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Research paper

Assessing general practitioners who may be underperforming: local assessment methods in two English health districts

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ABSTRACT

Introduction Primary care trusts (PCTs) in England are required to set in place local arrangements to identify and deal with concerns about general practitioners' (GPs') performance. Assessing GP performance at a local level can be challenging and there is little published information available to describe the methods PCTs use. This paper describes the local assessment methods developed by two PCTs.

Methods Gateshead and South Tyneside PCTs have jointly developed methods to locally assess whether GPs are underperforming. The methods involve lay, clinical and management representatives and employ a variety of tools including case-based assessment and a questionnaire to colleagues. Most of these tools measure performance against the standards set out in *Good Medical Practice* or collate data derived from nationally validated surveys. The methods have been developed to promote transparency, objectivity and consistency while making the most of scarce local expertise.

Results In our experience, case-based assessment and questionnaires to colleagues provide the most helpful information. Our local assessments enable practitioners to continue their work and do not incur travel or accommodation costs for the assessed or the assessors. GPs and their defence organisations find the methods acceptable.

Conclusions It would be helpful for other PCTs to publicise their assessment methods so that best practice can be developed and standardised, thus ensuring that all patients and GPs receive the same levels of protection and support at a local level.

Keywords: assessment methods, professional regulation, quality assurance

How this fits in with primary care

What do we know?
National changes to the regulation of general practitioners highlight the need for more local assessment of general practitioners. However, little is known about the local methods that primary care organisations use to assess concerns about general practitioners' performance.

What does this paper add?
This study provides an overview of the methods used in two English primary care organisations to locally assess GPs who may be underperforming.

Introduction

Measures to protect patients and assure the quality of general medical practice are current priorities for the NHS and the medical profession.[1,2] At a local level, primary care trusts (PCTs) are already required to set in place local arrangements to identify and deal with concerns about general practitioners' (GPs') performance.[3]

The arrangements for, and the activities of, the local performance procedures (LPPs) in Gateshead and South Tyneside, two PCTs in the north east of England, have previously been described.[4] These procedures have existed since 1997 and have evolved into the South of Tyne Assessment Advisory Group (AAG), established in 2003, which currently leads the process and comprises a multidisciplinary group of lay, managerial and clinical representatives. The AAG is responsible for investigating all concerns about local GPs, with the aim of identifying doctors who are underperforming and recommending how the PCT should manage the underperformance.

Since 1997, there have been few changes in the core membership of the supervisory group, resulting in 10 years of experience of locally assessing and managing practitioners whose performance gives cause for concern. The AAG investigates concerns about approximately 25 GPs annually. If cases are deemed serious or if the GP will not comply with LPPs then they are referred to either the General Medical Council (GMC) or the National Clinical Assessment Service (NCAS). We have averaged three such referrals per year since 2003.

The methods that the AAG uses to assess performance have evolved over time in response to local and national experience and guidance. The current methods were adopted in 2004. We see this structure and its processes fitting well with local GMC affiliates described in the recent White Paper.[5] Given the numbers involved, regional GMC affiliates will need to liaise with and co-ordinate local assessment bodies in primary and secondary care, as they are unlikely to be in a position to undertake all assessments in house and are encouraged to seek 'more effective engagement with local services'.[5]

The best way of assessing GP performance is the subject of significant debate.[1,2,6–8] The aim of this paper is to describe the local methods the South of Tyne AAG[4] currently uses to investigate local concerns about GP performance and make a judgement about performance. Our own experience is that doctors, managers and patients are poorly informed about the methods used to assess GP performance at a local level, and there may be considerable variation in the methods that are used. We have not identified any published information about the assessment methods used locally in other areas.

Methods

Identifying GPs who give concern

The AAG invites and considers concerns about contractors' performance from a wide range of voluntary, statutory and professional groups, organisations and individuals. All concerns are considered by the AAG at monthly meetings according to the two-stage assessment process outlined in Figure 1.

In Stage 1 the AAG members act as a peer review panel considering concerns raised, supporting information about the concern, and then collectively determining whether there is cause for concern. In many instances the concern requires further investigation before the AAG can come to a decision. Such investigations are undertaken by the chair (as lay representative) and one of the clinical members, by undertaking a structured interview with the practitioner concerned. The interviewees develop their questions and record their findings on a standard proforma based around the standards set out in *Good Medical Practice* (*GMP*).[9,10]

Once AAG members feel that they have sufficient information to make a decision about the concern, there are three possible outcomes to Stage 1. If the panel agree there is no cause for concern (for example if this was a nuisance complaint or the result of an unforeseeable event), the findings are noted and we thank the clinician for their co-operation. If there are only minor concerns regarding underperformance, the practitioner is informed, appropriate action is undertaken which may involve the PCT clinical governance or other support groups, and although there is no further assessment we do request follow-up to ensure the action has happened. If the panel agrees that there is significant cause for concern, then the practitioner moves to Stage 2 of the assessment process and the panel considers how to manage the concerns regarding performance. If the panel determines that further assessment is required before appropriate actions can be identified, then they will either recommend a full local or NCAS assessment. This decision is often made after consulting NCAS advisors.

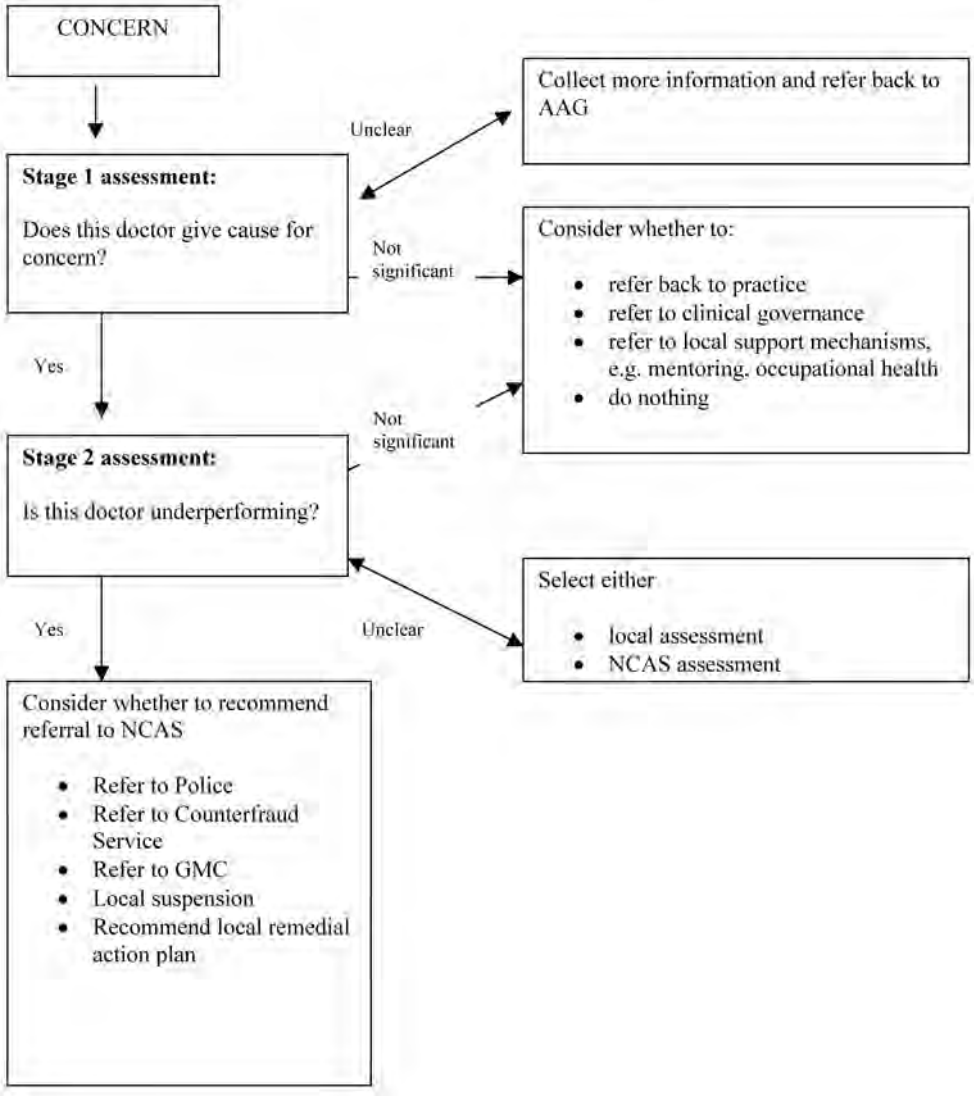

Figure 1 Gateshead and South Tyneside AAG: assessment process

Assessment tools used in Stage 2 to generate evidence about GPs' performance.

Principles

A range of assessment tools have been developed to meet the AAG's principles of assessment set out in Box 1.

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The tools aim to measure the dimensions of performance against the standards set out in *GMP* using local information which is easily accessible. These dimensions are summarised in Table 1 together with brief details.

Samples of two of the tools are provided in Appendix 1 (the questionnaire to colleagues) and 2 (the case-based assessment proforma). Both of these tools are based on the standards set out in *GMP*.[9,10] Colleagues are asked to rate practice and provide comments on strengths and weaknesses. If more than one colleague scores low in the same area then the pattern can point to areas of concern to follow up at the practice-based assessment. Further details of any of the tools can be provided on request.

For cased-based assessment the visiting clinicians examine 30 sets of notes drawn at random from a large sample for which patients have given their consent, to reflect the following groups: recent deaths and referrals; patients with chronic diseases such as ischaemic heart disease (IHD), diabetes etc, and any clinical group in which there has been reported cause for concern. For example if the concern is failure to visit patients we may request a sample of records of patients who were visited at home, as well as those who requested and failed to get a home visit. Details from the cases are then used in discussion with the clinician.

Box 1 Principles underpinning the local assessment tools

Tools should:
- promote a consistent approach which is transparent and externally accountable
- facilitate a structured and informed decision-making process
- generate timely results within the available resources of the local AAG
- mirror and complement NCAS procedures rather than duplicate or replace them
- make the most of local knowledge
- reflect published best practice
- explore four elements of a practitioner's performance:
  1 health
  2 professional conduct
  3 clinical practice
  4 premises and equipment.

Applying the assessment tools

The AAG sends relevant GPs a list of the areas of practice that will be assessed.

A new assessment team is convened to undertake each local assessment. The team comprises four assessors – the lay AAG chair to provide lay representation, the public health lead acting as a clinician focusing on the quality agenda, a primary care liaison officer from the PCT holding the contract and providing all the administrative support, and a clinical governance lead from the neighbouring PCT to undertake the clinical assessments without having any bias arising from previous knowledge in their local clinical governance role.

The team meets to plan the assessment, agree individual roles and responsibilities, and specify the criteria for identifying and retrieving case notes to be used for the case-based assessment. It also reviews the findings from assessments that have been completed in advance of the practice-based assessment as indicated in Table 1.

The practice-based assessment lasts a whole day, during which a range of assessments are completed (see Table 1) including seeking the views of the practice manager and members of the primary care team.

Using the evidence to assess performance

All of the information is recorded using standard proformas and then used to form a chain of evidence to support any conclusions about performance. To avoid bias arising from unsubstantiated evidence, concerns about performance are only recorded when there is evidence from more than one source (triangulation).

The assessment team considers each of the areas of *GMP* and concludes a level of concern – low, medium or high. On the basis of these conclusions, the team makes recommendations about a remedial action plan or referral to a regulatory body. The evidence, conclusions and recommendations are reported to the AAG and the GP, who is given the opportunity to comment within the body of the written report.

Results

These methods have been used to plan and undertake four GP assessments so far. The assessments have resulted in detailed action plans which have led to improvements in performance that have been demonstrable at the follow-up visit.

Experience of the effectiveness of the various techniques

Experience of the assessments has shown us that although every element of the assessment process can provide helpful information, two techniques are especially revealing. These are the questionnaires to staff and colleagues and the case-based assessments.

Colleagues' questionnaires are most valuable in identifying behavioural and management performance problems. However, colleagues are often reluctant to reveal what they know if it is critical of a fellow clinician, and we sometimes have to remind individuals that their clinical governance responsibilities and patient safety must outweigh any sense of loyalty.

The case-based assessments are most discriminatory in identifying poor clinical performance. Examples of areas that have been identified and used in subsequent discussions include:

- a visit where a patient was given antibiotics for a 'chest infection' and also a flu vaccination at the same time

Table 1 Tools used by Gateshead and South Tyneside Assessment Advisory Group to measure a GP's performance against the standards in *GMP*

Assessment tool	Brief description
Report to AAG from Stage 1*	Original concerns which initiated the AAG assessment, accompanied by the findings from the early discussions with the GP
Practice profile*	The PCTs collate routinely available statistics relating to the practice concerned – demographics, training status, screening and immunisation coverage
Report from the prescribing advisor*	The PCT prescribing advisor is asked to submit a commentary on the strengths and weaknesses of the GP's prescribing based on evidence of that GP's prescribing data in relation to a basket of indicators such as antibiotics, benzodiazepines
Recent access survey results*	
Recent QOF report, including Practice GPAQ Survey results*	
Questionnaire survey of staff, colleagues and peers *	A range of clinicians and managers are sent a standardised self-completion questionnaire, based around the standards in *GMP* (see Figure 1), e.g. practice manager, receptionists, local GPs, clinical governance leads, PCT practice liaison, nursing members of the primary healthcare team officer, local acute trust medical director
Recent complaints submitted to PCT*	The complaints are collated and reviewed for trends regarding management or performance issues
Review of complaints files, book and procedures	
Case-based assessments	Selection of medical records examined by two assessors using a structured proforma (see Appendix 1)
Premises and equipment inspection	Systematic inspection using a standard tick box form which checks the presence or absence of items on an agreed list of essential requirements
Interviews with members of the primary care team and the chronic disease management team, including reception staff	Questions are directed at issues raised by the findings prior to the practice-based assessment and any observations on the day. The questions are agreed by the team in advance and the answers recorded using a proforma
Meeting with the GP	Having completed all of the assessments, the assessment team reviews the findings, and designs interview questions that explore any concerns, giving the GP an opportunity to provide further insight into identified concerns. All questions and responses are recorded on a standard proforma
Occupational health assessment*	The GP is referred for an occupational health assessment if there are any concerns that ill-health or addiction may be a contributing factor

* Indicates that the assessment was completed in advance of the practice-based assessment. All other assessments are performed within the practice-based assessment

- a request from a hospital consultant to titrate the dose of an angiotensin-converting enzyme (ACE) inhibitor for a patient with diabetes, hypertension and microalbuminuria where the starting dose remained unchanged over 15 months
- a patient who had been noted as starting a reducing course of diazepam but for which there were no further records regarding dosage, and prescriptions for the original dose were still being issued two years later.

The financial burden of local assessments is largely staff and administrative costs. The AAG meets monthly, and this is regarded as part of the job of all involved from the PCTs whether clinical or administrative. The exception is the lay chair for whom this is their job. However, the assessment visits fall outside these commitments. The four members of the team spend about two days participating in planning, assessing and formulating a report and recommendations on an assessment. There are few financial implications for the assessed GP who can continue to practice and does not have to travel to a different location. There are no significant travel or accommodation costs for any party.

Local assessments may be quick to complete but can still be slow to organise. We have found that most GPs delay the assessment as long as possible. It is possible that closer links with the local GMC affiliates may minimise this.[5]

Despite the delays, GPs have bought into the process and they welcome the objectivity and transparency of the assessment process. One assessed GP wrote: 'I think it would be beneficial for all doctors to periodically go though a less formal version of such an assessment'.

All GPs assessed so far have involved their representatives from defence organisations in the assessment interviews and in responding to the assessment report. These representatives have provided verbal support for our methods and we have not received any critical feedback from them.

Conclusions

We appreciate that assessing performance at a local level is challenging for all parties. Assessed GPs face an emotionally demanding ordeal and are justifiably concerned about the objectivity, confidentiality, legitimacy and validity of LPPs. Assessors are aware of the gravity of their recommendations, and local relationships and existing knowledge may influence their ability to be objective and adequately protect patients or support doctors.

Our aim is to protect patients and support doctors by developing processes and tools which are consistent with our principles (see Box 1) and enable the local assessment of clinical performance (what the doctor actually does in the workplace) against the standards set out in *GMP*.[10]

All of the evidence and judgements are available for external scrutiny, thus promoting a transparent process which is open to challenge. Our use of standardised tools and triangulation of evidence promotes objectivity because assessors make recommendations based upon weight of evidence rather than subjective impressions. Furthermore, because a significant part of the evaluation is based on the clinician's own records, we are able to consider examples of actual practice rather than practice in simulated or atypical settings. Our case-based assessment is a context-rich assessment which explores application of knowledge to practice, not just the underlying knowledge base.[11]

Our methods are acceptable to doctors and their defence organisation representatives, and can be undertaken quickly although the speed with which they can be organised depends on the co-operation of the doctor being assessed. The main costs of the process relate to employing the assessment team over two days. There are no financial costs to the clinician, who can continue to practice.

The recent White Paper, *Trust Assurance and Safety – The Regulation of Health Professionals in the 21st Century* recommends an extension of regulatory powers to a regional level, working closely with local services.[5] Our experience and findings can be used to inform debate on that issue as well as allowing other PCTs to compare their practice with ours.

In the context of LPPs, more widespread information about local assessment methods would be helpful to enable PCTs to identify and agree best practice to ensure that all patients and GPs can expect the same levels of protection and support at a local level, and to link such procedures into a future regulatory structure.

ACKNOWLEDGEMENTS

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CONFLICTS OF INTEREST

None.

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Appendix 1: Extract from the questionnaire sent to colleagues and peers illustrating the questions around good clinical care

You are asked to rate the ability of the practitioner listed above to provide the following elements of good clinical care based on your experience from working with the practitioner:	Excellent	Good	Satisfactory	Poor	Unacceptable
An adequate assessment of the patient's conditions, based on the history and symptoms and, if necessary, an appropriate examination					
Providing or arranging investigations or treatment where necessary					
Taking suitable and prompt action when necessary					
Referring the patient to another practitioner, when indicated					

Strengths

Concerns

Appendix 2: The structured proforma used to record findings from the case-based assessment

Record identifier:	
Physical condition (paper records only): Is there a single identifiable set of paper notes in useable condition?	
Structure: Are records in date order? Are significant clinical conditions easily identifiable? Is there a record of current and long-term medications?	
Links (if both paper and electronic records are used for this patient): Is there a clear link between paper records and computer records?	
Legibility (paper records only): Are the doctor's entries identifiable? Are the doctor's entries legible?	
Detail – is there evidence of: Review of long-term medication? Recording risk factors in an accessible manner? Structured management of long-term care, e.g. templates, flowcharts? Clinical reasoning – diagnosis, management plan, involving the patient?	
Referral letters Present? Content relevant?	
Hospital correspondence – evidence of: Response to consultant's letters?	
Investigations – evidence of: Action taken in response to investigation results? Appropriate investigations making effective use of resources?	
SUGGESTIONS FOR IMPROVEMENT	