



The Royal College of Pathologists  
*Pathology: the science behind the cure*

Professional Standards Unit and Professional Performance Panel

**Concerns about performance in pathology:  
Guidance for healthcare organisations and pathologists**

**February 2006**

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In accordance with the College's publications policy, this document was placed on the Fellows' and Members' area of the College website for consultation from 29 September to 30 October 2005. Seven people submitted detailed comments, as did the Professional Performance Panel. The Professional Standards Unit considered the feedback and amended the document accordingly. Please email [publications@rcpath.org](mailto:publications@rcpath.org) if you wish to see the responses to the feedback received.

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**Director of Publications**

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# **Concerns about performance in pathology:**

## **Guidance for healthcare organisations and pathologists**

### **1 SCOPE OF DOCUMENT**

This document provides guidance to enable organisations and individuals to investigate concerns about the performance of individual pathologists or teams, appropriate remedial actions and the identification and management of the consequences of substandard performance to the patient.

This guidance covers the following:

- all pathologists working in the UK (both medically and non-medically qualified)
- the detection of poor performance of individual pathologists, teams or directorates
- the management of poorly performing services
- duty of care to patients in the detection and prevention of harm
- the management or resolution of personality or professional relationship difficulties
- the updating of the knowledge base and skills base through continuing professional development (CPD) and further training.

This document replaces the College's March 2004 document, *Substandard Performance in Pathology: Guidance for NHS Trusts and Pathologists*, and now includes guidance on duty-of-care reviews.

This document does not cover concerns about performance of pathologists in respect of work carried out for Coroners or Procurators Fiscal. This will be addressed in a separate College guidance to be developed in the future. If Coroners or Procurators Fiscal are concerned, they may contact the College for advice.

#### **1.1 Definition of pathology**

Pathology is the clinical diagnostic science that underpins patient care. The main disciplines are:

- chemical pathology/clinical biochemistry
- cytopathology
- forensic pathology
- genetics
- haematology and transfusion medicine
- histocompatibility and immunogenetics
- histopathology
- immunology
- microbiology
- neuropathology
- oral pathology
- paediatric pathology
- toxicology
- virology.

## **1.2 The role of the employing organisation**

The College expects organisations to fulfil their clinical governance obligations and, in particular, to have carried out appropriate preliminary investigations and audits before approaching the College for assistance. The results of these should be made available to the review team.

## **1.3 The role of the College**

The College will organise and undertake onsite reviews under terms of reference agreed with the employing organisation. The College will write a report, which will be the property of the employer and will contain recommendations for the resolution of any problem detected.

The College does not have the resources to undertake remedial action, whether this is handling behavioural or relationship issues, providing further training or the undertaking of duty-of-care reviews. These are the responsibility of the employing organisation.

The College will continue to work in partnership with the National Clinical Assessment Service (NCAS) to develop complementary processes.

## **2 BACKGROUND**

Under its Royal Charter, The Royal College of Pathologists has a responsibility to maintain professional standards in pathology practice. This extends to all aspects of the professional activities of pathologists, including both NHS and private work, diagnostic, managerial and educational activities. The College's Professional Standards Unit (PSU) supports this work. The primary aim of the College is to protect the public interest by ensuring that all pathologists perform high-quality work. Inevitably, there will be individuals or teams whose conduct and/or competence will be called into question, but the College also recognises that pathology specialists have a right to expect that any investigation of their professional practice is fair and expeditious.

### **2.1 The Professional Performance Panel**

The Royal College of Pathologists has a Professional Performance Panel (PPP) that oversees College involvement in reviews of individuals or wider services. Panel membership is drawn from senior members of the profession from various pathology disciplines and includes a lay member. The College President chairs the Panel. The PSU is responsible for the administration of the organisational aspects of the review process.

The College has a cohort of reviewers drawn from all disciplines and many subspecialties, who can undertake independent reviews at the request of employing organisations.

## **3 PERSONAL PROFESSIONAL PERFORMANCE**

### **3.1 Poor professional performance: detection and avoidance**

Healthcare organisations should already have procedures in place for dealing with untoward incidents and clinical risk. The Medical Director is usually responsible for ensuring that there is a clearly understood process via which doctors can report their concerns about the conduct, performance or health of medical colleagues.

There is evidence that the significant clinical reporting error rate is 1–2% of all cases for histopathologists. A systematic slide review will not establish evidence of poor performance; at best, it will only identify the error rate after a very large number of cases have been examined. The process is time-consuming and costly.

### **3.2 Audit and the identification of errors**

Errors may occur in all areas of laboratory medicine and common principles apply to all pathology disciplines. Mistakes may involve errors in relation to clinical advice and clinical management of patients, as well as diagnoses. Each laboratory medicine service should have a risk-management strategy, including regular and systematic audit of the diagnostic service and the generation of performance indicators for comparison, where appropriate, with national standards. This should complement a clinical governance strategy, which includes systems for incident reporting, internal and external quality assurance and handling complaints.

The identification of interpretive errors is problematic and their classification as ‘adverse incidents’ often cannot be assessed without full knowledge and discussion of the clinical situation in individual cases, for example, at multidisciplinary team meetings. Some types of error are clearly ‘adverse incidents’, such as specimen label transposition or incompatible blood transfusions. The National Patient Safety Agency (NPSA), through its National Reporting and Learning System (NRLS), encourages the reporting of incidents. The College strongly advocates local systematic audit of the clinical diagnostic service with effective mechanisms for remedial actions to reduce errors to the lowest attainable rate.

Regular audit of pathologists’ work occurs at clinicopathological or multidisciplinary team meetings. Refinements of diagnoses are commonplace and, in most instances, reflect good practice, which reduces potential harm to patients. If a major change in the treatment of the patient is indicated, the patient’s general practitioner or hospital consultant should be informed immediately. All doctors make occasional mistakes but, where it is suspected that an individual is not performing to an acceptable standard, the Clinical Director or Head of Department should seek local advice. Consultation at this stage should involve the relevant line manager in the organisation and agreed local policies.

Most errors are sporadic, but excessive workload, diverse professional demands, professional isolation and personal factors may lead to an unacceptable error rate. If there is a persistent problem, the reasons for this will need to be addressed; it is in this area that a performance review may be required – either internally, externally or undertaken by the College, the National Clinical Assessment Service or the General Medical Council (GMC).

### **3.3 Professional performance**

The individual demonstration of high standards of professional performance and the external assessment of professional performance must be fair, objective and transparent, using a range of valid and acceptable criteria.

The College has developed performance indicators (see Appendix 2) that should be used by individuals and employers to assure a high standard of practice. These performance indicators will also be used as assessment criteria when concerns about performance are raised, or a performance review is initiated.

### **3.4 Behavioural, team-working and relationship problems**

It is not uncommon for poor performance or perceptions of poor performance to be associated in some way with ‘difficult personalities’, dysfunctional teams or dysfunctional interpersonal relationships.

College review teams are capable of recognising that such problems exist but are unlikely to have the expertise to advise on the management of them. The involvement of further expertise, such as occupational psychology, by the employing organisation may be required.

The College is working closely with the NCAS to identify effective means of addressing these issues.

### **3.5 Performance review process**

Initial enquiries should be directed to the College's Professional Standards Unit. All enquires will be screened.

Where appropriate, the Professional Standards Unit will send a request form for a performance review visit (see Appendix 1). The form must be completed by the Medical Director or Chief Executive, and returned to the Director of Professional Standards.

The College does not accept requests for reviews from individuals other than the Medical Director or the Chief Executive of the employing organisation. Other individuals will be asked to address their complaint to the employing organisation or the GMC.

Based on the information provided in the request form and any supporting documentation, a decision will be taken as to whether or not a College review is appropriate.

The College will consider conducting a review visit if the problem relates to:

- concerns about the performance of an individual pathologist
- concerns about the overall quality of a pathology service.

The College will not normally initiate a review if:

- the doctor is suspended or under threat of suspension (referral to the NCAS)
- there are issues of health (appropriate referral, e.g. occupational health)
- there are issues of probity (referral to the GMC)
- the individual is subject to review by another agency, e.g. GMC or NCAS
- the episode is subject to any legal proceedings.

The request form will be reviewed by at least two members of the Professional Performance Panel (from the same discipline). Additional discussion with other senior members of College Council will take place as necessary.

The President and the Director of Professional Standards will be informed.

The individual or department must be told in advance by the healthcare organisation that a review is to be instigated.

## **4 ORGANISATION OF A REVIEW VISIT**

### **4.1 Selection of a review team**

If an assessment of the request form indicates that a review visit is required, the Professional Standards Unit will set up a review team comprising two pathologists from a list of reviewers. The team may include a lay reviewer.

Reviewers will be in good standing with the College, in active practice, satisfactorily participating in a CPD scheme and on the Specialist Register. The College will recruit and provide induction for new reviewers as appropriate.

The selection of reviewers will be based on a comparison between the profile of the individual(s) to be visited, the reviewer and the nature of the concerns about performance problem.

## **4.2 Conducting the visit**

All parties must enter into an indemnity agreement before the review can take place. The reviewers will be provided with a copy of the initial request form and all supplementary information.

The reviewers will liaise directly with the employer to arrange to visit the department concerned.

The Medical Director/Chief Executive must be kept informed of developments and progress at all times by the reviewers. In turn, they should ensure that the individual(s) under review are fully informed.

The individual(s) under review should not communicate with the reviewers outside of the agreed review process.

The terms of reference for the visit are to be agreed between the reviewers and the employer, and provided to the Director of Professional Standards before the review commences, although they may be adapted if necessary.

The review should be undertaken and a report produced in as short a time as possible.

Reviewers will normally spend one or two days at the organisation. This may be extended if a large department or multiple people are involved. The review will include:

- interviews with relevant parties, e.g. the individual(s) whose performance is in question, their manager, director and colleagues
- a review of the initial problem (case)
- a review of any other relevant material, e.g. audit, incident reporting, complaints.

The reviewers will classify any specific discrepancies that are identified as follows. The categorisation of discrepancies should not be used to determine an 'error rate'.

**Category 1:** A diagnostic error, which is likely to have a definite influence on clinical management and possible outcome.

**Category 2:** A misinterpretation or oversight, which has the potential to affect clinical management or outcome.

**Category 3:** A minor discrepancy of disease categorisation, which is likely to be of little clinical significance.

The reviewers will structure their review visit and report in line with the template for the assessment of professional performance.

The employer requesting the review must agree beforehand to make a final copy of the review report available to all those with a *bona fide* interest in the report. This includes the individual pathologist who is the subject of a professional performance review. All those interviewed as part of the review must be informed that the employer will be making the report available to all those considered by them to have a *bona fide* interest in it.

After the review has taken place, all communication from the employer should be directed to the Professional Standards Unit at the College, not to individual reviewers.

## 4.3 Reporting outcomes

### 4.3.1 The report

The reviewers will prepare a report for the College to an agreed deadline (normally within 4–6 weeks of the visit). The College will provide secretarial and administrative support to the reviewers to produce the report. The report must be structured as described in Appendix 3.

The reviewers and the College must ensure the content of the report remains confidential.

The reviewers will send the report, in electronic format, to the College for checking, editing and formatting. **The reviewers are not authorised to send the report, or a draft, to the commissioning organisation or to any other agency or individual.** The College will issue the final report to the commissioning organisation.

The findings of the performance review will be categorised as one of the following.

- a) The pathologist or team performs to an acceptable standard.
- b) The pathologist or team is competent, but there are significant constraints on performance imposed by working conditions, workload, culture, health problems, etc.
- c) There are concerns about the pathologist or teams capabilities in some areas. These should be specifically outlined, and detailed recommendations for remedial or further training should be made. The report must explain the objective of any further training or CPD, and how and to what standard it should be carried out.
- d) There are serious behavioural and/or relationship issues that have been identified by the reviewers as being detrimental to the pathology service. Referral to NCAS is recommended.
- e) There are serious concerns about overall performance of individual(s) and referral to GMC is necessary.

The recommendations in the report will be prepared and agreed by the reviewers and the College's Professional Performance Panel before publication.

## 4.4 Further training and CPD

Further training and targeted CPD should seek to address deficiencies in an individual's knowledge or skill base. However, further training and CPD alone cannot address behavioural or relationship problems; this must be tackled by the employing organisation with specialist advice and support.

If further training or CPD is recommended as a result of a review, an action plan should be devised and agreed by the individual, line manager and employer. The plan should be actioned as quickly as possible. Full records of the training and CPD should be kept by the individual in a portfolio.

The Professional Standards Unit can provide advice to employing organisations on identifying or creating appropriate training or CPD opportunities. In cases where a longer placement is required, the PSU may also advise on the educational contract, programme and any necessary pre- or post-assessment.

The aims of this further training or CPD are to allow the individual to return to or continue to practice unsupervised.

It is important that any further training or CPD also seeks to restore the individual's professional and personal self-confidence that may have been damaged by the review.

The College recommends that the employing organisation appoints a suitable mentor to guide the individual with their further training or CPD and to offer support. The mentor should be available for regular meetings with the individual.

The practitioner's employer will be expected to carry out a further performance review 12 months after the practitioner has returned to normal work (or earlier, if it is obvious that problems have re-emerged). The results of this should be reported to the Professional Performance Panel.

#### **4.4.1 Costs**

The employing organisation is responsible for all costs associated with further training, CPD and associated study leave.

Where the individual is not currently employed, alternative arrangements must be made by the individual to fund their further training.

The Royal College of Pathologists is unable to fund any further training.

#### **4.5 Follow-up actions**

The Professional Standards Unit will follow up all reviews within 12 months to request a progress report on the resolution of the problem and to solicit any feedback on the usefulness of the review and the report.

If it is believed that the practitioner's performance has once again become unsatisfactory, there will be no option but to proceed to an Annex E enquiry (or occasionally an Annex B enquiry) under the terms of HC(90)9 (WHC(90)22 in Wales, 1990(PCS)8 amended by 1990(PCS)32 in Scotland, or HSS(TC8)15/91 in Northern Ireland, including involvement of the GMC. Subsequent procedures will be decided by the NCAS or the GMC and governed by its professional performance assessment procedures.

This route will also have been adopted for those pathologists whose performance was deemed to be seriously defective at the time the local investigation took place.

#### **4.6 Duty of care**

Employers have a duty of care to those patients whose treatment or clinical management may need to be changed in the light of revised opinions arising from a review of a pathologist's or team's work. This would normally take place through the regular audit, review of cases and internal quality processes. Where good audit practice has broken down, it may be necessary for employing organisations to arrange a systematic review of cases to fulfil their duty of care. Normally, a duty-of-care review should only be conducted when concerns or allegations about the performance of an individual or team have been proven and demonstrated by the College's performance review criteria.

It is the responsibility of the employer to organise and bear the complete cost of any necessary duty-of-care review. This should be detailed in an indemnity agreement between all parties before the review can take place.

The principle aim of a duty-of-care review is to detect and prevent possible harm to patients. It is important to recognise that a significant error rate of 1–2% (in histopathology) is to be expected, even amongst competent pathologists.

The College recommends that the pathologists appointed by an employing organisation to undertake the duty-of-care reviews should be:

- in active practice as consultants
- participating in appropriate external quality assurance (EQA)
- satisfactorily participating in CPD
- working in a CPA-accredited laboratory, or make a declaration of the reasons why the laboratory is not accredited, which can be assessed for relevance to the proposed investigation
- prepared to make a declaration of any involvement in complaint or litigation proceedings against them
- not currently being investigated for poor performance themselves.

The organisation should select reviewers based on the criteria above and a comparison between the profile of the individual to be reviewed, the reviewer and the nature of the problem.

Discrepant results must be reviewed by a second reviewer, preferably blind to the discrepant opinions, before the original result can be classified as an error.

The reviewers should classify any errors or discrepancies according to the College system of categorisation as described in Section 4.2 above.

The employer and the reviewers should ensure that the review is carried out in accordance with the GMC's guidelines on confidentiality outlined in the 2000 publication, *Confidentiality: Protecting and Providing Information*.

## **5 PATHOLOGY SERVICE REVIEWS**

NHS employers and other health organisations should have procedures in place for dealing with untoward incidents and clinical risk. The Medical Director of each employing organisation is responsible for ensuring that there is a clearly understood process for doctors to report their concerns about the conduct, performance or health of medical colleagues. Occasionally, issues relating to the overall performance and safety of a pathology service or department may arise. Such concerns may arise as a result of the merger of departments, the creation of pathology networks, management difficulties or staffing issues.

The College is willing to undertake the external review of pathology services on behalf of an employing organisation to offer impartial advice and recommend appropriate action.

The College is not able to undertake the inspection of facilities.

## **5.1 The service review process**

In many respects, the service review procedure reflects the professional performance procedure described above. The College will only consider referrals from the Medical Director or the Chief Executive of the organisation. Referrals must be made in writing, with copies of all relevant supporting information, e.g. reports of earlier reviews or local investigations.

The written request will be reviewed by members of the Professional Performance Panel (PPP), as described in Section 3.5, to confirm appropriateness of a College review rather than referral to an alternative agency.

## **5.2 Selection of a review team**

A review team will be drawn from the College membership. The selection will be made with the assistance of members of the PPP, to ensure the reviewers have no prior involvement with the service or individuals concerned, are from the same specialty or subspecialty and are familiar with the requirements of the service.

The College does not keep a database of reviewers capable of undertaking such a review. The diverse nature of pathology services precludes the maintenance of an adequate database of reviewers. Reviewers will be drawn from the membership of the College and its Lay Advisory Committee where appropriate.

## **5.3 Organisation of the service review**

### **5.3.1 Conducting the visit**

The visit should be organised and conducted in line with the procedure outlined in Section 4.

## **5.4 Reporting outcomes**

### **5.4.1 The report**

The report will be prepared as described in Section 4.3, except that the structure of the report should reflect the agreed terms of reference for the service review. The outcome of the report will be a series of findings and recommendations, as opposed to a defined outcome for an individual or individuals.

## **6 SUPPORT FOR PATHOLOGISTS UNDER REVIEW**

Pathologists whose performance is being reviewed can experience great stress. To avoid unnecessarily prolonged investigation, employers are urged to contact the College's Professional Standards Unit at the earliest opportunity for expert advice and, in many instances, to arrange a visit by a review team. The employer must provide appropriate support to pathologists whose performance is being reviewed. This should be extended to all staff that may be affected by the review process.

Individuals who are interviewed may be accompanied by a representative from their defence organisation, the British Medical Association (BMA) or another organisation, or by another supportive person.

Any pathologist whose professional competence is being challenged should feel free to write, in confidence, to the College President, who will advise on appropriate action. Organisations such as the BMA, the Society of Clinical Psychiatrists, medical defence organisations and the Association of Clinical Pathologists are also important sources of help, advice and support.

## 7 COSTS OF COLLEGE REVIEW VISITS

The College makes an administrative charge for instigating and completing a review.

The members acting as reviewers will invoice the employer for financial reimbursement of their time, travel and reasonable expenses on completion of the review and report.

If there is a recommendation for remedial or further training as a result of the review, the employer will be responsible for these costs. The costs of any associated study leave will also have to be met by the employer.

If a supervised placement is recommended to meet these needs, the host department will need indemnification against any mistakes that the practitioner makes, both during the placement and in subsequent practice in the practitioner's own department.

## 8 CONTACTS

### **Professional Standards Unit, The Royal College of Pathologists (Stella Macaskill)**

Address: 2 Carlton House Terrace, London, SW1Y 5AF  
Tel: 020 7451 6736  
Fax: 020 7451 6701  
Email: [psu@rcpath.org](mailto:psu@rcpath.org)  
Web: [www.rcpath.org](http://www.rcpath.org)

### **President, The Royal College of Pathologists**

Address: 2 Carlton House Terrace, London, SW1Y 5AF  
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Fax: 020 7451 6702  
Email: [president@rcpath.org](mailto:president@rcpath.org)  
Web: [www.rcpath.org](http://www.rcpath.org)

### **Registrar, The Royal College of Pathologists**

Address: 2 Carlton House Terrace, London, SW1Y 5AF  
Tel: 020 7451 6714  
Fax: 020 7451 6702  
Email: [registrar@rcpath.org](mailto:registrar@rcpath.org)  
Web: [www.rcpath.org](http://www.rcpath.org)

### **National Clinical Assessment Service (Professor Alastair Scotland)**

Address: 1<sup>st</sup> floor, Market Towers, 1 Nine Elms Lane, London, SW8 5NQ  
Tel: 020 7273 0850  
Fax: 020 7273 0851  
Email: [alastair.scotland@ncas.npsa.nhs.uk](mailto:alastair.scotland@ncas.npsa.nhs.uk)  
Web: [www.ncas.npsa.nhs.uk](http://www.ncas.npsa.nhs.uk)

**General Medical Council**

Address: Regent's Place, 350 Euston Road, London, NW1 3JN  
Tel: 0845 357 3456  
Email: [gmc@gmc-uk.org](mailto:gmc@gmc-uk.org)  
Web: [www.gmc-uk.org](http://www.gmc-uk.org)

**GMC Fitness to Practise Directorate**

Address: St James' Building, 79 Oxford Street, Manchester, M1 6FQ  
Tel: 0845 357 0022  
Email: [practise@gmc-uk.org](mailto:practise@gmc-uk.org)

**Association of Clinical Pathologists**

Address: 189 Dyke Road, Hove, East Sussex, BN3 1TL  
Tel: 01273 775 700  
Fax: 01273 773 303  
Email: [info@pathologists.org.uk](mailto:info@pathologists.org.uk)  
Web: [www.pathologists.org.uk](http://www.pathologists.org.uk)

**Doctors' Support Line** (anonymous peer support)

Tel: 0870 765 0001  
Web: [www.doctorsupportline.org](http://www.doctorsupportline.org)

**National Counselling Service for Sick Doctors** (independent advisory service for sick doctors)

Address: 1 Park Square West, London, NW1 4LJ  
Tel: 0870 241 0535 (24 hours)  
Web: [www.ncssd.org.uk](http://www.ncssd.org.uk)

**British Medical Association Confidential National Stress Counselling Service**

Tel: 0845 920 0169

**THE ROYAL COLLEGE OF PATHOLOGISTS****PROFESSIONAL STANDARDS UNIT AND PROFESSIONAL PERFORMANCE PANEL****FEBRUARY 2006**



**Appendix 1**

**REQUEST FOR A REVIEW VISIT**

**Requests will only be considered from the Medical Director or Chief Executive**

**Please complete and return this form to the Director of Professional Standards**

**1) Details of person requesting a review**

Name: ..... Position: .....

Address: .....

Email: ..... Phone: ..... Fax: .....

**2) Does the query relate to:** one individual?  a team/department?

**3) Please give the name(s) of the individual(s) concerned; state whether they are in a locum or established post, and the length of time they have been in post. Please provide job plan(s).**

Name	Type of post (please tick)	Length of time in post (in months and years)
	Locum post <input type="checkbox"/> Established post <input type="checkbox"/>	
	Locum post <input type="checkbox"/> Established post <input type="checkbox"/>	
	Locum post <input type="checkbox"/> Established post <input type="checkbox"/>	
	Locum post <input type="checkbox"/> Established post <input type="checkbox"/>	

**4) Please outline the nature of the complaint or allegation, for example:**

Concerns about a poor standard of medical practice

Problems with professional relationship with patients

Problems in working with colleagues or in a team

Concerns of probity in professional practice

Other (please specify) .....

**Please provide as much supporting information as possible in response to the following questions. You may also be asked to provide further information if a review proceeds.**

**5) Describe how the above problem was identified. Attach a separate sheet if necessary.**

.....  
.....  
.....

**6) To what period of time do the concerns relate? .....**

**7) Who, if anyone, has made a complaint? .....**

**8) Has an internal investigation of the complaint or allegation been carried out?**

Yes  No

**8a) If yes, please enclose a copy of the report**

**9) Does/do the pathologist(s) concerned participate in relevant EQA/QA schemes?**

Yes  No  Don't know

**10) Does/do the pathologist(s) concerned satisfactorily participate in CPD?**  
(Information will be checked by the College CPD department)

Yes  No  Don't know

**11) Has the pathologist(s) participated in NHS appraisal in the last 12 months?**

Yes  No  Don't know

**12) What is the department/laboratory's accreditation status (CPA or other)?**

Accredited  Conditional approval  Not accredited  Not applied for

**13) Are there differences of opinion or interpersonal problems that may be relevant?**

Yes  No

If yes, please give details. Attach a separate sheet if necessary.

.....  
.....

**14) Please provide the following information:**

- Organisational chart
- Details of consultant staffing levels (in whole-time equivalents) within the department
- Details of other staffing levels within the department
- Details of any rotas participated in
- Workload of the department in terms of all types of specimen request, autopsies, clinics or on call requirements.
- Information on all relevant index cases (additional index cases will not be considered after the review has commenced)
- CV of individual, if appropriate

**15) The space below is left blank for any other relevant comments.**

**Signature:** .....

**Position:** .....

**Date:** .....

## Appendix 2

### PROFESSIONAL PERFORMANCE INDICATORS

The individual demonstration of high standards of professional performance and the external assessment of professional performance must be fair, objective and transparent, using a range of valid and acceptable criteria. The College has developed these performance indicators, which should be used by individuals and employers to assure a high standard of practice.

These performance indicators will also be used as assessment criteria when substandard performance is suspected, or a performance review initiated.

#### **A) The context in which the pathologist is working**

The following should be considered:

- conditions of work, staffing and workload
- Clinical Pathology Accreditation (UK) Ltd (CPA) status of laboratory, including whether accreditation has been applied for
- reports and recommendations from the Commission for Healthcare Audit and Inspection (CHAI)
- potential constraints on performance within the laboratory and the organisation
- individual on-call commitments
- quality of laboratory management systems and processes
- case mix and areas where the pathologist may be working outside his or her expertise
- any clinical responsibilities involving direct patient contact (e.g., diabetic foot clinic, lipid clinic, outreach services)
- single-handed practice.

#### **B) Appraisal**

The following should be considered:

- participation in an annual appraisal or individual performance review process
- potential constraints on performance identified at appraisal and their recording in the agreed outcome and objectives of the appraisal.

#### **C) Continuing professional development (CPD)**

The following should be considered:

- satisfactory participation in CPD, either as a member of an appropriate scheme or self-managed
- membership of the College's CPD scheme and willingness to subject their CPD portfolio for College review as part of the annual review of the CPD scheme
- demonstration of a profile of credits that reflects the job plan.

## **D) Clinical governance**

### **Audit**

The following should be considered:

- demonstration of ongoing participation in clinical audit
- adherence and application of National Institute for Health and Clinical Excellence (NICE), Scottish Intercollegiate Guidelines Network (SIGN) or other national guidelines
- use of guidelines and datasets where appropriate
- participation in critical incident reporting, e.g. National Patient Safety Agency (NPSA) or Serious Hazards of Transfusion (SHOT).

### **External quality assurance (EQA)**

The following should be considered:

- participation in appropriate laboratory EQA schemes, e.g. National External Quality Assessment Service (UKNEQAS)
- participation in appropriate individual interpretive EQA scheme/s (in interpretive schemes, the individual participant score is confidential).

### **Incident reporting**

- Evidence of a robust system of incident reporting and a record of action taken.

### **Complaints handling**

- Evidence of appropriate and timely procedures for handling complaints.

## **E) Clinical practice**

The following should be considered:

- quality of clinical advice given and the recording of advice
- quality and timeliness of pathology reports and clinical advice
- routine review of a sample of clinical cases or reports in selected areas
- review of individual diagnostic pattern to ensure fair comparison with peers
- appropriate treatment/management or diagnostic decision-making
- adherence to relevant national guidelines
- ability to describe the distribution of individual workload.

## **F) Professional behaviour and working relationships**

The following should be considered:

- availability and willingness to communicate and discuss clinical and professional issues with colleagues
- awareness of own diagnostic limitations as demonstrated by individual referral patterns
- participation in clinicopathological discussions/multidisciplinary team meetings/ meetings with colleagues
- team-working
- professional relationship with patients

- willingness to undertake a peer questionnaire or multi-source feedback exercise to review practice
- ensuring that there are no tensions relating to private practice, Coroner's work or other outside commitments.

#### **G) Management/leadership role**

The following should be considered:

- maintenance of a quality laboratory service
- confidence of the laboratory and clerical staff and colleagues
- demonstration of appropriate management systems and processes established in the laboratory.

#### **H) Teaching, training and research**

The following should be considered:

- participation in teaching and training of biomedical and clinical scientists, medical trainees, undergraduates and other healthcare professionals
- quality of the educational supervision provided
- provision of evidence of teaching quality through student or trainee feedback or evaluation
- provision of evidence of accreditation of teaching status (the College, Quality Assurance Agency, The Higher Education Academy)
- adherence to research governance, ethical and national research guidelines.

The emphasis placed on these categories will vary between specialty and individuals.

## Appendix 3

# GUIDANCE ON THE PREPARATION OF THE REVIEW REPORT

The aim of the review visit is to ascertain whether the concerns about performance are substantiated.

The outcome of the review will be a written report. The report must describe the evidence objectively, draw evidence-based conclusions and make recommendations for change. Terms of reference for the review will be agreed between the commissioning organisation and the reviewers on behalf of the College. The review report will seek to fulfil the terms of reference.

The reviewers must prepare a written report with evidence-based conclusions to an agreed deadline (normally within 4–6 weeks of the visit).

The report must be structured as follows.

1. Introduction, to include details of reviewers, the pathologist(s) or service under review and the dates the review took place.
2. Background to the case.
3. Terms of reference.
4. Main body of report, to describe the evidence in relation to the terms of reference and performance indicators.
5. Summary and conclusions, to pull together the findings of the review.
6. Recommendations for change or further action. These will be drafted jointly by the reviewers and the Professional Performance Panel.
7. Appendices, which may include written evidence.

On completion, the reviewers must send the report electronically to the Professional Standards Unit for editing, preparation of recommendations and authorisation. The staff at the PSU may need to contact reviewers for clarification of specific points during the editing process. They will also liaise between the Professional Performance Panel and the reviewer when drafting the recommendations.

The College will issue the final report to the commissioning organisation.

Reviewers should not disclose the findings of the review directly to the commissioning organisation.

The College expects the commissioning organisation to send a copy of the report to the individual(s) under review and anyone else with a *bona fide* interest in the report.