware of high profile public single episodes where clinicians may previously have had no problems or concerns. Indeed, the Bristol Inquiry suggested that reported clinical incidents should not lead to disciplinary action.

The National Patient Safety Agency have debated this issue and produced a culpability model set out in appendix 4 of the National Audit Office report, which takes a slightly more complex view (National Audit Office, 2003). The National Patient Safety Agency believe that one should consider whether the actions were intended, whether there was evidence of ill health or substance misuse, whether the individual knowingly departed from agreed protocols or safe procedures, and whether there was evidence of deficiencies in training or evidence of reckless behaviour. They offer a potential decision tree for action.

Interestingly the common ways that concern could be raised (*Table 1*) do

not specifically mention a single serious clinical incident although it could be covered by many of the other points. The reasons for involving the NCAA also mention performance or ongoing problems that have been encountered on at least two occasions. So by itself the guidance will not resolve the medical manager's dilemma of the single clinical incident although the National Patient Safety Agency's culpability model may help the decision-making process.

Re-entry

Finally the problem of 're-entry' is dealt with in one short paragraph. In reality this can be a major problem. It is interesting that the framework confirms that a trust can actually put restrictions on any clinician's professional activities on virtually a permanent basis. Even the GMC does not have the power to do this for more than 1 year at a time and only after a hearing before a full fitness to practice committee, usually in the presence of at least two QCs. Ideally, these new processes will reduce the time people are away from the workplace but all medical managers and human resources managers who have dealt with re-entry know how difficult this can be, particularly where relationships have broken down within a department, which may well have led to the original allegations. Only if this guidance significantly reduces the number of exclusions will this become less of a problem.

KEY POINTS

- A new NHS framework for investigating concerns about a doctor's performance, including the appropriate use of 'exclusions', will be implemented from April 2004.
- The National Clinical Assessment Authority has a key role in the new process.
- Postgraduate deans must be involved for trainees in difficulty.
- Medical managers will still face real like problems of weak evidence, single clinical incidents and 're-entry' to the workplace.

CONCLUSIONS

All doctors must be aware of the new framework for the initial handling of concern. Training will certainly be needed for both case investigators and the non-executive designated members. The framework does not resolve the problem of medical managers being clear which concerns are serious enough with enough likelihood of progression to be able to investigate. The single isolated clinical incident remains a problem as does the problem of re-entry into the workforce. HM

Conflict of interest: none.

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