The National Clinical Assessment Authority: a healthy sign of the times

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ABSTRACT – The National Clinical Assessment Authority (NCAA) is a special health authority established on the 1 April 2001 following recommendations made in the Chief Medical Officer's reports, *Supporting doctors, protecting patients* (November 1999) and *Assuring the quality of medical practice* (January 2001). The aim of the Authority is to provide a support service to NHS primary care, hospital and community trusts, and to the Prison and Defence Medical Services when they are faced with concerns at the performance of an individual doctor or dentist. The Authority provides advice, takes referrals and carries out targeted assessments where necessary, using trained medical and lay assessors. Once an assessment has been completed, the Authority will advise on appropriate courses of action and will facilitate a local plan of action. The NCAA does not take over the role of an employer, nor does it function as a regulator: its function is purely advisory and the NHS employer remains responsible for resolving the problem.

KEY WORDS: advice, assessment, regulation, poor clinical performance, suspension

Introduction

As today's accountants and auditors blink helplessly into the spotlights of professional ridicule and public contempt and wonder, 'where did it all go wrong?', most other professions can say, 'welcome to the club'. Auditors will have a long way to go before they catch up with other professionals – police, teachers, social workers, politicians, nurses and doctors – in accepting and implementing change to professional practice and regulation. Only lawyers and journalists seem exempt: it is the police rather than prosecutors, defence barristers or judges who are blamed when convictions are overturned, and to question journalistic ethics or practice would apparently bring the pillars of a free society crashing down.

The medical profession has travelled a long and frequently difficult road to modernise and democratise itself. Along the way it has been helped, hindered and cajoled by patients, the public, the media and government. This journey has been vital to the development of safe, caring and rewarding medical practice in the twenty-first century and to ensuring the evolution of a profession that remains as true to the Hippocratic oath as it ever was, and as true to the sense of vocation on which most doctors have built their careers.

The NCAA is rapidly establishing itself as an integral and significant force for sustaining good medical practice and promoting confidence in doctors. Its creation, and support for its work from across the medical and health community, is a sign of the mature and committed manner in which issues regarding the management of doctors in difficulty are being approached, whether its focus is on failures in medical practice themselves or on failure by the NHS in dealing with performance difficulties. The NCAA provides a unique bridge between the profession and the NHS for a collaborative and developmental approach that will mutually benefit doctors, managers and patients.

Background

The NCAA began work in April 2001, created by the Secretary of State for Health, as a Special Health Authority. Its remit was 'to promote clinical performance and to support NHS personnel dealing with under-performing doctors'.[1] The creation of the authority followed Government consultation on preventing, recognising and dealing with poor clinical performance of doctors in the NHS in England. Its proposals were set out in *Supporting doctors, protecting patients* published in 1999.[2] This document proposed the establishment of a number of Assessment and Support Centres to be run jointly by the NHS and the medical profession located in different parts of England. The centres would accept referrals of doctors from their employers or contracting organisations or self-referral, and would offer advice to referred and self-referred doctors and their referring organisations. A diagnosis of the problem would be made following an impartial assessment. Subsequently, recommendations would be made to resolve the problem.

Following the consultation, the Government

established the National Clinical Assessment Authority, replacing the idea of several permanent advice and referral centres, with a national body, acting locally. *Assuring the quality of medical practice – implementing 'supporting doctors, protecting patients'*,[3] was the Government's response to the consultation. The Government agreed with respondents to the consultation, that whilst the aim of referral centres was correct, the centres themselves would not be the best way of achieving them. Concerns had been raised during the consultation that advice and referral centres 'would not be conducive to developing a positive and non-stigmatising role for the service'.[3] The NCAA, therefore, was proposed to provide a nationwide advice and assessment service undertaken locally. This service would be more flexible than centres and be able to hone its work to local circumstances.

Since its establishment in April 2001, the NCAA has developed rapidly. It has built its infrastructure and created and implemented its advice and assessment services. The NCAA is currently operating in a prototype phase whereby it is providing a full advice service but a limited volume assessment service. Until April 2003, the NCAA will not undertake more than 70 assessments. This is to allow the Authority the opportunity to evaluate both the principles and practicalities of the service and implement changes and enhancements as necessary before the full service is offered from April 2003 onwards.

NCAA services

The Authority's services are designed to complement and not replace local procedures. The NCAA has sought to harness the expertise and insights of individuals and organisations with interest and experience in the management of doctors' performance concerns. Their services have also been developed following extensive consultation with the medical profession through the Medical Royal Colleges and Faculties, the deans of postgraduate medicine and directors of general practice education, medical defence organisations, the British Medical Association and Overseas Doctors Association, NHS management and patient organisations. The Authority has benefited enormously from all those who have and continue to contribute to its development and to the implementation of its work.

The NCAA has two core functions – advice and assessment – from which all its other work flows. The NCAA has published two handbooks detailing the services and process for general practice and hospital and community care sectors,[4] which are outlined below.

Advice

Where concerns are raised about the performance of a doctor, their employer or contracting organisation (in the case of most GPs) may seek advice from the NCAA on how to manage those concerns. Although there is no mandatory requirement, there is an expectation from the Department of Health and the Chief Medical Officer that the NCAA's advice will be sought. And specifically, where suspension of a doctor is being considered, the Chief Medical Officer has recommended to all NHS trusts and primary care trusts that the NCAA should be consulted first, except in the most urgent circumstances.[5]

NCAA advice is provided by a team of casework managers, NCAA advisers and senior officers of the Authority. All advice calls are triaged by a casework manager and range from the most simple enquiry about what the Authority does to the most detailed request for support and guidance in dealing with a complex issue. The team of 16 NCAA advisers, comprising senior clinicians and managers experienced in managing doctors' performance issues, located around the country and each covering a number of strategic health authority areas, form the core of the advice service. They liaise directly with the advice-seeking body, by phone or on site, and advise on the local management of a case of poor performance. NCAA advisers also assist in identifying and, where necessary, building appropriate local performance procedures with the aim of achieving resolution of the concerns raised.

Assessment

Where local resolution of concerns cannot be achieved, the NCAA will consider undertaking a thorough assessment of the doctor's performance. The purpose of the assessment is to:

- clarify areas of concern
- identify the cause of the poor performance (where possible)
- make recommendations to resolve the problems identified.

Assessment processes for GPs and for hospital and community doctors are built on the same principles but do reflect the different circumstances and challenges of the different sectors.

The NCAA will deliver clear conclusions and provide a practical framework for the creation of an action plan. The recommendations will, however, provide sufficient flexibility to enable those undertaking remedial work with the doctor to produce a detailed plan which both parties agree addresses the core issues.

Recommendations

Following the assessment, recommendations will be made as to what, if any, action should be undertaken to overcome the concerns. Recommendations are presented to the referred doctor and the referring organisation, and an NCAA adviser is available to help facilitate the local process for formulating an action plan based on the recommendations.

The NCAA will evaluate the effectiveness of action plans with regard to both individual remediation and as part of a broad programme of research, evaluation and development across all the Authority's work. As part of the action planning, the NCAA, the referring body and the referred doctor will agree mechanisms to identify how and when its implementation has been satisfactorily completed.

The NCAA has no formal powers to enforce its recommendations or compel parties to abide by them. However, if the Authority becomes concerned that recommendations are not being implemented and the performance concerns are still an

issue, it can raise the matter with the referring body's strategic health authority as part of the performance management line of the NHS. If it is concerned that the difficulties are so serious as to amount to a potential system failure, it may raise its concerns with the Commission for Health Improvement.

Although the NCAA was established as an English service for NHS doctors, its services are being made available more widely by agreement. Arrangements are in hand to provide services to the National Assembly for Wales, the Northern Ireland Legislature, the Prison Medical Service and the Defence Medical Services. Later this year, the NCAA's remit will be extended to include NHS hospital and community dentists. Later still, the Department of Health's response to the Kennedy report, *Learning from Bristol*,[6] indicated that the NCAA's remit may extend to other health professionals.

The future

The NCAA has rightly concentrated on establishing and bedding down its core services, and as the analysis of prototype assessments is available, the Authority will import its findings into the full service from April 2003. Establishing an evaluation, research and development strategy and education programmes will be the focus of new developments for the NCAA in 2002/3.

The NCAA is in a unique position to identify trends and assess and advise on their significance for the management of concerns about medical and dental performance. Analysis of referral patterns, advice provided, recommendations implemented and longer-term outcomes will, for the first time, provide the profession and the NHS with a clear understanding of the dynamics of dysfunction in medical practice and in its management. Currently there are many questions and few answers. The NCAA aims to meet this need with robust information and authoritative discussion of implications. It will continue to engage collaboratively, actively and enthusiastically with all parts of the profession and the wider health community to support doctors and the NHS in effectively identifying and addressing performance concerns, their causes and management.

From its inception, the concept of a locally delivered service has been at the forefront of the medium-term objectives for the NCAA. The Authority is keen to see its principles and its work adopted and used by local management with the NCAA acting as a developer, promoter and performance coach. The provision of an education service throughout the NHS will be key to achieving this objective. Peculiarly, perhaps, for any institution, the NCAA would be more than content to step aside when its work and standards have gained widespread local adoption through education and practice, and the need for a national organisation disappears. This is not a fantasy but the ultimate objective for the Authority.

Conclusion

As we turn again to the financial pages and gaze upon another profession in turmoil, institutions ridiculed and coaches and horses ambling through standards, the authors believe that the medical profession and NHS can consign its own experience to history, albeit recent. It has embraced the need to be dynamic and proactive in the way it addresses performance issues. It understands the need for public confidence in its behaviour that comes from effective scrutiny, promoting standards, collaboration with stakeholders and embracing quality. There is no room for complacency, though a little *schadenfreude* is possibly permissible.

The NCAA provides a resource that bridges management and the profession, develops and enhances the way doctors and managers work together and will highlight key trends and needs in a collaborative rather than accusatory fashion. It is a key element of the medical quality framework that, combined with the Commission for Health Improvement, the National Institute for Clinical Excellence and the National Patient Safety Agency, provides accountable, professional and modern healthcare in which patients can have confidence.

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