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Centre for Healthcare Improvement

Patient Safety and Quality Improvement Service

Managing Medical Practitioner Performance Concerns

A Handbook for Managers

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Queensland Health

Patient Safety and Quality Improvement Service

<http://www.health.qld.gov.au/patientsafety>

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Foreword

Managing doctors' professional performance and, in particular, addressing concerns in regard to poor performance, is one of the most challenging responsibilities of the medical manager and one which should not be undertaken in isolation. This handbook aims to provide a practical tool and guide to assist Directors of Medical Services and other medical managers provide the necessary leadership in responding to performance concerns with medical staff.

A theme of this handbook is that assistance can and should be sought from a range of sources. The principles and practices outlined in this handbook support Queensland Health's commitment, as articulated in the *Health Action Plan 2005*, to provide a statewide approach to clinician performance assessment and to the management of concerns about an individual clinician's performance.

In April 2007, the Queensland Health *Clinical Governance Policy* was released outlining Queensland Health's fundamental approach to clinical governance. To support this policy, the *Clinician Performance and Remediation standard* was implemented in conjunction with the *Safe Doctors: Fair System guidelines*. In September 2008, the Clinician Performance Support Service (CliPSS) was established to offer a performance management referral pathway that was non-adversarial and holistic in approach. The Clinician Performance Team (CPT) is a clearly defined entity within the Patient Safety and Quality Improvement Service, which provides a contact point for CliPSS referrals and for performance management advice.

In addition to CliPSS, which is specific to performance assessment and remediation of credentialed medical practitioners, CPT provides a range of services relating to the assessment and management of performance concerns in all medical practitioners employed or contracted by Queensland Health. The aim of CPT is to improve confidence in doctors by helping medical managers and Districts deal with concerns about clinician performance. Early contact with the service is encouraged so that CPT is able to work with medical managers to help address problems before they evolve into major concerns. CPT makes recommendations to employing Districts, rather than giving statutory instructions or having a regulatory function. It deals with any performance concern via advice and ongoing support, by assisting Districts on local performance reviews and, where necessary, by carrying out a clinical performance assessment under the oversight of a Quality Assurance Committee to clarify the concerns and formulate a performance support plan.

CPT also has a role in helping to share good practice across Queensland Health in the field of managing performance concerns. The efforts and experience of many individuals and groups, both locally and internationally, have helped inform this handbook for medical managers.

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Summary

Directors of Medical Services and other managers of medical staff have an important clinical governance responsibility to ensure standards of medical practice are maintained and that concerns around poor performance are appropriately addressed. This handbook outlines fundamental principles and practices in managing medical practitioner performance concerns.

Key elements of effective performance management are summarised below:

- Take active steps to prevent serious performance concerns by regular performance review, promotion of effective line management and, for senior medical officers, appropriate credentialing and defining scope of clinical practice.
- Consider patient safety, statutory obligations, occupational health and safety of employees and practitioner's safety and well-being when performance concerns are raised; ensure action is taken where required with due diligence and timeliness.
- Seek multidisciplinary advice early, e.g. via a multidisciplinary triage meeting.
- Consider whether performance assessment or formal investigation is most appropriate and proceed down appropriate referral or investigator appointment pathways.
- Document performance management steps well from the start and don't forget to brief up.

Throughout this document are "Practice tips" to provide additional clarification or guidance for the reader. For example:

Practice tip:

Remember the 'basic rules' with managing performance concerns:

- Is the patient okay?
- Is the doctor (and other staff) okay?
- Can anyone else be harmed?
- What do I need to do -
 - ▶ Immediately?
 - ▶ In the near future?
 - ▶ At a later stage?

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Section I: Preliminaries

Purpose

The purpose of this handbook is to help managers who are faced with the challenge of managing performance of medical practitioners. Like other clinical groups, performance of medical practitioners can impact on patient safety, and for that reason is governed by more than standard industrial and Human Resources (HR) processes.

This handbook seeks to guide managers through the complex interplay that exists between clinician performance management, clinical risk management, employer HR responsibilities, credentialing and scope of clinical practice and regulatory requirements.

The focus is on enhancing patient safety by supporting and improving professional performance in a supportive environment. Where possible, a non-adversarial approach which maximises support for the individual practitioner, without compromising patient safety, is favoured. The assessment and management of clinical performance issues must be fair, transparent and legally robust. The processes outlined within this handbook aim to meet these goals.

Scope

The provisions contained in this handbook apply to all registered medical practitioners who are employed or contracted by Queensland Health in medical positions. This includes junior doctors, senior medical officers, staff specialists, Visiting Medical Officers and contracted medical practitioners. It does not apply to individuals with medical qualifications and/or registration who are employed outside the Medical Officer industrial framework, such as a medically qualified District Chief Executive Officer (DCEO). The *Queensland Health Performance Management Framework* is to be referred to for performance management at the DCEO level and above.¹ The principles articulated in this handbook are to be enacted when significant clinical performance concerns are raised. However, individual performance issues should not only be considered when a serious allegation or incident occurs. It is part of a broader system of clinical governance spanning registration, recruitment, credentialing and scope of practice, regular performance appraisal and development, peer review, clinical audit, incident management and monitoring of quality indicators.

While the focus of this handbook is on clinical practice, the same principles apply to roles with little or no patient contact.² Specific considerations for medical administrators and medical practitioners undertaking research or teaching are outlined in Section IV. Clinical performance concerns and management of other health professionals are not included in the scope of this policy. However, aspects of this framework may be adopted in the management of performance concerns in other health practitioners and the same principles should be applied.

Principles of performance management

This handbook upholds a number of principles on which performance assessment and management is undertaken:

- Patient safety
 - ▶ The primary goal of medical practitioner performance management is the safety of patients. Any risk to the safety of patients must be immediately and effectively managed as the first step in clinician performance management.

Practice tip:

- Consider “retrospective” risk as well as “prospective risk” to patient safety.
- Ask: Is there a risk that patients may have been harmed? If ‘Yes’, further evaluation via a clinical review and case follow-up (where appropriate) may be required.
- Could subsequent patients be harmed if management steps are not undertaken? Restrictions on scope of practice and/or supervised practice are options that may need to be considered if the answer is ‘Yes’.
- If restrictions on practice are necessary, then notification of Australian Health Practitioner Regulation Agency (AHPRA) is required.

- A just culture
 - ▶ Queensland Health’s approach to managing adverse clinical outcomes is to take a “just” approach. This means the following elements apply:
- Serious clinical incidents are managed primarily at the systems level, and are not attributed to the performance of an individual clinician without good reason.
- Blameworthy acts are subject to disciplinary or criminal proceedings.
- Where individual clinician performance concerns are raised, the first approach is one of supportive remediation, with disciplinary action being a last resort.
- “To err is human”
 - ▶ All humans make mistakes.
 - ▶ The consequence of error is dependent on the context. For example, the same mistake of prescribing the incorrect drug can range in consequence from nil effect to death. Depending on system defences, timely intervention and/or luck or chance, the result may be a “near miss” or an adverse event.

- ▶ An unintentional act or omission which could have happened to any reasonable practitioner, i.e. human error, does not require individual performance management.
- ▶ Errors caused by knowledge and skills-based deficits require individual management in addition to system supports to prevent harm to patients.
- Timeliness of action
 - ▶ Early intervention into clinical performance issues reduces the risk of adverse outcomes and continuing risks to patient safety.
 - ▶ Concerns about performance are to be addressed as soon as they are raised, and must not await any process milestones, such as annual performance review, the credentialing cycle or registration renewal.

Practice tip:

Dealing with performance concerns must be undertaken by appropriate performance management, which includes assessment and/or development of a performance improvement plan. It is not sufficient to deal with performance concerns purely by a credentialing and scope of practice process unless the following apply:

- There is a high degree of certainty that the extent of clinical risk is limited to the issues dealt with by scope of practice, i.e. the initiating events are not “the tip of the iceberg”
- Both the practitioner and the health service agree that there is no desire or need to rebuild performance to re-instate full scope (e.g. a practitioner who is close to retirement).

- Obligation to report
 - ▶ All staff have the responsibility to report concerns about a clinician’s performance to their own line manager. It is the responsibility of all staff to be vigilant in identifying and raising a concern about a clinician whose health, conduct or performance is a risk to patient safety, themselves, others or the organisation.
 - ▶ All health practitioners, including student practitioners, have a responsibility to report notifiable conduct to the Australian Health Practitioner Regulation Agency (AHPRA); see Systems for managing the registration of health practitioners.

Practice tip:

Some Districts advocate a process whereby concerns about notifiable conduct are first discussed with the Director of Medical Services. If the Director of Medical Services undertakes to report the concerns to AHPRA, then the individual practitioner’s reporting obligations are met. If, however, after discussion the Director of Medical Services does not report and the original practitioner’s concerns about a colleague are not resolved, then the original obligation to report remains.

- ▶ If a crime is suspected, the Queensland Police Service and/or Ethical Standards Unit are to be notified immediately; the Police are to be directly notified if there is immediate danger to staff, patients or the public.
- Obligation to act
 - ▶ The obligation of line management to take action to remedy problems is clear, unambiguous and explicit.
- Responsibility for action
 - ▶ The DCEO (or sub-delegate³) must at first instance actively manage a concern. This obligation cannot defer to any other body.

Practice tip:

The Clinician Performance Team may be utilised as a consultancy body to assist Executive staff in determining the appropriate management pathway, including a Local Performance Review or full performance assessment via CliPSS.

- Procedural fairness
 - ▶ Clinical performance management must be carried out in compliance with the principles of natural justice. The processes must be undertaken fairly, in good faith and without bias or the perception of bias.
- Recognise victimisation
 - ▶ Differences in work style, personality, values, beliefs or culture should be recognised and respected and bullying and victimisation in the workplace must not be tolerated. Similarly, employees participating in performance management are not to be subjected to workplace harassment.⁴ Workplace harassment does not include reasonable management action taken in a reasonable way by the person's employer in connection with the person's employment.⁵
- Confidentiality
 - ▶ Appropriate confidentiality is to be maintained. This does not preclude escalation of concerns to the responsible line manager, a credentialing committee, or compliance with a statutory obligation to report (e.g. notifiable conduct).
- Transparency
 - ▶ Full and open communication with the practitioner should occur as part of clinical performance management. Practitioners must receive feedback on the results of all assessment outcomes and be actively engaged in the development of the performance appraisal and development plan and/or performance improvement plan.

- ▶ In general, all complaints should be disclosed to the subject practitioner; receipt of trivial complaints not requiring further action should also be disclosed, unless there is reasonable belief that doing so would cause undue distress to the practitioner or the service/team.
- Least restrictive path for the practitioner
 - ▶ Suspension or exclusion from work is distressing for the practitioner, burdensome for colleagues and expensive for the employer. These actions may be necessary to protect patients or for effective investigation, but should only be used if other alternatives, such as temporary restrictions or voluntary withdrawal from practice for a short period, are unavailable. The least restrictive path for the practitioner, while exercising due diligence, must be followed.
- Provision of information
 - ▶ All relevant parties in the process are to be informed of the outcome in a way that respects practitioner confidentiality. It will be appropriate for different parties to receive different levels of detail when informed of the outcome. For example, the practitioner and his/her line manager must receive full details of the outcome, while a complainant may only be notified that appropriate action has been taken and if not, the reason why.
- Independence and impartiality
 - ▶ Conflicts of interest are to be avoided wherever possible, and where unavoidable, must be disclosed.

Practice tip:

Guidelines jointly produced by the Crime and Misconduct Commission and the Independent Commission Against Corruption provide principles that should govern the management of conflicts of interest in the public sector.⁶

- Standards
 - ▶ The standards against which judgements are made must be made explicit. As a rule, this will be the standard reasonably expected of a clinician of an equivalent level of training and experience in the position in which they are employed.

Practice tip:

Comparison with “standard practice” should be used to identify practices with outcomes below accepted standards. The standards should not be used to stifle new and innovative practice where the result is improved outcomes for patients.

- Statutory obligations
 - ▶ These principles do not negate any statutory obligations in relation to reporting, investigating or otherwise dealing with a matter.

Definitions of key terms are contained in Appendix 1.

Related policies and documents

This handbook references many sources, including legislation, Queensland Health policies and documents. These documents are specifically referenced in context in the Sections that follow, but the following list is a summary of materials with which managers are to be at least familiar:

- *Code of Conduct for the Queensland Public Service*⁷
- *Queensland Health Governance Framework 2010*⁸ and *Queensland Health Performance Management Framework*⁹
- *Clinical Governance Policy 2007*¹⁰ which outlines Queensland Health’s fundamental approach to clinical governance
- *Safe Doctors: Fair System Guidelines (2007)*¹¹ and *Clinician Performance and Remediation Implementation Standard*¹², which outlines the responsibility to offer senior medical officers a “green” performance assessment and support pathway as an alternative to the “red” investigative pathway
- HR policies on learning, development and performance,¹³ including Performance Appraisal and Development *HR Policy G9* and Performance Improvement *HR Policy G11*
- HR policies on ethics and conduct,¹⁴ including Discipline *HR Policy E10* and Workplace Harassment *HR Policy E13*
- *HR Policy I5* on Public Interest Disclosures (Whistleblowers)¹⁵
- *Credentialing and Defining the Scope of Clinical Practice for Medical Practitioners and Dentists in Queensland Health (2011) policy and implementation standards*¹⁶
- *Incident Management Implementation Policy (2008)*¹⁷ and *Clinical Incident Management Implementation Standard (2009)*¹⁸
- *Human Resources (HR) Delegations Manual (2009)*¹⁹ which outlines powers (e.g. for disciplinary action, suspension and dismissal) according to levels of positions (see also District HR sub-delegations manuals)
- *Consumer Complaints Management Policy (2009) and Complaints Management Implementation Standard*²⁰

Relevant legislation is contained in Appendix 2.

Section II: Identifying concerns

Queensland Health has systems and processes in place to enable proactive surveillance of clinician performance and identify performance concerns at the earliest possible stage. Mechanisms are also in place to enable reactive identification and reporting of performance concerns when they arise. Following are some of the clinical governance systems and processes in place that allow for identification of performance concerns:

- Medical performance review
 - ▶ All senior medical staff, including full-time and part-time specialists and Visiting Medical Officers, are required to participate in a regular Performance Appraisal and Development (PAD) process. This process allows for discussion between practitioners and managers in relationship to performance goals, corporate values, learning strategies and actions required to obtain new skills or develop existing skills for the current position.²¹ The Senior Medical Performance Review includes a review of clinician outcomes and peer feedback as part of the PAD process.²²

Practice tip:

Regular and supportive performance review is essential for all medical staff. While junior doctors do not participate in a formal PAD process, other mechanisms must be in place to allow for regular supervisor reviews and to encourage discussions about performance between junior doctors and their supervisors.

- Multi-source (360 degree) feedback
 - ▶ Formalised processes for multi-source feedback in Queensland Health include 360 degree feedback as part of the “Better Workplaces” Leadership Program²³ and the team survey as part of the Senior Medical Performance Review. The aim of these multi-source survey tools is to stimulate self-reflection on professional development and performance and, in the case of the Senior Medical Performance Review, allow frank discussion between a practitioner and their line manager about performance.
 - ▶ Multi-source feedback also forms a component of formative or summative assessment in a number of specialty training pathways.

Supervisor feedback to junior doctors may be based on input from a number of team members in some settings (e.g. Emergency Department rotations).

- Peer review
 - ▶ Avenues for peer review are afforded by department/unit Mortality and Morbidity meetings, clinical audit and peer case discussions.

- ▶ Mortality and morbidity meetings are regularly held by clinical teams with the aim of learning from complications and adverse outcomes in a non-punitive setting. Significant performance concerns identified in mortality and morbidity meetings should be communicated with the Director of Medical Services.
- ▶ Clinical audit at an individual, team or service level involves a systematic review of the structure, processes and outcomes of care against explicit criteria in order to identify actions to improve clinical practice. For more information, see the Queensland Health *Clinical Governance Implementation Standard on Clinical Audit and Review*.²⁴
- Clinical outcomes data
 - ▶ Variable Life Adjusted Display (VLAD) is a statistical method used by Queensland Health to graphically display time series data to identify positive and negative trends in outcomes of interest. The VLAD technique includes a mechanism of signalling when further investigation of performance is warranted.²⁵ For more information, see the Queensland Health *Variable Life Adjusted Display Implementation Standard*²⁶
 - ▶ Other clinical indicators that are appropriate to the clinical specialty can also be helpful in identifying practice that varies significantly from peers, e.g. length of stay, operating time and blood product consumption.

Practice tip:

The Health Roundtable is an example of one benchmarking organisation to which a number of Queensland Health Districts and facilities have membership.²⁷ The Health Roundtable produces regular reports to assist hospitals benchmark organisational performance at the hospital and clinical service level, including identification of services which may require further audit. This data source can be used in evaluation of significant performance concerns.

- Consumer feedback
 - ▶ Queensland Health has mechanisms in place to receive and respond to feedback from consumers within the public health system, as outlined in the Queensland Health Consumer Complaints Management Policy and Implementation Standard.²⁸

Practice tip:

Whilst any practitioner may reasonably expect to be the subject of a single complaint, a practitioner who is the subject of even two complaints in a single year may be an outlier compared to peers. When considering the pattern of complaints, consideration needs to be given to the specialty and circumstances of practice.

- Staff procedures for reporting concerns
 - ▶ Staff who have concerns about the performance of any clinician should discuss their concerns with their own line manager, who in turn should ensure that the concerns are escalated according to the correct process of the local facility. For example, a nurse with a concern about a doctor should escalate the concern through the nursing management line, and be supported in discussing concerns with the Director of Medical Services or a Clinical Director.
 - ▶ Where the concern is about their own supervisor, the matter should be referred to the professional head of that profession, e.g. the Director of Medical Services. If the concern is about a professional head, this should be raised with the DCEO.²⁹
- Clinical incident review procedures
 - ▶ Clinical incidents must be managed according to the *Clinical Incident Management Implementation Standard*.³⁰ While the focus of incident analysis is on learning from system errors, performance concerns may be identified as a result of clinical incidents. These concerns must be addressed separately to incident analysis processes by notifying the Director of Medical Services (or equivalent professional head).
 - ▶ Mortality and Morbidity meetings are another forum for clinical incident review; see Peer review.

Section III: Managing concerns

Initial assessment by line manager

Initial assessment is concerned with immediate risk management and commencement of the correct management pathway. When a clinical concern, complaint or adverse event occurs, a first step is to perform an initial assessment and triage of the issue. The line manager who first becomes aware of a performance problem may be able to assess the issue and resolve it informally without referral to senior management. Examples of issues suitable for local line management action in the first instance include behavioural issues such as habitual lateness, non-compliance with standard processes (e.g. hand washing) or discourteous workplace behaviour.

Line managers who are managing performance concerns should refer to the *Clinician Performance and Remediation Implementation Standard*³¹ and *HR Policy G11 (Performance Improvement)*.³² In general, concerns about safety and quality of clinical care require escalation. If the line manager is of the view that the matters raised are not serious, or are vexatious, they must still be reported to the Director of Medical Services (or equivalent professional head) for oversight.

Responsibilities of all levels of staff are outlined in Appendix 3.

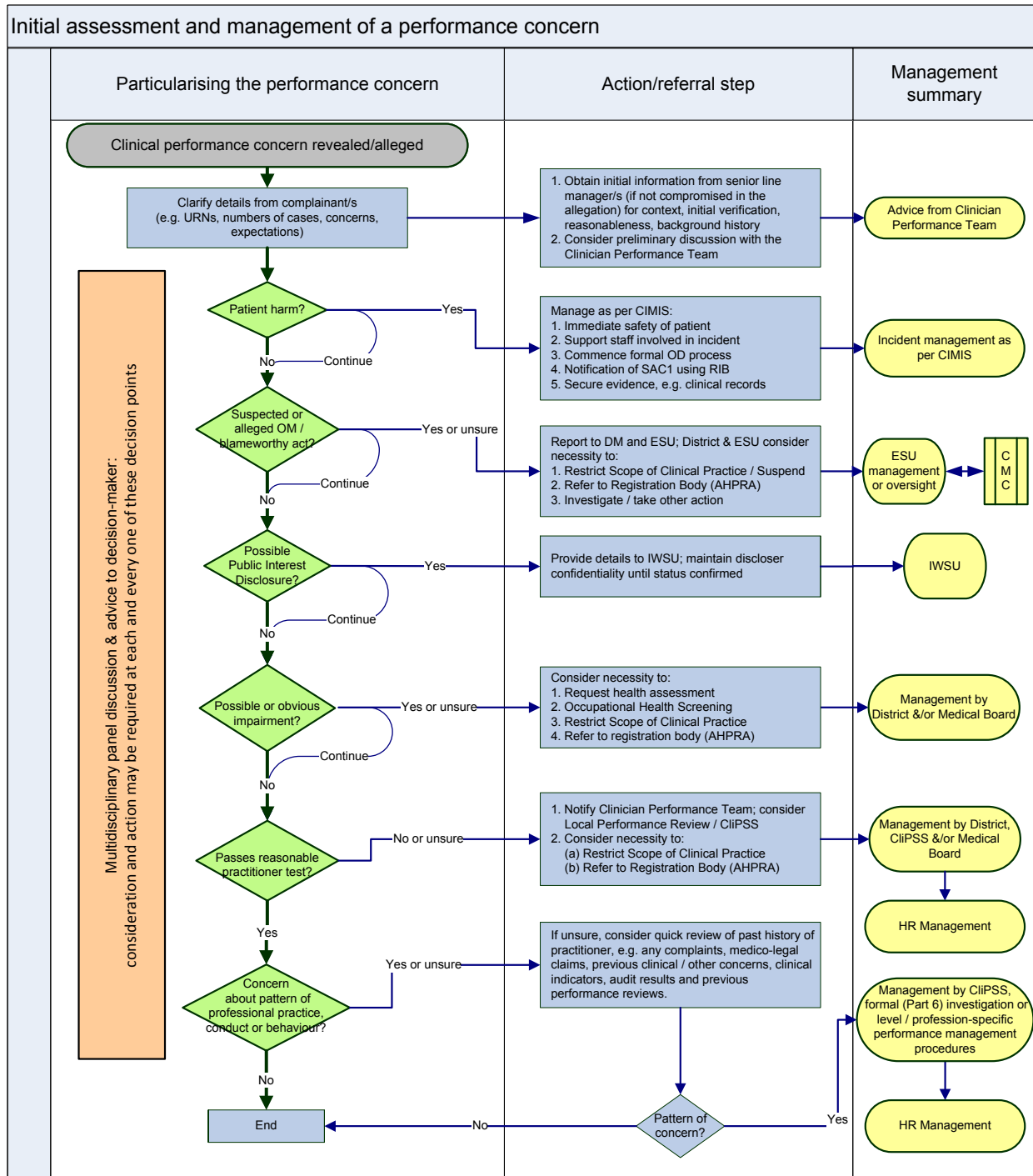
Preliminary assessment of escalated concerns

If there is concern about clinical competence or safe performance, the Director of Medical Services (or the equivalent professional head) must be notified immediately. Figure 1 outlines a decision-making tool for the initial assessment and management of clinical performance concerns. The model prompts the medical manager to ask a series of questions to help particularise the nature of the performance concern and provides guidance with consequent actions. Due to the complexity and subsequent impact of early decisions in the management approach, it is prudent to seek expert advice in evaluation of a serious performance concern. Advice from a multidisciplinary panel provides the Director of Medical Services (or other manager), with expert perspectives in order to formulate a defensible, coordinated, transparent and objective approach. The Clinician Performance Team may be used as a sounding board or to provide advice on process and management options.


Practice tip:

Ensure all aspects of the performance management are well documented from the start as actions may need to be justified if there are subsequent legal proceedings.

Figure 1. Triage flow diagram for initial assessment and management of a performance concern



Acronyms: AHPRA, Australian Health Practitioner Regulation Agency; CIMIS, Clinical Incident Management Implementation Standard; CiIPSS, Clinician Performance Support Service; CMC, Crime and Misconduct Commission; DM, District Manager; ESU, Ethical Standards Unit; HR, Human Resources; IWSU, Internal Witness Support Unit; OD, Open Disclosure; OM, Official Misconduct; RIB, Reportable Incident Brief; SAC, Severity Assessment Code; URN, unit record number.



As part of the preliminary assessment of escalated concerns, the Director of Medical Services (or other manager) must consider each of the following issues:

- Patient safety
- Statutory obligations (e.g. Public Interest Disclosure protection, health practitioner registration)
- Occupational health and safety of other employees
- Practitioner safety and well-being

Further details of how these issues should be managed are described below.

Phase 1: Patient safety

The following steps are the minimum recommended in the management of performance concerns where patient safety may be at risk:

1. Obtain as much detail as is possible in a rapid timeframe of the basis of the concerns, protecting notifier identity until Public Interest Disclosure status has been determined.

Practice tip:

Consider whether the matter might be subject to Public Interest Disclosure protections. Generally speaking if the concern is raised by one or more clinicians about another clinician, then consultation with the Internal Witness Support Unit is advised. There are two provisions under which a disclosure can qualify as a public interest disclosure: official misconduct or a risk to public health and safety. Generally, clinical performance concerns qualify under the latter, but official misconduct must also be considered.

2. Write a few sentences that express the concern. This is a good method of forcing the crystallisation of the issues. It is not, for example sufficient to have a concern which is merely couched as *“The anaesthetist believes the surgeon is unsafe.”* Specific cases and particulars are necessary. This allows the concern to be more accurately expressed, for example *“The anaesthetist believes the surgeon is unsafe because of the 8 cases undertaken using the new equipment; 6 cases have required more than 6 units of packed cells intra-operatively, and the operating time has doubled. There have been 4 unplanned admissions to the Intensive Care Unit out of the 8 cases, when fewer than 10 percent of cases using the old operating method required Intensive Care Unit admission.”*
3. Get expert clinical advice regarding the potential clinical impact of the concerns. The most difficult decision the Director of Medical Service or manager faces is usually that of *“Do I need to be worried about this?”* Usually, the clinical director will be able to provide this advice, but if he/she is the subject of the concern, or has a conflict of interest, then an external advisor with appropriate expertise is necessary.

4. Convene a discussion between the Director of Medical Services (or other professional head), a senior clinician of the same discipline and specialty, a HR or legal advisor and the Medical Director or Assistant Director of the Clinician Performance Team. Additional independent or external representation may also be considered (e.g. a Director of Medical Services from another District or a consumer/patient representative). If the concerns were raised by non-medical staff, then their relevant clinical director must also be involved (e.g. the Director of Nursing). Managers in rural and remote districts should consult with the Office of Rural and Remote Health's Clinical Support Unit for advice and assistance in constituting an appropriate multidisciplinary panel. The multidisciplinary panel is to review what is known so far and then advise the Director of Medical Services (or other manager) on options to verify and manage the concerns. Document minutes of the meeting.


Practice tip:

Sometimes, a problem has reasonably clear boundaries and remedies. Other problems can have origins which are difficult to unravel. This is where more intensive work with the Clinician Performance Team may be helpful, including full performance assessment with CliPSS (Appendix 6) or assistance with Local Performance Review (Appendix 7).

5. If the clinical advice is equivocal, a more structured review will be required, but must not delay intervention for safety. Unless the clinical advice is clear that there is minimal safety risk, management action must occur to ensure safety while the matter is further assessed. That action is to be the least onerous for the practitioner that is consistent with safety. Ideally, this should be achieved by agreement with the practitioner (e.g. a voluntary reduction in Scope of Practice).
6. Reviewers are to be appointed to conduct a rapid clinical review of the concerns (Appendix 4). Alternatively, the Clinician Performance Team may be contacted with a view to obtaining practitioner consent for a rapid review using CliPSS assessors. If the scope of the rapid clinical review is limited to a record-based review and the Reviewer is provided with de-identified records it is not necessary to make a statutory appointment of the Reviewer as an Investigator under the *Health Services Act 1991* (in most cases URN's will be sufficient as identifiers and should be provided to ensure any concerns identified can be appropriately followed up). However, if the scope of the review is to be more extensive (eg. gathering additional evidence or interviewing witnesses), or if patient records are not de-identified, the Reviewer must be formally appointed as an Investigator under the *Health Services Act 1991*.

Practice tip:

The Rapid Review template in Appendix 5 can assist in structuring the analysis of the concerns. Note that the template separates out the "facts" of the matter from the "concerns". This approach helps the expert reviewer provide a structured opinion.

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7. If the opinion warrants it, the Director of Medical Services (or other manager) may need to take emergency action around the practitioner's Scope of Practice, and then refer the matter to the Credentialing and Scope of Clinical Practice Committee for unscheduled review. For further information on this process refer to the *Unscheduled Review of Credentialing and Defining the Scope of Clinical Practice for Medical Practitioners and Dentists in Queensland Health – Implementation Standard (2011)*.
 8. Brief the DCEO about what has occurred and what has been done.

Phase 2: Statutory obligations

There are three important statutory systems to consider when issues of clinical performance arise. These are:

- Systems for managing Public Interest Disclosures³³
- Systems for managing the accountability of public sector employees
- Systems for managing health practitioner registration

Public interest disclosure

Public interest disclosure must be considered at the very beginning of a matter, before any actions are taken that could compromise the protection of the identity of the complainant (if any). The identity of the individual must be protected (see Practice tip, p. 17) until advice is obtained from the Internal Witness Support Unit. The Internal Witness Support Unit is responsible for the receipt, assessment and subsequent management of potential Public Interest Disclosures made to Queensland Health in line with the provisions of the *Public Interest Disclosure Act 2010*.

Practice tip:

While every attempt to protect confidentiality is to be made there may be occasions when disclosure of the identity of an internal witness may be required by law. These include:

- Responding to a subpoena or some other court order
- Responding to a search warrant
- Responding to a notice to produce or any other compulsive that means required or authorised by law
- A direction by a Parliamentary Committee
- Court proceedings.

Queensland Health employees are able to disclose different types of information under the *Public Interest Disclosure Act 2010* including:

- Official misconduct

- Maladministration that adversely affects a person's interest
- Substantial misuse of public resources
- Danger to public health or safety or danger to the environment (where the danger disclosed is substantial and specific)
- Danger to the health or safety of a person with a disability
- Conduct of another person that could, if proved, be a reprisal.

This information can be disclosed via internal reporting (e.g. directly to the Internal Witness Support Unit or via a line manager or supervisor) or external reporting (e.g. the Crime and Misconduct Commission) as outlined in the *Public Interest Disclosure Act 2010*. If the information is judged to be a public interest disclosure, the Internal Witness Support Unit will consult with the internal witness around implementation of a support network, which may include the appointment of some or all of the following: peer support person, line manager, supervisor, HR officer and DCEO (or delegate).³⁴

Systems for managing the accountability of public sector employees

All doctors employed by Queensland Health are public sector employees. Accordingly, they are subject to the provisions of the *Public Sector Ethics Act 1994*, the *Health Services Act 1991* and the *Crime and Misconduct Act 2001*. In certain circumstances, performance concerns raised may be of such gravity that referral to the Ethical Standards Unit is necessary. If there is any suggestion that a matter was a blameworthy act or involved intoxication by alcohol or drugs, then the Ethical Standards Unit is to be consulted. Some Districts may have complaint resolution managers in the District who can offer advice in the first instance.

Systems for managing the registration of health practitioners

All health practitioners who become aware, or reasonably suspect, that a doctor has engaged in notifiable conduct, have a mandatory requirement to inform AHPRA on-line or in writing as soon as practicable.^{35,36} Notifiable conduct that must be reported to AHPRA includes the following:

- Intoxication by alcohol or drugs while practising or training in the profession
- Engagement in sexual misconduct in connection with the practice or training of the profession
- An impairment that places the public at risk of substantial harm³⁷
- A significant departure from accepted professional standards that places the public at risk of harm.

All health practitioners involved in the management of a clinical performance concern have an independent obligation to report, unless they have a reasonable belief that another health practitioner has already made a report about the same incident or matter (see Practice tip, p. 8).

Practice tip:

For impairment or a departure from accepted professional standards to constitute notifiable conduct there must be an associated public risk of harm. If in doubt about whether a practitioner's professional practice constitutes notifiable conduct, contact AHRPA to discuss.

Voluntary notification about a health practitioner may also be made to AHPRA under s144 of the Health Practitioner Regulation *National Law Act 2009* with protection from liability for notifications made in good faith provided in s237.

Phase 3: Occupational health and safety responsibilities to other staff

Having determined that a practitioner, although the subject of unresolved concerns about their clinical practice, is safe to practise, consideration must be given to safety of other staff in the workplace. For example, a practitioner who has made threats against another staff member or who has been found with a weapon in the workplace, may be safe to practise, but unsafe to have in the workplace. In these circumstances, management action ranging from modification of duties, management of rosters to avoid conflict, through to suspension must be considered.

Removal of a staff member from an after-hours roster places an additional burden on remaining staff. Rosters should be reviewed and re-examined for fatigue risk, and if the risk created by the modified roster is unacceptable, then emergency relief (e.g. temporary transfer of a practitioner from another unit, department or facility, or use of locums where other options don't exist) should be mobilised. Under no circumstances must a practitioner who is the subject of concerns about performance, and who has been removed from the roster for safety, be mobilised to relieve fatigue or maintain service continuity.

Phase 4: Practitioner safety and well-being

Although discussed fourth, this consideration is woven through all of the previous considerations. At all times, a manager must be mindful of the safety and well-being of a medical officer who is the subject of concerns about performance. While there may be privacy issues (e.g. an employee may wish to keep details of their health care private), the manager must support the practitioner in obtaining the necessary care and support for the safety of themselves and patients.

Consider the possibility of impairment arising from a physical or mental health condition as a source of significantly diminished performance in a previously well-performing staff member. Levels of depression are higher in medical practitioners than in the general public, while misuse of drugs and alcohol are amongst the most prevalent of health factors affecting doctors' performance.³⁸ Physical illness and chronic disease can be associated with physical limitations, altered behaviour, depression and cognitive impairment, with examples including Parkinson's disease, epilepsy, diabetes mellitus, thyroid disorders and peripheral vascular disease.

For the practitioner with a suspected health problem, help is available via a number of avenues, including their General Practitioner, the Doctors' Health Advisory Service,³⁹ a staff health clinic (available in some Districts) or an independent occupational health physician. The medical manager should consider options available for the medical practitioner and work with them to formulate a management plan. The impact of life distracters, such as divorce, money problems or sick children, should also be considered and an empathic and supportive management style is encouraged. Employee Assistance can provide counselling, crisis response services and manager assistance to support staff.⁴⁰ Larger institutions may have a psychologist on staff to provide support and counselling to a practitioner, while other options include colleague support or a General Practitioner who is able to provide independent support and advice.

Practice tip:

Doctors may try to manage their own health care or seek medical advice from colleagues. However, good medical practice involves having a General Practitioner and seeking independent, objective advice about health care when needed. Managers should encourage and support the practitioner staff to find a General Practitioner whom they feel comfortable with.

Consider whether the practitioner presents a risk of harm to themselves or others. Ensure there are adequate support structures in place. This may include enquiring whether the practitioner has a supportive adult present at home and making sure there is a team member aware of the practitioner's medical condition and what to look out for if the practitioner continues to work with a medical condition.

If there are concerns about impairment, specific measures apply. In particular, if there is a substantial risk of harm to the public because of impairment, notification to AHPRA must occur. AHPRA will assess the notification and determine if health assessment under the *Health Practitioner Regulation National Law Act 2009* is required.

Regardless of the decision made by AHPRA, under the *Public Service Regulation 2008* and the *Public Service Act 2008*, an employee can be required to submit to a medical examination if there is a reasonable suspicion that unsatisfactory performance is the result of mental or physical illness.⁴¹ The DCEO (or sub-delegate) has the delegation to direct an employee to attend a medical examination.⁴² Consultation with People and Culture Corporate (Workplace Services) must occur before undertaking this step.

The practitioner may require a period of leave while treatment is sought. Alternative work roles, redeployment, transfer or retirement may need to be considered for longer-term health issues. The HR policy of Reasonable Adjustment⁴³ applies to all Queensland Health staff, including medical staff. A supported and/or staged return to work may need to occur. If there are concerns about potential de-skilling after a period of absence, safety mechanisms must be considered and put in place. This may include a period of supervised practice. If there is an extended absence from procedural practice, supervisory requirements may need to be formalised by the Credentialing and Scope of Practice Committee.

Definitive assessment of escalated concerns

Once the initial safety decisions have been made, a pathway for definitive resolution must be chosen. There are three possible pathways available:

- Performance assessment by CliPSS (for CliPSS-eligible practitioners)
- Performance assessment by Local Performance Review (for non-CliPSS-eligible practitioners)
- Formal (“Part 6”) investigation

The decision between proceeding with performance assessment or formal investigation, should involve discussion with the practitioner concerned. The option for performance assessment, or the “green” pathway as described in the *Safe Doctors: Fair System Guidelines*, must be offered to all medical practitioners with performance concerns. The “red” investigative pathway is the default pathway if the practitioner does not provide consent for performance assessment. A practitioner must be told that a concern has been raised and what it is, unless, very exceptionally, this could prejudice the investigation. Secrecy should be limited to investigations of fraud or criminal acts or other serious matters when disclosure could prejudice the investigation and this decision must follow legal advice, with reasons recorded. The practitioner is to be told how the performance assessment or investigation can be expected to progress. Strengths and limitations of both approaches are discussed below.

Performance assessment

The purpose of performance assessment is to observe the practitioner in his/her own environment with real patients or a simulated environment in order to assess whether the practitioner’s professional performance is provided safely at a level consistent with the position in which he/she has been employed. Performance assessment is the method of choice when it is clear that something is wrong with the practitioner’s clinical practice, but it is not clear what is wrong or why it is happening. For example, performance assessment may involve two senior colleagues closely examining a practitioner’s real-time practice, using direct observation, to inform an understanding of the practitioner’s strengths and deficits.

Practice tip:

Assessors must be selected to reduce potential conflicts of interests, e.g. they should not be from the same facility or in a working relationship with the practitioner, and be formally appointed to the role for indemnity purposes. The Clinician Performance Team has a pool of trained assessors which can be utilised in performance assessment undertaken by CliPSS or Local Performance Review.

Performance assessment does not re-examine the initial trigger events, and does not make findings about guilt or innocence. It is an attempt to predict future performance and to build a platform from which tailored remediation can be designed.

CLiPSS offers the most comprehensive and confidential method of performance assessment. It is conducted within a privileged environment, and is only available to those practitioners who are practising independently, i.e. who are not under any type of supervision (either for registration or training purposes). Due to the seniority of the practitioner and lack of a designated supervisor, the CLiPSS approach uses a very broad suite of information sources to deliver the most accurate assessment results possible. Appendix 6 provides an overview of the CLiPSS performance assessment process.

Local Performance Review is a scaled-down version of a CLiPSS-type assessment, but conducted locally, with supervisor involvement. Local Performance Review must have a minimum of three assessment modalities to ensure sufficient cross-validation. Appendix 7 provides an overview of performance assessment offered via Local Performance Review.

Formal investigation

Formal investigation into a medical practitioner's performance and professional conduct may be conducted under the provisions of Part 6 of the *Health Services Act 1991*. Investigation involves a careful and accurate search or inquiry into events which have led to concerns about performance. It is an alternate option for assessment if a senior medical practitioner declines to consent to CLiPSS or Local Performance Review is deemed unsuitable.

As a risk management tool, it is inferior to performance assessment in that the reviewers are confined to examining past events. Isolated examination of known aberrant events has been shown to be a poor predictor of future performance, and will almost certainly fail to detect latent shortcomings. However, in some circumstances, it is the only tool available.

An investigation must be commissioned by the DCEO with appointment of investigators and Terms of Reference for the investigation. Investigators are appointed to provide independent and expert opinion in relation to professional standards of a practitioner associated with specified cases. Investigators are not responsible for deciding outcomes or mitigating factors, with the DCEO responsible for subsequent judgements and decisions on how to act.

Appendix 8 contains sample Terms of Reference for a formal investigation into a practitioner's performance.

Practice tip:

Choose investigators carefully. A trained/skilled investigator and a clinician may need to be jointly appointed to ensure the necessary evidence gathering, interviewing and expert clinical opinion skills for a thorough and defensible investigation.

Thought needs to go into the purpose of the investigation and Terms of Reference need to be tailored to the performance concern raised. Typically, investigators are appointed to gather facts. However, if investigators are being asked for recommendations, they need to be given that power in the Terms of Reference of the investigation.

Section IV: Specific considerations

Resident medical officers

Performance management of Interns requires special consideration. Internship, i.e. Post Graduate Year (PGY) 1, occurs under provisional registration by the Medical Board of Australia as outlined in the *Health Practitioner Regulation National Law Act 2009*. There are specific practice requirements for the individual and facility, including processes for mid and end of term performance assessments and development of an Improving Performance Assessment Plan (IPAP) for identified underperformance. Management of performance concerns of Interns must involve the Director of Clinical Training with consideration of Medical Board requirements. Performance management of interns should primarily be the Director of Clinical Training's responsibility, liaising with the Director of Medical Services as required.

Performance assessment and management of resident medical officers not on a specialty training programme, e.g. Junior House Officers (PGY 2) and Senior House Officers (PGY 3), is to follow a similar process to that of Interns with an end of term assessment and development of an IPAP where indicated. Identified underperformance is to be managed by the Director of Clinical Training or Director of Medical Services with line manager input.

Official misconduct and blameworthy acts must be managed as for all Queensland Health staff. Credentialing and scope of practice considerations do not apply to resident medical officers.

Medical practitioners on a specialty training pathway

Registrars on a specialty training programme with significant performance issues must involve liaison with the supervisor and training college.

Principal house officers not on a specialty training programme require performance assessment and management similar to that for Junior and Senior House Officers, but will not usually be managed by the Director of Clinical Training. The appropriate supervisor is the key responsible officer.

Official misconduct and blameworthy acts must be managed as for all Queensland Health staff. Credentialing and scope of practice considerations do not apply to medical officers whose practice is under direct supervision.

Medical practitioners with limited registration

Medical practitioners with limited registration for "postgraduate training or supervised practice" or "area of need" under the *Health Practitioner Regulation National Law Act 2009* (sections 66 and 67) require a supervision and training plan with regular performance reports by supervisors submitted to the Medical Board of Australia. If concerns are raised about the safety and competence of limited registrants to practice, there is an obligation to notify the Medical Board of Australia. Notification, management and practitioner support should involve the supervisor/s and the Director of Medical Services (or other professional head).

Medical practitioners under contract

Visiting Medical Officers under contract conditions must be managed in accordance with the Visiting Medical Officers standard contract⁴⁴ instead of the HR policies used for management of employees. “Withdrawal of Approval” is the contractual equivalent of dismissal proceedings. Withdrawal of Approval on the basis of conduct which is negligent, careless, incompetent, inefficient, disgraceful or improper must be managed in accordance with clause 12 of the Visiting Medical Officers standard contract.

However, prior to a decision for Withdrawal of Approval, where there are practice concerns, the employing district still has the option of referral to CliPSS for performance remediation. The Visiting Medical Officer contract does not oblige the District to terminate the contract, but provides an enabling clause upon which the District may rely in the event of the specified conduct. Visiting Medical Officers are likely to require significant reassurance about confidentiality because of their dependence on private-practice income.

Locum medical practitioners

A locum may be either an employee or agent of a locum agency (ie. Queensland Health pays the agency for services provided, not the locum directly) or a temporary employee of Queensland Health sourced through an agency (ie. the agency is paid a placement fee and the locum is placed on Queensland Health payroll).


Locums who are employees or agents of a locum agency must be managed in accordance with the terms of the contract with the locum agency (which must contain a termination clause)⁴⁵.

Locums who are temporary employees of Queensland Health should be managed in accordance with applicable HR policies.

The Office of Rural and Remote Health (ORRH) credentialing committee is the designated committee for managing SoCP for rural general practice locum medical officers for all districts. The ORRH maintains and publishes a register of all rural general practice locum medical officers who have been credentialed and granted a SoCP, and practitioners appearing on this register are deemed to have an approved SoCP (consistent with the CSCF service level(s)) for all rural facilities across the state. Therefore, it is important that concerns about performance of rural general practice locums (whether employees or agents of a locum agency, or temporary employees of Queensland Health) are discussed with, and managed in conjunction with, the ORRH Clinical Support Unit.

Medical practitioners in administrative roles

Performance management of a medical practitioner working in an administrative or non-clinical role (e.g. a Director of Medical Services or Clinical Director) requires line manager responsibility for action (e.g. by the DCEO). Specific considerations for medical practitioners working in an administrative role, include assessment of clinical, operational and staff risks and appropriate risk mitigation strategies. In the short term, a line manager should consider which responsibilities of a medical manager can be continued, delegated to another person or undertaken with closer supervision. The principle of following the least



restrictive path for the practitioner must be followed provided patient, staff and individual safety is not compromised. Credentialing and scope of practice considerations apply and must be managed as for other senior medical officers.

In the assessment of a performance concern, consideration should be given to potential underlying causes, for example, health issues, substance misuse and personal and work-related stressors and management strategies appropriate to the situation are to be followed. Performance concerns must be documented and a performance support and review plan put into place. ClIPSS can provide performance assessment, which is benchmarked against the Royal Australasian College of Medical Administrators core competencies, and contacting the Clinician Performance Team for advice or performance assessment is advised where performance concerns are identified.

Medical practitioners undertaking research or teaching

The performance of research is governed by the Australian Code for the Responsible Conduct of Research (2007),⁴⁶ which sets out researcher, supervisor and institutional responsibilities. Breaches of the code giving rise to concerns about performance are to be handled via line management and HR processes. The management by institutions of more serious breaches of the Code, termed research misconduct, is set out in Part B of the Code. For performance concerns related to university-appointed medical practitioners, notification should be made to the university line manager for action. The DCEO should also be informed in all serious breaches of performance related to research and in cases of research misconduct as they are the authorising body for all research conducted within the District. The Chair of the relevant Human Research Ethics Committee should be contacted if there are ethical concerns in relationship to the conduct of research including serious breaches of the Code. For scope of practice violations, notification must be made to the Director of Medical Services (or other professional head) and the Credentialing Committee.

Investigation by external authorities

With involvement of external authorities such as professional and healthcare regulators (e.g. the Medical Board of Australia and the Health Quality and Complaints Commission), courts and judicial bodies (e.g. the Coroner) and investigative and law enforcement agencies (e.g. the Crime and Misconduct Commission and the Queensland Police Service), local investigation and management of performance issues may be impacted. The DCEO will have to consider whether internal action is to continue or whether to postpone further investigation until external inquiries are complete. The DCEO still has a duty to establish that patient safety is not at risk. The organisation and practitioner may both need to take legal advice. If an external inquiry fully exonerates an individual practitioner, further action may become unnecessary. However, in certain circumstance an internal investigation may need to proceed, e.g. where there are ongoing concerns over patient safety or where no prosecution is made because the level of proof needed in a criminal case cannot be met.

Media considerations

Performance concerns with doctors may result in significant media interest with important considerations, including confidentiality for the staff and any patients involved. All media inquiries should be discussed with district or corporate media officers immediately to enable joint management by media liaison personnel and medical administration as required.⁴⁷ Only authorised staff may speak to the media on behalf of Queensland Health. Matters of a political nature should be referred to the Senior Departmental Liaison Officer with a request that the information be communicated to the Minister's office. The Director of Medical Services (or other professional head) must immediately brief the DCEO (or equivalent) of performance concerns about a doctor that has incurred media interest given the sensitive nature of the issue. Concerns about the Director of Medical Services (or other professional head) should be communicated directly with the DCEO.

Section V: Human Resources management

An employee may be disciplined under section 187 of the *Public Service Act 2008* if the Director-General or delegate is reasonably satisfied that the employee has undertaken one or more of the following:

- Performed duties carelessly, incompetently or inefficiently
- Been guilty of misconduct
- Been absent from duty without approved leave and without reasonable excuse
- Contravened, without reasonable excuse, a direction given to them as an employee by a person with authority to give the direction
- Used, without reasonable excuse, a substance to the extent that the substance has adversely affected the competent performance of the employee's duties
- Contravened, without reasonable excuse, a provision of the *Public Service Act 2008* or the *Code of Conduct for the Queensland Public Service*. This includes the contravention of a departmental policy or procedure.

In addition, grounds for discipline include failure of the employee to adequately address unsatisfactory work performance, workplace conduct or workplace behaviour despite management action.

Practice tip:

It is important to recognise that some of these behaviours will be exhibited by doctors with a physical or mental illness. Therefore, it is important to consider potential impairment before going down a disciplinary path. Early 'triage' with HR (People and Culture) involvement is essential.

Delegated responsibility for undertaking specific actions must follow the HR delegations manual and District sub-delegations manual (e.g. performance management may be sub-delegated by the DCEO, while suspension is a DCEO delegation). Discuss with People and Culture staff if unsure of delegated powers.

If disciplinary action is considered necessary, then District People and Culture staff must be consulted prior to commencing the disciplinary process. The practitioner should be offered access to the employee assistance service and informed of their entitlements to discuss the matter with a support person and union or legal representative. Steps in the disciplinary pathway are outlined in the *HR Policy on Discipline (E10)*.⁴⁸

Appendix 1: Definitions of key terms

Term	Definition
Adverse event	An incident in which a person receiving health care is harmed. ⁴⁹ An incident that had the potential to cause harm (a potential adverse event), but didn't, is termed a "near miss".
Blameworthy act	An intentionally unsafe act, deliberate patient abuse or conduct that constitutes a criminal offence. ⁵⁰
Human error	Unintentionally wrong conduct or judgment (a mistake) that usually manifests in doing the wrong thing (commission) or not doing the right thing (omission), may or may not result in harm, and is not the result of the operation of chance. ⁵¹
Natural justice	Concerned with ensuring that an objective decision-maker reaches a procedurally fair decision. There are two basic rules of natural justice: (i) the hearing rule requires that when an action could adversely affect an employee's interests, the employee is to have a chance to state his/her case before action is taken, (ii) the rule of bias requires that the decision-maker brings, and is seen to bring, an impartial and prejudice-free mind to resolving the question to be decided. ⁵²
Notifiable conduct	Conduct by a health practitioner which constitute mandatory reporting obligations to AHPRA, specifically: <ul style="list-style-type: none"> a) Practise of the profession while intoxicated by alcohol or drugs, or b) Engagement in sexual misconduct in connection with their profession, or c) Placing the public at risk of substantial harm in their practise because they have an impairment, or d) Placing the public at risk of harm during their practice because of a significant departure from professional standards.⁵³
Official misconduct	Any conduct connected with the performance of an employee's duties that is dishonest or lacks impartiality, involves a breach of trust or is a misuse of officially obtained information or material required. The conduct could, if proven, be a criminal offence or serious enough to justify dismissal. Conduct which may constitute official misconduct includes, but is not limited to: <ul style="list-style-type: none"> • Theft of Queensland Health property • Unauthorised release or disclosure of confidential and/or patient information • Misuse of Queensland Health assets and/or equipment

	<ul style="list-style-type: none"> • Conducting a private business during working hours and/or utilising Queensland Health resources • Conflicts of interest including contracting and/or approving a contract on behalf of Queensland Health with a firm or business in which an interest is held • Theft and/or fraudulent dealings of the property or possessions of Queensland Health patients • Assault in the workplace of fellow employees, patients or other persons • Utilising the Queensland Health computer network for accessing or transmitting pornographic images • Reprisal under the <i>Public Interest Disclosure Act 2010</i> • Other serious misconduct which would tend to bring Queensland Health into disrepute and which is likely to result in disciplinary action, including dismissal • Wilful neglect which may be defined as malicious or reckless conduct.^{54,55}
Reprisal	Where a person causes, attempts or conspires to cause detriment to another person because of a belief that they have made, or may make, a public interest disclosure or being involved in a proceeding under the <i>Public Interest Disclosure Act 2010</i> .
Peer	A health practitioner with relevant clinical experience in a similar health service organisational environment who also has the knowledge and skills to contribute to the review of another health practitioner's competence and performance. ⁵⁶
Performance	The extent to which a medical practitioner provides healthcare services in a manner which is consistent with known good practice and results in expected patient benefits. ⁵⁷ Refers to the knowledge, skills and experience possessed and applied by the practitioner in the practice of medicine in the position to which they have been appointed by Queensland Health.
Public interest disclosure	Defined under the <i>Public Interest Disclosure Act 2010</i> by reference to the person who makes the disclosure, the type of information disclosed, and the entity to which the disclosure is made. Disclosures may include information pertaining to official misconduct, maladministration, substantial misuse of public resources, danger to public health or safety or to the environment, danger to the health and safety of a person with a disability and conduct that, if proven, could be a reprisal. ⁵⁸

Appendix 2: Relevant legislation

Crime and Misconduct Act 2001

Health Practitioner Regulation National Law Act 2009

Health Practitioners (Professional Standards) Act 1999

Health Quality and Complaints Commission Act 2006

Health Services Act 1991

Information Privacy Act 2009

Public Interest Disclosure Act 2010

Public Sector Ethics Act 1994

Public Service Act 2008

Public Service Regulation 2008

Right to Information Act 2009

Queensland legislation is available at:

<http://www.legislation.qld.gov.au/OQPChome.htm>

Appendix 3: Staff responsibilities relating to performance management

Staff member	Responsibility
All staff	<p>Adhere to the <i>Code of Conduct for the Queensland Public Service</i> and other relevant standards, policy and legislation</p> <p>Report clinical incidents as outlined in the <i>Clinical Incident Management Implementation Standard 2009</i></p> <p>Report performance concerns to their line manager, including reporting safety issues to the Director of Medical Services (or professional head)</p> <p>Participate in regular Performance Appraisal and Development or a performance review process</p>
Line managers	<p>Immediate risk management and management or escalation to the Director of Medical Services (or professional head) of performance concerns</p> <p>Conduct regular Performance Appraisal and Development / performance reviews with line report staff</p>
Clinical directors	<p>Establishment and maintenance of peer review and audit processes to identify concerns regarding clinical performance</p> <p>Conduct regular Performance Appraisal and Development / performance reviews with line report staff</p>
Directors of Medical Services	<p>Initial assessment, management, and referral or notification of clinical performance issues</p> <p>Conduct regular Performance Appraisal and Development / performance reviews with line report staff</p>
District CEO	<p>Conduct regular Performance Appraisal and Development / performance reviews with line report staff</p> <p>Ensure concerns raised over clinician performance are acted upon</p> <p>Undertake appropriate processes, including disciplinary action (if necessary) for blameworthy acts and reportable misconduct</p>
Medical Director, Clinician Performance Team	<p>Leadership and management of CliPSS</p> <p>Provision of advice to Executive staff on performance management and Local Performance Review</p>
Senior Director, Assurance and Risk Advisory Service	<p>Timely determinations regarding Public Interest Disclosure status for disclosures under the <i>Public Interest Disclosure Act 2010</i></p>
Director, Ethical Standards Unit	<p>Management of official misconduct and liaison with the Crime and Misconduct Commission</p>

Appendix 4: Letter of appointment for rapid clinical review

Dear [Assessor]

Re: Rapid Clinical Review

Thank you for agreeing to undertake a rapid review of concerns regarding the practice of Dr [Medical Practitioner], [Position] in [Specialty] at [Facility]. I confirm this review is being undertaken in order to allow the [District] to ensure standards of care are maintained and to perform its functions under the *Health Services Act 1991*.

If there is more than one reviewer: Dr [Name, Position, Specialty] has also agreed to undertake a rapid clinical review in relation to this matter.

Issue

The District has [received/raised] concerns about Dr [Medical Practitioner]'s performance related to [specify number] patients treated in the [Department]. The detail of the concerns is set out in the **enclosed** template report.

The Director of Medical Services of [Facility] is concerned that Dr [Medical Practitioner]'s level of skill in [Specialty] may be below the standard that could reasonably be expected of a Fellow of [his/her] training and experience and as such may pose a risk to patient safety because of [brief description of concerns.]

[or otherwise describe key concerns]

Dr [medical practitioner] has been advised of these concerns and that the District will undertake a review of relevant cases to assess their veracity.

Request for Review

Your initial task is to undertake a review of, and report upon, the following cases [or otherwise describe what the reviewers are to review:]

- [list URNs of patient cases and include de-identified copies of charts as necessary]

With regards to these cases, I seek your opinion on the following questions:

1. Are the events giving rise to concerns factually verified in the available documentation?
2. Is there *prima facie* evidence to support the Director of Medical Services' concerns? E.g. documented serious adverse outcomes, significant morbidity?
3. If the concerns were subsequently proven to be true, would there be a substantial and specific risk to patient safety?
4. If the concerns were subsequently proven to be true, what would be the least restrictive action that could be taken to protect patients?

Conduct of the Review

Natural Justice

The overall concern is that Dr [Medical Practitioner] may not be safe to practise at the level consistent with the position in which [he/she] is employed at [Facility]. This is a matter that is for my determination as the District Chief Executive Officer. Your role, in the conduct of the rapid clinical review, is advisory only. Accordingly, in providing your opinion on the above questions, please:

- refer to the information relied upon (e.g. from the patient chart or the standards of practise generally in this speciality) upon which your advice or opinion is based; and

- inform me immediately you become aware of any conflict of interest for you (potential or actual) that may impact on your ability to conduct this review.

Privacy

The information provided to you regarding Dr [Medical Practitioner] is “personal information” under the *Information Privacy Act 2009* and the use and disclosure of this information is subject to this Act. To ensure compliance with this Act, you must not:

- disclose this information to anyone else, except as necessary to conduct your review; nor
- retain any hard or soft copies of this information or the report at the completion of your review.

These obligations survive your completion of the review.

Confidential Information

Information that could identify a person who is receiving, or has received, a public sector health service is “confidential information” under the *Health Services Act 1991* and the use and disclosure of that information is subject to that Act. You have been provided with patient information in a de-identified form to preserve its confidentiality. To ensure confidentiality is maintained, you must not:

- disclose this information to anyone else, except as necessary to conduct your review; nor
- retain any hard or soft copies of this information or the report at the completion of your review.

These obligations survive your completion of the review.

Indemnity

*For QH-employed doctors and VMO employees only:

I confirm that you will be conducting this review as a Queensland Health employee. Accordingly, the indemnity provided under HR Policy 12 (“*Indemnity for Queensland Health Medical Practitioners*”) is available to you as the services comprise “*associated clinical services*” for the purposes of this policy.

*For non-QH-employed doctors:

I advise that in conducting the review, you will be provided with indemnity on the same terms as contained in the terms of the indemnity provided under the Queensland Health HR Policy 12 (“*Indemnity for Queensland Health Medical Practitioners*”) and that for the purposes of this policy, your review comprises “*associated clinical services*”.

Report

Please complete the **enclosed** Rapid Clinical Review Report template and return it to me, together with the **enclosed** documents, [by date or as soon as practicable.]

Please be aware that your report may be subject to disclosure as required by law or procedural fairness.

If you have any questions or would like to discuss any aspect of the case, please do not hesitate to contact [specify contact] on [contact details].

Yours sincerely

Chief Executive Officer

[District]

Appendix 5: Rapid review template

The following template is modified from the *ClIPSS Medical Record Rapid Review – Report Template*.

Part 1: Case specific concerns

Case A

1) Brief Description of Patient Presentation		
Describe here the who / what / when / where of the alleged events. For example, a 3 year child presented to the emergency department in an obtunded state, with overt septic shock. The emergency department contacted Dr XX, who advised administration of paracetamol and did not attend. When the ED contacted the Dr a second time, he is alleged to have used inappropriate language, and to have hung up the phone.		
2) Summary of Concern:		
The Director of Medical Services is concerned that the advice to administer paracetamol was inappropriate, and reflected a poor appreciation of the severity of the illness, in spite of the communication of the necessary information to Dr XX. Furthermore, the DMS is concerned that the interaction between the department and Dr XX reflects inappropriate professional behaviour which may be indicative of impairment.		
3) Materials provided for consideration of Assessor		
Patient Record Letter of complaint from patient’s parents ***If response from doctor is available, should be included too****		
4) Assessor Opinion:		
Question	Please circle as appropriate	Reasons (if applicable)
1. Are the events giving rise to concerns factually verified in the available documentation? (That is, do documents support the contention that this doctor treated this patient at this time)	Yes/No	
2. Is there prima facie evidence to support the alleged concerns, e.g. documented serious adverse outcomes, mortality, significant morbidity that is potentially attributable to the performance of this clinician?	Yes/No	If yes, please summarise evidence which, in your opinion, prima facie supports the alleged concerns.
3. If the concerns were subsequently proven to be true, would this clinician’s ongoing practice represent a substantial and specific risk to patient safety?	Yes/No	Reasons:
4. If the concerns were subsequently proven to be true, what would be the least onerous action that could be taken to protect patients?	1. No action necessary 2. Recommend action.	Details of recommended action and reasons:

Part 2: Aggregated concerns / pattern of practice

A) Is there a concern about safety and professional performance based on consideration of the totality of the cases above, which each individual case alone may not present?		
Summary of DMS concerns.		
1. If the concerns in aggregate were subsequently proven to be true, would this clinician’s ongoing practice represent a substantial and specific risk to patient safety?	Yes/No	Reasons:
2. If the concerns in aggregate were subsequently proven to be true, what would be the least onerous action that could be taken to protect patients?	1. No action necessary 2. Recommend action.	Details of recommended action and Reasons:
Other Assessor Comments.		

Appendix 6: Clinician Performance Support Service

Overview

CLiPSS is a voluntary and confidential service available for Queensland Health medical officers, including Visiting Medical Officers, to whom the *Credentialing and Defining the Scope of Clinical Practice for Medical Practitioners and Dentists in Queensland* policy applies and who hold general, specialist or limited registration for area of need with the Medical Board of Australia. Referrals can be received from any member of Queensland Health's senior executive staff or by self-referral with notification of the Director of Medical Services (or other professional head). Confidentiality is maintained unless there is a matter of public protection, professional misconduct or other similar, serious concern.

A CLiPSS assessment is not an investigation into wrongdoings, but seeks to identify existing strengths and focus attention on areas where structured support will make a difference. It uses comprehensive assessment procedures, including a personal health assessment, as well as peer assessment of on-the-job performance of normal daily tasks. The goal of CLiPSS assessment is to decide if a support plan is needed, and to clarify what elements the support plan should contain.


The primary role of CLiPSS is to support professional development and, if required, remediation to the level of appointment based upon the findings of personalised assessment. Some of the benefits of the CLiPSS approach are that it:

- Balances the important priorities of patient safety and support for clinicians
- Provides a global approach to risk management, rather than an examination of who is at fault
- Provides a personalised professional development plan, with a support structure to ensure it is delivered.

Intake interview

Following preliminary discussions with the referring party as to the appropriateness of the matter for a CLiPSS assessment, the following intake process can commence:

1. The Director and/or Assistant Director will conduct an intake interview with the referring party to obtain details of the clinical performance concerns and the risk management strategies undertaken.
2. A formal CLiPSS Case Description document will be prepared which includes a summary of clinical performance concerns as described by the referring party.
3. The referring party will be asked to confirm that the clinical performance issues have been presented to and discussed with the practitioner concerned. This will also provide an opportunity for the referring party to discuss the CLiPSS process with the clinician.
4. As CLiPSS is a voluntary process, the practitioner must provide his/her consent. A meeting will be arranged with CLiPSS staff to fully brief the practitioner about the CLiPSS assessment processes.

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5. Should the practitioner consent, the CliPSS Quality Assurance Committee will consider if the matter is appropriate for a full performance assessment. Once the Committee commissions the performance assessment, the assessment process commences.
 6. Should the practitioner decline to consent, the matter will be referred back to the district to manage using alternative management pathways.

A CliPSS Case Manager will be appointed to work with the practitioner from beginning to end of the CliPSS process. A Performance Support Panel will be established comprising of a Chair/Procedural Expert (usually the Case Manager), and two clinicians from the relevant college(s).

A typical Performance Assessment will include the following:

1. Health assessment – The health assessment comprises physical and mental health and cognitive functioning screening tests conducted by qualified medical and psychology professionals. If any concerns are identified in the screening examinations, full assessments in the relevant areas will be undertaken. Assessment of performance will not proceed if it becomes clear that a medical condition is impacting on the practitioner’s ability to perform well.
2. Medical record review – A random selection of 15-20 medical records will be chosen and assessed by the Performance Support Panel against standard criteria to assess the administrative quality of the record and the practitioner’s day-to-day decision making.
3. General interview – The purpose of the general interview is to:
 - a. Introduce the practitioner to the CliPSS Assessors
 - b. Ensure a common understanding about the Performance Assessment process
 - c. Provide a summary of the proposed assessment schedule
 - d. Explore the practitioner’s background, training and experience (where applicable).
4. Clinical Evaluation Exercise - For the purposes of observing consultations generally 8-10 patient encounters will be observed. Consultations should be conducted in the practitioner’s usual manner and there should be no interaction with the CliPSS Assessors during the consultation. Examples of areas assessed include:
 - a. Communication skills
 - b. Clinical judgement
 - c. Organisation/efficiency.

5. Procedural Evaluation Exercise - The procedures observed should be representative of the practitioner's usual procedural practice. The CliPSS Assessors may interact with the practitioner providing this is compatible with the patient's safety and well-being. Examples of areas assessed include:
 - a. Consent
 - b. Basic surgical technique
 - c. Visualisation of the surgical field.
6. Facilities inspection – The CliPSS Assessors will undertake a review of the work environment to determine its potential impact on the practitioner's performance.
7. Interview with colleagues – The CliPSS Assessors will interview a selection of the practitioner's colleagues. The practitioner will be given the opportunity to nominate between two and four colleagues to be interviewed. The referring party will also be asked to nominate between two and four practitioner colleagues for interview. Interviews will only proceed if the interviewee is prepared to have his/her comments documented and attributed to him/her in the assessment report.
8. Clinical practice interview – The purpose of the interview is to explore the practitioner's knowledge and attitudes and will be based on hypothetical cases and issues arising from the observed consultations or procedures and record review. Where there are specific concerns arising from the original referral, questions that are relevant to those concerns will also be incorporated.
9. Supplementary assessment, e.g. clinical simulation (where applicable)

Figure 2 provides an overview of performance assessment via CliPSS.

The Case Manager will then meet with the referring party to discuss the outcomes of the performance assessment and if required, commence discussions about performance support.

Development of a support plan

If there are areas where support is required, CliPSS will work to develop and implement a personalised support plan, which can include clinical training, communication skills, technical knowledge or workplace conflict resolution. CliPSS has a dual role of ensuring that the workplace provides the support that has been promised, and that the practitioner undertakes the activities he/she has agreed to do.

Implementation of the support plan

CliPSS will liaise with appropriate resources or institutions to facilitate the support plan. For example, CliPSS might help find a place for a clinical attachment, or may identify courses that would help address any of the identified areas for development.

Periodic re-assessment by Performance Support Panel

Reviews will be undertaken at reasonable intervals with reference to the Support Plan, until completion. CliPSS will aim to have these reviews done by the same team who formed the initial Performance Support Panel, but this may not always be possible.

Completion

When the agreed goals have been achieved as evidenced at re-assessment, the process will be considered as having been completed.

Appendix 7: Local Performance Review

Overview

The Local Performance Review is based on the same philosophy, guiding principles and framework as that of CliPSS. However, there are several key differences:

- Local Performance Review is designed to be managed within the Health Service District by the DCEO and/or Director of Medical Services. The Health Service District is accountable for management of the process. The Clinician Performance Team acts as a supportive consultancy service through an appointed Case Manager and will guide the Health Service District through the process.
- The Health Service District will incur associated costs related to the Local Performance Review process, including health assessments which are undertaken. There will be no charge for the utilisation of the Clinician Performance Team.
- Local Performance Review applies to all medical practitioners who do not fall into the scope of CliPSS.
- Local Performance Review does not attract the same privilege and confidentiality as CliPSS under the *Health Services Act 1991*.

Right to privacy

While Local Performance Review is a confidential service, it is subject to the *Right to Information Act 2009* and lawful requirements to produce information and issues concerning public protection, professional misconduct or other similar, serious concerns.

Referral and intake process

The initial referral process is by direct contact with the Clinician Performance Team requesting advice or support. Referrals can be received from any member of Queensland Health's senior executive staff or by self-referral.

The Director and/or Assistant Director will conduct an intake interview with the referring party to obtain details of the clinical performance concerns and the risk management strategies undertaken. A formal Local Performance Review Case Description document will be prepared which includes a summary of clinical performance concerns as described by the referring party. The referring party will be asked to confirm that the clinical performance issues have been presented to and discussed with the practitioner concerned.

Performance assessment

Following the intake interview and case analysis, the Clinician Performance Team will advise the District on the recommended case specific assessment methodology. The suite of assessment modalities that pertain to CliPSS are available in the Local Performance Review process. However, the District is able to choose what is most appropriate in conjunction with the advice given by the Clinician Performance Team.

The performance assessment may therefore differ on a case by case basis.

Once a pathway of assessment has been decided upon, the Clinician Performance Team will appoint a Local Performance Review Case Manager to liaise with the District and the practitioner throughout the assessment process. The District will be responsible for executing the assessment with advice and support, including documentation and templates, from the Clinician Performance Team.

Development and implementation of a support plan

If there are areas of practice where support is required, the Clinician Performance Team will assist the District to develop a personalised support plan. If required the Clinician Performance Team will also liaise with appropriate resources or institutions to facilitate the support plan. For example, the Clinician Performance Team might help find a place for a clinical attachment, or may identify courses that would help address any of the identified areas for development.

Periodic re-assessment

Reviews will be undertaken at reasonable intervals with reference to the Support Plan, until completion. The District will aim to have these reviews done by the same team who formulated the initial support plan, but this may not always be possible.

Completion

When the agreed goals have been achieved as evidenced at re-assessment, the process will be considered as having been completed.

Appendix 8: Sample terms of reference for formal investigations

TERMS OF REFERENCE

INVESTIGATION INTO ALLEGATIONS AGAINST [Name]

1. Background

[Name of respondent] is the [position title] of [facility] in the [Area/District/Division].

A complaint has been received from [name of complainant if appropriate, or a patient, a group of employees of this District etc] alleging that:

- [Specify the allegation/s or concern/s].

[OR]

Concerns have been identified via [specify source, e.g. medical performance review, clinical audit, clinical incident review etc.] about the clinical competency and work practices of the above practitioner with specific details as follows:

- [Specify the allegation/s or concern/s].

2. Further Allegations / Clinical Concerns

Where any further allegations arise during the course of the investigation, I am to be advised of the specifics of those allegations. Where I am of the view that the additional allegations are relevant to this investigation, I may choose to amend these terms of reference to include the investigation of such allegations.

If this occurs, [name of respondent] will be advised of the specifics of the further allegations and be provided with an opportunity to respond to all the allegations prior to this investigation being finalised.

3. Appointment of Investigator

I have appointed [Investigation Officer A] from [name of Area/District/Division] and [Investigation Officer B] from [name of Area/District/Division], under section 52(1) of the *Health Services Act 1991* (the Act), to ascertain whether there is evidence to support or deny the allegations made by [name of complainant/s as above].

4. Investigation

The investigation is to proceed in accordance with the principles of natural justice.

The Investigation [Officer/s] has/have the authority under sections 56 and 62K of the *Health Services Act 1991* to access any evidence under the control of a Health Service District, which either proves or disproves the allegations that have been made. The Investigation [Officer/s] should also make a reasonable attempt to obtain any other relevant evidence that either proves or disproves the allegations that have been made.

The Investigation [Officer/s] has/have the authority under the Health Services Act 1991 to interview any person who may be able to provide further evidence, in relation to the allegations. The Investigation [Officer/s] may seek to interview persons who are not employees of Queensland Health who may be able to

assist with the investigation. Where this will incur a cost to the District, approval must first be sought from myself.

The Investigation [Officer/s] need only interview persons who can provide information that is credible, relevant and significant to the matter under investigation.

The Investigation [Officer/s] must provide [name of respondent] with the opportunity to attend an interview and the opportunity to respond verbally to the matters under investigation.

Material, which is adverse to [name of respondent], and credible, relevant and significant to the findings to be made by the Investigation [Officer/s] is to be released to [name of respondent] during the course of the investigation. This can be released verbally at interview.

The Investigation [Officer/s] are delegated the authority to give any appropriate lawful directions which may be required during the course of the investigation. For example to provide a lawful direction to an employee to maintain confidentiality, to attend an interview, or to provide copies of Health Service District documents etc.

5. Relevant Legislation and Policies

The legislation and/or Queensland Health policies relevant to this investigation include (but are not limited to):

- *Code of Conduct for the Queensland Public Service;*
- *Public Service Act 2008;*
- [Insert any further relevant policies/legislation]
 - ▶ e.g. HR Policy 15 *Public Interest Disclosures (Whistleblowers);*

6. Investigation Report

The report should specifically:

- address the complaint and the allegations outlined above;
- list all relevant evidence obtained in the course of the investigation;
- provide an assessment of the evidence as to whether the evidence either substantiates or does not substantiate each allegation on the balance of probabilities, including reasons for these conclusions;
- clearly identify any inferences derived from hearsay in the assessment of the evidence where it is relevant and significant to the findings made by the Investigation Officer/s;
- include quotes or excerpts from evidence in the assessment of the evidence where it is credible, relevant and significant to the findings made by the Investigation Officer/s;
- append all documentary evidence, including signed records of interview/statements and append these to the report.

7. Findings

The Investigation Officer/s is required to determine whether there is sufficient evidence to substantiate the allegations on the balance of probabilities. The Investigation Officer/s should not make any other findings or recommendations in relation to the allegations.

[Note: whether other findings or recommendations are made may vary on a case by case basis with specific provision for such spelled out here]

8. Further Instructions

The Investigator is also requested to [insert any specific requests of Investigator]

9. Timeframes

The report is to be finalised by [date], unless otherwise agreed in writing by me or my delegate.

10. Confidentiality

The investigator must not disclose to another person, whether directly or indirectly, any information acquired during the course of this investigation except in the following circumstances:

- a. Disclosure necessary for the purpose of this investigation
- b. Disclosure required or permitted by law.

11. Decision Maker

The District Manager, [insert District], will be the decision maker in this matter.

If necessary, the Investigation [Officer/s] should report back to me for further instructions during the course of the investigation.

Signed

[Chief Executive Officer, District]


[Date]

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