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Clinical governance in action

Recognising and dealing with poor performance amongst general medical practitioners: local arrangements in two English health districts

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ABSTRACT

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. These arrangements, commonly described as local performance procedures (LPPs), vary widely between PCTs.

Gateshead and South Tyneside PCTs have jointly developed local arrangements to deal with concerns about GPs' performance, to protect patients and to support doctors. The structures have strong lay and professional involvement and comprise one supra PCT assessment advisory group (AAG) and one decision making group (DMG) in each PCT.

Between 1 April 2002 and 31 March 2003, the AAG dealt with 28 concerns relating to 25 different GPs (23 principals, 1 locum and 1 registrar). In 12 cases, the AAG found no evidence of underperformance but there were performance problems in the remaining 16 instances, six of which were serious enough to involve either the General Medical Council (GMC), National Clinical Assessment Authority (NCAA) or local deanery. The areas of practice that most commonly generated concerns were clinical care, relationships with patients and colleagues, and equipment and buildings.

Our LPP arrangements offer a model that other PCTs could build on. They promote confidentiality, fairness and consistency while making the most of locally scarce expertise. We have also provided valuable information about the number and nature of concerns about general medical practice in two PCTs, which were referred to LPPs. This information gives a quantitative indication of the workload faced by LPPs and highlights the need for professionals and managers to address interpersonal, management and administrative skills in terms of primary care development.

Keywords: general practitioner, management, performance, quality

Introduction

Over the last decade, the General Medical Council (GMC) and the NHS have introduced a range of new measures in England designed to protect patients and assure the quality of general medical practice.[1–5] Within the NHS, these measures include a requirement for primary care trusts (PCTs) to set in place local arrangements to identify and deal with concerns about general practitioners' (GPs') performance.[6]

These arrangements are commonly described as local performance procedures (LPPs). Because they operate close to doctors and patients, LPPs are ideally placed to respond quickly to concerns about patient safety and to manage GP performance issues at an early stage. However, our experience suggests that patients and GPs are poorly informed about these arrangements, which vary between PCTs in terms of

their membership, accountability arrangements and activities.[7]

In this paper, we describe the arrangements for, and the activities of, the LPPs in two PCTs in the north east of England. We believe this information will be of interest to all practising GPs and also the health professionals and managers concerned with the challenges of assuring patient safety and good standards of general medical performance.

Local GP performance procedures in Gateshead and South Tyneside PCTs

Gateshead and South Tyneside PCTs serve neighbouring health districts in the north east of England. They are responsible for the health of 362 000 residents and hold responsibility for 206 principal general medical practitioners (GPs) working across 63 practices.

Structures

The LPPs for GPs working in these districts were first established in 1997 by the health authority which was responsible for both districts at that time. They were subsequently revised in March 2003 to accommodate the new and different governance arrangements in the two PCTs, to reflect a range of national and professional guidance, and to build on the strengths that had evolved over the previous six years.[8–11] The new LPPs deal with all concerns regarding any GP working in either of the two health districts, including principals and non-principals, registrars, locums and salaried GPs. The LPPs comprise one assessment advisory group (AAG) serving both PCTs (supra PCT) and two PCT-specific decision-making groups (DMG). The membership of these groups, and the roles and responsibilities are summarised in Figure 1. The same lay and medical members have been involved in the LPPs since 2000, ensuring stability and developing expertise based on experience.

Aims and principles

Our LPPs have two core aims: to protect the safety and wellbeing of patients, and to provide a fair and effective process for assessing GP performance. We have also developed a set of guiding principles that underpin our work (see Box 1).

Box 1 Principles and values underpinning the work of Gateshead and South Tyneside PCTs' joint Assessment Advisory Group

- Patient safety is paramount
- Supporting and involving doctors
- Confidentiality
- Openness and accountability
- Working in partnership with relevant groups
- Timeliness
- Objectivity
- Non-discriminatory
- Continuing quality improvement

Identifying GPs who may be underperforming

The AAG uses a variety of sources of information to identify GPs whose performance gives cause for concern. These sources include GPs or other health and social care professionals, GP practice staff, patients, voluntary groups, PCT officers and routine practice indicators. In addition, on an annual basis, the AAG Chair writes to a wide range of local organisations to explain the LPPs and to invite concerns.

Each PCT has a lead officer who is responsible for collating all concerns and referring them to the AAG. The AAG keeps in touch with the parties who expressed a concern so that they can appreciate the action that ensued.

Protecting patients

Members of the AAG assess and investigate every concern to determine whether there is any significant problem with performance as measured against the standards set out in *Good Medical Practice for General Practitioners* and *Duties of a Doctor*.[12,13] If underperformance is identified, the AAG then develops and implements an action plan to protect patients, address the problems, and support the doctor concerned. Such plans are usually developed in consultation with relevant experts including the local postgraduate deanery, the National Clinical Assessment Authority (NCAA) and the GMC. Our concerns for patient safety drive the decision-making process such that any potential danger to patients would trigger an immediate contact with the police, GMC or the NCAA as appropriate.

Supporting doctors

We constantly strive to recognise and meet the needs of doctors. In 2001 we developed communication guidelines that still apply to our procedures. These

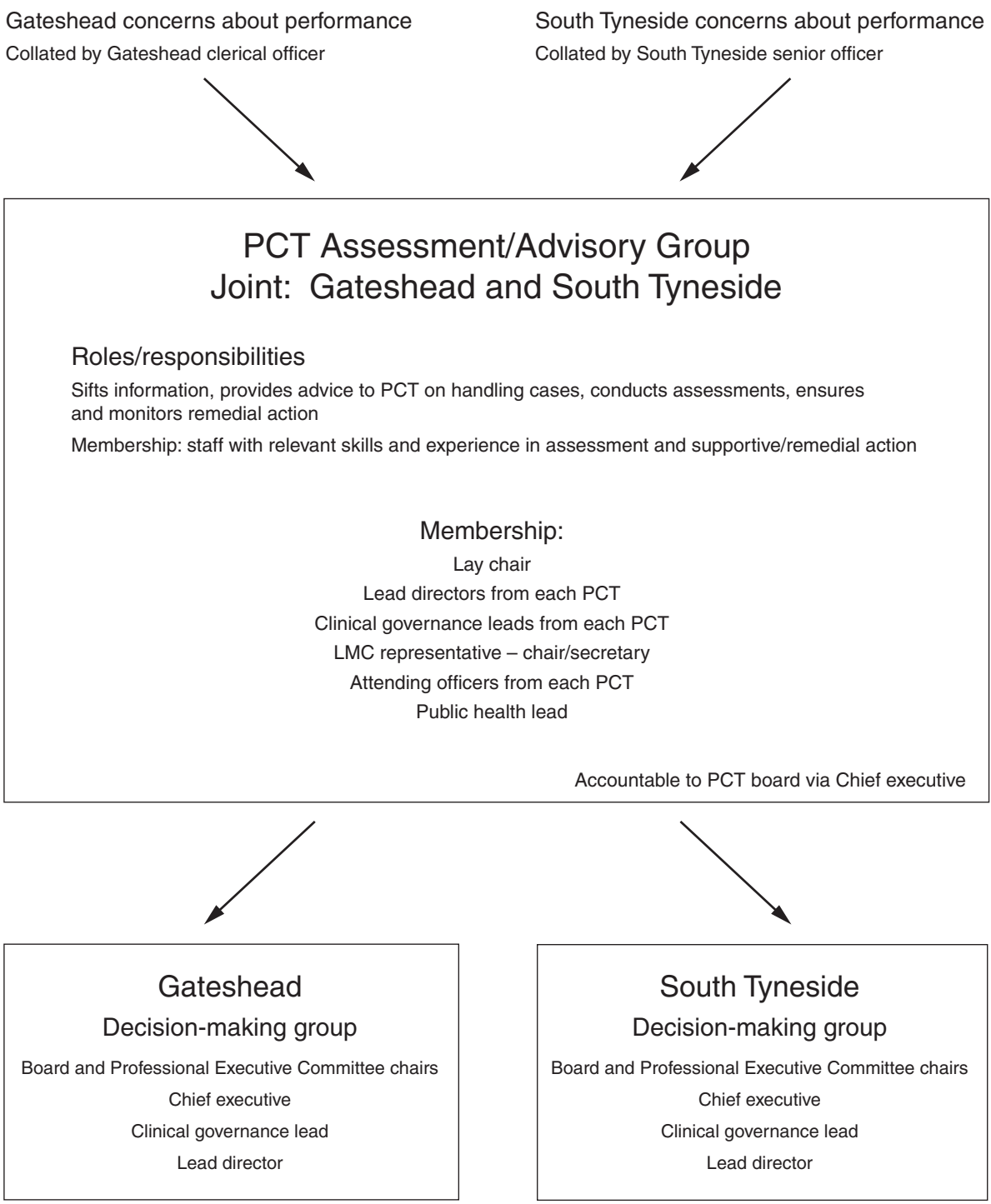

Figure 1 Gateshead and South Tyneside PCTs: joint structures for local performance procedures

guidelines ensure that we inform all the relevant parties, especially the GP concerned, and that we subsequently involve and support the GP during any subsequent investigations and action planning.

Members of the AAG work closely with GPs and PCT managers to identify support needs and to influence the development of new services to meet those needs. The new services that we developed include a local professionally led GP mentoring scheme, which was established in July 2002, and an occupational health service for GPs which also started in April 2002.

Public involvement and accountability

In 2004 we held our second public and professional meeting to publicise and clarify our LPPs, the first being in 2000. We also produce an annual report, which is considered by each PCT board. The report describes our work over the year including anonymised information regarding the concerns we have managed.

Audit and quality

All members of the AAG and the DMG are committed to continually improving the quality of our work. We all participate in regular meetings to review complaints, critical incidents, audit specific issues and review our practice in the context of new guidance. We also participate in local and national educational events. The lay Chair of the AAG is also an NCAA lay assessor.

Activity: Concerns about GP performance considered by the LPPs during 2002–2003

Between 1 April 2002 and 31 March 2003, there were 17 new concerns (eight in Gateshead and nine in South Tyneside) raised in relation to 14 GPs (seven from each PCT area). During that time, the LPPs were also dealing with 11 ongoing concerns which had been raised during the previous year in relation to 11 other GPs. Further details of the total of 28 concerns relating to the total of 25 different GPs (23 principals, 1 locum and 1 registrar) are presented in Table 1 in a format, which promotes the anonymity of the relevant GPs. This approach means that the concerns have been assigned to categories relating to those in *Good Medical Practice* and specific details have not been included.[5]

The areas of practice that most commonly generated concerns were clinical care, relationships with patients and colleagues, and equipment and buildings.

Our investigations of the 28 concerns showed no evidence of underperformance in 12 cases. We developed local action plans to deal with the specific problems found in eight cases. We had serious concerns about five GPs. In one instance the relevant GP chose to resign from the medical list, and the other four concerns were referred to other agencies, i.e. the GMC (2), the NCAA (1) and the Northern Deanery (1).

Two other concerns related to GPs who were already involved with the GMC and these concerns merely required some collaborative action on our behalf.

At the end of the 12-month period, we were still investigating one concern.

Discussion

LPPs play an important role in protecting patients and managing poor performance at an early stage. However, recognising and dealing with poor medical performance is exceedingly challenging for all concerned.[1] LPPs can only operate effectively if GPs, the public and patients are confident that their concerns will be treated fairly, in confidence, with sensitivity and efficiency. All parties must also be assured that patients will be protected and that appropriate and effective action will be taken to address poor performance.

We believe that our arrangements for LPPs, which reflect NCAA guidance,[8] offer a model that other PCTs could build on. The membership and accountability arrangements of our LPPs promote confidentiality, fairness and consistency, and the joint PAG, serving two PCTs, has many benefits. It encourages objectivity independent of local prejudices or service restrictions and promotes benchmarking and other quality improvement activities. Furthermore, it makes the most of locally scarce expertise for dealing with concerns about GP performance.

Our paper also provides valuable information about the number and nature of concerns about general medical practice in two PCTs which were referred to LPPs. We considered a total of 28 concerns affecting 25 GPs, which provides a quantitative indication of the workload faced by LPPs. We developed local action plans in eight cases and a further seven cases were serious enough to involve the GMC, NCAA or deanery.

During the study period, 14 doctors were referred to our AAG because of concerns about performance problems. This figure relates to an annual incidence of approximately 6.8% of the GPs in the area (based on 206 GP principals in post in November 2004 – we were unable to ascertain the number of principals in post during the study period). However, this approximation is likely to be an overestimate because our AAG deals

Table 1 The areas of practice which generated 28 concerns in relation to 25 general medical practitioners in Gateshead and South Tyneside during the period 1 April 2002 and 31 March 2003, and details of their management by the local performance procedure panels

Area of practice that generated a concern	Number of concerns	LPP actions (number of concerns)
Clinical care	6	Local action plan (1) Detailed investigation in progress (1) Referred for NCAA assessment (1) Referred to Northern Deanery for further training (1) GP resigned (1) Investigated – no further action required (1)
Keeping records, writing reports and keeping colleagues informed	0	
Access, availability and providing care out of hours	1	Investigated – no further action required (1)
Keeping up to date, and maintaining performance	2	Local action plan (2)
Relationships with patients: maintaining trust	6	Investigated – no further action required (3) Referred to GMC (1) Local action plan (2)
If things go wrong	2	Investigated – no further action required (2)
Working with colleagues and working in teams	3	Local action plan agreed (2) Investigated – no further action required (1)
Referring patients	2	Local action plan (1) Referred to GMC (1)
Financial and commercial dealings	1	Investigated – no further action required (1)
Equipment and buildings	3	Investigated – no further action required (3)
Other	2	Collaboration with GMC (2)
Total	28	

with all general medical practitioners in the area, including registrars and locums and other non-principals, and the calculation is only based on GP principals. It is essential to recognise that this figure reflects concerns about performance rather than proven performance problems. Our local investigations lead to action in only some of these cases.

In 1999, the Department of Health (DoH) estimated that between three and five GPs in each health authority might have some performance problem.[1] The two PCTs served by our LPPs represent a similar administrative area as a health authority, suggesting that DoH figures underestimated the scale of the problem.

In an effort to preserve anonymity we have been unable to provide specific details regarding the concerns we investigated. But, broadly speaking, clinical care was the cause for concern in less than a quarter of instances. Although the numbers are small, they do indicate that other areas of practice, such as maintaining trust, and working with colleagues are problematic. These results reinforce policies that highlight the need for GPs, registrars, trainers and NHS managers to address interpersonal, management and administrative skills in terms of primary care development.

We could find no other published details about concerns referred to LPPs in other PCTs. Consequently, we cannot assess whether our experience is representative of other LPPs with comparable primary care services. For the same reason, we cannot draw any conclusions regarding the appropriateness of our management of the concerns.

We referred two doctors to the GMC and one to the NCAA. Although the GMC does not publish data regarding the numbers of GPs in each PCT who are referred to any of its performance committees, our informal discussions with the GMC indicate that we are not referring excessively high numbers.

Our assessment procedures are beyond the scope of this paper, but would also influence the number of referrals to the NCAA and the GMC. If our experience is representative of that in the 301 other PCTs in England, then the NCAA could expect an annual total of about 150 referrals, and the GMC could expect about 300 referrals each year. Although raised awareness of LPPs might increase the number of concerns, this would not necessarily increase the number of GPs referred to the GMC or the NCAA.

We believe it is helpful for PCTs to publish anonymised information about their LPPs.[14] Such an approach helps to promote accountability, and is consistent with a culture of openness, responsive to the needs of patients, and a commitment to quality improvement. It can also encourage more awareness of the problems and challenges enabling GPs to enter into an informed debate about their prevention and management by the NHS and the GMC at a local and national level. The information can also inform planning in organisations such as the NCAA, the GMC or local deaneries, and enable PCTs to benchmark their own activity.[15] Finally, the data from different PCTs could be combined to generate patterns of information which could be used to inform policies and strategies for recognising and dealing with doctors whose performance gives cause for concern.

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Membership of the Gateshead and South Tyneside PCTs' Joint Assessment Advisory Group is as follows:

Rev B Howell (Lay Chairman)
Dr J Gray (Public Health Lead and Deputy Chair)
Dr K Megson (LMC Secretary)
Dr C Rowntree (LMC Chair)
Mr J Ellam (S Tyneside PCT Director with responsibility for primary care)
Mrs C Brown (Gateshead PCT Director with responsibility for primary care)
Dr S Kirk, Dr P Cassidy, Prof C Bradshaw: Clinical Governance Leads
Ms C Robb (senior officer supporting the panel)
Ms S Gair (senior officer supporting the panel).

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CONFLICTS OF INTEREST

None.

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