Royal College of Anaesthetists

Managing the poorly performing anaesthetist

Introduction

> Good Medical Practice says that the safety of patients must come first at all times. ...You must [also] protect patients from risk of harm by another colleague's conduct, performance or health by taking appropriate steps immediately so that the concerns are investigated and patients are protected where necessary.
>
> Para 2: Raising and Acting on Concerns about Patient Safety (GMC, 2012)

> You must support colleagues who have problems with their performance or health. But you must put patient safety first at all times.
>
> Para 43: Good Medical Practice (GMC, 2013)

The GMC sets out the standards of performance it expects from medical practitioners in its guidance Good Medical Practice.[1] These include the provision of good clinical care, maintaining a proper professional relationship with patients and working constructively within medical and multidisciplinary teams. Evidence of departure from the standards described under these general headings may be used to support a complaint to the GMC of impaired fitness to practise. If and when any doctor becomes aware of bad practice by another doctor, especially where this may lead to harm to patients, he or she has a duty to take appropriate action.[2] Doctors must also provide support to colleagues with a performance concern but within the remit of putting patient safety first at all times.[3]

The management of the poorly performing anaesthetist is governed by a complex set of arrangements. These arrangements have been shaped by key reports and guidance documents published by the Department of Health (see Appendix A) and GMC (Appendix B). It is a very sensitive issue and there is considerable scope for the problem to be mishandled. This guidance document from the Royal College of Anaesthetists (RCoA) therefore summarises:

- what is meant by poor performance and the terms used in Department of Health and GMC documents
- methods within departments of anaesthesia for preventing the performance of their members from falling below an acceptable standard
- guidance on how Clinical Directors should proceed in the event of concerns arising about an anaesthetist's performance
- objectives and procedures for managing the poorly performing anaesthetist.

Definition of the poorly performing anaesthetist

A poorly performing anaesthetist is one whose performance is outside the accepted limits of practice. Within these limits an anaesthetist may adopt practices which are different from those of other departmental colleagues provided that there is a reasonable body of anaesthetists who would practise in a similar way. It is widely accepted that the practice of individual anaesthetists may vary where evidence supports a range of different techniques.

1 Good Medical Practice. *GMC*, London 2013 (http://bit.ly/1cNq7UM).
2 Raising and acting on concerns about patient safety. *GMC*, London 2012 (http://bit.ly/2sJSQa7).
3 Leadership and management for all doctors. *GMC*, London 2012 (http://bit.ly/2sJYjxG).

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The definition of poor performance must also take into account the law governing the way in which the GMC handles complaints about doctors.[4] The law was changed in 2004 and current procedures for complaints about doctors no longer follow separate streams for health, performance and conduct. Instead, the GMC looks at the doctor's fitness to practise in the round, assesses whether or not it is impaired, and determines if any impairment requires action on the doctor's registration.

For anaesthetists this encompasses the whole spectrum of peri-operative care, critical care and pain management which they are trained to provide. All doctors are expected to remain up to date and competent in the work they are contracted to do. Failure in one area may be regarded as evidence of poor performance, as would failure to seek help from a colleague if an anaesthetist's knowledge and skill were inadequate for the level of care required for a given patient. In practice, repeated patterns of poor performance rather than a single episode are more likely to lead to concern.

Fitness to practise may be impaired by reason of misconduct, criminal conviction or caution, determination by another regulatory body, deficient performance or ill-health. When dealing with performance or health issues, the GMC tries to identify areas where remedial action such as retraining or medical treatment is possible, whilst protecting patients from harm. It is also well known, for example, that the practice of anaesthesia is stressful and there is continuing concern about the suicide rate among anaesthetists.

The GMC through the Medical Practitioners Tribunal Service (MPTS) – see below – has the power to impose conditions on a doctor's registration, to suspend it or to erase the doctor from the Medical Register. Only doctors with a GMC licence are permitted to practise clinically, and apart from erasure the above sanctions will be applied to the licence rather than to registration. Under the regulations the GMC also has the power to issue a warning where a doctor's fitness to practise is not impaired but there has been a significant departure from the principles set out in Good Medical Practice.[1] Warnings will be disclosed to the doctor's employer and any enquirer for a period of five years.

Prevention of poor performance

The aim of clinical governance is to secure better quality care, and observance of its key principles should help materially in the maintenance of professional standards.[5]

The culture within an anaesthetic department is central in maintaining high standards of anaesthetic practice. There should be clear delineation of:

- the individual anaesthetist's personal responsibility for professional standards
- departmental responsibility for providing a high quality service
- managerial responsibility for providing the necessary staff and facilities to achieve this.

> Up-to-date directives, guidance and standards of safe anaesthetic practice in specific areas should be used when considering the provision of all anaesthetic services.
>
> Guidelines for the Provision of Anaesthetic Services (RCoA, 2015)

4 A health professional's guide: how to refer a doctor to the GMC. *GMC*, London 2013 (http://bit.ly/2sK3fm8).

5 Effective governance to support medical revalidation: a handbook for boards and governing bodies. *GMC*, London 2013 (http://bit.ly/2sKaoTj).

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Where little attention is paid to individual professionalism, efficient running of the department, record keeping, agreement on clinical guidelines, audit, and local and central programmes of continuing education, standards are likely to fall. The local implementation of the recommendations made in the RCoA Guidelines for the Provision of Anaesthetic Services, will go a long way to maintaining the standards of performance of individual anaesthetists.[6] They provide the framework set by the RCoA within which anaesthetists are expected to practise, and hence the benchmarks by which they may be assessed. Anaesthetists should concentrate on maintaining overall standards within their department and take appropriate steps to prevent any individual's performance from becoming seriously deficient. However, anaesthetists in general and Clinical Directors in particular also need to understand the procedures to be followed if seriously deficient performance in a colleague is suspected (see below).

The role of appraisal

The role of appraisal and revalidation in preventing or addressing poor performance has been highlighted by the GMC – see Appendix B.

The appraisal should have a constructive focus and if any performance concern is identified it should be addressed in a supportive and targeted way (e.g. through the personal development plan and continuing professional development). If necessary, the appraiser should seek advice from local or specialty sources such as the medical royal colleges.

However, if potentially serious performance issues become apparent during the appraisal process the appraisal should be suspended whilst the appraiser ensures that these issues are addressed urgently, especially if they pose a threat to patient safety.

Responsible Officers should be made aware of doctors who do not engage in local appraisal processes. This includes failure to act on opportunities to collect the required supporting information for appraisal. The Responsible Officer may notify the GMC that the doctor is failing to engage in revalidation which can potentially result in the GMC withdrawing the doctor's license to practise (see the GMC Responsible Officer Protocol – Making Revalidation Recommendations).

Being alert to concerns

Concerns about a doctor's conduct or capability can come to light in a wide variety of ways, for example:

- concerns expressed by other clinical or non-clinical staff
- review of performance against job plans
- concerns raised at appraisal or disengagement with the appraisal process
- clinical audit
- clinical governance (including reports of significant events/critical incidents)
- lack of participation in or inadequate continuing professional development
- information from regulatory bodies
- litigation following allegations of negligence
- information from the police or coroner.

6 Guidelines for the provision of anaesthetic services. *RCoA*, London (www.rcoa.ac.uk/gpas).

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Clinical governance

Clinical Directors must ensure that appropriate informal and formal procedures are in place within a directorate to monitor the quality of clinical practice and discuss any performance issues with the Medical Director at the earliest possible stage. In cases involving trainees, responsibility will be shared with the Head of School in conjuction with the Postgraduate Dean. Most Medical Directors are also, for the purposes of revalidation, the Responsible Officer for their organisation and can consult their regional GMC Employer Liaison Advisor. Advice is provided on GMC thresholds and procedures relating to performance issues.

NHS complaints process

Complaints and/or concerns raised by patients through the NHS complaints process, or locally (formally and informally), are other avenues by which performance concerns may come to light.

Parliamentary and Health Service Ombudsman

The Ombudsman considers complaints raised already with an NHS organisation in England where attempts to resolve the complaint locally have failed. Concerns may come to the attention of the Clinical Director through this route.

Healthcare Professionals Alert Notices (HPANs)

From 1 April 2013 the system of issuing HPANs (letters of concern) now falls to the National Clinical Assessment Service (NCAS). Once authorised by NCAS, copies of a HPAN will be distributed to the Medical Director in lieu of Chief Executive in each English NHS Region and the Chief Medical Officers for Northern Ireland, Scotland and Wales. The GMC is also informed, as well as any NHS body or other organisation which provides services to an NHS body which, in the opinion of NCAS, may be approached by the subject of the HPAN with a view to work in the NHS.[7]

HPANs are issued to organisations when it is considered that a healthcare professional could pose a significant risk of harm to patients and there is a pressing need to alert employers. The system is particularly targeted at locums who may move employers at frequent intervals and are outside the normal appraisal process – thereby circumventing a more routine system of identifying and dealing with conduct, capability and performance concerns. When appointing a doctor an organisation may wish to check against any current HPANs and, where appropriate, seek further information as to the concern.

The HPAN system is not intended to replace direct referral to the GMC where patient safety concerns exist, rather it allows a system of collecting information on an individual who could pose a significant risk and enabling NCAS to co- ordinate such reports for appropriate action. HPANs are reviewed at intervals of no more than six months and must be revoked if NCAS considers that the circumstances which have given rise to the issue of the notice no longer apply.

Principles in managing the poorly performing anaesthetist

Identifying and managing the poorly performing anaesthetist is always difficult. The person concerned will be a colleague, and often a friend, sometimes of long standing. It is not easy to view the situation objectively and it helps, therefore, to benchmark your actions to the following four fundamental principles:

- Protect patients from harm. This is the primary objective which must always be uppermost.
- Ensure that the anaesthetist is treated justly. Procedures should be fair and open.

7 NCAS operational protocol: issue of health professional alert notices: *NCAS*, London 2013 (http://bit.ly/2sJOcJ6).

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- Provide opportunities for the anaesthetist to improve their performance.
- Identify appropriate standards and milestones against which improvement can be assessed, and criteria for success or failure of remediation.

In any investigation into a colleague's performance it is important:

- To keep records of everything: conversations, telephone calls, meetings and interviews. These may be needed at a later stage.
- That you do not jump to conclusions about the outcome of the investigation. A thorough and persistent investigation to establish the facts and openness with the colleague concerned is the only way to protect patients, maintain standards and act justly.

All parties should strive to maintain confidentiality although at times rumours may spread during an investigation of an anaesthetist's performance. It is important, therefore, to keep colleagues informed in general terms only but at the same time keep confidential the details of the investigation until it has been completed.

Fairness and openness

Doctors who are the subject of procedures dealing with poor performance concerns should always be given the opportunity to have an advocate or supporter with them at formal or informal meetings. All discussions should be documented (even if the concern is low) and the doctor should be allowed to verify what has been recorded.

Seeking advice and further guidance

In managing inadequate performance a number of individuals and organisations can (and in some cases should) be involved, sometimes making the process a complex one. The local and external procedures detailed below for managing performance concerns are an attempt to provide clarity.

Professional bodies representing anaesthesia also act as a first point of contact for advice in relation to the procedures and processes to be taken in managing a performance concern.

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For advice on performance issues relating to professional standards, conduct and competence, contact the Director of Clinical Quality (020 7092 1694 or clinicalquality@rcoa.ac.uk).

Association of Anaesthetists of Great Britain and Ireland

The AAGBI provides advice on welfare issues. Further information can be accessed from the AAGBI Welfare (Support and Well-being Committee) webpage. A number of useful guidance documents have also been published by the AAGBI (some in conjunction with the RCoA) and these are listed in Appendix C.

Other organisations also provide advice and supporting resources – again see Appendix C for details.

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Procedures to be followed

If inadequate performance is suspected or has been detected it should be dealt with locally, within the trust or health board. Involvement of an external agency (e.g. NCAS) should be considered if the performance concern is a serious one and the matter can also be referred to the GMC. Involvement of an external agency or referral to the GMC does not necessarily bring local procedures to an end.

Level	Criteria	Action
Local (trust/health board) procedures	Where it is apparent that improvements in skills, knowledge or behaviour are required	The Clinical Director may recommend that further training or other action is necessary. This may be arranged internally within the local department or externally
Procedures involving external agencies, e.g. NCAS – National Clinical Assessment Service	Where there are more serious concerns regarding a doctor's performance	The Medical Director of the trust/health board should, in England, Wales and Northern Ireland, contact NCAS at the earliest opportunity. In Scotland the use of NCAS services is not mandatory; however, they remain available to advise where invited
Referral to GMC – General Medical Council	Where a very serious problem has occurred	A doctor may be immediately excluded from work and referred directly to the GMC. In these cases the situation must be discussed at the earliest opportunity following the exclusion

Which procedure should be followed?

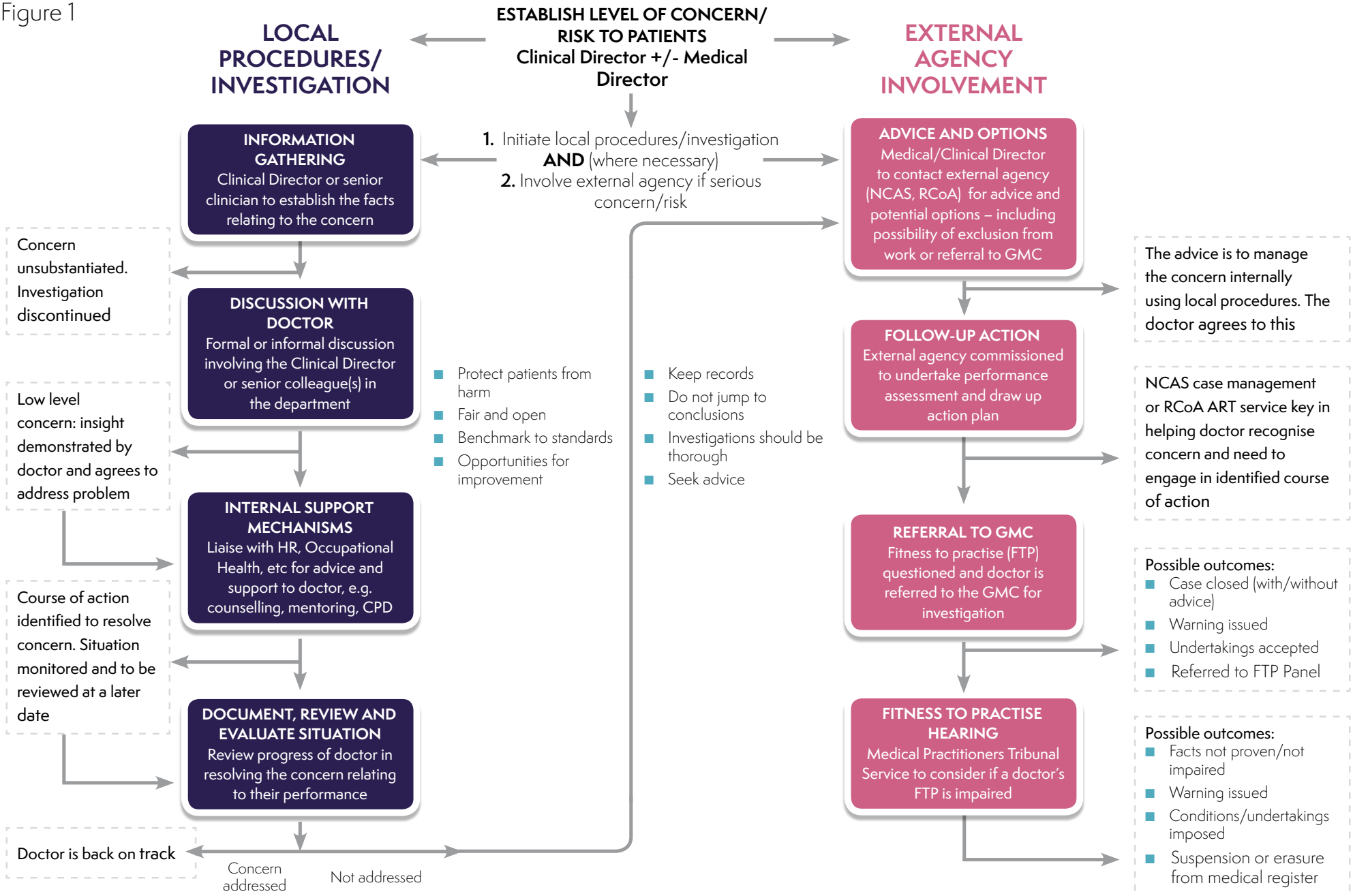
The procedure to be followed depends on the nature of the concerns about the poorly performing anaesthetist – this is summarised in Figure 1.

Most performance, health and conduct problems in doctors are best handled locally, using the agreed procedures in the trust or health board. This is the responsibility of the Medical Director, who is required to work in partnership with the Director of Human Resources.[8] For example, referral of an anaesthetist to the organisation's occupational health service for assessment and counselling could be a step towards resolving a concern or preventing it from escalating.

In some cases both local procedures and involvement of an external agency, at the same time, will be necessary. In other cases, where local procedures have been activated first but the anaesthetist has failed to respond to any actions, involvement of an external agency should be considered. The preferred outcome is for the concern to be resolved early on, rather than the need for further action with any local or external procedure.

8 The management of suspensions of clinical staff in NHS hospital and ambulance trusts in England. *NAO*, London 2003 (http://bit.ly/2sK6Ccu).

Figure 1


ESTABLISH LEVEL OF CONCERN/ RISK TO PATIENTS
Clinical Director +/- Medical Director
LOCAL PROCEDURES/ INVESTIGATION
EXTERNAL AGENCY INVOLVEMENT
1. Initiate local procedures/investigation
AND (where necessary)
2. Involve external agency if serious concern/risk
INFORMATION GATHERING
Clinical Director or senior clinician to establish the facts relating to the concern
Concern unsubstantiated. Investigation discontinued
DISCUSSION WITH DOCTOR
Formal or informal discussion involving the Clinical Director or senior colleague(s) in the department
Low level concern: insight demonstrated by doctor and agrees to address problem
INTERNAL SUPPORT MECHANISMS
Liaise with HR, Occupational Health, etc for advice and support to doctor, e.g. counselling, mentoring, CPD
Course of action identified to resolve concern. Situation monitored and to be reviewed at a later date
DOCUMENT, REVIEW AND EVALUATE SITUATION
Review progress of doctor in resolving the concern relating to their performance
Doctor is back on track
Concern addressed
Not addressed
Protect patients from harm
Fair and open
Benchmark to standards
Opportunities for improvement
Keep records
Do not jump to conclusions
Investigations should be thorough
Seek advice
ADVICE AND OPTIONS
Medical/Clinical Director to contact external agency (NCAS, RCoA) for advice and potential options – including possibility of exclusion from work or referral to GMC
The advice is to manage the concern internally using local procedures. The doctor agrees to this
FOLLOW-UP ACTION
External agency commissioned to undertake performance assessment and draw up action plan
NCAS case management or RCoA ART service key in helping doctor recognise concern and need to engage in identified course of action
REFERRAL TO GMC
Fitness to practise (FTP) questioned and doctor is referred to the GMC for investigation
Possible outcomes:
Case closed (with/without advice)
Warning issued
Undertakings accepted
Referred to FTP Panel
FITNESS TO PRACTISE HEARING
Medical Practitioners Tribunal Service to consider if a doctor's FTP is impaired
Possible outcomes:
Facts not proven/not impaired
Warning issued
Conditions/undertakings imposed
Suspension or erasure from medical register

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Military anaesthetists

For anaesthetists working in the defence medical services a separate structure of support and management is in place (also covering issues relating to performance concerns). The Defence Consultant Advisor (DCA) for Anaesthesia, Pain Management and Critical Care is nominally the line manager for these anaesthetists, though they remain under the aegis of the host trust or health board (military anaesthetists are very widely scattered, with many 'singleton' posts). The Responsible Officer for military doctors is the Head of the Medical Service for each single service and can be contacted via the DCA. Clinical and Medical Directors of a trust or health board may not be familiar with support and management structures for defence medical services and therefore should liaise with the DCA in matters connected with performance concerns (see Appendix C for contact details). Although not a problem group, it is worth bearing in mind that after ten years of significant armed conflict the risk of mental health issues leading to performance affecting problems should be considered.

Local (trust/health board) procedures

Concerns which are initially non-specific and where patients may or may not be immediately at risk

Gather, discreetly, as much information as possible. Ignore hearsay evidence and try to establish the facts. Anyone making an allegation against a colleague must be prepared to support it in writing. It is usually helpful to consult trusted, senior colleagues before deciding how to proceed.

If a concern appears to be well-founded but not serious it may be sufficient for one or two colleagues to bring it informally to the anaesthetist's attention, together with appropriate advice. All concerns – including those deemed as low level – should also be reported to the Clinical Director (and in some organisations the Medical Director), so that he or she has an overview of these informal conversations. Repeated low level concerns about an individual anaesthetist over a period of time may represent a pattern of behaviour which needs addressing more formally, and raising such concerns with the Clinical or Medical Director may help to reduce the risk of them escalating to a high level performance concern.

The anaesthetist has no insight into the problem

In this situation the anaesthetist should be informed that the Clinical Director must be involved at an early stage. This enables the Clinical Director to see the issues in perspective and to consider a range of options for how best to proceed. It may also be helpful later should the Clinical Director be criticised by the anaesthetist concerned or by other colleagues.

Concerns are serious or patients are clearly being put at risk, or informal discussions have failed to resolve the problematic issues

The Clinical Director and Medical Director should be contacted urgently. The Medical Director should contact NCAS (optional in Scotland), especially when exclusion is being considered.

The Medical Director, who is responsible for deciding which particular procedure should be followed, may wish to seek help from the RCoA in providing impartial advice. The Clinical Director, however, may be asked to be the investigating officer. This is appropriate as the Clinical Director is familiar with accepted standards of practice and the day-to-day running of the department of anaesthesia and understands how the specialty is practised locally. The Clinical Director's responsibility is to provide the facts and such information and advice as required for the Medical Director to decide how to proceed.

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Exclusion from work

The number of doctors who have been excluded from work for long periods is a cause for concern. In the context of this guidance document, the phrase 'exclusion from work' is used to avoid confusion with 'suspension' of the right to practise which may be imposed by the GMC. Whenever exclusion is being considered, there is a requirement for the case to be fully discussed by the trust/health board Chief Executive, Medical Director, Director/Head of Human Resources, NCAS and other interested parties such as the police where there are serious criminal allegations.[8] Advice from the regional GMC Employer Liaison Advisor should also be sought and the GMC must be involved in discussions at the earliest opportunity following the exclusion.

It should be noted that restricting a doctor's practice for long periods can lead to isolation and loss of clinical skills. Exclusions should therefore be considered as a last resort.

Procedures involving external agencies

National Clinical Assessment Service (NCAS)

Established in 2001 (originally as the National Clinical Assessment Authority), NCAS works to resolve concerns about the practice of doctors, dentists and pharmacists by providing case management services to healthcare organisations and to individual practitioners. NCAS provides services in England, Wales and Northern Ireland under national direction, and is available as an option for use in Scotland. When specialty input is required from a professional body, NCAS does work with the medical royal colleges including the RCoA Anaesthesia Review Team (see below).

Members of a trust or health board can seek advice from NCAS about a doctor they think is poorly performing at any stage in the handling of the case, although it is usually the Medical Director who makes the referral to NCAS. A staged approach to the services NCAS provides to NHS organisations and practitioners has been developed. This involves:

- immediate telephoned advice, available 24 hours
- advice, then detailed supported local case management
- advice, then detailed clinical performance assessment
- support with planning and implementing recommendations arising from assessment.

The NCAS website has a number of excellent guidance documents and templates for use in planning the management of poorly performing doctors.

RCoA Anaesthesia Review Team

The Anaesthesia Review Team (ART) is an invited review service offered to trusts and health boards which feel they would benefit from an independent professional opinion and recommendations provided by the RCoA. This can be in light of concerns relating to a department or specific individual. Issues relating to an individual anaesthetist must be below a level requiring GMC involvement and the aim of an ART review is to address potentially damaging issues before they reach a crisis point. Each situation is considered on a case-by-case basis and a report is produced offering practical and fair advice taking into account any patient safety issues. Further information about the ART service can be found on the RCoA website.

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GMC Fitness to Practise procedures

The criteria for referral to the GMC's Fitness to Practise procedures include situations where:

- local action by the trust/health board, with or without advice from NCAS, would be impractical or has been tried but has failed to resolve the problem
- local action has resolved the immediate local issue but the matter has wider implications
- the problems are so serious that immediate referral to the GMC is clearly required regardless of whether or not local action may also be appropriate.

Referral should be considered if the anaesthetist fails to display appropriate insight into the problems, has left the district but may have taken those problems to another area of the country or has moved exclusively into private practice. In particular the GMC may be the only body able to take effective action where serious problems arise in relation to a doctor working as a transient locum or working solely in non-NHS practice.

Performance and health issues are unlikely to require immediate referral to the GMC if the anaesthetist has insight into the problem and is willing to co-operate with local initiatives to help resolve the concerns.

A factsheet providing an overview of the GMC's Fitness to Practise procedures can be downloaded from the GMC website.[9]

Medical Practitioners Tribunal Service (MPTS)

The MPTS, launched on 11 June 2012, is an impartial adjudication service for the medical profession in the UK. It runs hearings for doctors whose fitness to practise is called into question and has powers to impose sanctions against the doctor's registration where necessary, to protect the public. The MPTS is part of the GMC, but is operationally separate and is accountable to Parliament.

There is operational separation from the GMC's investigation and case presentation work, and hearings which were previously run by the GMC are now be run by MPTS. More information about MPTS can be found at www.mpts-uk.org/home.asp.

9 The GMC's Fitness to Practise procedures. *GMC*, London 2012 (http://bit.ly/2sJVLiT).

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Appendix A

Department of Health guidance

In its publications Supporting Doctors, Protecting Patients (1999) and Assuring the Quality of Medical Practice (2001), the Government indicated its intention to introduce a new approach to the way poor clinical performance is dealt with in the NHS.[10–11] The approach complements the reforms proposed by the GMC, medical royal colleges and other professional bodies. It proposed a change from the traditional approach using disciplinary solutions applied late in the day to one that attempts to identify problems early so that doctors can be helped by educational measures.

In 2005 the Department of Health issued the document Maintaining High Professional Standards in the Modern NHS, outlining a framework for handling concerns about doctors and dentists.[12] All NHS bodies were required by 1 June 2005 to implement the framework, and it was agreed with Monitor that it should be issued to NHS foundation trusts as advice. The framework replaced the previous disciplinary procedures for doctors as set out in circular HC(90)9 as well as the 'three wise men' panels provided for in HC(82).[13] It abolished the right of appeal to the Secretary of State previously held by certain doctors under paragraph 190 of the Terms and Conditions of Service, except in Wales.

The framework, which was drafted in close association with NHS Employers and the National Clinical Assessment Service (NCAS) and agreed with the British Medical Association and British Dental Association, consists of five parts:

- Part I: Action when a concern arises.
- Part II: Restriction of practice and exclusion.
- Part III: Conduct hearings and disciplinary matters.
- Part IV: Procedures for dealing with issues of capability.
- Part V: Handling concerns about a practitioner's health.

The key changes are that:

- the distinction between personal and professional misconduct is abolished. Doctors and dentists employed in the NHS will be disciplined for misconduct under the same locally based procedures as any other staff member
- there is a single process for handling capability issues about the practitioner's professional competence closely tied in with the work of NCAS
- health issues are routinely dealt with through the occupational health service
- the employing trust is squarely responsible for the disciplining of its medical and dental staff – not outsiders
- there is scope to bring in expert advice for panels considering capability issues
- the capability panel will be handled by an independent chair
- the same disciplinary procedures will apply to all doctors and dentists employed in the NHS.

10 Supporting doctors, protecting patients: a consultation paper. *DH*, London 1999.

11 Assuring the quality of medical practice: implementing 'supporting doctors, protecting patients'. *DH*, London 2001.

12 Maintaining high professional standards in the modern NHS: a framework for the initial handling of concerns about doctors and dentists in the NHS. *DH*, London 2005.

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Where there are concerns about a doctor's clinical performance that cannot be resolved locally, the Medical Director of the trust or health board will refer the doctor to NCAS (optional in Scotland). This may initiate an assessment of the doctor's clinical performance and NCAS will give advice on any action to be taken. It is, however, an advisory body, and the Medical Director will remain responsible for dealing with the problem, either by local resolution in accordance with the framework, with the assistance of NCAS where appropriate, or by referral to the GMC.

NCAS became an operating division of the NHS Litigation Authority on 1 April 2013. NCAS Services, with the exception of team reviews, are currently free of charge to NHS organisations.

The NHS Revalidation Team – part of NHS England – seeks to deliver an effective system for doctors in England. There is published guidance helping Responsible Officers to understand and enact their statutory duty to respond effectively to concerns about a doctor's practice. There is a generic model for establishing the level of concerns, listing the essential components of an organisational policy to allow for a consistent, equitable and fair process (Supporting doctors to provide safer healthcare: responding to concerns about a doctor's practice).

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Appendix B

GMC guidance

Patient safety has been placed at the very heart of the GMC's work. In its guidance Raising and Acting on Concerns about Patient Safety (2012) the GMC sets out the expectation that all doctors, whatever their role, will take appropriate action to raise and act on concerns about patient care, dignity and safety. This includes when these concerns arise from the practices of colleagues or the systems, policies and procedures in an organisation. The guidance is separated into two parts:

- Part I: Raising a concern – provides guidance on raising a concern that patients might be at risk of serious harm, and the help and support available to you.
- Part II: Acting on a concern – explains your responsibilities as a doctor when concerns are raised with you and how those concerns should be handled.

All doctors, especially those with 'extra responsibilities' due to being in a formal management role (e.g. Medical and Clinical Directors), must take into account the GMC guidance document Leadership and Management for all Doctors (2012). It places the onus on doctors to respond constructively when they become aware of a poorly performing colleague. Doctors are encouraged to support colleagues but at the same time remember the duty to raise concerns where the colleague may not be fit to practise or pose a risk of serious harm to patients. Those with managerial responsibilities should be prepared to discuss constructively and sympathetically performance problems with those they manage and make sure support is available.

Since the launch of revalidation on 3 December 2012 the GMC, together with the Care Quality Commission in England and system regulators in Wales, Scotland and Northern Ireland, has published a useful resource for employers – Effective Governance to Support Medical Revalidation: a Handbook for Boards and Governing Bodies (2013) which is also intended to help organisations evaluate arrangements in providing quality and safe patient care. In regard to performance reviews of individuals, central to the process is the annual appraisal, which all doctors must now engage in if they are to retain a GMC license.

Underpinning the GMC's thinking is the new edition of Good Medical Practice which came into effect on 22 April 2013. Making patients the first concern for all doctors and the focus towards ensuring patient safety are features of this core standards document for the profession. Doctors will be appraised and revalidated against these standards – including those covering how individuals contribute to and comply with systems to protect patients and respond to risks to safety.

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Appendix C

Sources of advice and supporting resources

Organisation	Contact information/resources
General Medical Council (GMC)	The GMC telephone helpline for Medical and Clinical Directors 0161 923 6402. You should also refer to the following key GMC guidance documents: Raising and acting on concerns about patient safety (2012) Leadership and management for all doctors (2012)
The Royal College of Anaesthetists (RCoA)	The RCoA Clinical Quality Directorate can be contacted on 020 7092 1694 or clinicalquality@rcoa.ac.uk Anaesthesia Review Team (ART) enquiries 020 7092 1572 or ART@rcoa.ac.uk
National Clinical Assessment Service (NCAS)	NCAS Advice Line: 020 7972 2999 (England and general enquiries) 028 9266 3241 (Northern Ireland) 029 2044 7540 (Wales) Out of hours emergency contact: 020 7972 2999 Publications on managing performance concerns
Association of Anaesthetists of Great Britain and Ireland (AAGBI)	Clinical Directors may find the AAGBI Welfare Resource Pack (2008) particularly helpful. This resource together with the following guidance documents can be downloaded from the AAGBI website: ■ Catastrophes in anaesthetic practice (2005) ■ Core survival guide (2009) ■ Drug and alcohol abuse amongst anaesthetists - guidance on identification and management (2011) ■ Fatigue and anaesthetists (2014) ■ Good anaesthetist: standards of practice for career grade anaesthetists (2010) (jointly published with RCoA) ■ Good practice: a guide for departments of anaesthesia, critical care and pain management (2006) (jointly published with RCoA) ■ Independent practice (2008) ■ Staff and associate specialist grade (2008) ■ Welfare resource pack (2008) ■ Working arrangements for consultant anaesthetists in the United Kingdom (2011)

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Managing the poorly performing anaesthetist

Defence Consultant Advisor (DCA) for Anaesthesia, Pain Management and Critical Care	Colonel Duncan Parkhouse, British Army can be contacted by email in the first instance at: SGJMCMEDD-DCAAnaes@mod.uk
British Medical Association (BMA)	Contact the BMA Counselling and Doctors for Doctor Advisory Services on 08459 200 169/020 7383 6739 or info.d4d@bma.org.uk
Department of Health (DoH)	The following contain useful information for Medical and Clinical Directors: ■ Supporting doctors to provide safer healthcare: responding to concerns about a doctor's practice (2013) ■ Tackling concerns locally (2009) ■ Report of the DoH Steering Group on Remediation (2011)

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