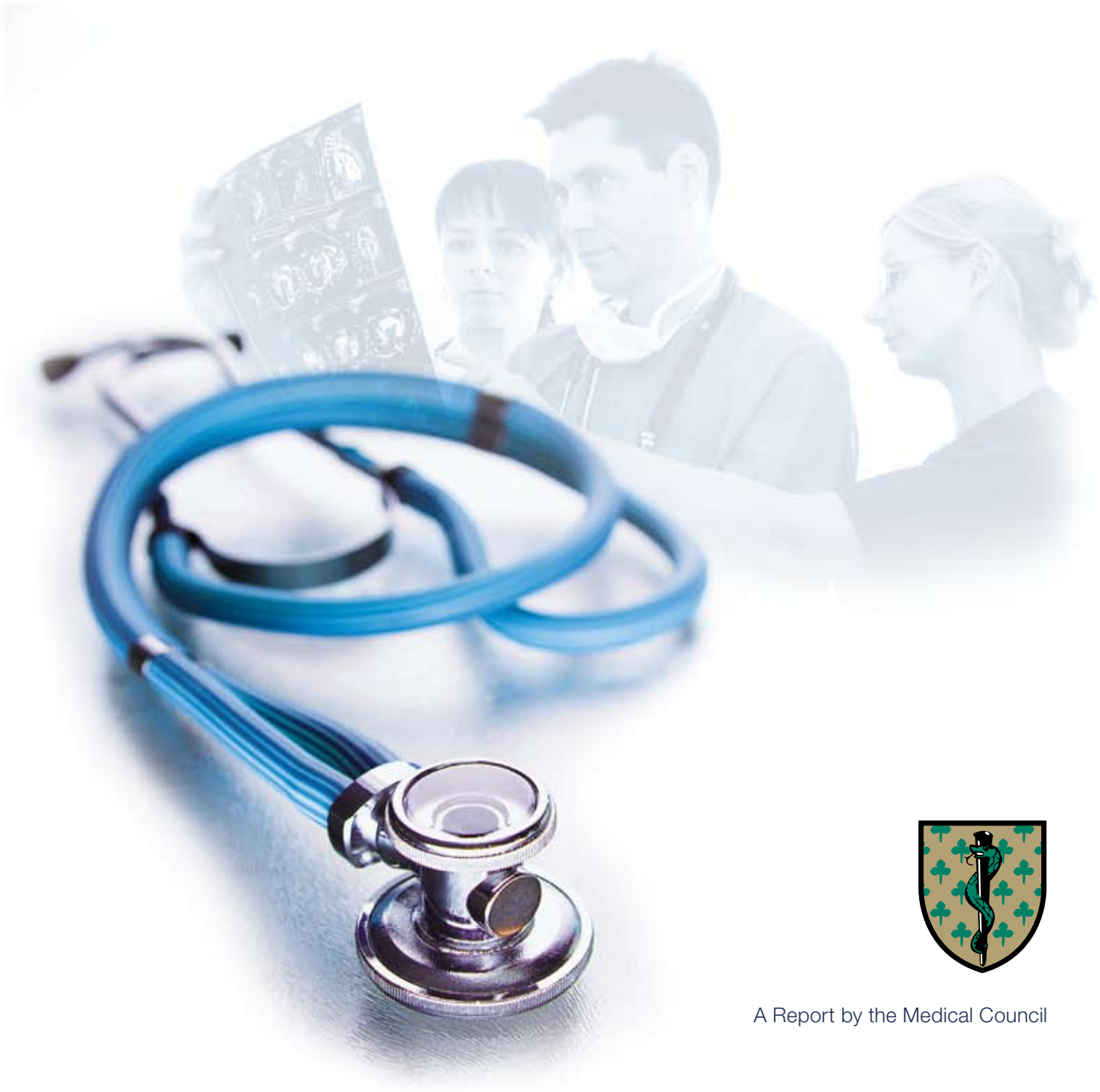
PERFORMANCE ASSESSMENT

Developing Standards **2008**



A Report by the Medical Council

PUBLISHED BY THE MEDICAL COUNCIL

MEDICAL COUNCIL

LYNN HOUSE, PORTOBELLO COURT,

LOWER RATHMINES ROAD, DUBLIN 6, IRELAND

TELEPHONE + 353 1 498 3100 FAX + 353 1 498 3102

Developing Standards and Structures for

PERFORMANCE ASSESSMENT

Professional Competence

Contents

1. Introduction / Project Summary

1.1 Objectives of Performance Assessment Pilot Project

The discussion about Competence Assurance Structures (CAS) has been ongoing for several years. The first element of CAS is Clinical Quality Assurance (CQA), which includes Continuing Medical Education, Continuing Professional Development, Clinical Audit and Peer Review. Undertaking this lifelong learning will, in the vast majority of cases, ensure that doctors are equipped to deliver high standards of care throughout their professional careers.

This project focuses on another element of CAS – Performance Assessment. Performance Assessment is a system for assessing doctors who are giving cause for concern and who will therefore be required by the Medical Council to undergo an assessment of their performance.

1.2 Background to the Project

The following questions need to be asked of doctors about whom concerns are expressed:-

1. Is this doctor fit to practise without restrictions?

2. What is it about this doctor that led to these concerns?

The questions can be answered by carrying out a thorough performance evaluation. Doctors are evaluated in the context of their practice. Clinical capability is evaluated in the context of the broader performance issues. Environmental issues such as personal or family concerns or organisational issues such as excessive workload may contribute to poor performance. A doctor's health may also affect his/her ability to practise safely and may also need to be assessed. Other behaviours and attitudes, including personality traits such as arrogance or over-conscientiousness, can sometimes contribute to poor performance and should also be considered.

It was recommended that a series of tools, already in use internationally, be identified and used in the evaluation of clinical performance. Evaluation of knowledge alone may not predict competency, and it is important that competency-based-evaluations are employed in the evaluation of performance. Performance assessments should be carried out by trained peers and non-doctors as a part of a team-based evaluation.

Initial concerns about under-performing doctors should be dealt with at a local level, where possible, preferably with a local clinical hierarchy i.e. Clinical Director / Chairman of the Medical Board. It is only when local governance structures have been exhausted or when cases give serious concern that doctors should be referred to the Medical Council.

1.3 Overview of the Project

The core of the project was to develop and trial the Performance Assessment process: recruiting and training assessors to pilot the performance assessments; recruiting and briefing a number of volunteer doctors; undertaking a series of "mock" assessments; and using the results as the basis for implementing a system of Performance Assessment. Vertical themes throughout the project would include devising protocols for Performance Assessment, producing documentation, and fostering communication with stakeholders about the assessment.

1.4 Tools

Evaluation tools must meet certain criteria if they are to achieve what they set out to achieve i.e. they must be valid and robust if challenged. They must be acceptable to patients and the profession as well as having a degree of credibility with the public. The evaluation must be sufficient yet proportionate. An effective tool will correctly diagnose deficiencies in underperforming doctors yet accurately show competence where no deficiencies are found. All measurement tools should be evaluated and their use monitored effectively.

1.5 International Authorities

Extensive research on international standards and tools was conducted. Research indicated that although there was no blueprint, there were many similarities in the tools used by different authorities in most of the developed countries including Canada[1+2], USA, UK[3+4], New Zealand[5] and Australia[6], amongst others. The breadth and depth of the assessment varied from jurisdiction to jurisdiction. The project focused on the jurisdictions most similar to Ireland - New Zealand, Canada and the United Kingdom, and it was decided to look closely at the UK model for the purposes of the pilot.

A UK performance appraisal authority, the National Clinical Assessment Service (NCAS), provided invaluable information and assistance at this stage in adapting tools to suit the healthcare-system in Ireland.

NCAS provides an appraisal service to the NHS which covers concerns from basic governance issues to most serious performance and competence issues which may lead to a referral to the General Medical Council (GMC). This system provides support to management and doctors alike. Both NCAS and the GMC have extensive experience in assessing under-performing doctors and both assessment processes have evolved in conjunction with each other over the years. The NCAS assessment is broader and includes routine medical and psychological assessments that are not part of the GMC routine assessment.

For the purpose of the pilot project it was decided to focus on General Practitioners as a sample base. This was initially due to the number of volunteer doctors and potential assessors who contacted the Performance Office to express an interest in taking part.

2. Co-ordination and Governance of the Project

2.1 Project Office

The office was staffed by a team of 3.5 people. A part-time Director of Competence Assurance was appointed in November 2005. A Senior Executive Officer was appointed in May 2006 adding to the existing staff of one Executive Officer. A Clerical Officer was appointed to the team in February 2007.

2.2 Governance

The Competence Assurance Working Group was disbanded and replaced by the Performance Committee in December 2006, under the terms of the ***Consensus Statement***[7] published in August 2006.

The Performance Committee had an independent chair and was advised by the Competence Assurance Advisory Committee, chaired by the President of the Medical Council.

There was ongoing liaison between the Performance Committee and other Medical Council Committees e.g. Registration Committee, Education and Training Committee and Fitness to Practise Committee.

2.3 Standards

The generic standards against which doctors would be measured were adopted from the Medical Council's *'A Guide to Ethical Conduct & Behaviour'*. At the time of writing, the Ethical Guide is due to be reviewed and it has been requested that these standards will be formally reviewed in this forum. International standards reviewed from countries such as New Zealand, New South Wales – Australia, United States of America and Canada, demonstrate that there are seven main parameters by which a doctor needs to be assessed. The General Medical Council uses the document *'Good Medical Practice'* as a benchmark. The following core competencies were used as measures and are expected to be reflected in the updated edition of the Ethical Guide:-

i. Relating to Patients

ii. Clinical Skills

iii. Communication & Inter-personal skills

iv. Collaboration

v. Management

vi. Scholarship

vii. Professionalism

See '**What makes a good doctor**' (Appendix 11.1)

3. Recruitment of Assessors / Case Managers

3.1 Medical Assessors

Medical assessors were recruited in several ways. Some were recruited through a national advertising campaign and some were nominated by the relevant Postgraduate Training Body.

Medical assessors were not asked to undergo an interview process and were invited to attend the training session on the understanding that they would be appointed as assessors on the successful completion of the training programme.

The criteria and role of a medical assessor was defined at the beginning of the project, although in practice the role evolved as the project progressed.

3.2 Non-Medical Assessors

Non-medical assessors were recruited as part of a national advertising campaign. Short-listing criteria were established and a number of assessors were interviewed. A panel of potential assessors was established following the interviews. The assessors were advised that no appointment would be made until the successful completion of training programme.

The criteria and role of the non-medical assessor was defined at the beginning of the project and evolved as the project progressed.

3.3 Case Managers

Two staff from the Project Office were assigned the role of Case Managers. Both members of staff attended the assessor training days and had an opportunity to liaise with Case Managers in the NCAS office. An initial attempt was made to identify the key roles of the Case Manager, however, in practice the roles developed as the process evolved.

4. Training / Volunteers

4.1 Training Plan

It was agreed that the training of the assessors would be carried out by trainers with experience of assessments in both the NCAS and the GMC. Although there are some differences in the assessment processes in these organisations, the assessment tools used are similar. Two assessor trainers were recruited for an initial two-day training programme followed by a separate one-day report writing training day, to be held following the pilot assessments.

4.2 Training Precepts

It was agreed that the assessors would be trained in tools which were adapted from international examples for use in this jurisdiction. The details of each assessment tool are outlined in the Performance Assessor Manual for On-Site Visits. This manual was developed in conjunction with the National Clinical Assessment Service who assisted greatly in this process.

1. Initial Interview with the Practitioner
   An initial interview was held in order for assessors to understand the context in which the practitioner operates.

2. Clinical Record Review
   Copies of between 30-50 records were made available to the assessment team for review. Areas of concern were highlighted and assessors noted examples of both good and poor practice, mapping this against the domains of good practice.

3. Case Based Assessment
   Up to 12 cases for discussion were selected from the records. Assessors met with the doctor to discuss each case in detail. The practitioner's responses were recorded and mapped against the domains of good practice.

4. Direct Observation of Practice
   With patients' consent, the assessors directly observed 12 consecutive consultations. Clinical observation reports were mapped against the domains of good practice.

5. Final Interview with the Practitioner
   A final interview was held to allow the practitioner to comment on the assessment process and to allow assessors to focus on any outstanding concerns or issues that had not been considered.

6. Practice Inspection (review of the work environment)
   An inspection of the practice facility was carried out. This inspection covered maintenance of equipment and systems, premises, access and availability, policies and procedures. The purpose of the practice inspection was to assess the quality of clinical management systems in place to provide safe and effective services.

The findings of the assessors were triangulated in order to establish comprehensive evidence of both good and poor practice, and used as a basis for recommendations for the report.

4.3 Training Days

A two-day training programme took place in Dublin in 2006. Seven GP assessors and five non-medical assessors were invited to participate. Successful completion of the training resulted in an appointment as an assessor. The Performance Assessor Manual for On-Site Visits was developed by the Project Office for use within the parameters of the pilot project.

4.4 The Assessment Team

The performance assessment teams were convened by the Project Office. Each volunteer and team was assigned a Case Manager. Two peer assessors and one non-medical assessor formed the team and were asked to carry out the on-site performance assessment.

One of the peer assessors was identified as the lead clinical assessor. The non-medical assessor was assigned the role of chairman of the group.

The volunteer doctor was notified in advance as to the identities of the team members and the assessment process. The volunteer doctor was given the option of objecting to a particular member of the assessment team in advance of the assessment although no objections were lodged.

5. Protocols, Documentation and Communication

5.1 Volunteer Practices

Five GPs volunteered to have their practices assessed for the pilot projects. Each GP was contacted with the relevant pre-visit documentation and assessment dates were agreed in advance. Assessment teams were convened by the Case Managers and met briefly on at least one occasion for a planning meeting. Four assessments were carried out following the withdrawal of the fifth volunteer for unspecified reasons.

5.2 Documentation

The Project Office adopted assessment documentation for use in the Irish context. Pre-visit questionnaires were developed in addition to a Training and On-site Manual for recording data during the on-site assessment. A report template was also adopted for the pilot assessments.

5.3 Communication

All communications regarding the assessment, the assessment teams, and the volunteer doctors were facilitated by the Case Manager. The Case Manager also communicated with the practice staff in advance of the assessment to organise photocopying of charts, consent forms for patients etc.

6. Reports

Assessment teams were given a report template and a sample report on which to base their final report. Each team attended a report writing training day and had an opportunity to discuss their findings with the trainers and the office staff. Final reports were submitted to the office and sent to the Performance Committee for review and were sent out to the volunteer doctors for comment. The reports were then anonymised and sent to Council for information purposes.

7. Possible Outcomes

There are a number of potential outcomes following a performance evaluation. International experience would suggest that a combination of recommendations may be required as a result of the evaluation.

Anticipated recommended outcomes to the Medical Council include:

- Recommendation for no further action
- Recommendation for no further action pending further review
- Recommendation for referral for remediation and re-training
- Recommendation for referral for counselling/personal development programme
- Recommendation for referral to Health Committee
- Recommendation for referral to Professional Standards

It was agreed that formal protocols for referral to Health Committee and Professional Standards would need to be clarified under the new legislation.

8. Findings from the Project

In the discussions that ensue it must be remembered that the practices that were assessed were volunteer practices only. No concerns were raised about the volunteer doctors in advance and the focus in the project was on developing the processes around the assessment. Although minor issues were raised as a result of the assessment no concerns were deemed serious enough to warrant any further action.

8.1 Medical Practitioners Act 2007

This project ran from September 2006 to May 2007 during which time a new Medical Practitioners Act (MPA) was signed into law. The new MPA allows for mandatory assessment of doctors who are thought to be under-performing. This meant that the assessments took place during a changing regulatory environment. The pilot project came under intense scrutiny from both the profession and the press. Issues regarding self regulation with a non-medical majority in Council were raised and may well affect any discretionary effort on the part of the profession in committing to assessment tasks such as this. The passing of the legislation in this time may have been a factor in the withdrawal of the fifth volunteer from the pilot.

The new MPA will also mean that complaints to the Medical Council will be handled differently. Complaints will be processed initially by a Preliminary Proceedings Committee who will have the option of referring the matter to the Performance Committee for further evaluation. The Performance Committee will be responsible for establishing criteria under which a Performance Assessment should take place.

8.2 Role of Assessors

Recruitment

Many issues were raised about the roles of the medical and non-medical assessors throughout the project. One of the first concerns was the issue of recruitment. Non-medical assessors were subject to an initial interview whereas medical assessors were not. Anecdotally, concerns have been expressed when medical assessors are nominated by institutions and it has been recommended that medical assessors and non-medical assessors should apply and be interviewed in a standard way. Of the seven medical assessors that attended the training days, two did not complete the training. All five non-medical assessors completed the training.

Previous Assessment Experience

The criteria that were used for the selection of assessors may need to include a requirement for previous assessment experience. The assessment tools are complex and there is much to absorb in the short training period. Previous experience in this area gave a clear advantage.

Non-Medical Assessors

On the assessment days it was clear that the role of the non-medical assessor was a new role that may need further definition. Some of the volunteer doctors had concerns about a non-medical person sitting in on patient consultations despite the fact that the patients had given their consent and it was made clear that the assessor was not a medical doctor. The non-medical assessors are meant to bring a patient's perspective to the assessment. The physical difficulties of fitting three assessors into a clinic space were also noted. Nonetheless, the Medical Council is committed to the involvement of non-medical personnel in assessments and recommends that the non-medical assessor is present for at least half of the consultations.

Time Commitment and Remuneration

It was clear that there is a considerable time commitment required from each of the assessors when training, assessment and report writing days are taken into consideration. Concerns were expressed about this time commitment by both medical assessors and non-medical assessors who were self employed, about the sustainability of maintaining a business and yet committing to the process. Assessors were paid a daily honorarium. All expenses, including locum cover where necessary, were covered. The honoraria

were comparable to those paid, at the time, to assessors on Mental Health Tribunals. Subsequent reviews of assessor payments in other jurisdictions suggest that this payment should be increased to a higher daily rate and that assessors be subject to a contractual arrangement. This contract would cover all aspects of professional and employment responsibilities and liabilities.

Professionalism

Another issue that arose over the course of the pilot was the availability of the team in a consistent way for the completion of the reports. Most assessors approached the commitment in a professional and honourable way. However others found it more difficult to prioritise the project and had many other demands on their time. Commitment and professionalism is essential for producing high quality reports in a timely and efficient way. It has been agreed on review that the third assessment day be allocated as the report writing day and that the report be completed on site in future.

Numbers of Assessors

It is clear that the numbers of assessors trained will have to sensibly reflect the needs of the assessment programme and the small numbers of assessments needed, in the broader context.

Assessors with a background in general practice, general medicine or general surgery with access to subspecialty expertise including the use of external assessors should adequately cover the initial requirements of the assessment process. Inevitably as the programme develops the pool and diversity of trained assessors will increase.

8.3 Role of the Case Manager

The role of the Case Manager was new to the Project Office. Practical issues such as the booking of hotels and arranging transport for the assessment team were consistently challenging for each assessment. Liaising with the practice staff and arranging for tasks, such as the photocopying of charts, were particularly time-consuming and problematic in some of the practices. Each assessment brought a fresh challenge varying from the inability to print computer based charts in one practice to the inability of the team to physically fit in a consultation room in another.

From an office perspective, it was clear that the Case Manager would need to be off-site for four days for each two day assessment, a fact that impinged greatly on the manpower needs in the office.

The Case Manager was also expected to make decisions at a very high level and needed to have a degree of seniority and authority in order to facilitate the assessment team and the practice over the period of the assessment.

It was also quite clear from the outset that although the Case Manager could provide the report template and assist in the writing of the reports, at no point could the Case Manager do the work of the assessment team in completing sections of the report or editing aspects of the report. This seems like a minor issue but in fact the delineation of roles at this stage was critical in the credibility of the assessment process and could otherwise have legal implications.

8.4 Selection of Tools

There are many other assessment tools available with which to assess doctors. The decision to use the tools in this assessment was partly based on the suitability of these tools in assessment, but also for their ease of use and the fact that the trainers were very experienced in the use of these tools. Other tools that may be considered, even within the context of these assessments, include a multi-source feedback tool such as a 360° review.

It was agreed that if the Performance Committee or the assessors felt that the volunteer doctor needed either an Occupational Psychology review, an Occupational Health or a neuropsychological assessment that these would be requested and carried out before the report was written. It was decided not to include these routinely in the initial assessment. This decision should be kept under review.

The assessment of the practice in terms of assessing the context in which the doctor works is perhaps something that could be shared with another regulatory agency. Discussions have begun with HIQA in this regard and sensible, prudent sharing of this information should be considered.

8.5 Training Days

Some of the issues around the training days have already been alluded to above. Many assessors felt that the training days were too intense and too pressurised. It was generally felt that three days would be a more appropriate time-frame and that aspects of report writing could be incorporated into this training programme. This would influence the costs of the programme considerably.

There was no sense of how often assessors would need training updates although it is expected that an annual update was the minimum required to maintain essential skills. Some of those trained did not get an opportunity to carry out an assessment because of the cancellation of the fifth assessment at a late stage. These who participated in more than one assessment felt that the extra experience was beneficial and that their skills improved with practice.

8.6 Assessment Day

Issues around the assessment day have also been mentioned above. The Case Managers consistently felt that despite their best efforts at communication many of the practices were unprepared for the assessment day. Some shortcuts were identified e.g. the photocopying of charts for review off site, although concerns were expressed about the confidential issues of this practice.

Liaison with international colleagues would suggest that there is no blueprint for streamlining this aspect of the assessment. Each assessment presents a new set of difficulties and that one of the essential skills of the assessors and the Case Manager is that of flexibility.

8.7 Patient Safety Issues

Although no serious patient safety issues arose in the context of the assessments, some concerns were expressed about some of the practices. For example it was thought that one volunteer doctor was stretching himself very thinly and was working onerous hours without sufficient support. The lack of guidelines and standards made it very difficult for the team to quantify this. Concerns were expressed about the ability of the volunteer doctor to continue to provide a safe service for patients at this rate. The assessors felt that the tools may not adequately capture the softer issues in this regard. **The ongoing development of guidelines and standards by the Postgraduate Training Bodies will greatly facilitate the assessments in this regard.**

8.8 Report Writing

There was no doubt that this was the most challenging aspect of the project. The ability to correctly identify aspects of poor and good practice and capture this in a report in terms of evidence and findings took time and effort. Reports were not always completed in a timely way and Case Managers spent valuable time and effort in trying to complete reports. The decision to complete the report by the end of the third day should greatly improve the process.

Preliminary review of the reports suggested that they may be too short and consequently insubstantial. Critics were reminded that the reports were written about doctors about whom no concerns were expressed and this may well be the reason for this succinctness. In fact when historic cases from the Professional Standards archives were reviewed using the report template it became apparent that the template adequately captured and reflected the areas of concerns. It was agreed, however that a quality review system should be put in place and this will be arranged with the project trainers and advisors. This would include an annual report of referral and assessment data.

8.9 Feedback

All participants in the projects were invited to give their feedback and this is reflected in the above comments.

8.10 FOI / Confidentiality

The 2007 Medical Practitioners Act (Part 11 Section 95) specifically states that 'the Freedom of Information Acts 1997, 2003 shall not apply to a record relating to any professional competence scheme'. This pilot was carried out in the knowledge that the FOI Act has not, in the past, applied to pilot schemes.

Other issues around confidentiality did arise during the pilot. The main issues that arose included the photocopying of charts for the chart review and whether or not they could leave the premises. In cases where confidential material was removed from premises for practical purposes they were under the guardianship of the Case Manager at all times and anonymised.

Insofar as it was possible, all documentation relating to the assessments were kept in a locked cabinet in the project office. Reports were anonymised on referral to the Performance Committee and the identity of the volunteer doctor was known only to the director and the Case Manager.

Issues surrounding confidentiality are likely to be ongoing. The office has committed to the highest standards of confidentiality at every level and will continue to make every reasonable effort to maintain these standards.

9. Recommendations

Performance Assessment – Summary of Recommendations

Recommendation 1- Assessment Model

i). That the assessment model piloted in this project be adopted with some minor amendments.

ii). That the use of a MSF questionnaire, Occupational Health Assessment and Occupational Psychological Assessment should be considered on a case by case basis at the initial review. Over time, templates for these assessments could be considered. Experience alone will be able to guide us in determining the breadth of assessment that is needed at this level.

iii). That the performance assessment be extended from a two-day assessment to a three day assessment. This would allow for a less pressurised environment for the teams and would enable the report to be completed by the end of the third day.

iv). That the above processes be reviewed formally one year after implementation.

Recommendation 2 - Assessor Model

i). That the pilot assessor model be adopted with minor changes.

ii). That the recruitment of all assessors be standardised and a training schedule, including refresher courses be set.

iii). That the training programme be extended from a two-day programme to a three day programme. This would reduce the intensity of the training and improve assessment skills.

iv). That a minimum of a further 20 assessors be recruited and trained to meet the expected assessment needs, effective immediately.

a) That non-medical assessors should continue to be recruited and trained and be used to assess any specialty.

b) That, in the first instance, medical assessors be recruited and trained in broadly-based specialties for example General Practice, General Medicine, General Surgery, General Psychiatry and Obstetrics & Gynaecology.

c) That, in the first instance, assessments in the subspecialties be carried out by generalists with expert specialist input at a clinical level.

d) That use be made of external assessors, trained in similar systems in other jurisdictions on a reciprocal basis.

v). That a formal contract be developed with assessors for retention and remuneration of their services.

vi). That a generic assessor panel be formed to work with the Medical Council. This would entail recruiting assessors who can then be trained in different forms of assessment and can be employed in **all** areas of the Medical Council where assessments take place e.g. Professional Competence, Education and Training, Monitoring Group etc.

vii). That the above processes be reviewed formally one year after implementation.

It must be remembered that other assessment models do exist although they are not dissimilar to the model piloted. This model is tailored to the assessment of underperforming doctors in response to concerns. In some countries similar assessments are carried out randomly in doctors in practice. Any change in assessment strategies would require further piloting.

10. Remediation

The implementation of remediation processes were outside of the scope of this project but will be one of the major challenges of ensuring professional competence under the new legislation.

Many methods of remediation have been proposed, including end-point assessments, mentor programmes, and courses in management and communication skills among others.

Fixed-term training appointments (FTTAs) are being considered by Postgraduate Training Bodies in a number of specialties.

It will be necessary for all stakeholders involved in remediation, including employers and Postgraduate Training Bodies, to establish further forums for discussion as a matter of urgency.

11. List of Appendices

1.1 'What Makes a Good Doctor?'

12. References:

1 http://www.cpsa.ab.ca/home/home.asp

2 http://www.par-program.org/PAR-Info.htm

3 http://www.ncas.npsa.nhs.uk/

4 http://www.gmc-uk.org/

5 http://www.mcnz.org.nz/

6 http://www.nswmb.org.au/

7 http://www.medicalcouncil.ie/_fileupload/education/Medical_Council_Booklet.pdf

Appendix 1.1

What makes a good doctor?

Relating to Patients

- Advocacy
- Putting patients first
- Putting aside your own personal views- on gender, culture, beliefs, race, colour, sexuality, age, religion, social or economic status
- Ensure that dignity of patient is preserved
- Empathy
- Compassion

Clinical Skills

- Assessment and diagnosis
- Investigations
- Patient management (including prescribing and operative skills)
- Recognised limits of professional competence

Communication & inter-personal skills

- Patients & families
- Colleagues
- Record-keeping

Collaboration

- Teamwork with both medical and non-medical colleagues: respect the skills and contributions of all team members
- Minding each other- health & well-being
- Participate in regular reviews and audits of standards / performance of the team- be prepared to recognise when deficiencies need to be remedied and take steps to resolve

Management

- Personal management- including insight and recognising limits
- Use of time and resources

Scholarship

- Life-long learning
- Teaching
- Research
- Critical appraisal
- Dissemination of knowledge

Professionalism

- Honesty
- Integrity
- Moral reasoning and ethical practice
- Commitment to continuous improvement in the healthcare system

Notes:

Notes:

Notes:

Medical Council
Lynn House, Portobello Court,
Lower Rathmines Road, Dublin 6, Ireland
Telephone +353 1 498 3100 Fax +353 1 498 3102