Assuring the Quality of Medical Practice

Implementing *Supporting doctors protecting patients*

January 2001

Foreword

Patients have a right to expect high quality care and treatment from the NHS, whichever part of the NHS they use and wherever in the country they use it. Of course, most patients do receive high quality care. And the Government's unprecedented investment is expanding the capacity of the NHS – with more doctors, nurses and other staff, modern equipment and better buildings – to improve the quality of care everywhere and to tackle poor quality care.

But things do sometimes go wrong. New investment and more staff alone will not guarantee high quality services.

We know from the new Commission for Health Improvement that the quality of services and the mechanisms for ensuring high standards can vary widely, even within individual hospitals. Sometimes poorly designed systems expose patients to the risk of, for example, receiving the wrong medication. And, in a small minority of cases, patients receive their care from clinicians whose practice is poor or dangerous.

Since 1997 this Government has developed a comprehensive strategy to raise and ensure high clinical standards. We recognised the need to provide more support to NHS staff, to keep their skills up to date in their demanding and pressured jobs. New systems needed to be developed to enable NHS staff to identify the strengths and weaknesses in existing services and plan means of improvement. More effective means had to be found of identifying, supporting – and if necessary tackling – those doctors whose performance was below the standard patients should expect.

Achieving consistently high clinical standards requires much more than tackling the small minority of very poor doctors. The Government, with the medical profession and the NHS, is taking action on a broad front, and this report sets out the progress we have made on clinical governance, support for appraisal and professional development, serious incident reporting, patient representation, professional self regulation and independent monitoring.

But the last few years have seen a series of high profile medical scandals. And while public confidence in the medical profession remains high, patients and the medical profession want to know that action to identify and tackle problems is being taken. No system can guarantee to be risk-free: problems of poor practice will always arise, but we must do all we can to reduce risk.

The National Clinical Assessment Authority (NCAA) is a new approach to the problem of poorly performing doctors. Instead of waiting until a problem becomes a scandal or a disaster, the NCAA will work with doctors and the NHS to identify problems early; to offer appropriate support and training to enable doctors to reach a good standard of practice again as swiftly as possible. Together with a reformed GMC and changes to disciplinary procedures the new system will also be able to deal with the genuinely dangerous doctor much more quickly and effectively, before patients are harmed.

This report has been published to mark the formation of the NCAA. It shows how the NCAA will work to protect patients and shows how it fits into the much wider strategy to raise standards continuously in every part of the NHS.

John Denham
Minister of State for Health

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Introduction

1 This Government has made it clear that the modernisation of the NHS requires new, robust systems for quality assurance and quality improvement. This implies significant changes in culture and working practices. Two years ago we published our NHS quality strategy in *"A First Class Service: Quality in the NHS"*. This sets out a framework comprising:

- **clear national standards** – through the establishment of **the National Institute of Clinical Excellence (NICE)** to provide clear guidance to the NHS on clinical and cost-effectiveness across a range of health interventions, and the development of **National Service Frameworks (NSFs)**, to help raise national standards of care and reduce unacceptable variations;
- **effective local delivery** of these standards through a new system of **clinical governance**, a framework through which NHS organisations will be accountable for continuously improving the quality of their services. This will be underpinned by **life long learning** for health professionals and by modernised systems of **self-regulation**; and
- **strong monitoring mechanisms** – a new **Commission for Health Improvement (CHI)** to provide independent scrutiny of local efforts to improve quality and to help address serious problems, a new **NHS Performance Assessment Framework** and a **National Patient Survey**, which will for the first time provide systematic, comparable information on the experiences of the people who actually use the NHS.

2 The *NHS Plan*, published in July 2000, takes this quality agenda further, increasing the emphasis on customer service and patient/citizen representation. It proposes a new and more powerful voice for patients than ever before in the history of the NHS. The Department of Health's Quality Taskforce is taking forward the NHS quality agenda set out within the *NHS Plan* under the following main themes:

- Improving patient and public representation
- Improving clinical quality across primary and secondary care
- Ensuring a better quality environment
- Providing more and better information for patients

3 With this comprehensive strategy for assuring and improving the quality of NHS services as a backdrop, this document provides an update on progress with implementing the proposals set out in the consultation document *Supporting doctors, protecting patients*. The document attracted a great deal of interest, setting out as it did, a completely new approach to preventing, recognising early, and resolving more effectively, problems of poor clinical performance. The 400 or so responses received from consultation have been valuable in shaping the approach to implementation and have led to some changes to the original proposals. Examples of these comments are included in boxes in this document, and a summary of all the comments will shortly be published on the Department's website (www.doh.gov.uk).

4 A key element of implementation is the establishment of a new Special Health Authority – the National Clinical Assessment Authority (NCAA). The NCAA is an important new initiative to underpin the effectiveness of local delivery. While poor performance of individual practitioners in the NHS is thankfully rare, when it does occur its effects can be catastrophic. No system can guarantee to be risk free: problems of poor practice will always arise, but we must do all we can to reduce risk. We also expect that over the next three to five years, an increasing number of incidents will surface as local services begin to "declare" long-standing problems that have not been addressed.

5 For all the reasons described in *Supporting doctors, protecting patients*, these problems are not always dealt with well at present. Major problems often surface as a serious incident when they have been known about in informal networks for years. Over-reliance is placed on disciplinary solutions to problems late in the day, whilst mechanisms to produce earlier remedial and educational solutions are particularly weak. Often the Human Resource function is not involved until disciplinary proceedings are unavoidable. NHS Trusts and Health Authorities are sometimes deterred from taking action because the disciplinary processes are regarded as daunting and legalistic. There is no clarity at local level about the interface between General Medical Council (GMC) procedures and NHS procedures, so there is confusion about who does what and when.

6 The creation of the NCAA addresses these problems. It will operate a new performance assessment and support service to which a doctor can be rapidly referred, where the concern about their practice will be promptly assessed, and an appropriate solution devised. It will see an end to lengthy, expensive suspensions, multiple investigations of the same problem, variable local approaches and delay in acting to protect patients. It will be fairer for patients and doctors. More details of how the NCAA will operate are set out in chapter four.

7 *Supporting doctors, protecting patients* asked whether its proposals should apply to dentists as well as doctors. Most responses which dealt with this point, including those from dentists, felt that in general they should. As we said in the *NHS Plan*, we intend to progressively break down the demarcations between NHS staff wherever this benefits patient care. Since the NCAA is a novel approach, we will begin by applying it only to doctors, where the stakes of poor performance are usually highest. We will monitor the outcome closely and consider the applicability and cost-effectiveness of this approach for other health professions.

8 The new framework described in this document for addressing problems of poor clinical performance in the NHS will offer the opportunity to provide fast, fair and effective solutions. The leaders of the profession themselves have always laid great stress on promoting high quality clinical services, and so it is hardly surprising that they have very largely welcomed these new Government initiatives. The measures described here will establish clear connections between the NHS and professional bodies. They will provide a common pathway of referral, assessment and recommendations for action covering all NHS doctors and all NHS organisations. In this way we will continue to improve the protection of patients from poor practice.

1 Assuring the quality of individual practitioners

The starting point for promoting high standards of practice is helping doctors to keep their skills up to date so that problems are prevented. This chapter sets out action being taken in this area.

- Continuing Professional Development
- Appraisal for all doctors, underpinned by revalidation
- Clinical audit required of all NHS doctors

Continuing Professional Development

1.1 Continuing Professional Development (CPD) programmes are the means by which doctors, like other health care professions, ensure that their practice is up to date. It prepares them to work safely in all the clinical areas in which they are required to, and develops their abilities to handle new kinds of work as necessary. It starts from a strong base in the NHS but the present coverage of some groups such as locums is patchy. Another weakness of some existing CPD is the tendency for learning to follow a doctor's interests rather than seeking out improvement where he or she is weakest or in other areas in which they need to develop expertise. We will extend appraisal (see 1.3) to all groups of doctors including locums. This will mean that for the first time there will be a structured, comprehensive way to identify and meet the professional development needs of doctors.

1.2 The comprehensive programme of CPD which operates today does not cover doctors in training, as that training is already focussed on acquiring specified skills and expertise. However, they will have access to appraisal so that trainers can adopt a more rounded, holistic approach to their development needs. Significant progress has been made in reforming higher specialist and general practice training and plans are in hand to modernise the Senior House Officer grade by introducing better structured and well planned training. The Government places great value on the support offered by the medical Royal Colleges to these reforms so far, and looks forward to its continuation.

> Good education and training relevant to the needs of the modern health service, reinforced by continuing learning and professional development throughout a career are the cornerstone to preventing poor individual performance.
>
> **British Medical Association**

Appraisal and clinical audit

1.3 In the *NHS Plan* the Government announced its intention that all doctors employed in or under contract to the NHS will, as a condition of contract, be required to participate in annual appraisal and clinical audit from 2001. This will contribute to the General Medical Council (GMC)'s five-yearly mandatory revalidation process for all doctors. Revalidation will require all doctors to provide evidence of good practice to the GMC. We are working closely with the GMC to develop this. The GMC plan to finalise the main proposals by the summer. We will explore with the GMC what changes to the Medical Act 1983, are needed. The first revalidation decisions may take place in 2003. Appraisal (and hence revalidation) link back to CPD by helping individual doctors and their appraisers to identify and address development needs.

> We have consistently encouraged and endorsed regular appraisal for all doctors. We were already working under the assumption that appraisal would be a compulsory component of clinical governance and would in turn be a cornerstone of revalidation. Certainly all medical practitioners should be included.
>
> **Royal College of Physicians of London**

1.4 We have reached agreement with the profession about the appraisal arrangements for consultants – for example , all consultants will have job plans which reflect the service needs and priorities of their NHS Trust. They will also have personal professional development plans which should help them keep their skills up to date. We are working towards similar arrangements for all other doctors working in the NHS, including GPs and locums. The medical profession as a whole, led by the GMC, the medical Royal Colleges and other professional bodies, has shown great commitment to placing higher standards at the heart of their work. They have provided a clear response to some of the well-publicised failures in standards of care which have occurred. The agreement to introduce revalidation of doctors' right to practise, an initiative led by the GMC, is a case in point.

> Clinical audit is an effective tool for reflecting on and improving care. Significant event reporting can help to celebrate good care whilst also identifying opportunities for improvement.
>
> **British Medical Association**

1.5 We will publish shortly a comprehensive overview of the principles governing the appraisal for all NHS doctors and an outline action plan to introduce it. This will be followed by detailed guidance on implementation.

2 Learning from failures

The next stage in protecting patients is to ensure that the lessons from serious incidents are learned and applied. Since we published *Supporting doctors, protecting patients*, the Government has accepted the recommendations of an expert group chaired by the Chief Medical Officer which produced a report called *An Organisation with a Memory* addressing the need for a system to identify and learn effectively from adverse events and near misses in the NHS.

- New system for reporting adverse incidents

2.1 The report *An Organisation with a Memory* was published in June 2000. Ministers agreed all 10 recommendations made in the report, including the four key categories of serious recurring adverse events initially identified for action. The report recommends that a new national mandatory system be established to record and analyse adverse events in health care. It also advocates a change in culture towards reporting by encouraging a more open and blame free approach which will ensure that lessons learnt in one part of the NHS are properly shared with the whole of the health service.

2.2 The *NHS Plan* cites establishment of a national reporting system for adverse events as a key initiative intended to protect patients. The implementation project is in hand, and it is expected to have the system in place by the end of 2001.

2.3 By establishing this confidential system of reporting from local to national levels, by joining-up existing systems and by taking account of other available information from the UK and abroad it will be possible to take an integrated approach to learning lessons. This should help the NHS to improve the quality and safety of health service delivery for the benefit of all patients and staff.

3 Improving NHS-wide systems for quality improvement

Another part of the Government's strategy for protecting patients is to ensure that nationwide NHS systems such as the ones described in this chapter play their part in preventing incidents of poor performance. Here we set out a number of developments which we have begun to this end, including the important role which we envisage for input from patients.

- developing clinical governance
- giving patients a voice
- improving the complaints procedure
- developing better local Human Resources strategies
- delivering better clinical data to healthcare professionals
- checking the suitability of doctors at the appointment stage
- Retaining confidence in existing doctors: proposed changes to general practice
- improving Occupational Health Services
- stress reduction for doctors
- management training for doctors
- Modernisation Agency

Clinical governance

3.1 The implementation of clinical governance from April 1999 onwards puts in place a comprehensive programme of measures, at local level, that will ensure that all clinical staff take an active part in reviewing the quality of the services they provide and in planning ways of improving them. The effective introduction of the essential elements of clinical governance – for example, clinical audit, the use of evidence-based practice, continuing professional development, and active working with patients and service users – will raise standards, ensure earlier identification of doctors who may be performing poorly, and will enable earlier interventions to be made where necessary.

We believe it is extremely important that proposals recognise the organisational aspects of dealing with poor performance , which may not simply be a result of individual practice but flow from problems associated with organisational culture , managerial or leadership issues.

NHS Confederation

3.2 Clinical governance encompasses local work to deliver NICE guidelines and National Service Frameworks. It is central to plans to provide a health service that continually improves the overall standard of care that it delivers, reduces unacceptable variations in treatment, and ensures that clinicians are supported in making decisions that are based on the most up-to-date evidence. It provides NHS organisations and health care professionals with a coherent framework which links together a number of the elements essential for service development at local level:

- clear lines of accountability and responsibility;
- a comprehensive programme of quality improvement activities;
- clear policies aimed at managing risk;
- procedures for all professional groups to identify and remedy poor performance, and
- a partnership with patients in the design and delivery of services.

3.3 NHS organisations are required to demonstrate their progress through their clinical governance development plans and annual reports. These reports are required to set out the progress that has been made on a range of quality improvement activities, including continuing professional development, lifelong learning and workforce planning and development. One of the key issues for enabling clinicians' participation in efforts to achieve improvements in patient care is providing for protected time– 'service modernisation sessions' – to allow staff to look at how they can deliver care of the very highest standards. Health communities will shortly be expected to work together to identify ways of enabling staff to take time out to improve the quality of patient care. This protected time initiative is one strand of the Government's clinical governance programme and is a key part of its commitment to supporting clinical staff in improving NHS services.

3.4 The new NHS Clinical Governance Support Team, (NCGST) was established in August 1999, with Professor Aidan Halligan as its Director. This multi-disciplinary team is working with NHS organisations to develop practical models for implementing clinical governance at team and specialty level. The team provides practical support to clinicians and managers in putting clinical governance into action. Its work includes:

- a help line for NHS staff;
- worked models of clinical governance in practice;
- a focus on leadership development;

- a development programme for NHS staff;
- a website www.cgsupport.org.uk (from 1 February 2001).

3.5 The NCGST will form part of the Modernisation Agency announced in the NHS Plan. By March 2001, the NCGST will have supported 250 NHS organisations in their implementation of clinical governance. The reports of the first year of the Cancer Services Collaborative and the work of the Primary Care Development Team – also to become part of the Modernisation Agency – also show how a patient-centred approach to clinical governance can transform patient services.

Giving patients a voice

3.6 Clinical governance derives some of its most important information from patients themselves. The *NHS Plan* states: "Patients are the most important people in the Health Service… NHS care has to be shaped around the convenience and concerns of patients. To bring this about, patients must have more say in their own treatment, and more influence over the way the NHS works".

> You will need to… include lay people in – and thereby strengthen – the partnership between the NHS and medical professional bodies to prevent, recognise and deal with poor clinical performance
>
> **Patient Concern**

3.7 The Health and Social Care Bill contains major new provisions to reinforce the independence and strength of the patient's voice. An independent statutory body – the patients' forum- will be established to relate to each NHS Trust and PCT. This means that, for the first time, patient representatives will have the right of access to monitor primary care services. The role of the forum will be to monitor services, obtain patients' views about them and provide advice to the Trust. It will have direct representation on the Trust Board, through a non-executive Director who will be appointed from the patients' forum membership. The forum will be supported by a new Patient Advocacy and Liaison Service, which will also provide information to patients and resolve concerns patients and their families may have about the services they receive.

3.8 Steps are also being taken to provide an additional independent advocacy service to support complainants. This will be available in those instances where a patient feels that the assistance needed can only be provided by an external body, and one which has specialist advocacy skills. Such providers will be commissioned by the local health authority, not the Trust. Independent advocacy will be provided by organisations that have the necessary expertise. The providers will be determined by the level of competence in this area, and by the nature of the issue requiring independent support.

3.9 The Bill will contain a new statutory duty on all NHS organisations to consult and involve patients and the public in the planning and management of the service. All NHS bodies will have to regularly ask patients for their views and will be required to publish a Patient Prospectus reflecting the views of the patients forum outlining the action they have taken to respond to those views. In addition, the Bill will give Local Authority Scrutiny Committees the power to scrutinise the NHS locally, similar to their role in respect of Local Authority services, and giving local democratic oversight of the local NHS for the first time ever.

3.10 The Government firmly believes that the system which the Plan describes will ensure that patients, users and carers have more power over their own health; that patients are full partners in their own healthcare, and that members of the public have a greater say in health care policy. We will be as inclusive as possible in our discussions with key stakeholders as we put together implementation plans, to ensure that these aims are achieved.

> Patients want to be able to trust the competence and the efficiency of their caregivers. Patients want to be able to negotiate the health care system effectively and to be treated with dignity and respect.
>
> **The Patients' Association**

NHS complaints procedure

3.11 Complaints from patients have an important positive role to play. Organisations which are focussed on quality improvement welcome the chance to learn from the complaints they receive.

3.12 The NHS complaints procedure is currently undergoing an extensive UK-wide two-year evaluation. When the new NHS complaints procedure was introduced in 1996, the then Ministers were committed from the outset to a formal, independent evaluation of the new system. The present Government has maintained this commitment and the evaluation is now almost finished. An independent research team made up of the York Health Economics Consortium, Public Attitude Surveys Ltd and the King's Fund is carrying out the study. The team carrying out this project is due to report to Ministers by the end of January 2001. This is a comprehensive project aiming to cover all aspects of the complaints procedure. It is examining how the procedures are operating across all parts of the NHS through the use of workshops, questionnaires and face-to-face interviews, based on the actual experience of complainants, NHS staff and others involved in the operation of the procedures. There are three key aims to the evaluation study –

- to highlight any potential barriers to the effective operation of the procedure;
- to suggest ways for overcoming these; and
- to identify examples of good practice that can be shared with the NHS as a whole.

3.13 In Chapter 10 of the *NHS Plan*, the Government made a commitment to act on the outcome of this evaluation and reform the complaints procedure to make it more independent and responsive to patients. Work will be taken forward speedily once the evaluation report has been submitted. This will include support for independent advocacy (see paragraph 3.8).

Human Resources policies

3.14 Better human resources (HR) policies will also help improve service quality. In September 1998 we published the national HR strategy, *Working Together*, which has encouraged a new way of working within local NHS communities. We have always recognised that offering fast, quality care to patients and

delivering modern and dependable services with courtesy and understanding means attracting and retaining high quality staff, committed to developing their skills and keeping them up to date.

> We particularly welcome the recognition of the need for an effective local human resources strategy to support clinical governance and performance improvement. Given that in many cases the organisational context for clinical failure is critically important, access to managerial, organisation development and training will be important.
>
> **NHS Confederation**

3.15 First class health care delivered by first class staff also requires first class employers who are committed to involving their staff in decisions on the delivery of services, developing their skills, rewarding them fairly and providing a good, safe working environment, free from discrimination and harassment. *Working Together* has provided a national framework to achieve this, setting three strategic aims: improving working lives; modernising employment practices and improving recruitment and retention. This gives a clear direction against which we are measuring progress. The *NHS Plan* makes clear that performance on a range of HR measures will be a key part of the assessment of performance of NHS organisations. Ministers attach great importance to the achievement of these objectives, and expect employers to make continued improvement in this key strand of NHS modernisation.

Clinical data

3.16 Access to good clinical data is an essential underpinning to the delivery of high quality healthcare. The NHS information strategy, *Information for Health*, recognised that improvements were needed in the way in which clinical data were managed. Modern information systems can provide clinicians with access to up-to-date comprehensive electronic medical records at the point of care and produce clinical audit as a by product of the information needed to deliver care. *Information for Health* and the *NHS Plan* set out our major programme of investment to put in place the information systems needed to provide comprehensive clinical data to clinicians. This investment includes developing the infrastructure and analytic support required to produce comparative data, for example risk adjusted clinical outcomes for benchmarking purposes.

3.17 *Information for Health* is a dynamic information strategy which has been updated in the light of the NHS Plan. More details are set out in *Building the Information core: Implementing the NHS Plan*, to be published later in January 2001. Its implementation will continue to be tested against the requirement to provide high quality clinical data about individual patients to support clinicians in the delivery of good quality care, and aggregate data to support continuous improvement through the clinical governance process. The introduction of modern information systems in the NHS requires a partnership between information specialists and healthcare professionals to ensure that the information systems which are developed meet clinical needs. As well as putting in place a reliable infrastructure, we will identify with the NHS those practical IT applications to help clinical staff deliver better care which are best developed nationally, and then begin to roll them out.

Checking the suitability of doctors at the appointment stage

3.18 In every sector of care it is a first principle to check, at the point of recruitment, that all professional staff meet the high standards expected by the public. These checks are sometimes described as credentialling, that is, checking the doctor's registration establishing that a doctor is who he or she says he is, has the qualifications and references required, and does not have a record of poor performance which would call his or her suitability to work for the NHS into question. A number of high profile cases have shown that existing systems do not always spot problems in a doctor's past practice at the time the appointment is made.

3.19 Work is therefore in hand to strengthen credentialling or pre-employment checks, in hospitals and in primary care. Revised guidance on the "Management of Health, Safety and Welfare Issues for NHS Staff," to be published in early 2001, will include strengthened guidance on pre-employment checks for hospital locums and other staff. It will also cover effective pre-employment health assessment and the position of staff coming into the NHS from abroad. In primary care, similarly, we are making the existing good practice of taking up clinical references – when a doctor joins the medical list or is engaged as a deputy by a practice – compulsory.

3.20 Funding has been made available to pilot the use of smart cards for doctors in training in three NHS regions from April 2001. Smart cards will record pre-employment checks data, such as checks on suitability to work with children, police and GMC checks, together with occupational health and immunisation records for medical staff. This should make these checks more streamlined and reliable – at present they are time-consuming for junior doctors, who regularly move to a new training post, and a wasteful way of working for employers.

3.21 For general practice, the Department issued a consultation paper in August 2000 with a number of proposals which included amending the rules through which Health Authorities (HAs) choose which doctors are allowed to provide primary medical care for their communities. The consultation was issued to a number of interested groups including the BMA and the GMC. Feedback from many areas was positive and many helpful comments were received. The Department is now talking to the BMA about the final package of changes, examining their views and looking with them at the likely local impact. The legal powers necessary to underpin these changes are being sought as part of the Health and Social Care Bill which is presently before Parliament.

3.22 Some of the main proposals from the consultation paper are set out in the following paragraphs.

3.23 GP principals already have to be on a HA's Medical List in order to work as a GP in that area. However, beyond basic checks that doctors are qualified and are who they say they are, the current legislation gives HAs little scope to consider wider issues that might call into doubt their suitability to provide NHS care for patients. To remain on this List or be admitted to it in future, it is proposed that a GP will have to declare any criminal convictions, binding-overs, cautions and "findings against" by professional, regulatory or licensing bodies. This includes criminal convictions or professional investigations outside the UK.

3.24 For the most serious offences, it is proposed that exclusion from the Medical List would be mandatory. This would apply to conviction in the UK for murder or any other crime leading to a sentence of imprisonment

of more than six months. In other cases, although all convictions and the like will need to be declared to give the HA a full picture on which to base its judgement, exclusion by the HA will be discretionary and it is not intended that every conviction or adverse finding would render a doctor unsuitable.

3.25 At present the HA Medical List only regulates the work of GP Principals. A significant number of GPs also work as deputies, assistants and locums. It is right that the same standards should in future apply to these doctors, and to achieve this each HA would in future also hold a "supplementary list" for doctors wishing to work in this way in the HA's area. The right to be on the Supplementary List would be regulated in the same way as for the Medical List. Once these lists were in place no doctor would be allowed to work in GMS unless he is on a HA list. However, to restrict the administrative burden, being on the supplementary list of one HA will allow the doctor to work in other HA areas.

Retaining confidence in existing doctors: proposed changes to general practice

3.26 It is obviously not sufficient to check that a newly appointed doctor is safe and practices to a good standard; patients need to know that the NHS continues to be confident about that doctor as his or her NHS work continues. This mirrors the self-regulation arrangements under which the GMC first checks that a doctor can be licensed to practise by being placed on the Medical Register, and then continues to assure itself of his or her fitness to practise – if necessary by investigating any complaint it might receive, and in future by requiring revalidation of all doctors' fitness to practise every five years (see paragraph 1.3). Appraisal and continuing professional development play a key role here.

3.27 Whilst hospital doctors should already have to inform their employers of convictions (and we have created a new duty on the GMC to report regulatory investigations to employers), in primary care there is a need to do more if we are to secure a similar level of confidence. The Government proposed in its August 2000 consultation paper that, once on the Medical List, GPs would have to report promptly any offences for which they are charged by the police or any new investigations by professional, regulatory or licensing bodies.

3.28 To protect patients in the most serious cases, HAs would be entitled to suspend a GP from their Lists pending the resolution of concerns about his or her conduct.

> We support the proposal that health authorities have the power to suspend general practitioners. The drive for a consistent approach in both primary and secondary care is one of the most positive aspects of the consultation paper.
>
> We believe that the current role of the NHS Tribunal is ineffective. The new arrangements would obviate the need for NHS Tribunals. We therefore would recommend not simply that the role of the NHS Tribunal be reviewed but that the Tribunal is abolished.
>
> **NHS Confederation**

3.29 Alongside the protection of patients it is important to safeguard the rights of GPs to a fair hearing and there would be a right of appeal against the HA's exercise of its discretionary powers to refuse to admit a doctor to, or remove a doctor from, its lists to an independent body. *Supporting doctors, protecting patients*

questioned the need for the NHS Tribunal. Recent cases have shown that the Tribunal is unable to deal with the most serious cases with the speed needed to protect patients and retain public confidence. The Health and Social Care Bill therefore also contains proposals to abolish the NHS Tribunal, to give to Health Authorities the existing Tribunal power to suspend and remove general medical practitioners where this is necessary, and to provide general medical practitioners with a right of appeal to an independent Family Health Services Appeal Authority.

3.30 Other proposals to tighten up on the regulation of general practice include:

- Only allowing doctors who are on the HA's Lists to be engaged in providing deputising services in the area.
- Requiring any deaths at the GP's surgery to be reported to the HA
- Requiring gifts from patients to be declared to the HA.

3.31 The Health and Social Care Bill also contains provisions to introduce similar arrangements where GPs are working under the new Personal Medical Services arrangements rather than the established General Medical Services and in respect of the Pharmacy, Optical and Dental Family Health Service practitioners.

3.32 Subject to the changes being approved by Parliament and final consultations with the BMA we will take steps to implement them as quickly as circumstances allow.

Occupational Health Services

3.33 The *NHS Plan* confirmed that the government would spend £6million in 2001/02, rising to £8million in 2003/04, on extending Occupational Health Services, already available to staff working in NHS Trusts and Health Authorities, to GPs and their staff.

> The orientation of the paper towards an improved rapid response to suspected difficulties in professional practice is welcome.
>
> **Faculty of Public Health Medicine**

3.34 The Improving Working Lives standards launched on 4 October 2000 by the Secretary of State include a commitment to introduce service standards for Occupational Health provision. These standards will be published as part of the revised "Management of Health, Safety and Welfare Issues for NHS Staff" guidance in early 2001 and are currently being drawn up by a working group of occupational health professionals.

Stress reduction

3.35 An organisational stress management tool has been developed by the *Health at Work in the NHS* project team and the University of Birmingham, funded by the Department of Health. The tool was launched in August 2000. It will be evaluated in 2001 to see what impact it has on individual doctors.

> Stress should be tackled through proper occupational health service for all doctors with access for those working in primary care.
>
> **Institute of Healthcare Management**

3.36 New guidelines were published by the NHS Executive in August 2000 on the provision of counselling services for NHS staff. All NHS staff should now have access to confidential counselling services as part of the Government's human resource strategy for the NHS. A recent (unpublished) survey to check compliance found that 95% of NHS Trusts are now providing access to counselling services.

Management training

3.37 Many doctors who report unacceptable levels of stress at work also highlight the need for doctors to have access to management training. As part of the *NHS Plan* we are actively engaged in developing a Centre for Leadership which will embrace the needs of clinical staff. We expect the Centre for Leadership to be operational from 1 April 2001 and we are currently seeking the views of NHS staff on the programmes to be offered. We also sponsor a number of programmes through the British Association of Medical Managers (BAMM). For example in 1999-2000 we commissioned BAMM to work with 50 newly appointed Medical Directors, taking them through Development Centres and providing individual support programmes. This work is continuing in 2000-01 and extending to Clinical Directors.

Modernisation Agency

3.38 Finally, the *NHS Plan* announced that we would create a Modernisation Agency for the NHS, which will help local clinicians and managers redesign services around the needs and convenience of patients. This will provide targeted expert support to spread best practice and stimulate change locally. The activities of the Modernisation Agency will bring together different strands of work which improve the quality of care such as the cancer services collaborative, the accident and emergency collaborative, the booked admission and waiting times programmes, and the clinical governance and primary care support teams.

4 Identifying problems with a doctor's practice and putting things right

This chapter deals with the steps which need to be taken when an individual doctor's performance falls short of what is required. This can occur for a number of reasons. To help deal with this, the proposal in *Supporting doctors, protecting patients* was to provide a performance assessment and support service.

The Government has since announced in the *NHS Plan* that this work will be carried out by a new Special Health Authority, the National Clinical Assessment Authority (NCAA). This chapter sets out the broad principles under which it will operate. Detailed procedures will be worked out by the new Authority's Chair, Medical Director and Board in consultation with interested parties such as medical Royal Colleges and patient organisations.

Moving on from issues of ability to those of conduct, this chapter then reaffirms the Government's commitment to reform the national disciplinary procedures for doctors to provide faster, fairer results.

Finally, performance may fall below par because a doctor is ill. We describe elsewhere in this document (at paragraphs 3.33-3.34) how we are improving the service sick doctors will receive from the NHS' occupational health services.

- Establishing the National Clinical Assessment Authority
- Reviewing NHS disciplinary/suspension/alert letter procedures

Establishing the National Clinical Assessment Authority

4.1 The functions which the Government has in mind for the National Clinical Assessment Authority (NCAA) remain very much as set out in chapter 6 of *Supporting doctors, protecting patients*. However we have taken on board comments received during consultation that a single national centre to which doctors would be referred would not be conducive to developing a positive and a non-stigmatising role for the service. The new Authority will operate more flexibly using local visits as part of its assessment procedures. We have established the NCAA in law (as a Special Health Authority) and have now appointed a Chair and Medical Director (who will lead the organisation). Non-executive Directors to guide the work of the NCAA are being interviewed this month and will be appointed as soon as possible.

4.2 Where there are doubts or concerns about clinical performance which cannot be resolved locally, the employer (or Health Authority in the case of a general practitioner) will refer the doctor to the NCAA. The NCAA will respond quickly in giving advice or more often by initiating an assessment of the doctor's clinical practice and will provide a thorough, objective and authoritative report on the problem with advice on any action which ought to be taken.

> The early detection of… lowered standards is important, but this must be matched by immediate and focused help with retraining, counselling and mentorship… There is, I believe, general support for local arrangements to assist doctors in difficulties which are external to a Trust but at the level of a Region or sub-Region, with close links to Regional Advisors and Programme Directors and with established procedures for remedial training….
>
> Examination of performance must be carried out within the doctor's working environment. This would be difficult to achieve if there were only a small number [of] centres.
>
> **Royal College of Psychiatrists**

4.3 The NCAA's assessors will conduct local visits and will gather information and relevant data as well as talking to other staff in the service concerned. This may involve gathering information on patients' experience of the doctor's service. The Authority will endeavour to provide the doctor with a supportive environment while he or she is undergoing assessment, and will strive to be non-stigmatising. We do not envisage that assessment will be a lengthy process. The focus will be very much on problem-solving, and where a problem with the doctor's performance is found, on answering the question "what practical steps need to be taken so that this doctor can return to practice without risk to patients?"

4.4 The NCAA is an advisory body. The employer or Health Authority remains responsible for resolving the problem, at all stages. If the right way to deal with a case is clear, there may be no need to refer it to the NCAA: it can be dealt with locally. Similarly, if there is a clear and immediate danger to patients, referral to the GMC should not be delayed. Past experience however shows that local services have difficulty in dealing with complex problems of professional practice and it is likely that a discussion with the Medical Director of the NCAA might be very helpful in the initial stages of handling such problems.

> The importance of early detection together with the emphasis on rehabilitation and educational solutions rather than disciplinary ones is also welcomed. The suggestion that the employer or HA would take responsibility for implementing and funding any proposed action (with suitable provision for the doctor concerned to make representations ….) has been a goal of the profession for many years.
>
> **Joint Consultants' Committee**

4.5 The NCAA's assessment will involve trained medical and lay assessors. Referral to the NCAA will be made by a senior person at the health authority or NHS Trust. More work needs to be done on the circumstances in which a doctor will be able to self-refer but we think it could be an effective course of action for a doctor who feels himself or herself to be the target of unjustified allegations.

4.6 Recognising the time consumed by an assessment, we will fund the NCAA – at least in its first few years of operation – to reimburse the Trust or the general practice for the costs of employing locum cover while he or she is being assessed. This will also cover periods of subsequent training/ supported practice in a different setting if these are recommended. In the longer term the responsibility and funds for this might pass to the local NHS.

4.7 The NCAA's report could recommend a number of outcomes:

- the doctor returning to practice with the employer or Health Authority reassured that there were no major problems;
- the doctor returning to practice whilst being monitored against specific criteria;
- a period of re-education and retraining followed by re-assessment;
- reskilling in a different field of medical practice followed by reassessment;
- referral to the GMC;
- referral for medical treatment;
- referral back to the employer or Health Authority with a report which assessed the problem as serious and intractable;
- and any of these options plus notification to the Commission for Health Improvement and the relevant NHS Regional Office that a review was necessary because there were wider organisational problems in the service concerned.

> We support the concept of Assessment centres. The fundamental concern expressed to us by NHS Organisations is the need for Support and Assessment Centres to tackle performance issues in a clear, unambiguous and decisive fashion in a way that previous outside mechanisms have failed to do. It is vital a referral results in a clear outcome which resolves or can lead to speedy resolution of a problem.
>
> **NHS Confederation**

4.8 The doctor will have the opportunity to record his or her views on the conduct and findings of the assessment before the report is submitted.

4.9 The employer or HA will take responsibility for implementing the findings of the NCAA in each case, with – in the case of any disciplinary action – the usual provision for the doctor concerned to make representations and appeal against the action proposed. Strong links and involvement with the postgraduate deans and clinical tutors will be developed so that tailored education and training solutions to the clinical problems can be delivered.

4.10 It will – as explained above – always be in a doctor's best interests to co-operate with an NCAA assessment, which will be an impartial examination of the problem and an expert recommendation of the next steps to take. Observers believe that in some cases of poor performance, however, the doctor lacks insight into his or her behaviour and denies that a palpable problem exists. We must therefore address the question of what should happen if a doctor refused to co-operate with assessment. In this position, a hospital doctor would have refused to comply with a reasonable instruction of his or her employer. This would constitute a breach of their contract of employment and lay them open to disciplinary proceedings. We will discuss how to secure similar protection of the patients of a GP with the BMA's General Practitioners' Committee.

4.11 These paragraphs have described the major policy decisions already taken about how the NCAA will operate. A good deal of the work of establishing procedures for referral, assessment, reporting and follow-up will necessarily fall to the Chair and Medical Director, supported by the rest of the Board. They will of course need to consult a range of interested parties such as patients' organisations and medical Royal Colleges before reaching firm decisions.

4.12 The new Authority will work with leading experts in the assessment of medical performance to devise assessment tools and processes which are fair, evidence-based and effective. This will include the selection and training of good quality assessors, medical and lay. We will continue to share expertise and work closely with the GMC in this area. We are keenly aware that the NCAA's processes will need to stand up to critical examination if the body is to be successful. Indeed we will want it to organise an evaluation of its effectiveness during its early years in order to learn lessons and secure continuous improvement in its working techniques.

4.13 We are attracted to the suggestions made in response to *Supporting doctors, protecting patients* that the NCAA's remit could be wider than cases of suspected poor performance. This would tend to reduce the likelihood that attending the NCAA would stigmatise a doctor. The NCAA will explore how it could offer assessment services to for example doctors returning from career breaks.

> BAMM strongly supports the concept of the support and assessment centre. BAMM believes that the centres will considerably assist and support the local Trust process and provide a much needed system of rapid response…. It is crucial that…the stigma of having one's clinical performance questioned is removed…. BAMM has discussed this issue at some length. The view is that these …centres could conceivably provide a service that is wider than dealing with poorly performing doctors… including those returning to medicine after a career break, those keen to enter a different stream of a specialty….
>
> **British Association of Medical Managers**

National disciplinary procedure

4.14 We turn now from cases where the doctor's ability is at issue to cases where his or her conduct is being questioned. In the former situation, the emphasis must be on support and, where necessary, education. In the latter situation, we are dealing with employees' contractual responsibilities. Employees have a contractual responsibility to perform to a satisfactory level (and should be given every assistance and

opportunity to do so). Employers have a responsibility for setting realistic and measurable standards and objectives, and for ensuring employees are aware of what is expected of them. They should establish what kinds of performance and behaviour are unacceptable, drawing on for example the GMC's publication *Good Medical Practice*.

4.15 We are developing a national disciplinary procedure that will offer more help for employers and hospital doctors in identifying problems and their solutions. The intentions are twofold:

- to make doctors who are investigated for misconduct (for example sexual assault, fraud) or failure to meet their contracts (for example regularly failing to turn turning up for a ward round or outpatient clinic) responsible for their actions in the same way as other NHS employees. While recognising the different legal status of GPs, the aim of our reforms in this field is to achieve the same outcomes in terms of patient protection, effective discharge of NHS business and respect for a doctor's rights and reputation, wherever he or she works.

- To provide a faster, fairer system for investigating and resolving problems, instigating disciplinary procedures and hearing appeals. As part of this process, we announced in *Supporting doctors, protecting patients* that we are intending to abolish the "Paragraph 190" rights of appeal that are still held by certain doctors and dentists, replacing this right with a process internal to the employing organisation.

> We support the abolition of existing mechanisms with replacement by a new integrated process able to make early diagnosis within the categories: personal misconduct and clinical dysfunction of a serious enough nature being referred to the GMC. We also support the extension of this process to include all doctors including GPs. We feel that HC(90)9 requires replacing.
>
> **Faculty of Public Health Medicine**

4.16 Within the national disciplinary procedures there will be a revised suspension procedure. Decisions on whether or not to suspend a medical or dental practitioner are and will remain a local matter. The revised guidance will highlight the fact that suspension is not a punishment but a necessary tool to ensure quality of care and a level of protection to patients. NHS employers have a responsibility to investigate any alleged breach of acceptable standards by clinicians, and to consider whether any disciplinary action is required. A doctor who is suspended to protect patients should in future have to give a binding undertaking not to practice in another NHS or private sector setting until their position has been resolved.

4.17 Following the introduction of the NCAA and the issue of the improved guidance, suspensions for poor professional performance should become increasingly rare. Employers will need to consider whether it is in the interests of patients, the investigative process or the doctor themselves to suspend the practitioner during such investigations and to consider whether alternatives to suspension would be more appropriate. Once a practitioner has been suspended, it is essential that investigations are dealt with speedily. Employers must combine the responsibility to protect the interests of patients with that of ensuring their employees are treated fairly and with the minimum of delay.

> [Your approach] will provide a streamlined and comprehensive framework for dealing with problems of poor clinical performance… The adoption of the same or similar approaches for all the health care professions is supported.
>
> **UK Central Council for Nursing, Midwifery and Health Visiting**

4.18 We want to be fair to doctors who have been suspended and wish to ensure that there are proper arrangements in place to deal with them quickly and fairly.

4.19 NHS employers must take a wide view in carrying out their public protection function: other employers need to be alerted. The objective of the Alert Letter system is to protect patients and colleagues by ensuring that employers are aware of any doctors or dentists where the prospect of their continuing in practice gives rise to a serious concern for patient or staff safety.

4.20 Recent cases have highlighted the possible need to tighten the existing system. As a result of the Health Select Committee Report, which raised the issue of Alert Letters, and following the issues raised in *Supporting doctors, protecting patients* we have looked at the existing system and are developing revised guidance.

4.21 We are looking to provide a system that recognises the importance of sharing information with all those organisations that could potentially employ an individual covered by an Alert Letter. This includes the private sector, Health Authorities and NHS Trusts, as well as locum agencies and other government departments. We are also working up plans to extend this system to cover all people working within the health care sector.

5 Monitoring the quality of NHS services

Alongside the new measures described in the previous chapters it will be necessary to have a continuing system of monitoring to ensure that local quality measures are effective. This chapter describes the work of the Commission for Health Improvement and the strengthening of the Government's NHS Performance Assessment Framework which we announced in the *NHS Plan*. Both complement the strengthened influence of patients set out in paragraphs 3.6-3.13.

Commission for Health Improvement

5.1 The Commission for Health Improvement (CHI) was set up to provide independent assessment of local systems to assure and improve quality in the NHS, with the power for rapid intervention to address serious service problems. It also has the function of providing advice and guidance to the Health Service. The *NHS Plan* underlines the central role which CHI will play in helping to raise the quality of care; for example NHS organisations assessed under the Performance Management Framework as under-performing or "red light" (see 5.6) will be subject to more regular reviews by CHI, every 2 years instead of every 4, until they have improved sufficiently.

5.2 Since beginning its first full year work programme on 1 April 2000, the Commission has undertaken pilot clinical governance reviews in four NHS acute Trusts. The pilot reviews will help inform CHI's approach to its rolling programme of visits to all NHS organisations, checking the implementation of clinical governance and efforts across the NHS for the continual improvement of services to patients. As set out in the *NHS Plan*, CHI will assess all NHS bodies at least every four years and will target those organisations that are not performing to the required standards for more frequent visits. CHI will identify poor standards of care and work with the NHS to put this right, as well as highlighting good practice.

5.3 CHI also has the power to investigate where real concerns are raised about local services. Where there is clear evidence of serious failure in the management, provision or quality of health care, then it may be appropriate for the Commission to undertake an investigation. The Commission is currently undertaking three investigations, and two have recently been published – one in England and one in Wales. The results of these investigations provide valuable lessons for the NHS as a whole.

Supporting Performance Improvement

5.4 Chapter 6 of the *NHS Plan* sets out new arrangements for performance improvement in the NHS. The key features of this new system of performance improvement are:

- a Performance Assessment Framework (PAF) for HAs and NHS Trusts (and in time Primary Care Groups and Primary Care Trusts) covering all major areas of NHS
- traffic light status (rating organisations' performance as green, yellow or red) based on performance against the NHS Plan "must do" targets and the PAF
- support for performance improvement from the Modernisation Agency
- a performance fund to incentivise improvement
- increased managerial freedom for successful green light organisations under a new system of earned autonomy
- new powers to intervene in failing red light organisations.

5.5 The Modernisation Agency (see paragraph 3.38) will have a pivotal role in the redesign of services envisaged in the NHS Plan with the emphasis on improved access and patient centred care. The Agency will work in support of line management with *all* parts of the NHS – green, yellow and red organisations – helping to spread best practice in all organisations, as well as developing the capability of yellow organisations and supporting red organisations with targeted assistance. Integral to the Agency will be a Leadership Centre, which will facilitate the step change in management needed to deliver performance improvement throughout the NHS. It will also support the development of clinical leadership, in parallel with the Agency's role in overseeing the successful implementation of clinical governance.

5.6 "Red" organisations will be failing some or most of the core national standards. Once an organisation has been assigned a red light, the Regional Office will review the situation to identify which level of intervention is most appropriate. Three possible levels of intervention are described below. At each level the organisation is required to agree a detailed performance improvement plan and its share of the performance fund is used in accordance with the plan.

5.7 The first level of intervention would simply be to instigate the actions identified above. Level 2 intervention involves increasing the capacity or capability of the failing organisation. This would involve Regional Offices, working with the Modernisation Agency, deploying additional managers and clinicians to work closely with the failing organisation for a period to support implementation of the recovery plan. The final level of intervention is the point at which senior managerial teams may be removed or mergers required. As a last resort, if "red" organisations fail to respond to special measures or have a record of persistent failure, the Secretary of State will be able to place the failing organisation under the control of new senior managerial teams. These reserve powers of intervention would only be used when an organisation had failed, over a period of time, to raise its performance to an acceptable level, or if it experienced an incident of sufficient seriousness to merit immediate intervention.

6 The contribution of self-regulation

The current system of self-regulation, or professional-led regulation as some describe it (exercised, in the case of medicine, by the GMC) determines who should enter and remain in the profession at different levels and in different fields of practice. This helps health organisations to achieve high quality standards through clinical governance. The Government continues to believe that self-regulation makes an essential contribution to maintaining and raising standards. But regulation has to be responsive to patients and public, transparent, and accountable. We also want to see a co-ordinated approach to the modernisation of regulation across the health care professions. This chapter reports on recent developments affecting the work of the GMC, as they contribute to improving the protection of patients.

- Interim changes to GMC's procedures
- Reform of the GMC

Interim changes to the GMC's procedures

6.1 Following concern about the GMC's ability to act swiftly and effectively when a doctor's fitness to practise is called into question, in August 2000 the Government introduced legislation to widen the powers of the GMC. The key provisions are:

- a new power to impose interim suspension or conditions quickly, to stop a doctor who represents a danger to patients from practising until his fitness to practice has been determined.
- Introducing a minimum 5 year period before a doctor who has been struck off the Medical Register may apply for restoration. Doctors who are erased from the Register should not expect to return to medical practice, save in the most exceptional circumstances.
- Placing a statutory duty on the GMC to notify employers and any other person or body who may need to be informed, of doctors whose fitness to practise is under consideration.
- Enabling the GMC to co-opt non-members of the Council to any of its committees – chiefly to help tackle the backlog of cases, but also to open up the Council to wider involvement in its committee work, and bring in wider views and experience.

- Giving the GMC the power (similar to that of the General Dental Council) to suspend or place conditions on the registration of a doctor convicted of a criminal offence abroad which constitutes a criminal offence in this country.

6.2 This is the first step towards wider and broader change which will be the subject of further discussion with the GMC. However, strengthening the GMC's powers in these important and significant ways demonstrates the Government's determination to apply the lessons of recent events so that patients get the protection they need.

Reform of the GMC

6.3 Looking to the longer term, we set out in the *NHS Plan* the minimum requirements for health care self-regulatory bodies including the GMC. The *NHS Plan* states that they must change so that they are smaller, with greater patient and public representation in their membership, have faster, more transparent procedures, and develop meaningful accountability to the public and the health service. We also said in the *NHS Plan* that:

- we will wish to see consideration of options for overseeing medical undergraduate curricula, as part of the radical review of the GMC;
- the GMC and the other health regulatory bodies will be part of a new UK Council of Health Regulators. This will help develop common approaches across the professions for matters such as complaints against practitioners. Were concerns to remain about the individual self-regulatory bodies, its role could evolve;
- the GMC should explore introducing a civil burden of proof and making other reforms so as to genuinely protect patients;
- These modernised and more accountable regulatory arrangements will work alongside the NHS' own quality assurance arrangements to offer better protection for patients.

We are pleased that the document raises the issue of how professional self-regulation should operate in a modern context and want to see professional self regulation for all appropriate groups operating effectively in a modern context, alongside other management initiatives, to protect patients and improve the quality of services

In this context we endorse the "Modern Principles of Professional self-regulation in the Health Field."

The NHS Confederation believes that NHS organisations are having to devote considerable resources to meeting the requirements of differing monitoring and inspection processes. There is evidence that there is some duplication in the work involved and the NHS Confederation would like to see moves to co-ordinate and standardise procedures.

NHS Confederation

6.4 The Government's programme of modernisation for the NHS, including our stress on the quality of care, needs partnership with professional bodies if it is to succeed. As well as their statutory roles in relation to training, the expertise of medical Royal Colleges and others will play an important role. It is important that the principles behind the interfaces and accountability are clearly understood, and these have been mapped out in *Supporting doctors, protecting patients*, in the *NHS Plan*, and here.

6.5 On 11 October 2000 the GMC's Governance Working Group published a first consultation paper on the reform of its constitution, structure and governance. Following that consultation, in December the GMC announced some key decisions on radical reform, and will consult on more detailed proposals shortly. The Government welcomes this progress, which indicates the GMC's willingness to tackle the key areas of effectiveness, inclusiveness and accountability. As we said in the *NHS Plan*, Government and Parliament will have to judge whether the reforms proposed by the GMC following its own consultation process will indeed protect patients and restore public and professional confidence. The Government has made it clear in the *NHS Plan* that radical reform of the GMC is necessary, and will open a dialogue with the GMC at the proper time on the changes so far proposed.

> If self-regulation is to continue the Institute welcomes a strengthening of a more open and transparent system.
>
> **Institute of Healthcare Management**

7 Conclusion

7.1 This document has set out the Government's record of achievement to improve the protection of patients. A lot has been done since we published *Supporting doctors, protecting patients* in November 1999 – and much has only been started and needs to be brought to fruition. The NCAA is for example a central piece of the machinery, which will begin to operate for the first time in 2001. When fully functioning it will do much to help the NHS avoid the pitfalls and dysfunction which have attended the handling of poor clinical performance in the past.

7.2 The Government has acted and is continuing to act to

- promote patient safety as paramount;
- establish clinical governance as the cornerstone of the quality of local services;
- raise the already high standard of day-to-day practice by the great majority of doctors;
- reassure the public that regulation is being improved, and
- protect patients from the small but significant amount of poor practice which currently exists.

7.3 Some have misunderstood this programme of work as an attack on the medical profession. This could not be more mistaken. The leaders of the profession themselves have always laid great stress on promoting high quality clinical services, and so it is hardly surprising that they have very largely welcomed these new Government initiatives.

- competent doctors have much to gain from these initiatives – in particular the public will be reassured and give them the trust and respect their high quality practice deserves.
- for the minority who fall short of the standard, these measures offer support and help to put things right where possible rather than a regime of punishment. The new quality programme offers far more relevant learning and development opportunities, tailored to their needs and to those of the service.

- Only the tiny number who do not put patients at the centre of their practice have any cause to be concerned about these reforms. Unacceptable practice of this kind needs to be stopped, as the profession itself makes clear, for example in the GMC's document *Good Medical Practice*.

7.4 We know that modernisation of the NHS cannot happen overnight, but we have made a strong start. There is much more to do. A significant first step has been the introduction of clinical governance, which promotes a culture of patient-centred, accountable, safe and high quality healthcare delivery in an open and questioning environment.

7.5 In *Supporting doctors, protecting patients* we set out to consign to the past the failures in standards of NHS care which have harmed patients and their families, reduced confidence in health services and hit the morale of those working in the clinical services affected. This document has shown how we are going about this and what we have achieved so far, assisted greatly by the responses we have received to the consultation document as well as comment and advice since.

This document can be found on the internet at www.doh.gov.uk/assuringquality

The NHS Plan itself can be found on the internet at www.nhs.uk/nhsplan

Further copies of this document and copies of a Summary of the NHS Plan are available free of charge from:

Department of Health
PO Box 777
London SE1 6XH
Fax: 01623 724524
E-mail: doh@prolog.uk.com

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