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ScHARR
SCHOOL OF HEALTH AND RELATED RESEARCH

University of Sheffield

Measures to assist GPs whose performance gives cause for concern

Executive Summary

Background

In late 1996, the School of Health and Related Research at the University of Sheffield (ScHARR) was commissioned by the Department of Health to produce guidance for health authorities in developing local arrangements for supporting GPs whose performance gives cause for concern. The guidance is based on a research project, conducted by ScHARR, which involved securing the views of professional and managerial bodies and individuals with a keen interest in GP performance.

The guidance has been developed against the backdrop of significant policy advancements:

- a primary care led NHS;
- the formation of the new health authorities;
- the introduction of the General Medical Council's (GMC's) new powers to address the performance of doctors in addition to health and misconduct matters.

While the GMC's new powers are intended to deal with the very few doctors whose performance is 'seriously deficient', it is recognised that there will be a larger minority of others identified as under-performing to a lesser extent who will need support to improve their performance. Providing help to this group of GPs is the main focus for the guidance.

The guidance is presented in the form of answers to key questions, dealing with matters of principle, definition, identification, diagnosis, intervention, resourcing and evaluation. These are each covered in detail in their own separate chapters, while the final chapter suggests a practical management framework for linking these different aspects together, including proposals about the roles and functions of the key players.

This summary is a checklist of the key points which ScHARR recommends health authorities consider in the development of local support arrangements. They are drawn from the individual chapter summaries captured in text boxes within the body of the main report.

What principles should apply to working with GPs whose performance gives cause for concern? – ScHARR's suggestions

- establish a framework of principles, in partnership with local professional representatives, to guide your approach;
- ensure that the framework includes commitments about the following:
  - working in partnership with the profession
  - adopting an approach which is supportive, fair and sensitive to the individual GP
  - establishing arrangements which are transparent, widely promoted, well understood and easily accessible by self referral;
- ensure these principles are applied to the practical delivery of your approach.

How do you define GP under-performance? – ScHARR's suggestions

- adopt a clear but broad definition of under-performance;
- do not be over-preoccupied with detail;
- encompass inadequate knowledge or skills leading to behaviour which places patients at risk;
- recognise the relevance of clinical and non-clinical dimensions of performance;
- accept that single incidents may not constitute under-performance;
- set the local approach within the context of nationally accepted views on the performance one could reasonably expect from a GP.

How do you identify a GP who may be under-performing? – ScHARR's suggestions

- establish a practice development planning process which acts as a stimulus for development, a focus for dialogue and an effective mechanism for monitoring performance;
- adopt a broadly-based, circumspect approach to indicators of under-performance;
- do not put too much reliance on any one measure or source, but ignore none of them;
- in particular, develop a convention for dealing with informal expressions of concern which acknowledges their value but demands responsible, ethical interpretation and management;
- work at a culture of informed supportiveness which commands confidence and trust.

How do you reach an understanding of why a GP is under-performing? – ScHARR's suggestions

- there may be many complex reasons for GP under-performance;
- the reasons may differ from instance to instance, even where the manifestations of performance problems are similar;
- if interventions are not to be ineffective, wasteful or counterproductive they should be tailored to the needs of the individual GP;
- therefore, take steps to ensure that diagnostic work with under-performing GPs is sufficiently sophisticated to identify the underlying problems;
- put the responsibility in the hands of senior people who have an excellent understanding of general practice;
- consider the use of structured diagnostic frameworks to supplement more conventional discussion.

What interventions should be considered to support these GPs? – ScHARR's suggestions

- be aware of the wide range of potential interventions that may be available in terms of education and mentoring, the improvement of practice infrastructure and measures to deal with ill-health;
- in most instances a package of support and interventions will be required which should be specified in an action plan or learning contract, together with the improvements in performance expected from the GP;
- individual GPs, as well as having different problems to contend with and therefore different plan content, may also have natural preferences in terms of learning methods and these should be taken into account;
- consideration should be given to the role of a mentor in supporting the GP through the process of rehabilitation.

How do you resource the support arrangements? – ScHARR's suggestions

- conduct an audit, with the LMC and others, to identify how resources are currently being used to support general practice performance and what opportunities there may be for refocusing them;
- the GP might be expected to fund remedial education and training, but consider funding cover arrangements to release the GP;
- be prepared to contribute to developments in practice infrastructure – premises, staff and staff training – where these are the cause of under-performance.

How would you evaluate the success of your approach? – ScHARR's suggestions

- set clear objectives in the action plan both to act as a focus for the GP and to enable the GP's performance to be reassessed following any action;
- objectives should be:
  - individual to the GP
  - relate specifically to the areas of concern
  - measurable
  - based on outcomes wherever possible
  - be understood by all parties involved
  - have defined timescales for completion;
- consider piloting an evolving approach with non-live cases;
- consider methods of evaluating the authority's approach on an ongoing basis, including securing feedback from subject GPs themselves.

How would you establish an overall management process for working with GPs whose performance gives cause for concern? – ScHARR's suggestions

- identify a health authority senior manager (director level) to lead on GP performance issues;
- ask the LMC to identify a similar lead person;
- constitute a Support Panel which, as a minimum, includes clinical and non clinical health authority membership, two LMC representatives and a GP educationalist;
- invite the Panel to bring forward proposals for the whole process, which include:
  - arrangements for co-ordinating and assessing information
  - contacting the GP and involving a 'friend'
  - diagnosing the underlying causes of a GP's under-performance
  - agreeing a package of support and action plan with clear objectives to enable evaluation
  - determining what further action (including long term support) to take following the completion of the action plan;
- establish clear procedures for ensuring issues concerning individual GPs are treated in strict confidence;
- maintain good detailed records;
- consult with the profession on the proposals;
- ensure copies of the procedures are sent to all GPs, jointly if possible with the LMC.

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Chapter 1

Introduction and background

1. This report is about the professional performance of general practitioners. Its purpose is to give health authorities a framework of guidance within which to develop their arrangements for supporting GPs whose performance gives cause for concern.

2. The Department of Health commissioned the School of Health and Related Research at Sheffield University (ScHARR) to prepare the guidance on the basis of a brief research project which distilled the experience and views of health authorities, the profession itself and a wide range of other interested bodies and individuals.

Importance for health authorities

3. In October 1994, with EL(94)79[1], the NHS Executive set out a policy framework for a primary care led NHS. This has since unfolded into successive white papers, legislation and a raft of development programmes in and around general practice. The EL began to define the responsibilities of the new health authorities that were to come into being in April 1996, replacing the former District Health Authorities and Family Health Service Authorities[2]. It outlined their duty to *"provide support to GPs in both their primary care provision and fundholding capacities through the provision of advice, investment and training"*.

4. In December 1996 the White Paper *Delivering the Future*[3] reinforced the need for *"clear arrangements to help identify inadequate performance by GPs"* and promised to *"encourage the development of local arrangements for supporting doctors whose performance gives cause for concern through the issue of guidance ... based on existing good practice and consultation with the profession"*.

5. It is clear, and does not need to be rehearsed in detail here, that the performance of GPs and general practice is now intimately entwined with that of the health authorities themselves. It is not sufficient that those at the leading edge of general practice consistently meet or exceed the highest expectations. It is also essential that the position of GPs who, for whatever reason, are struggling to maintain standards is properly addressed. Their difficulties contribute to inequitable and unacceptable variations in levels of care, now in sharp focus as a policy issue for health authorities. Health authorities have a key role in addressing under-performance, working with others, and it is hard to see how they can achieve their overall aims without playing it well.

6. Whatever its advantages, the relationship between GPs and the NHS is a complicating factor for health authorities seeking to address performance issues. GPs are independent contractors running small businesses with the NHS as their main customer. There is no conventional line of management and the nature of the relationship between a health authority and the GPs in contract with it is necessarily subtle. The position is set to change with the implementation of personal medical services pilots under the NHS (Primary Care) Act 1997[4], which enables GPs to be employed directly by NHS trusts and practices, but the independent contractor model of employment will dominate for the foreseeable future. The present guidance has been prepared with this model in mind, although many of its principles could and should be extended to other contractual arrangements.

Importance for the medical profession

7. From the medical profession's perspective, performance issues are central to its relationship with society.

8. The profession values and guards its independence, believing that the degree of knowledge and skill involved in medical work means that non-professionals are not equipped to evaluate or regulate it. It argues that doctors are responsible and can be trusted to work conscientiously without supervision, and that the profession itself can be relied upon to take appropriate action when individuals do not perform competently or ethically[5].

9. The General Medical Council, established under the Medical Act 1858, maintains the register of practitioners and accordingly has wide responsibilities in enunciating the duties and standards expected of doctors, ensuring appropriate education for them, admitting them to the register and, if necessary, removing them from it.

10. The public expects not only that initial registration reflects competence but also that doctors remain safe and capable throughout their practising lives. This means that the profession as a whole, and the GMC in particular, must ensure – and be seen to ensure – that action is taken when appropriate standards of practice are not maintained. The constitutional independence of medicine depends on it.

11. The responsibility for protecting patients (as the first priority) does not rest solely with the GMC. It is clearly a duty of the individual practitioner in relation to his or her own practice, but it is also a doctor's duty to respond when the practice of a colleague can be called into question.

Timeliness

12. The currency of performance issues arises from the implementation in July 1997 of the Medical (Professional Performance) Act 1995[6]. Until now the GMC has had powers to act in relation to doctors on the grounds of ill health or serious professional misconduct. The 1995 Act gives it important new powers to investigate a doctor's *performance* and, where it finds the standard of performance to be seriously deficient, to impose conditions on or to suspend a doctor's registration[7]. Health authorities may refer a GP to the GMC where it believes such action may be necessary. The GMC's performance procedures apply equally to GPs and NHS trust doctors but the health authority's primary concern is clearly with the former.

13. Although the GMC's new performance powers are obviously relevant to the work ScHARR has been asked to do, they relate to a very small minority of GPs. This guidance is concerned not only with them but also – and indeed mainly – with the health authority's responsibilities towards the larger group of GPs whose performance gives cause for concern but not to the extent that GMC referral is necessary.

14. It is also right to stress that whereas the GMC's powers apply by definition to the individual practitioner, the performance concerns of health authorities will often be perceived at the level of the practice and this is recognised at various points in what follows.

15. This guidance is therefore wider in scope than the GMC's new powers: it is mainly about a larger number of doctors (and their practices) whose performance gives some but lesser cause for concern; and it is about the health authority's responsibility for doing something about it and how this might be discharged. However, at the heart of this group are those few GPs for whom the new performance powers will be relevant and the health authority in referring to the GMC will have to demonstrate that it has first done all in its power to improve performance through appropriate support.

Methodology and organisation of the guidance

16. ScHARR's sources in preparing this guidance have been:

- an initial review of the available material, including discussions with key stakeholders;
- detailed monitoring of six 'learning sites' in the North West region – health authorities which have 'fast-tracked' the development of their approaches to under-performance;
- a literature survey;
- a national postal survey of health authorities;
- discussions with individuals and organisations who have a keen interest in GP performance.

Appendix A gives more detail.

17. Although funded through the Department of Health's Policy Research Programme, this is not a conventional research report. The very clear aim has been to offer health authorities accessible and practical guidance to help them tackle one of their more difficult responsibilities. It may however be useful to emphasise here – because it is not laboured elsewhere – that the conclusions and suggestions made have a foundation in systematic enquiry.

18. The guidance is presented in the form of answers to key questions, dealing with matters of principle, definition, identification, diagnosis, intervention, resources and evaluation. These issues are each covered in detail in separate chapters (2 to 8). Chapter 9 describes a practical management process which draws these different issues together and includes suggestions for the roles and functions of key players. It has been noted that much of what needs to be done is a natural extension and application of good management practice from other areas of work and this appears to the ScHARR team to be true.

19. At the end of each chapter the key points are summarised in a text box.

Chapter 1 – key points

- this report provides health authorities with a framework of guidance on arrangements for supporting GPs whose performance gives cause for concern;
- it is based on the findings of research carried out by ScHARR;
- this first chapter describes the medical profession's own commitment to maintaining professional standards, and summarises the GMC's new powers to deal with performance;
- Chapters 2 to 8 describe in some detail how health authorities might approach issues of principle, definition, identification, diagnosis, intervention, resources and evaluation;
- Chapter 9 provides a practical management framework for working with under-performing GPs.

Chapter 2

What principles should apply to working with GPs whose performance gives cause for concern?

1. In responding to ScHARR's survey the great majority of health authorities were clear about the need to develop more explicit and systematic arrangements for addressing GP under-performance, particularly in the light of the new GMC performance procedures, and acknowledged that ad hoc approaches were no longer sufficient. Most were also clear that these new approaches, to be acceptable and effective, would have to be well grounded in principle.

2. It was suggested that any system for addressing GP under-performance should be:

   - developed in partnership with the profession;
   - supportive of general practice and individual GPs;
   - fair;
   - confidential for individuals;
   - clear and transparent as process;
   - widely promoted and well understood;
   - accessible through self referral;
   - sensitive to the needs of the GP;
   - led within the health authority at a very senior level.

Partnership

3. The statutory role of Local Medical Committees (LMCs) in dealing with GP under-performance is described in both the NHS (General Medical Services) Regulations 1992[8] and the NHS (Service Committees and Tribunal) Regulations 1992[9], as subsequently amended. Health authorities, in discharging their own responsibilities, should be able to turn to LMCs as natural partners with a shared concern for standards.

4. Several HAs reflected this in their survey replies, highlighting the importance of working in partnership with the profession locally to develop, implement and evaluate systems of support. One authority said *"it is a question of building up relationships and offering satisfactory interventions"* and another *"it is question of getting it right, which includes securing the active involvement and agreement of the LMC"*.

5. This belief in the value of collaboration was also shared by many within the profession, one GP representative suggesting that *"doctors have their own agenda and so do health authorities, which can be the source of tremendous tension. But the approach* (for supporting GPs whose performance gives cause for concern) *can only be defined as 'sensitive' if both parties* (management and the profession) *are in agreement and working together"*.

6. A manager in one of the North West learning sites explained that within the joint group established to develop formal procedures, the various parties had all approached the issue from different angles. However through *"common commitment, mutual respect and developing a shared understanding of the task, we are developing a process which is jointly owned and supported"*. Initial concerns from the professional members of the group revolved around the Department of Health's and health authority's motivation for addressing the performance issue, perceiving a potential for a *"witch hunt"*. Through dialogue, the manager claimed, the health authority had been able to convince their professional colleagues that they wanted to develop in partnership *"a constructive, supportive and proactive approach"*.

Support

7. The notion of establishing a supportive approach to individual GPs who are under-performing was a consistent theme in the replies of health authorities:

   "The key to all of this is having a system that is seen as being supportive and providing assistance rather than being punitive in focus"

   "We are concerned with establishing a supportive mechanism, designed to identify, help, support and enable GPs to carry on practising"

   "It is important that the Authority is in the position to be supportive and facilitative when problems are uncovered rather than simply monitoring and bringing retribution"

   "Wherever it is possible, the under-performing GP should first be offered the opportunity and support to improve their performance"

Fairness

8. The need to achieve fairness in performance arrangements was highlighted by both managers and the profession. The Overseas Doctor's Association (ODA) considered it crucial, in view of the potential for prejudice against overseas doctors, that health authorities should adopt – and be seen to adopt – *"ethical"*, *"just"* and *"equitable"* approaches to addressing GP under-performance. It is widely accepted that overseas doctors attract higher levels of complaints, not necessarily because of differential levels of skill or performance but because of cultural differences, communication difficulties and problems of prejudice or expectation[10].

9. One of the learning sites had considered the issue of racism at length and concluded that *"the process has to be open, fair and transparent to avoid prejudice influencing the approach with any doctor"*. Another learning site highlighted the need to guard against racism, which had influenced their thinking in seeking to develop *"a clear, transparent process, including a diagnostic approach which hopefully ensures consistency and fairness to all GPs"*.

10. Concerns were also registered by single handed GPs and the Small Practice Association about the potential for health authorities to target single handed practitioners, whose performance may be more visible than that of their colleagues providing care in partnerships. With reference to both race and single handed GPs, a health authority manager suggested that *"having a structured approach, developed and operated with the active involvement of all key stakeholders, should ensure consistency"*.

Appropriate communication

11. The need to ensure individual confidentiality was at the heart of many concerns from the profession, but encouragingly it was also acknowledged separately by many health authorities who identified it as a key principle which should underpin their whole approach. It was considered that confidentiality should not only relate to the individual GP, but also extend to other individuals who might wish to disclose concerns anonymously about a GP, and to the GP's patients with respect to the disclosure of personal health details within the course of inquiries.

12. While confidentiality was seen as essential in dealing with individual GPs, many also identified the need to have, conversely, very transparent overall *processes*, open to scrutiny and well understood by the profession.

13. It was suggested by a number of people that information about a health authority's approach should be communicated to all GPs so that they are fully aware of the range of support options available to them. It was also considered important that these support arrangements should be easily accessible through self referral.

Sensitivity

14. A GP expressed his anxiety about the new arrangements by telling the ScHARR Team *"there are enough pressures without feeling you are being watched"*.

15. The need for sensitivity when approaching the issue of GP performance was expressed by several health authorities, one noting that *"health authorities are under very real danger of alienating a number of GPs where the concept of scrutinising their performance is not familiar to them ... However, where a GP's livelihood might be threatened by this approach, one can understand the need for sensitive handing."*

Seniority

16. Respondents, in particular representatives of the profession, considered it important that a senior manager, probably at director level, should have lead responsibility for overseeing performance issues within the health authority. This person should be knowledgeable about general practice, although not necessarily a clinician.

17. Health authority arrangements must command the respect and confidence of GPs. A senior lead demonstrates commitment and regard for the profession, underwrites the authority's seriousness about the issues, and enhances access to appropriate resources.

Practical implications

18. The various practical steps described in the guidance either directly enact the principles or are compatible with them.

Principles – ScHARR's suggestions

- establish a framework of principles, in partnership with local professional representatives, to guide your approach;
- as a point of principle, give lead responsibility within the health authority to a senior manager, preferably working at director level;
- ensure that the framework includes commitments about the following:
  - working in partnership with the profession
  - adopting an approach which is supportive, fair and sensitive to the individual GP
  - establishing arrangements which are transparent, widely promoted, well understood and easily accessible by self referral.

Relative performance

7. It was suggested that under-performance may be defined relatively – i.e. as performance which is substantially poorer than that of the majority of GPs. One city health authority said: *"Our definition of an under-performing GP is one whose pattern of performance in a range of key areas is well below the standards achieved by the majority of GPs in the city."* This was also the view of a practising GP who defined under-performance as *"not performing as the average doctor would do"*.

Scope of definition

8. Several respondents urged that under-performance should be defined more broadly than in terms of patient safety and clinical practice. *"This* (said one health authority) *is wider than just satisfying the Terms of Service. We also consider attitude to patients, their commitment to development of a comprehensive range of services, their skills in practice management and their fundholding performance."* Another said they would *"incorporate the four headings used in the Accountability Framework*[12] (for fundholders) – *clinical and professional, patients and the wider public, management, and finance."*

Frequency and severity

9. There was a recognition that under-performance can often be more about repeated failures than single episodes – which in many of the most extreme cases would be dealt with through the GMC's powers around serious misconduct. One respondent reflected that *"everyone does make mistakes; a single mistake is not necessarily 'under-performance'. A definition should include failure to meet expectations over a period of time, or on a number of occasions, or in a number of different fields."*

Definition – ScHARR's suggestions

- adopt a clear but broad definition of under-performance;
- do not be over-preoccupied with detail;
- encompass inadequate knowledge or skills leading to behaviour which places patients at risk;
- recognise the relevance of both clinical and non-clinical dimensions of performance;
- accept that single incidents may not constitute under-performance;
- set the local approach within the context of nationally accepted views on the performance that could reasonably be expected from a GP.

Chapter 4

How do you identify a GP who may be under-performing?

1. During the course of ScHARR's research many measures and sources were proposed as potential indicators that a GP was falling below recognised standards. They can be grouped under the following headings:

   - practice development planning;
   - health authority information sources;
   - formal complaints;
   - informal expressions of concern;
   - patient perspectives;
   - self identification.

Practice development planning and practice visits

2. Many health authorities have, or are in the process of establishing with their professional colleagues, joint frameworks to support general practice development planning. Several saw the planning frameworks as a mechanism not only for stimulating development but also for monitoring performance.

3. South Cheshire Health Authority viewed their general practice planning framework explicitly *"as the vehicle for looking at performance and improving quality"*. The framework has been designed to enhance general practice development and performance in the four areas defined in the NHS Executive's Accountability Framework[12]:

   - clinical and professional;
   - patients and the wider public;
   - management;
   - finance.

4. Within the framework, each practice is expected to produce an annual plan, with support, which is then formally agreed with the health authority. The plan includes objectives, defined by the practice, which are *"intended to focus the attention and energy of the practice"*. Practices are encouraged to monitor their own performance, and progress against the plan is reviewed on a regular basis jointly with the health authority. A senior manager considered that the framework will *"enable problems and solutions to be identified more easily and will be more positive for GPs."*

5. It was argued that the changing role of health authorities, linked to the emergence of primary care as a key area of national policy, has resulted in many more health authority visits being made to practices than ten or even five years ago – including those entailed by formal joint planning. Several health authorities noted that through regular visits managers themselves are able to detect problems, particularly around the organisation of the practice. *"Senior managers in the Primary Care Directorate maintain a programme of regular visits to practices. During each visit, detailed discussions take place regarding practice staff issues including, training and education; development and contractual issues; the suitability of practice premises; target levels; postgraduate training; service development plans; and the range of general medical services available to the practice population"* (a health authority).

6. However a risk is that visits can often be conducted by a number of different staff across a wide range of issues with little systematic sharing or co-ordinated appraisal of the information gathered.

7. The ScHARR Team considers that channels of communication might in some cases be structured more effectively, perhaps by focusing contact with the practice primarily around the practice development planning process, with practice liaison co-ordinated through one lead officer. Ideally the practice plan, led by the practice but constructed jointly, should define clear targets and responsibilities for both the practice and the health authority. It should reflect a supportive approach through which problems can be identified earlier and positive action taken swiftly to prevent escalation.

8. Other sources of information should be handled in the context of the practice planning process.

Health authority information sources

9. Health authorities currently process significant amounts of data relating to practices and individual GPs. The value of this data was recognised by both health authorities and the profession, and most people accepted its potential for indicating that there may be under-performance.

10. Several health authorities explained that they were working jointly with their professional colleagues to identify a framework of indicators which would reflect quality within general practice. This involved setting standards for minimum performance and good practice. A number of these health authorities noted they were keen to apply national standards where they existed, with specific references being made to recognised frameworks of 'good practice' such as:

    - the guidance issued by the Joint Committee of Postgraduate Training (General Practice) setting standards for teaching practices[13];
    - the Royal College of General Practitioners publications *Quality Initiative*[14], *What Sort of Doctor*[15] and *Fellowship by Assessment*[16];
    - the GMC's *Good Medical Practice*[17];
    - the King's Fund Organisational Audit[18].

11. Weightings were often being applied to indicators to reflect agreed differences in importance and priority.

12. A number of health authorities noted that they would be concentrating on using existing data sources well rather than developing new ones. South Cheshire spoke for many when they explained *"we have sufficient information already without the unnecessary distraction of attempting to invent new data-sets"*. This was welcomed by local GP representatives who had expressed concern about possible requirements to collect and provide additional data solely to inform the performance monitoring process.

13. Several health authorities had upgraded, or were seeking to upgrade, their computer capability and centralise their information systems to make data handling easier. In addition to simplifying access to the full range of data items and indicators, health authorities were keen to be able to *"contextualise performance"* (or benchmark it) by comparing individual scores with national, district and locality averages and distributions. The geographical dimension was seen as important in view of the varying demands on GPs providing services to different communities with distinctive local characteristics. A number of health authorities also mentioned that they distribute information routinely to all their practices, showing how the practice is performing compared with other (anonymised) practices within their area, supporting self-audit and development.

14. The indicators or sources suggested by health authorities included:

    - performance against the GP Terms of Service (item of service, targets, PGEA, etc.);
    - prescribing data (PACT);
    - hospital utilisation data (accident and emergency attendances, referrals by specialty);
    - organisation management (staffing levels, staff turnover, training etc.).

15. Single health authority performance indicators alone are insufficiently sensitive to define under-performance but a pattern of deviation from local norms on more than one indicator may provide an important pointer and trigger further exploration.

16. There was particular awareness amongst health authorities of the limitations of performance measures when attempting to distinguish between an individual GP's performance and that of their practice, as most of the data is captured at practice level. It was noted that the performance of an under-performing GP may be masked within a partnership with data aggregated across several GPs.

17. By comparison, single handed GPs are far more exposed as their individual scores and performance cannot be masked by the contribution of other GPs.

18. Caution was expressed about the use of some particular indicators, especially hospital referral data. While it is widely accepted that rates of referral provide little or no indication of the appropriateness of referrals[19,20], one Regional Director of Postgraduate GP Education ventured that *"major deviations are significant and should warrant further investigation"*.

Formal complaints

19. There were mixed views about a reliance on complaints as an indicator of poor performance. Following the introduction of the new complaints procedures, with the emphasis much more on practice arrangements for handling the initial complaint, most health authorities have reported that the number of complaints reaching their attention in detail has dropped significantly. They receive information only about the numbers of complaints dealt with at practice level.

20. There was also a recognition that the incidence of complaints is not influenced only by the actual performance of the GP, and that a range of other factors such as patient empowerment and better patient education and understanding play a part.

21. *"Complaints may appear to be a useful area (said one health authority) but they may reflect the patient's expectations of service. That is practices who consistently provide a poor service may produce low expectations in their patients and therefore they do not complain whereas a good practice may receive complaints if their service falls below their normally high standard."*

22. Basing an overall judgement on an individual complaint was seen by most health authorities as unsound, although they accepted that the severity of an allegation could sometimes be decisive. It was considered very important to distinguish between complaints which had been upheld and those that were dismissed. The general view was that trends in complaints might indicate a problem and trigger further enquiries.

23. Several GP representatives highlighted the devastating effect a complaint can have on a GP, noting that complaints are not only a possible manifestation of under-performance but also a potential cause. While the profession has very much welcomed the new procedures, it was suggested that complaints, whatever their outcome, tend to lower morale and often lead to defensive practice. Support and rehabilitation at this stage can be crucial in maintaining standards.

Informal expressions of concern

24. Several health authorities referred to the 'richness' of information which people communicate informally about GPs. The following were identified by health authorities as potential sources of information:

- patients, carers and community groups;
- primary health care teams, particularly community nursing staff;
- staff of other agencies, e.g. social workers, voluntary workers;
- other GPs, including partners, the LMC, educationalists;
- health authority staff;
- secondary care clinicians and managers;
- relations of the GP.

25. Some concern was expressed about the use of information from sources who were not prepared to register their views formally. However it was accepted that, for a variety of reasons, people are often understandably uncomfortable about making a formal complaint about someone with whom they have to maintain a close working relationship. This is true in particular for the GP's partners, and staff who may be directly employed by the GP.

26. While a number of health authorities and professionals considered it inappropriate to include such information in approaches to under-performance, there was a balance of professional and managerial opinion that it does constitute a legitimate trigger for further investigation.

27. *"Where a concern was raised verbally it would be appropriate to look closely at 'hard' information such as performance indicators in an attempt to validate the concern"* (a health authority manager). *"You have got to work with soft information because it may be too late when it becomes hard"* (a GP Representative).

28. Some health authorities who had come to this view had identified the need to establish more structured processes, external and internal, to capture this intelligence effectively – but with a sense of balance.

29. Many health authorities have adopted locality management arrangements, and locality managers were seen as key players, naturally gathering 'soft' information from local communities, community health service staff (nurses, mental health professionals), local authority staff and the local voluntary sector.

30. A number of health authorities recognised that many officers throughout their organisations interact either directly with GPs or with bodies who relate to GPs. They saw a need to ensure communication channels were established and clear in order for all staff to be able to contribute their understandings – positive as well as less so.

31. Several health authorities suggested it was important that local arrangements do not encourage an 'open season' on GPs, but that *real concerns are captured effectively*, and then *dealt with appropriately:* there is no room, several thought, for unprincipled or indisciplined reporting.

32. A communication loop should be established to ensure feedback to the original source. This would *"discourage the propagation of scurrilous rumours"* (a health authority), but also ensure the health authority was seen to be dealing fairly with the issue and not shielding GPs inappropriately. In addition it was pointed out by a GP representative that it was important to safeguard the identity of the person disclosing the information.

Patient perspectives

33. Patient views will feed into this process both through the formal complaints route and through informal expressions of concern. However there were suggestions, mainly from GPs themselves, that more proactive approaches to securing patient views should be employed. One GP noted that *"Patients should be the judge of practice. It should be possible to survey a random selection of patients when assessing a practice"*.

34. But others expressed their caution about the value of using patient surveys to identify GP under-performance. It was suggested that satisfaction surveys may often deliver high recorded levels of patient satisfaction, almost irrespective of actual quality. Moreover a number of GPs mentioned that patients can sometimes collude with poor practice to get what they want (drugs, sick notes, hospital referral etc.) rather than challenging or reporting it.

35. A middle view was that good patient surveys, despite their pitfalls, may help the practice to identify areas for development, in addition to potentially highlighting areas of concern.

Self identification

36. Several health authorities mentioned that GPs who are experiencing problems occasionally contact the health authority directly in order to seek support. One health authority made reference to a single handed GP who was feeling isolated and wished to shadow other GPs in order to support his own professional development. Other health authorities mentioned GPs who had contacted managers with concerns about their abilities to cope or with anxieties about their health.

37. It was however accepted that it was very rare that a GP would first share concerns about their own performance with their health authority. For this to be seen as an appropriate step for GPs to want to take, several health authorities felt they would need first to demonstrate that their approach was informed and *"supportive of general practice"*. Health authorities saw self identification as a medium to long term aim, reflecting an incremental process of demonstrating the value of the support that they can offer.

38. It was suggested by many health authorities that the locality approach to developing closer working relationships with general practice may help to remove barriers and encourage greater openness. While some members of the profession agreed that locality organisation and processes were helping to facilitate the building of relationships, several bodies such as the GMSC felt it was equally if not more important for the GP to know that they could approach individual very senior managers or senior professional colleagues, sympathetic and knowledgeable about their plight, and able to deliver a package of support.

Health authority overview

39. Despite the declarations by health authorities about their commitment to fair and transparent arrangements, there was concern and almost resignation from many professionals that health authorities believe they know who the poor performers are and will use the new GMC arrangements and other performance management approaches simply as a way of *"sorting out"* – almost settling scores with – these GPs.

40. Within this context of suspicion and anxiety, it is important that health authorities should establish procedures (see Chapter 9), including systems of identification, which are developed with the active involvement of the profession and are consistent and equitable in their application. Personal views, not based on clear criteria or on the information sources described in this section, have no place within these arrangements.

Identification – ScHARR's suggestions

- establish a practice development planning process which acts as a stimulus for development, a focus for dialogue and an effective mechanism for monitoring performance;
- adopt a broadly-based, circumspect approach to indicators of under-performance;
- do not put too much reliance on any one measure or source, but ignore none of them;
- in particular, develop a convention for dealing with informal expressions of concern which acknowledges their value but demands responsible, ethical interpretation and management;
- work at a culture of informed supportiveness, including at the most senior levels, which commands confidence and trust.

Chapter 5

How do you reach an understanding of why a GP is under-performing?

Responding to variety

1. The previous chapter outlined the various sources of information which might indicate that a GP was under-performing. Identification is obviously important but of itself unproductive. There also need to be mechanisms for establishing the underlying causes.

2. One health authority noted that *"Only by understanding the underlying cause or causes can one hope to start to improve performance"*. Another suggested *"you need to be experienced and sufficiently knowledgeable about the potential causes to look for the right clues"*.

3. Sir Donald Irvine, the President of the General Medical Council, wrote recently (with characteristic directness) *"Some doctors seriously breach accepted standards of professional conduct and practice. Others become ill without recognising the consequences for their patients. Yet others show evidence of a pattern of poor practice, the causes of which include professional isolation, complacency, arrogance, idleness and simply losing touch"*[21].

4. ScHARR's discussions and survey work have left a clear impression that health authorities will need to achieve considerable sophistication in understanding why things are going wrong in the case of individual GPs. There is a risk that inaccurate or oversimplified understanding of the issues may lead to inappropriate, wasteful and counterproductive interventions. If for example the underlying problem for a GP is stress related to relationships between practice partners, and this has interfered with his or her ability to keep in touch with professional developments and resulted in poor clinical work, an educational intervention as the first and only response is quite likely to make things worse. The interpersonal issues may need to be addressed first as a way of preparing the way for successful learning.

5. An indication of inadequate diagnostic work might be a lack of variety in the way GPs recognised as under-performing are supported. Even where the manifestations of under-performance are similar the causes are likely to vary – and so therefore should the chosen interventions if they are to address the issues in a tailored way.

6. It is obviously impossible here to capture all the potential causes of under-performance and the ways in which they may interact with each other. A number of suggestions (which are not mutually exclusive) were however made in health authority survey responses, including:

   - poor preparation for general practice;
   - isolation from both professional colleagues and management;
   - lack of involvement in continuing education;
   - problems of physical health;
   - mental health problems, including addiction or alcohol abuse;
   - stress related to work or domestic circumstances;
   - low morale;
   - poor practice infrastructure and insufficient resources;
   - excessive workload;
   - poor relationships within a practice;
   - inappropriate or complex relationships with patients;
   - especially tragic or upsetting patient experiences;
   - an unsupportive or inappropriate attitude on the part of the health authority;
   - attitudinal problems on the part of the GP.

7. The need for clarity about causes as a basis for properly chosen and targeted intervention has the important implication for health authorities that those responsible for performance issues should have a genuinely strong understanding of the general practice environment and the concerns of GPs.

Diagnostic tools

8. While a majority of health authorities took the view that an understanding of the issues in play could be achieved through conventional discussions with a GP, a few concluded that a more structured diagnostic approach was required. It is interesting and significant that the North West region learning sites, where there has been a good deal of focused thinking and discussion, were more likely than health authorities in general to favour this approach.

9. Morecambe Bay Health Authority, in collaboration with their LMC, has developed a diagnostic checklist which covers all aspects of general practice. The checklist is used by their GP Facilitator, during practice visits, as a prompt to ensure consistency and as a tool to identify areas of need or deficiency.

10. One health authority medical adviser said that in addition to talking with a GP, there may need to be a more thorough investigation of his or her practice, which might include options such as reviewing a sample of case notes and looking at the appointment systems. The medical adviser considered the analysis of case notes to be *"a useful test of the GP's awareness of their responsibilities"*.

11. Other health authorities were considering using existing assessment tools or frameworks for 'good practice' such as those mentioned in Paragraph 10 of Chapter 4. A number of educationalists and medical advisers, favoured the assessments applied to the accreditation of training practices[13].

12. It was noted by many including the RCGP that caution should be applied when employing these tools to identifying and assessing under-performing GPs, since they were developed primarily to recognise good or exceptional practice. If standards are to be used they might need to be adjusted sensitively to reflect the difference of purpose and expectation, with the involvement and agreement of the profession locally.

13. When focusing down in detail on the specific cause of a problem, it was suggested that a single diagnostic tool is likely to be insufficient to establish that a GP's performance is inadequate, and that it is safer to rely on evidence which is supported by more than one assessment instrument.

Diagnosing the underlying causes of under-performance – ScHARR's suggestions

- there may be many complex reasons for GP under-performance;
- the reasons may differ from instance to instance, even where the manifestations of performance problems are similar;
- if interventions are not to be ineffective, wasteful or counterproductive they should be tailored to the case;
- therefore, take steps to ensure that diagnostic work with under-performing GPs is sufficiently sophisticated to identify the underlying problems;
- put the responsibility in the hands of senior people who have an excellent understanding of general practice;
- consider the use of structured diagnostic frameworks to supplement more conventional discussion.

Chapter 6

What interventions should be considered to support GPs who are under-performing?

Improving performance

1. Securing improvements in performance is recognised as difficult and often time consuming[22]. It was suggested by a health authority manager that improvement is most likely to happen when there is *"a recognition by the GP of the need to change and a willingness by the GP to undertake actions which bring change about"*.

2. A health authority medical adviser suggested that the introduction of the GMC's new powers would be *"useful in securing the attention of the GP"*, suggesting that this in itself would be a driver for change. This may be true but it is clearly not sufficient. Almost every respondent has recognised that establishing a productive change process requires skill on the part of those working with the GP to identify the personal issues and respond to these with appropriate interventions and support, designed to improve performance.

3. As there are many reasons why a GP may be under-performing so there are many approaches which may be used to support GPs whose performance gives cause for concern. This section of the report provides ideas and examples of different types of interventions and support, drawn from the ScHARR research.

Support packages and action plans

4. An exploration of the literature[22] and the views of some educationalists and GP representatives advanced during the research, suggest that one-to-one contact, in particular with respected peers, can be especially effective in influencing behaviour. However it is also widely acknowledged that because the underlying causes of under-performance will often be several and complex, no single approach is likely to deliver the necessary improvements in performance: rather a package of support and interventions will be required.

5. Many health authorities said they envisaged that the range and type of interventions and support being offered, and the improvements expected from the GP in return, would be expressed in the form of an action plan or contract between the health authority and the GP.

6. The types of interventions and support identified through this project can be categorised into three main groups:

   - education, including mentoring;
   - measures to improve practice infrastructure;
   - steps to address health issues.

Education

7. Where a GP was identified as having shortfalls in his or her professional skills or knowledge, or in their application, it was generally expected that they would benefit from a package of remedial or additional training (with the caveat expressed in Chapter 5, paragraph 4).

8. It was suggested that when an educational need was identified the GP should be referred to an educationalist (independent of the general assessment process described in the management model in Chapter 9). A number of people identified the Regional Director of Postgraduate GP Education as the appropriate person to refer to in the first instance, as the person best placed to access educational resources (funding, as well as other educationalists) within the patch.

9. Several of the current incumbents of this regional role, when the ScHARR Team met them, suggested it would be important for health authorities to talk with their own Associate Advisor and their local Regional Director of Postgraduate GP Education to come to a general understanding about local arrangements for supporting GPs whose performance gives cause for concern. This would include establishing:

   - criteria for referral to a named educationalist;
   - clear assessment procedures;
   - arrangements to support the construction of personal learning plans;
   - access to a range of education and training interventions;
   - mechanisms to evaluate the success of these interventions.

10. Following a referral and assessment identifying deficiencies in either skills, knowledge or application, it was suggested that the GP educationalist should agree with the GP a personal learning or professional development plan to address these deficiencies. Several health authority managers suggested this plan should also be agreed with the health authority as the body responsible for overseeing the process and as a potential co-resourcer (see Chapter 7).

11. A number of people said the plan should be tailored to the individual's needs, geared to rehabilitation, and include specific outcome measures to aid evaluation. One Regional Director of Postgraduate GP Education noted that *"the prescription for each case will be different and the training should be tailored accordingly. Education should not be time serving but should be shown to meet pre-determined objectives."*

12. During the course of the research, the attention of the ScHARR Team was drawn to many interesting approaches to education and training. In addition to the more conventional PGEA accredited courses, the following were also identified as being potentially relevant:

   - action/portfolio based learning sets for small groups of GPs to learn together, reducing isolation and encouraging mutual support;
   - secondment schemes to enable a GP to gain practical experience, knowledge and skills from 'shadowing' respected peers in a 'real' environment;
   - visiting GPs with appropriate experience providing practical training and support to an under-performing GP in their own surgery;
   - GP induction schemes aimed at newly qualified GPs or returners could also be appropriate for the isolated under-performing GP;
   - practice based multi-disciplinary training aimed at improving practice cohesion and communication;
   - computer based interactive training packages;
   - management training for GPs;
   - audit groups to support more effective care through audit and reflective learning.

13. These initiatives reflect research into GP needs and preferences concerning their education[23], which has shown that GPs in general prefer and respond best to education which is:

- close to the practice;
- in small groups of respected peers;
- with personal contact and active participation;
- reflecting on and reviewing performance;
- offering new information or skills;
- aiming to reduce uncertainty and elevate the status of their work.

14. A note of caution is appropriate however. Stanton and Grant's recent review of continuing professional development in general practice[24] pointed out that *"evidence suggests...individual doctors vary considerably in their preference for different learning methods. These preferences must be taken into account rather than adopting a rigid view of how doctors 'ought' to learn."* Response to variety, based on sound assessment, comes across again as an issue not just for the targeting and content of remediation approaches but also for the learning methods they rely on.

15. The notion of *mentorship* featured significantly in the thinking of management and the profession as a vehicle for one to one training and as a way of supporting a GP through the whole process of rehabilitation.

16. Although mentorship can take a variety of different forms, it was suggested that the key features of the mentoring role in supporting GPs whose performance gives cause for concern were:

- providing the GP with protected time in a confidential context;
- supporting the preparation of a personal learning plan;
- helping the GP to apply their previous knowledge to present tasks;
- offering help in identifying barriers to development, including the formulation of solutions;
- providing personal support for an individual's professional development.

17. While it was generally considered that the mentor should be a respected peer, views varied on who was the most appropriate type of mentor for this group of GPs. It was suggested that GP Trainers and CME Tutors had the appropriate skills to be mentors. However it was also noted that in some areas the Trainers may be significantly younger than the GP identified as needing support. One suggestion from the profession was for older GPs to be trained specifically for the role, providing mentorship services to under-performing GPs across a number of health authority areas to ensure a large enough pool for the subject GP to make their selection.

18. Whatever the choice in terms of mentor, it was suggested that the key skills identified for the mentor's role were that they should be credible, respected, facilitative, empathic and have a broad knowledge of the support available to GPs. Selection, preparation and ongoing support for the role were considered essential[25].

Measures to improve practice infrastructure

19. Under-performance may be attributed to an underdeveloped practice infrastructure[10].

20. A number of health authorities acknowledged that GPs can be severely hampered in the range and quality of services they provide by the limitations of their surgery premises. It was recognised that small, cramped accommodation inhibits the provision of the type of primary health care service expected in the 1990s. Health authorities were clear that they had a responsibility to support GPs in developing their premises, which included help with design, planning and funding.

21. Similarly, it was recognised that a GP working without access to appropriate levels of support staff would also find it difficult to provide an adequate level of service. Several health authorities mentioned specifically the contribution which a practice nurse can make, but there was also a recognition that administrative and clerical staff play a valuable role in releasing the GP to practice more effectively. Many health authorities acknowledged they had a responsibility to support the GP not only by making reimbursement available, but also by helping with recruitment and staff training and facilitating the adoption of practice based personnel policies.

22. One Regional Director of Postgraduate GP Education noted that *"it's not just doctors that perform badly, it's whole practices"*. Another, Dr Bob Hedley, based in the Postgraduate Office in Nottingham, agreed that performance is undermined where teamwork is poor. In response his office has developed a 'total facilitation service' aimed at assessing the performance of a whole practice across a wide range of areas, identifying development needs and providing training to meet these needs. The training is practice based and multidisciplinary, which Dr Hedley believes helps practice cohesion and communication, so improving performance.

23. The value of multidisciplinary learning was also recognised and supported by a number of health authorities, who were either running, or in the process of developing, practice based educational programmes.

24. The view that GP performance is enhanced by efficient practice management[26] was widely endorsed by health authority managers and members of the profession. The converse was also noted in that some GPs may be poor managers themselves or their management arrangements may be poor, either of which could be reflected in inefficient or ineffective patient care.

25. Measures to support improved practice management suggested by health authorities included:

    - management training for GPs;
    - the appointment of practice managers to practices without a manager;
    - training programmes for practice managers;
    - practice manager support groups;
    - pairing practices to learn from each other;
    - respected practice managers working with other practices experiencing organisational difficulties.

26. The role of the practice manager was seen as a key feature of modern general practice, one health authority manager explaining that *'a good practice manager can lift so much of the administrative and management burden off the shoulders of a GP, releasing the GP to be more effective in their clinical role'*. Several health authorities believed they had responsibilities to help GPs to recruit good quality managers, and to support practice manager development through training and networking.

27. In recognition of the management difficulties often experienced by single handed or small practices, Manchester Health Authority has established a Small Practice Advisor Scheme. This involves two very experienced practice managers working with a number of small practices to support them in their practice organisation.

Health

28. Poor physical or mental health can severely impair the performance of a GP[10]. Many within the profession did however draw attention to the reluctance of GPs to access health services available to the general public. It was suggested that GPs often feel that they have a responsibility to take care of themselves, but that being *"objective about one's own health is impossible"* (a GP). In addition, it was claimed that, because of their position as *"guardian of other people's health"* (a GP), GPs are particularly sensitive about the perceived stigma of being seen by patients or colleagues to have a health need, particularly where this relates to mental health or addiction problems.

29. Several people highlighted the difficulties associated with GPs registering for general medical services. In particular, the potential conflict of interest arising from a GP being registered with their own practice was identified, especially where a period of absence due to sickness might impinge on the workload and finances of the GP's partners. For this reason the GMSC and some health authorities encourage GPs to register with a practice other than their own.

30. One health authority medical adviser said that when he encountered a GP whose under-performance could be attributed to sickness, he would usually encourage them to visit their own GP and would follow their progress informally (with the GP's consent).

31. The idea of care and support away from the immediate area, avoiding the GP's own patients and colleagues, was considered important by many within the profession even where this might necessitate an extra contractual referral by the health authority.

32. One health authority and their LMC had reached a joint agreement that any GP identified as potentially under-performing due to ill health could be referred for a private 'out of area' consultation paid for by the health authority. This was considered to be an independent and confidential arrangement which was sensitive to the GP's needs, but also safeguarded the patients' interests.

33. The GMSC has recently revised its guidance to LMCs on a model scheme to help GPs who are sick and this is a valuable source[27].

34. As independent contractors, GPs are responsible for their own health care but many within the profession believe strongly that GPs should have recourse to an *occupational health scheme* specifically geared to the needs of GPs. The GMSC will shortly be publishing a report aimed at encouraging health authorities and LMCs to establish local schemes. GPs as employers have a responsibility for the occupational health of their employees, and since their own performance is intimately linked to that of the practice team it is important that they address it positively, and are supported by the health authority in doing so.

35. The mental toll of providing care on a long term basis has been identified as a potential source of GP 'burnout' and counselling initiatives have been proposed as the appropriate responsive measures[28]. In addition to the BMA's well respected National Counselling Hotline, several health authorities referred to their own local arrangements to support GPs through the provision of dedicated counselling.

Interventions and Support – ScHARR's suggestions

- be aware of the wide range of potential interventions that may be available in terms of education and mentoring, the improvement of practice infrastructure and measures to deal with ill-health;
- interventions and support should be tailored to the needs of the individual GP;
- in most instances a package of support and interventions will be required which should be specified in an action plan or learning contract, together with the improvements in performance expected from the GP;
- individual GPs, as well as having different problems to contend with and therefore different plan content, may also have natural preferences in terms of learning methods and these should be taken into account;
- consideration should be given to the role of a mentor in supporting the GP through the process of rehabilitation.

Chapter 7

How do you resource the support to GPs whose performance gives cause for concern?

General

1. Many health authorities had recognised that there would be no additional funding provided centrally to support work with under-performing GPs – including those for whom GMC referral cannot be avoided. However, it was acknowledged that resources would be needed to:
   - establish and run the assessment process described in Chapter 9;
   - support individual GPs in taking forward the recommended action from the assessment.

2. Several health authority officers suggested that they would need to make the case for additional resources within their own authority. A number of managers explained that they would be seeking to establish support for poorly performing GPs as a priority for the use of available growth monies.

3. Two health authorities said they intended to audit the current use of resources in support of under-performing GPs including staff time. This would identify what is available and open the way, at least to some extent, to reprioritisation. One of the health authorities planned to involve their Regional Director of Postgraduate GP Education and LMC so as to achieve a shared understanding of all the resources available to support GPs in the area.

4. A number of health authorities acknowledged that cash limited General Medical Services (GMS) funding was distributed disproportionately and perhaps inequitably amongst practices. Some could see a case for some gradual redistribution in favour of practices experiencing performance problems.

Resourcing the assessment process

5. In general, health authorities considered that the overall officer contribution to new performance-related arrangements would not necessarily have to change significantly, although there would need to be some refocusing around a more defined and formal process. They considered that the same might apply to the involvement of GP educationalists and LMC members. While several educationalists did express anxiety that they were not resourced for this type of work, LMC representatives generally accepted that supporting struggling GPs was part of their role and therefore involvement in the process was a legitimate call on their time.

Resourcing support arrangements for individual GPs

6. Under the GMC's new performance procedures the onus of meeting the costs of remedial training rests with the GP. In the wider context of work with GPs whose performance gives cause for concern, health authorities tended to agree that training costs should be met by the GP but several also indicated that they were prepared to help. Some felt a 50% split would be appropriate.

7. *"While GPs have a responsibility to support their own professional development, we also have a clear responsibility to support primary care development which includes support to individual GPs."* This health authority manager reflected a more widely held view that work with under-performing GPs is part and parcel of practice development work in general, not qualitatively different from it.

8. A number of people, including managers, GPs and educationalists proposed that an individual GP might be expected to set all or part of their Post Graduate Education Allowance (PGEA) against the cost of retraining. Others expressed opposition to this suggestion on the grounds that the allowance should be used for continuing medical education (CME) rather than remedial training. The ScHARR Team are clear that the wording of Section 37 of the Statement of Fees and Allowances is sufficiently flexible to enable Directors of Postgraduate GP Education to accredit remedial training towards PGEA and believes that this should become accepted practice.

9. There was a recognition that GPs, particularly single handed GPs, will require support to run their practice so they can be released for training. Several health authorities suggested that they would consider contributing to the cost of locums.

10. Many health authorities accepted they had a responsibility to support GPs in developing their practice staffing structure, particularly where it was hindering the provision of services. However they were all anxious that – in line with established practice – the GP should take some responsibility in contributing to costs.

11. However several health authorities said that with the agreement of their LMCs they had contributed 100% reimbursement for peripatetic posts working across a number of practices. These included specialist practice management advisers working with small practices or practices needing support with their organisation

Resources – ScHARR's suggestions

- conduct an audit, with the LMC and others, to identify how resources are currently being used to support general practice performance and what opportunities there may be for refocusing them;
- the GP might be expected to fund remedial education and training, but consider funding cover arrangements to release the GP;
- be prepared to contribute to developments in practice infrastructure – premises, staff and staff training – where these contribute to under-performance.

Chapter 8

How would you evaluate the success of your approach?

Evaluating individual GP performance following intervention

1. In attempting to improve the performance of individual GPs, several people acknowledged the importance of setting clear objectives within the action plan both to focus the attention of the GP and to enable the GP's performance to be reassessed following any action.

2. During the course of ScHARR's research, it was suggested that objectives should:

   - be individualised;
   - relate specifically to the identified areas of concern;
   - be measurable;
   - be based on outcomes rather than inputs wherever possible;
   - be understood by all parties involved;
   - have defined timescales for completion and review.

3. It was noted that certain areas were more amenable to monitoring than others. Where under-performance was attributed to lack of knowledge, skill or understanding and a course of training was recommended, it was suggested from several quarters that this should be followed up with some formal testing. Where poor performance was a consequence of ill health and the GP was under supervision of another health professional, there would be a clear duty on the health professional to allow the GP to return to practice only when they were clinically fit. Where attitudinal issues are involved in under-performance the measurement problems are greater.

4. Several health authorities emphasised the need to measure progress and change in terms of the information sources which contributed to identification and diagnosis. Some went on to say that the same caution had to be exercised in interpreting information as evidence of actual change as in interpreting it as evidence of the need for change.

5. The point was made that performance gains made in the short term can also be short lived. There may in some cases need to be monitoring approaches which operate over a longer time scale.

Evaluating the process

6. A number of health authorities, particularly the Learning Sites in the North West, indicated their determination to review their own arrangements for supporting under-performing GPs. This included:

   - piloting procedures with volunteer GPs in advance of implementation with GPs believed to be under-performing;
   - post-implementation monitoring of the process.

7. Several learning sites were testing their assessment procedures by conducting visits to volunteer GPs. While this was recognised as no substitute for visiting a perhaps reluctant under-performing GP, it was considered that the pilots would enable authorities to:

   - iron out obvious flaws in their approach;
   - test the appropriateness of any diagnostic tools;
   - enable key staff members to gain experience in a 'safe' environment.

8. A number of health authorities considered it would be important to continually check whether a process, once operational, was successful in identifying under-performing GPs, diagnosing their problems and ultimately achieving improvements. One health authority suggested that in addition to monitoring the performance of GPs against the objectives set out in the action plans, they should also check with individual GPs to understand the approach from their perspective. This would include asking them to suggest ways of improving it.

9. Another health authority officer was keen to commission an independent study into the effectiveness of their own approach, currently being developed. She considered it was important to be able to demonstrate that their approach was supportive, believing that this might encourage GPs who are struggling to maintain standards to contact the health authority for help and assistance.

Evaluation – ScHARR's suggestions

- set clear objectives in the action plan both to act as a focus for the GP and to enable the GP's performance to be reassessed following any action;
- objectives should be:
  - individual to the GP
  - relate specifically to the areas of concern
  - measurable, as far as possible
  - based on outcomes wherever possible
  - be understood by all parties involved
  - have defined timescales for completion;
- consider piloting an evolving approach with non-live cases;
- consider methods of evaluating the authority's approach on an ongoing basis, including securing feedback from subject GPs themselves.

Chapter 9

How would you establish an overall management process for working with GPs whose performance gives cause for concern?

1. The previous sections have focused in detail on separate elements of work with under-performing GPs – identification, diagnosis, intervention and so on. Health authorities charged with offering support to under-performing GPs will need to put in place a clear overall management process which links the elements together in an effective, comprehensive approach.

2. The following proposed approach has been distilled from ideas advanced by a large number of health authority managers and members of the profession. It is meant to serve as a practical framework for developing local approaches to supporting GPs whose performance gives cause for concern.

3. The approach will hold few if any surprises for health authority managers and is a natural extension of good management practice in other areas of work.

Health authority lead senior manager

4. The ScHARR team is convinced that there should be someone senior (at director level) with clear responsibility for managing this area of performance work within the health authority. The person should be knowledgeable about general practice although not necessarily a clinician, and command (or quickly secure) the obviously essential respect of the profession.

5. This person would be responsible for co-ordinating the practice development planning and information sources described in Chapter 4. They would have arrangements in place for routinely reviewing performance indicator data and would be the 'assembly point' for other concerns and information about performance.

6. Where the data or a concern implied possible under-performance, this senior officer would need to make a decision on an appropriate initial response. A number of health authorities noted that many of the concerns arising can be dealt with informally at this stage by the health authority alone, usually through a low profile practice visit.

7. One health authority manager was keen to note that indicators of poor performance should not be seen as *"...cut and dried: it is important for senior managers to adopt a mature and comprehensive approach by sharing concerns at an early stage with GPs, talking with them to establish what the underlying problems might be, and working with the GPs on ways in which to address the problems"*.

LMC lead

8. Where the level of concern was relatively high, a number of health authorities suggested that the health authority lead officer should contact a nominated member of the Local Medical Committee (LMC) to seek their view. It was proposed that the nominated LMC member should have an ongoing responsibility for this area in order to build up expertise around the process and also develop an effective working relationship with the health authority lead.

9. The two would meet to consider the issue, with supporting information provided by the health authority – including practice profile information built up from the performance indicator data. Based on the information available, they would decide whether it was appropriate to continue with an informal approach (through one or the other, or together) or whether it was necessary, because of the grounds for concern, to adopt a more formal approach. It might be that informal contact would in turn yield additional information which strengthened the level of concern, tilting the process in the direction of the formal. If a formal approach was necessary the two would call a meeting of the Support Panel.

Support Panel

10. Several health authorities had reached the decision to establish a group of people, drawn from health authority senior managers, the LMC and GP education, to be responsible for:

    - reviewing concerns about individual doctors;
    - assessing a doctor's individual needs;
    - supporting their rehabilitation through appropriate action;
    - evaluating the success of the action.

11. Reflecting the essence of the group's role, one health authority referred to it as a Support Panel.

12. The Mersey Group of Health Authorities were looking to establish a Panel in each of the four constituent health authorities. Each would include two health authority managers (one non-clinical, the other the medical adviser), two LMC members and an educationalist. Manchester has a panel – again with representation from the LMC, the health authority and GP education (Postgraduate Adviser and GP Tutor) – but also including a CHC representative and an independent (non-LMC) GP.

13. Some GP educationalists have registered concern about being involved in the identification and general assessment of GPs whose performance gives cause for concern, suggesting they should have an independent role within the process, geared solely to the support of a GP once identified and assessed. Others have agreed that while it might be more appropriate for the educational support or intervention itself to be provided independently of the assessment process, it was nevertheless desirable to have an educationalist involved in the assessment stages for their 'distinctive' analytical skills and their ability to assess whether a GP would benefit from educational support.

14. There was a suggestion from the Overseas Doctors' Association (ODA), that an ODA member should also be on the Panel to reduce concerns about racism. The ODA is represented in most LMCs, so there are opportunities for one person to cover both aspects of the role. It was also recognised that in certain areas doctors from minority ethnic backgrounds might have separate arrangements for representation which should be considered within the local process.

15. Presented with information that a doctor may be under-performing, the Panel would need to make a decision on what action to take. Depending on the information, it might choose one of the following options:

    - consider there was insufficient cause for concern and decide that no action was necessary;
    - the same, but with a review scheduled for a point in the future;
    - consider there was some cause for concern but that it should be dealt with informally;
    - consider there was sufficient cause for concern to initiate a formal practice visit;
    - in rare circumstances, consider that the evidence was so overwhelming that the GP should be referred directly to the GMC.

16. If the health authority lead manager and their LMC colleague had done their job well, there would be few doctors at this stage for whom the first three options would be appropriate. Equally, immediate referral to the GMC would be rare. In the majority of cases, the appropriate course of action would be to visit the GP, normally at the practice but exceptionally elsewhere.

Composition of the Visiting Team

17. There was general agreement from health authorities pursuing this approach that the Visiting Team should be drawn from the Support Panel and should comprise a minimum of two people, with a maximum of three. There needed to be sufficient numbers to ensure a balance of expertise and opinion, but more than three was considered unnecessarily intimidating for the subject GP.

18. One health authority manager suggested that *"the Visiting Team would consist of two people from the Panel, chosen on the basis of their knowledge of the particular area of concern."* Others considered that a team of three, including a health authority senior manager, an LMC member and a GP educationalist would be more appropriate. In this model it was argued that the senior manager should be a non-clinician, acting almost in the capacity of a GMC 'lay assessor'.

Contacting the GP

19. A number of health authorities acknowledged that the first contact with the GP should be handled particularly sensitively. It was suggested that a personal telephone call by one of the Visiting Team was the most appropriate approach. The purpose of this first contact would be to:

    - set out the broad areas of concern;
    - clarify the process;
    - emphasise the supportive intent;
    - secure a date and venue for the visit;
    - clarify where the GP would like any correspondence to be sent.

20. This conversation would be followed up immediately by a letter sent to the address of the GP's choice. One health authority suggested that a proforma or checklist with the details (an agenda for the visit, in a sense) should be enclosed with the letter and the GP asked to complete and return some form of confirmation of understanding and agreement.

21. Some GPs might refuse to meet with the Visiting Team or be unwilling to address any concerns around their own performance. Several health authorities acknowledged that it was natural for a GP to have reservations about the process. In such cases, through its most appropriate member, the Visiting Team should attempt to allay the GP's fears as far as possible by emphasising strongly that the intention was to try and understand the nature of the problem and agree a programme of help and support which would enable the GP to re-establish satisfactory practice. If the subject GP refused resolutely the Team, as one health authority manager said, would have *"no choice but to refer to the GMC"*.

GP friend/supporter

22. Several people recognised that a GP might well feel vulnerable, isolated and agitated on receiving first news of performance concerns. They might wish to have 'independent' support to help them through the process – including preparation for the visit, during the visit itself, and through any programme of action or rehabilitation. The right to this kind of support should be made clear during the initial telephone conversation and reaffirmed in the follow-up letter.

23. It was generally considered that the GP's friend or supporter should be another practising GP on the basis that they would empathise and understand the issues. But views differed on how the support person should be identified.

24. Some respondents believed that the subject GP should be able to choose any GP to act as their friend, others that the GP should only be able to make their choice from an approved panel. Membership of the panel would be based on having gone through an interview and specific training for the role. The ScHARR Team's clear view is that the subject GP should be free to choose anyone they wish to support them, but that a list of appropriate GPs should indeed be formed and held by the LMC as a resource for subject GPs to consider.

25. The ODA represented particularly that it was important for a GP from a minority ethnic community to have the right to choose a friend from the same community.

26. Several people remarked that the role of the mentor (described in Chapter 6, paragraphs 15 – 18) and that of the GP's friend/supporter potentially overlap. Although the skills required would be similar, it might make sense for the roles to be considered distinct, with the friend/supporter concentrating on helping the GP through the process and the mentor specifically supporting and contributing to educational and rehabilitative measures.

Focus of the visit

27. During the visit, the Visiting Team would:

    - explore their concerns with the GP;
    - attempt to diagnose the causes of the problems identified;
    - try to agree a way forward.

28. From the research, and particularly the experience of the learning sites, the ScHARR Team consider that this would best be achieved with the aid of a diagnostic checklist, developed and agreed with the profession locally but based on nationally recognised frameworks of good practice.

29. A number of health authorities felt that there may need to be more than one visit, suggesting that at the first meeting the Visiting Team would attempt to secure from the GP a recognition of the problem and a general commitment to working together to tackle it. Subsequent meetings would deal with the issues in more detail and might involve a range of people with specific skills, e.g. a prescribing adviser.

30. In responding to the range of problems which might be identified there would need to be the possibility of a referral on to 'independent' specialist advice and skills. For instance, where an educational need was identified many health authorities were clear that the Team would seek advice from an educationalist.

Action plan/contract

31. At the appropriate point the Visiting Team would prepare a draft action plan with the GP.

32. The Visiting Team would produce a report for the Support Panel, giving their findings and proposing the action plan – with outline costings – for agreement. Because all the key stakeholders would be represented on the Panel, it would be in a position to assess, commit, mobilise and co-ordinate the relevant available resources (including understanding, time, people, funding, and support systems). The Panel would agree a support package only on the basis of what was affordable, within the context of all other priorities.

33. The Panel would negotiate and agree a written contract with the GP, embodying the action plan, specifying the responsibilities of both sides and detailing clear objectives with defined timescales to enable the action taken to be evaluated.

34. Clearly, for a process of this kind to work well, there needs to be one person responsible for overall co-ordination and the ScHARR Team consider that this should be the health authority senior manager on the Visiting Team, with appropriate support.

Evaluating performance and deciding further action

35. Evaluation would be focused on progress made against the GP's performance objectives as set out in the plan and contract. The senior manager would prepare a report on progress at appropriate points in consultation with all involved including colleagues from the Visiting Team. This would form the basis of a meeting between the Visiting Team and the GP to determine what further action was needed. Depending on the progress made, the Team would make recommendations to the Support Panel, which might include:

- where the plan was completed and the objectives achieved, the Team might recommend that the GP be discharged from these arrangements but encouraged to retain the support of their mentor who could provide support to help ensure sustainable improvements in performance;
- where objectives were only partially met but there was evidence of both a commitment and an ability to improve, the Team might recommend a further action plan with revised objectives;
- where objectives were not being met and there was no evidence to suggest that the GP had the commitment or capacity to improve their practice, then the recommendation might be to refer to the GMC or encourage/facilitate the GP to leave general practice.

Long term support

36. Improvements might prove to be temporary. There would always be a chance, particularly if the root causes of under-performance had not been recognised and addressed, that the GP's performance would once again deteriorate.

37. While a fully functioning GP, capable of taking long term responsibility for their own professional standards and development, might be the desired outcome, it is anticipated that many GPs who have been through this process will require some form of ongoing support. Vehicles for this might be a continuation of mentoring arrangements or membership of a peer learning set.

Ensuring confidentiality within the process

38. In order to translate the principle of confidentiality into practice there will need to be well defined rules and safeguards, agreed by all the main parties to the process. They should include a clear statement that only those involved directly with the process should have access to information or be aware of individual GPs who are being supported. They would cover the handling of written material. Each body represented should be responsible for ensuring that their representatives acted in accordance with the agreed procedures.

39. Health authorities and Support Panels will need to consider the retention of information following a programme of intervention. A GP representative suggested that there should be provision *"to wipe the slate clean"*, believing that once a GP was considered to be performing satisfactorily there should be no permanent record which could be a source of embarrassment. But a health authority manager argued that good, detailed records should be prepared and retained in strict confidence where patient safety had been an issue, saying *"it is essential that the group acts consistently, fairly and with regard to both the right of the doctor to confidentiality and the right of the population to a high quality, safe primary care service"*.

Dissemination

40. A number of health authorities indicated that, following discussions with professional representatives, they were intending to circulate their proposals to all GPs as part of a broad consultation. One manager explained that she was keen for this to be a true consultation, emphasising her interest in the process being shaped by ordinary GPs, some of whom might eventually need the support they were being invited to shape.

41. Several health authorities said they would be sending a copy of their finalised procedures to all their GPs. Some signalled their intention to send out the information jointly with their LMCs, which one manager said *"shows our commitment to a professionally supportive approach."*

Establishing a process for supporting GPs whose performance gives cause for concern – ScHARR's suggestions

- identify a health authority senior manager (director level) to lead on GP performance issues;
- ask the LMC to identify a similar lead person;
- constitute a Support Panel which, as a minimum, includes clinical and non clinical health authority membership, two LMC representatives and a GP educationalist;
- invite the Panel to bring forward proposals for the whole process, including ...
- ...arrangements for co-ordinating and assessing information, contacting the GP and involving a 'friend', diagnosing the underlying causes of a GP's under-performance, agreeing a package of support and action plan with clear objectives to enable evaluation, determining what further action (including long term support) to take following the completion of the action plan;
- establish clear procedures for ensuring issues concerning individual GPs are treated in strict confidence;
- maintain good records;
- consult with the profession on the proposals;
- ensure copies of the procedures are sent to all GPs, jointly if possible with the LMC.

Further Help and Support

1. Health authorities requiring advice in developing local arrangements are encouraged to contact their NHS Executive Regional Office Primary Care Lead.

2. In addition, the ScHARR Team will be available, on a contracted basis, to support individual health authorities in conducting an audit of their own current arrangements and provide advice on the development of more structured approaches. Health authorities who would like to explore this option in more detail should contact Guy Rotherham or David Martin on 0114 222 0792.

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Appendix A

How was the research conducted?

Summary of approaches

1. The research was conducted using a range of qualitative survey methodologies:

   - an initial review of the available material, including discussions with key stakeholders;
   - the monitoring of six 'learning sites' in the North West;
   - a literature survey;
   - a national postal survey of health authorities;
   - discussions with individuals and organisations who have a keen interest in GP performance.

Initial review of the Initial material

2. In the initial phase of the research, early discussions were held with the Department of Health, the GMC, GPs and health authority managers in addition to considering readily available information about working with under-performing GPs. While there was some evidence of differences of view on the detail there was remarkable commonality about the key elements that would be found in any sensible approach to under-performance (identification, assessment intervention, evaluation, etc.). These common themes were used to construct a semi-structured interview schedule which was used as the basis for all the interviews and the national survey. This enabled consistency in approach and reporting, but also allowed sufficient flexibility to accommodate a variety of perspectives from a range of different bodies.

North West learning sites

3. In July 1996, the NHS Executive's North West Regional Office hosted a workshop for its health authorities which considered how they should assist GPs whose performance gives cause for concern. In response to the interest and the commitment of the participants, the North West RO secured 'pilot status' for nine health authorities to take the issue forward, with the four Mersey health authorities working together as one pilot.

4. The sites were:

   - Manchester Health Authority
   - Morecambe Bay Health Authority
   - North Cheshire Health Authority
   - South Cheshire Health Authority
   - Stockport Health Authority
   - The Mersey Group:
     - Liverpool Health Authority
     - St Helens and Knowsley Health Authority
     - Sefton Health Authority
     - Wirral Health Authority

5. Reflecting that the health authorities were not technically pilots, but rather that they were addressing this issue in advance of other health authorities, the term 'learning site' was considered more appropriate.

6. Each site was visited at least twice during the course of the research, and contact was maintained between the ScHARR team and the lead officers throughout.

Literature survey

7. The literature survey was carried out by ScHARR's Information Resources Section. Searching on a number of key words and phrases, the initial search produced over 250 references from five databases of material. From this list the Project Team identified around 60 useful references which, even if not cited here, have influenced the content of the guidance.

National postal survey

8. It was initially intended that the survey would be conducted using a structured questionnaire. This approach was later dropped in favour of a letter to chief executives indicating our areas of interest and encouraging them to respond in the way they thought was most relevant and appropriate to their health authority. A draft letter was piloted with four health authorities and feedback was very positive. The open ended approach was appreciated as developmental in its own right.

9. The letter was sent to all chief executives of health authorities in England on 13 February 1997 (Appendix B). In addition, a copy of the letter was sent to all NHS Executive Regional Office primary care leads seeking their support in identifying good practice.

10. Discounting the Learning Sites who were not included in the survey, the response rate to the letter was 65% from 91 health authorities, distributed fairly evenly across the country and between rural, metropolitan and inner city authorities.

11. In addition, letters were also sent to health authorities and boards in Wales, Scotland and Northern Ireland, producing a response rate of 50%.

Interviews with interested parties

12. Using the semi-structured interview mentioned earlier, interviews were held with a range of organisations and individuals who were considered to have a keen interest in GP performance. During the course of our work, the list was often expanded as a result of suggestions by people being interviewed.

13. Interviews were held with representatives of the following bodies:

- General Medical Council
- General Medical Services Committee, British Medical Association
- Overseas Doctors' Association
- Small Practices Association
- NHS Confederation
- Committee of Regional Directors of Postgraduate GP Education
- Department of Health
- NHS Executive
- practising GPs
- individual Regional Directors of Postgraduate GP Education
- a number of LMC secretaries
- primary care academics
- GP Tutors
- Health Authority Managers, including Medical Advisers
- Community Health Council Secretaries.

Application of the findings

14. As noted in Chapter 1, the findings from these various methods were used as the basis for the guidance.

Appendix B

12 February 1997

To: **Chief Executives of all Health Authorities in England**
NHS Executive Regional Office Primary Care Leads for information

Dear Colleague

GPs whose performance gives cause for concern

Introduction

I am writing to request your help with a development project we have been asked to conduct by the Department of Health. The project is concerned with assisting health authorities in identifying and supporting GPs whose performance gives cause for concern. The issue, which is an important element in taking forward a primary care led NHS, needs to be viewed against the backdrop of:

- *Choice and Opportunity*
- *Primary Care: Delivering the Future*
- *the Medical (Professional Performance) Act 1995.*

Context

The recent primary care White Papers have reinforced the position of primary care development as one of the leading challenges facing the NHS. Health authorities in particular have a major role in supporting primary care professionals as both providers and purchasers.

The role of the general practitioner is a key factor, but there are wide variations in the quality of services they provide. Although it is clear that the profession in general has always provided high quality personalised care – probably, overall, the best of its kind in the world – it is inevitable (as with any professional group) that there will be some who for whatever reason fall below an acceptable standard.

The *Medical (Professional Performance) Act 1995*, which comes into force in September of this year, confers new powers on the General Medical Council to act in relation to GPs whose professional performance falls short. Under the Act, health authorities will be able to refer GPs to the GMC where their pattern of practice is identified as 'seriously deficient'. While it is considered that a very small minority of GPs will fall in this category, there will be others who are identified as under-performing to a lesser extent, who will need support to improve their practice.

In *Primary Care: Delivering the Future*, in the chapter headed *Developing Professional Knowledge*, reference is made specifically to the Government's intention to 'encourage the development of local arrangements for supporting doctors whose performance gives cause for concern'. The document reaffirms that health authorities have a key role in ensuring that GPs who are struggling in one way or another are offered appropriate support to help them deliver good, progressive practice.

Information and Advice

To assist health authorities in dealing with this challenging issue, the School of Health and Related Research (ScHARR) at the University of Sheffield has been commissioned by the Department of Health to produce an independent report to be released in July. The report will provide information to health authorities based on good practice from around the country looking at supporting GPs whose performance gives cause for concern.

National Survey

As a key contribution to the work we are keen to establish a picture of how health authorities throughout the country are taking these issues forward. We

need to establish a baseline of current understanding and activity, capture what is planned or is under development, and identify demonstrable good practice.

I should be most grateful if you would arrange for the appropriate Director within your health authority to write to me with an outline of the approach either being taken or planned by your organisation. Rather than inflict a questionnaire framework on you, we thought that it might be more acceptable and productive to indicate our areas of interest and leave it to you to write in whatever way seems relevant and appropriate.

Key Issues

- How do you define GP under-performance?
- How do you identify a GP who may be under-performing?
- What arrangements do you have for diagnosing the reasons why a GP may be under-performing?
- What sort of interventions would you make with a GP who was considered to be under-performing?
- What mechanisms do you employ for evaluating these interventions?
- Who are the key players in your approach?
- Are you satisfied with your Authority's approach, in particular what lessons have you learnt?
- How might you be seeking to develop capacity within your health authority to deal with GP under-performance?
- Approximately how many GPs (or what percentage) within your area do you suspect are under-performing?
- Approximately how many GPs (or what percentage) within your area do you suspect will need referring to the General Medical Council under the new arrangements?
- What would you like to see in any guidance?

I should also welcome, with your letter, copies of any policy papers, procedure notes or protocols which relate to this issue.

It is well understood that each health authority will have a distinctive approach, and that the way the work is being taken forward will vary according to how the issue sits in the local order of priorities. What I would find very helpful is a frank account, however brief or lengthy, of where you are in thinking about or developing practice in this area, even if you feel you are in the early stages. We may wish to follow up your reply with you, which I hope you would find acceptable.

Confidentiality

As our work is concerned with identifying and sharing good practice, we do intend to illustrate our report with positive examples from named health authorities. However, I should like to assure you that we will only make specific reference to a health authority with their explicit agreement.

Timescale and Advice Available

I have enclosed a stamped addressed envelope for your Authority's response. I should be most grateful to receive a reply by 7 March 1997.

Thanks for your help and please feel free to contact me on 0114 2220743 if you have any concerns.

Yours sincerely

Guy Rotherham
Senior Research Fellow

Project Team

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