



Revalidation Support Team

Supporting Doctors to Provide Safer Healthcare

Responding to concerns
about a doctor's practice

Version 2
March 2013

www.revalidationsupport.nhs.uk

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Introduction

Revalidation of doctors is a key component of a range of measures designed to improve the quality of care for patients; it is the process by which the General Medical Council (GMC) confirms the continuation of a doctor's licence to practise in the UK. The purpose of revalidation is to assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and fit to practise.

Through a formal link with their organisation, determined usually by employment or contracting arrangements, doctors relate to a senior doctor in the organisation, the responsible officer. The responsible officer makes a recommendation about the doctor's fitness to practise to the GMC. The recommendation will be based on the outcome of the doctor's annual appraisals over the course of five years, combined with information drawn from the organisational clinical governance systems. Following the responsible officer's recommendation, the GMC decides whether to renew the doctor's licence.

The responsible officer is accountable for the quality assurance of the appraisal and clinical governance systems in their organisation. Improvement to these systems will support doctors in developing their practice more effectively, adding to the safety and quality of health care. This also enables early identification of doctors whose practice needs attention, allowing for more effective intervention.

All doctors who wish to retain their GMC licence to practise need to participate in revalidation.

This publication has been prepared by the NHS Revalidation Support Team (RST). The RST works in partnership with the Department of Health (England), the GMC and other organisations to deliver an effective system of revalidation for doctors in England.

All RST publications are created in collaboration with partners and stakeholders.

Supporting doctors to provide safer healthcare – purpose and context

The purpose of this document is to help responsible officers to understand and enact their statutory duty to respond effectively to concerns about a doctor's practise. It provides a generic framework, a model for establishing the level of concern, and lists the essential components of an organisational policy to support an effective, consistent and fair process.

In this way, responsible officers, designated bodies, doctors and the public can be assured that patient safety is the highest priority in a process that is fair, transparent and consistent.

This document is aimed at designated bodies, responsible officers and other personnel involved in responding to concerns.

Version 1 of this document was published in March 2012. This version has been updated, where relevant, to include developments between April 2012 and March 2013.

Section 1: Statutory duties of the responsible officer

This section covers the statutory duties of the responsible officer in relation to investigating, monitoring and responding to concerns. It outlines the key principles of good practice and references a range of important source documents. The section also makes reference to current knowledge on levels and categories of concerns. A number of key messages are outlined for designated bodies.

All doctors relate to a single responsible officer¹. *The Medical Profession (Responsible Officers) Regulations 2010* and *The Medical Profession (Responsible Officers) (Amendment) Regulations 2013* place a number of duties on responsible officers and designated bodies in relation to responding to concerns. The legislation makes it clear that the designated body in which the responsible officer is based has a statutory obligation to support the responsible officer in discharging their duties, including providing the appropriate level of resource to support them in this.

In the context of responding to concerns about a doctor's practice, the responsible officer must:

- identify concerns through corporate governance processes
- initiate investigations and ensure these are carried out with appropriately qualified investigators separate from the decision-making process
- initiate further monitoring
- initiate measures to address concerns which may include re-skilling, re-training, rehabilitation services, mentoring and coaching
- if necessary, exclude or suspend a doctor or place restrictions on their practice, pending further investigation
- if necessary, refer to the GMC, comply with the conditions applied by the regulator and provide appropriate information as required
- address any systemic issues within the designated body which may have contributed to the concerns identified.

The responsible officer must take into account information from all areas of the doctor's scope of work when responding to a concern and must consider any fitness to practise assessments.

¹ The responsible officer may delegate particular roles and functions covered by the regulations to others. For the purposes of this document, the term responsible officer should be interpreted as including those acting with appropriate delegated authority.

Principles

Responsible officers will need to assure themselves that existing policies and procedures that already exist in the designated body allow them to discharge their statutory responsibilities and, if this is not the case, work with their teams to put the necessary procedures in place. The principles of good practice in handling concerns about a doctor's performance are described in several publications, including:

For NHS Trusts

- *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003)

For GP Performers Lists

- *The Medical Profession (Responsible Officers) Regulations 2010*
- *The National Health Service (Performers Lists) (England) Regulations 2013*
- *Primary Medical Performers Lists – Delivering Quality in Primary Care*, (Department of Health, 2004)

Publications relevant to all sectors

- *Remediation Report – Report of the Steering Group on Remediation* (Steering Group on Remediation, 2011)
- *Tackling Concerns Locally* (Department of Health, 2009)
- *How to Conduct a Local Performance Investigation* (National Clinical Assessment Service, 2010)

These principles can be summarised as:

- Patients must be protected.
- All action must be based on reliable evidence.
- The process must be clearly defined and open to scrutiny.
- The process should demonstrate equality and fairness.
- All information must be safeguarded.
- Support must be provided to all those involved.

What constitutes a concern?

The majority of doctors provide a high standard of patient care. The principles and values which underpin medical professionalism, and the behaviour required of a doctor are described in *Good Medical Practice* (GMC, 2013). As medicine and technologies evolve, doctors need to enhance their skills and keep up to date, in order to remain fit to practise. Doctors are supported in the process of continuing professional development, which is facilitated through annual appraisal. Continuing professional development is enhanced by local self-directed learning, team-based discussions and clinical governance processes led by the organisation in which they are working.

In the course of their professional career every doctor will experience variation in the level of their practice and clinical competence. Every doctor will make mistakes and, on occasion, patients will come to harm as a result. All doctors must therefore be vigilant in recognising and taking responsibility for mistakes and for reductions in the quality of their practise. Learning from these will improve patient safety in the future.

Where a doctor's standard of care falls below that defined within *Good Medical Practice*, continuing professional development measures alone may be insufficient to address the problem.

A concern about a doctor's practice can be said to have arisen where the behaviour of the doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in *Good Medical Practice*. While minor concerns may be addressed through normal continuing professional development processes, this document is primarily concerned with responding to those instances where normal continuing professional development processes are not sufficient to address the concern (see Section 3).

Once a concern is recognised the responsible officer is responsible for making an initial assessment and for deciding whether an investigation should take place. Concerns about a doctor's practice can be separated into three categories: conduct, capability and health. There is often considerable overlap between these categories and concerns may arise from any combination or all three of these. An investigation will clarify the nature of the concern, confirm the facts, establish its severity and give an indication of the appropriate response.

Current situation

Current processes for responding to concerns may result in significant delay and lengthy periods of time during which a doctor is unable to practise. Implementation of planned and managed remedial programmes will support doctors in maintaining their career path and will contribute to the delivery of safe, high quality care to patients. Earlier intervention and prevention can avoid possible restriction, exclusion or suspension.

Average levels of suspension or exclusion in the NHS in England are around 44 weeks for primary care and 19 weeks for secondary care (NCAS, 2012)². Although these figures have been falling in recent years they represent significant financial costs to the NHS as well as a personal cost to the doctor.

Many doctors will need some form of support during their professional lives. Estimates vary between 1-5% of doctors needing support at any one time. The GMC received 8,781 enquiries in 2011 (3.5% of doctors) with 56% cases closed with no further action and a further 17.5% closed after further investigation.³ The National Clinical Assessment Service (NCAS) received 1,020 requests for advice in 2010/11 (0.4%) and 0.5-1% of doctors required specialist health services (NHS Practitioner Health Programme, 2012)⁴. These figures from national bodies clearly relate to high-level concerns. Lower-level concerns are more routinely dealt with by the designated body or through local mechanisms. There is currently no accepted basis for categorisation of level of concerns, nor of the resulting actions. This issue is explored further in Section 3.

In December 2011, the NHS Revalidation Support Team (RST) conducted a survey of known designated bodies in England. Designated bodies reported that there were concerns about 4.1% of doctors overall; 2.4% of doctors were deemed to have low-level concerns about them, 1% medium-level, and 0.7% high-level. These figures indicate a level of concerns consistent with the estimates described above. In addition, analysis of the themes arising from the RST survey indicates that activity in several areas will improve quality and consistency of systems and processes for responding to concerns in designated bodies in England (Box A). Some of these may be achieved in-house, but others may require the development of locally shared external resources.

² *Use of NHS Exclusion and Suspension from Work amongst Doctors and Dentists 2011/12*
www.ncas.nhs.uk/about-ncas/statistics/ (NCAS, 2012)

³ *The State of Medical Education and Practice in the UK* (GMC, 2012)

⁴ *The NHS Practitioner Health Programme - Three Year Report* (NHS Practitioner Health Programme, 2012)

Box A: Key messages from NHS Revalidation Support Team 2011 survey of designated bodies in England

- All designated bodies should follow a generic framework for responding to concerns about a doctor's practice.
- All designated bodies should have a policy for responding to concerns and remediation.
- Regional responsible officer networks should facilitate shared learning and benchmarking, especially if supported by inclusion of expertise from others such as GMC employer liaison advisors, human resources teams and, where appropriate, the National Clinical Assessment Service (NCAS) and medical royal college advisors.
- All designated bodies should work towards establishing a pool of trained investigators, whether in-house or shared across several designated bodies.
- Work should be undertaken to develop ways of establishing the level of a concern objectively, and for stratifying the resulting response appropriately.
- All designated bodies should have a standardised system for recording and monitoring concerns that is open to scrutiny.
- Responsible officers should consider pooling resources, for example within a regional professional support unit, to provide adequate numbers of trained investigators and providers of remediation.
- Responsible officers should work towards developing strategies for prevention of concerns, such as structured mentorship and prolonged inductions or peer support programmes for new doctors.
- There should be a proactive approach to evaluating the above, so that effective developments can be accelerated and ineffective ones discarded.

We discuss these aspects in the following sections of this paper.

Section 2: Generic process framework

This section describes a generic framework for processes underpinning responding to concerns and describes how a designated body can demonstrate evidence in each of the four areas.

This framework has been developed to help designated bodies assure themselves that processes for responding to concerns fulfil statutory responsibilities and operate in an effective, consistent and fair manner.

An optimum organisational framework would be able to demonstrate evidence in four key areas:

1. Corporate leadership
2. Provision of skills
3. The responding to concerns pathway
4. Organisational infrastructure.

1. Corporate leadership

There should be commitment from the highest levels of the designated body to the delivery of a quality assured system for responding to concerns, which is effective, consistent and fair. This system should be fully integrated with local clinical governance systems and support an organisational culture where patient safety and quality of care will flourish. A vital component of this corporate leadership is the presence of a formal policy approved by the board (or equivalent) of the designated body.

The organisation should be able to show evidence of:

Commitment

Through the publication of a policy, formally approved by the designated body's board (or equivalent), describing the system for responding to concerns. The policy is the lynchpin of the system for responding to concerns, and describes all the key aspects of an effective, quality assured system. We discuss the content of such a policy in Section 3.

Local agreement

The policy for responding to concerns should describe how the local medical profession, other staff, patients, relatives, carers and members of the public are engaged in the development and agreement of the system for responding to concerns.

Quality assurance

As a minimum, the process for responding to concerns should be reviewed internally on an annual basis. Data should be collected in managing concerns and this can be used for identifying themes and producing prevention strategies as well as an annual board report. Ideally this will be supplemented by periodic external or peer review. Such quality assurance measures may be integrated with other quality control mechanisms, for example the Organisational Readiness Self-Assessment (ORSA) for revalidation processes in general.

Transparency and fairness

The policy and pathway for responding to concerns should be shared within the organisation and be publicly available. There should be mechanisms for doctors to provide input, comment and suggestions, and for incorporating these into the policy and pathway. There should be a complaints and an appeals process for doctors who wish to challenge the handling of a concern raised about them.

Integration within local clinical governance systems

Clinical governance systems should be orientated towards early identification of concerns and provide useful information in the investigation of a concern. These governance systems can also support the monitoring of a doctor's practice to continually assure the designated body that the doctor has returned to an acceptable standard of practice.

2. Provision of skills

The designated body should have a process for identifying, providing appropriate training for and ongoing review and development of teams involved in responding to concerns, particularly case investigators and case managers. At present, many case investigators are identified on an ad hoc basis to investigate a particular concern. The RST survey identified this as a source of inconsistency.

There is merit in establishing a clear description of both the case investigator and case manager roles, with the desired attributes required to fulfil them. Furthermore, whether

identified ad hoc or from an identified pool, case investigators and case managers should be trained and supported in their continuing development in this function.

The organisation should be able to show evidence of:

Active identification of case investigators and case managers

Case management and case investigation are significant professional roles. Case managers and case investigators should be identified proactively, based on a suitable role description and person specification.

How to Conduct a Local Performance Investigation (NCAS, 2010) provides guidance on the roles and competencies that individuals in these roles should be able to demonstrate.

The RST survey has indicated that the role of responding to concerns is, of necessity, commonly provided by staff with other responsibilities in their portfolio. This creates a challenge of ensuring that these key personnel have the appropriate competencies and experience for responding to concerns. The application of a role description and person specification when identifying suitable personnel for responding to concerns, whether or not they also carry other responsibilities, is a useful means of confirming suitability.

Training of case investigators and case managers

Case investigators and case managers should receive initial training appropriate to that role.

Evidence of performance review and ongoing development of case investigators and case managers

Case investigators and case managers should undergo regular review of performance, with the identified development needs being included in their personal development plans.

In line with the findings of the RST survey, the responsible officer in a designated body may judge that some or all of the functions and skills required in responding to concerns should be provided externally, for example by a professional support unit jointly commissioned across several designated bodies. In this case the responsible officer will need to be satisfied that these indicators are met by the externally commissioned organisation.

3. The responding to concerns pathway

The designated body must have a clearly described, effectively disseminated and locally agreed pathway for responding to concerns. This pathway will incorporate a mechanism for establishing the level of the concern, and of ensuring the resulting actions are appropriate and proportionate.

The organisation should be able to show evidence of:

A well-described pathway, written in a clear format

This describes each step from the raising of a concern, through the initial response and investigation, assessment of the doctor's needs, formal action planning and further action including a monitoring process, to a review of the concern and confirmation either of its resolution (in which case it should describe the process for reintegrating the doctor into normal practice) or the need for escalation.

For NHS trusts, the basis of this pathway is described in the guidance *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003). Non-NHS designated bodies may also find the pathway described to be of value.

Effective dissemination

The policy for responding to concerns should describe how the policy will be disseminated and communicated within the designated body to ensure awareness of the policy and an understanding of its contents. This should include an explanation of how the effectiveness of this communication will be evaluated.

Establishing the level of the concern

There should be an agreed mechanism for assessing the level of the concern that takes into account the risk of harm to patients (see Section 3).

The RST survey indicated varying approaches to this, with some organisations relying on professional judgement alone and others supporting professional judgement with a variety of risk-assessment matrices and other tools.

Ensuring a proportionate response

There should be a locally agreed approach to ensuring the action taken in response to a concern is proportionate to the level of the concern. It should consider the following three areas:

- i. the need for supervision of the doctor
- ii. the doctor's development and personal needs
- iii. the need to place limits on the scope of work of the doctor.

4. Organisational infrastructure

There must be a sufficient level and range of support within the designated body. All organisations require access to expert investigators and there may be value in a shared pool of expertise in one or more of these areas. There must also be identified managerial and administrative support to allow for an effective system for responding to concerns.

The organisation should be able to show evidence of:

A collaborative approach using appropriate expertise

The responsible officer should work closely with others, such as human resources and occupational health teams, where available. The corporate team is a valuable resource to the responsible officer in supporting the implementation of processes for responding to concerns. Smaller organisations may not have such a team but the responsible officer should have access to advice on human resources and occupational health.

An establishment described in terms of organisational support

It is important that the responsible officer has a clear understanding of the level and range of resources they can call upon to administer the designated body's responding to concerns system.

All personnel involved in responding to concerns must have time to perform their responsibilities in order to ensure that the process is of high quality. As well as effective administration of individual concerns processes, this will include provision of capacity and skills for collating data on concerns, production of audits and reports, effective information governance, and the provision of backfill for staff deployed in a case investigator role.

Section 3: Establishing the level of concern

This section provides a generic framework for designated bodies to establish the level of a concern. It describes how adopting a framework can improve the consistency of response to and management of concerns. It also covers the use of information for monitoring at both an individual and organisational level. A content guide for an organisational policy for responding to concerns is provided.

The immediate task for a responsible officer when a concern comes to light is to determine whether there are any urgent safety concerns relating to patients, staff or the doctor about whom the concern has been raised.

The responsible officer will need to decide, based on the information available, whether the doctor's practice should be restricted immediately pending formal investigation. Options may include sick leave, suspension, exclusion or, in extreme circumstances, immediate dismissal. The advice of occupational health or human resources departments will be valuable in supporting this assessment.

The responsible officer will also need to consider which other factors need to be taken into consideration, for example, a concern may affect not just one individual but a whole clinical team or organisation.

The responsible officer will need to decide whether the issue can be resolved within the organisation, either through discussion with the doctor concerned or through formal procedures. They will also need to decide whether others should be consulted, informed and involved in the process. This will involve a decision on the need for an investigation and which bodies, if any, should be called upon to assist in this. It may be that immediate referral to the regulator or the police is required. The responsible officer must decide what steps should be taken immediately, in the next 24-48 hours, one to two weeks and over a longer, structured timescale.

The RST survey of designated bodies in England in December 2011 revealed a strong need for the development of effective tools to help assess these issues and improve consistency and objectivity of response. No single common tool was being used for this purpose. Organisations varied in their approach from relying solely on the professional judgement of the responsible officer, to using locally-created risk categorisation frameworks.

Methods for categorisation and thresholds should be consistent and defined within the organisational responding to concerns policy. Escalation between the levels of categorisation should be clearly defined. The level of concern may change at different points in the process as further information becomes available.

An example of a categorisation framework to illustrate the potential merit of such an approach is provided on the RST website [here](#). All the SHA cluster steering groups identified this issue as requiring development, and as consensus emerges as to the most useful tools, these will be provided or signposted via the RST website: www.revalidationsupport.nhs.uk.

Information and data collection

Responsible officers will benefit from the development of systems to monitor data collected about a doctor's practice on an ongoing basis, so that any trends causing concern may be identified at an early stage and appropriate corrective action taken.

A number of triggers will alert the responsible officer, such as a significant event or a series of complaints. Often one concern or event will prompt the responsible officer to examine other available data, but low-level concerns revealed by data in different areas should be triangulated with data from other sources to allow earlier intervention before a more serious concern occurs.

The RST has produced *Information Management for Medical Revalidation in England* (RST, 2013), a separate guidance document relating to information storage, sharing and governance. In particular responsible officers will find it helpful to:

- keep accurate and timely records of all discussions relating to a concern
- inform all those concerned that records of discussions will be kept
- store records securely, and inform the doctor concerned as to the content of the records that are being kept
- share information collected by the responsible officer for monitoring a doctor's performance and fitness to practise with the doctor for inclusion in their portfolio and discussion at appraisal
- share relevant information appropriately with other parties, in particular the new responsible officer, should the doctor move to a different job
- ensure documentation is processed and managed in compliance with the requirements of the *Data Protection Act 1998* and the *Freedom of Information Act 2000*.

It is important for the responsible officer and designated body to understand the local picture of concerns and whether the organisation is experiencing a higher or lower frequency of concerns than expected, so that appropriate resources can be allocated. Responsible officers will therefore find it helpful to monitor the concerns relating to the doctors for whom they are responsible.

The responsible officer may also find it helpful to compare patterns of concerns with other organisations. Sharing experiences through responsible officer networks will stimulate developments within their own designated bodies. This will also enable designated bodies to consider whether organisational factors are impacting on the practice of the doctors who work for them and what steps might be taken to address these.

The responsible officer may therefore wish to identify a dataset of items that will enable effective monitoring and comparison of the level of concerns. This may include, for example, gender, specialty and career grade, and the nature, category and level of the concern.

Organisational policy for responding to concerns

An organisational policy is required to enable the responsible officer to carry out their statutory duties in relation to responding to concerns. This is both a means of expressing corporate or organisational leadership in this regard, and of providing the basis of consistency within the designated body. Through the policy, the responsible officer can demonstrate how the system for responding to concerns will ensure:

- continued delivery of safe, effective clinical care
- a consistent and equitable process
- clear criteria for assessment and decisions
- an organisational culture of support and development
- a transparent process and policy understood by all
- use of evidence-based intervention and support
- responsible use of funding and resources

An organisational policy for responding to concerns should operate on the basis of the principles outlined earlier, to ensure effective, consistent and fair management of doctors who require support to continue to deliver safe, high quality care to patients.

Responding to concerns policy: suggested content

The following content may need to be covered in the designated body's policy for responding to concerns. Some of these areas may not be required depending on the needs of the designated body. Examples of responding to concerns policies are available on the RST website at

www.revalidationsupport.nhs.uk/responsible_officer

Corporate leadership:

- description of how the policy has been developed, stakeholder involvement and review process
- engagement of stakeholders (e.g. doctors, staff, patients and the public in development of systems and processes)
- the role of the responsible officer (overall responsibility for responding to concerns)
- anonymised annual report to board detailing processes and outcomes of concerns
- integration with other relevant policies (e.g. appraisal, whistleblowing and disciplinary/HR policies)
- policy on resourcing of support and interventions
- complaints and appeals processes
- equality and diversity impact assessment.

Provision of skills:

- the role and responsibilities of all individuals involved in responding to concerns, which may include human resources, the line manager, the appraiser, the case investigator and the case manager
(This may vary depending on the size and structure of the designated body. Note that National Clinical Assessment Service guidance⁵ will provide helpful advice in relation to this.)
- an outline of where responsibilities sit for agreement of process, potential resourcing, delivering support and ensuring appropriate progress with action plan
- the responsibilities of the doctor
- training, support and performance review for the above roles

⁵ *How to Conduct a Local Performance Investigation* (National Clinical Assessment Service, 2010)

- involvement of GMC employer liaison advisors, National Clinical Assessment Service (NCAS), medical royal colleges etc.

The responding to concerns pathway:

- definitions of categories and level of concern
- corporate structures in place (e.g. performance review panel)
- investigation processes, including timeframes
- decision-making processes including suspension, exclusion, practice restriction including timeframes
- process for hearings/panel meetings
- process for agreeing formal action planning
- processes around monitoring and supervision
- success criteria and key performance indicators
- processes for monitoring formal action plans and implications of non-compliance
- principles for return to practice⁶, including strategies for phased and supported return
- what to do if remediation is unsuccessful.

Organisational infrastructure:

- organisational governance structures in place to identify concerns about a doctor's practice e.g. complaints, significant events, colleague feedback, patient surveys, mortality reviews, national clinical audit activity (Health Quality Improvement Partnership, National Institute of Health and Clinical Excellence.)
- information management processes including sharing with the doctor and other relevant parties
- reference to organisational databases, appraisal documentation and sharing relevant information with other organisations the doctor works for
- a description of interventions available, which may be local, regional or national. Local interventions may also include placements at nearby organisations where reciprocal arrangements are in place. For example, this could be clinical placements for re-skilling or trained coaches in two organisations providing a shared coaching resource.

⁶ See *Return to Practice Guidance* (Academy of Medical Royal Colleges, 2012) for guidance

Section 4: Targeted support and intervention

This section describes the most common types of support and interventions detailing a number of models of support including internal and shared resources. Support for the responsible officer and the benefits of a responsible officer network for are also considered.

The type and amount of support and intervention that a designated body may need to access will differ depending on the size of the medical (and non-medical) workforce and on the range of specialties and grades of that workforce.

The RST survey of designated bodies in England in December 2011 identified the percentage of each level of concern over a 12-month period across organisational type and grade of doctor, as well as possible levels of intervention requirements. This data may assist responsible officers in making provision for the likely level of investigations and interventions required by their workforce.

The organisational policy on responding to concerns should clarify what support is available to doctors and the conditions for accessing this support; this should include arrangements for support during periods of exclusion or suspension and arrangements for managed, supported and/or phased return to work.

The most common types of intervention identified by designated bodies are listed below.

Supervision:

- supervised practice
- formative work-based assessments:
case-based reviews, mini-clinical evaluation exercises (Mini-CEX), objective structured clinical examinations (OSCE), on-site assessment and training (OSAT), video recording, simulation, colleague and patient and feedback

Development:

- educational activities:
re-training and re-skilling activities including tutorials, workshops, courses, e-learning, focused reading, language/communication skills-based activities

- specialist interventions:
behavioural coaching, occupational, psychological and specialist health (mental health and addiction) interventions, counselling (career or therapeutic), boundary awareness, cultural competence
- practitioner support:
mentoring, vocational rehabilitation, protected learning and development time, career guidance, financial advice
- organisational support:
human resource, legal advice, team or workplace mediation

Scope of work:

- amendment/restriction of aspects of scope of work

An explanation of some of these terms can be found in the glossary at Appendix 1.

Models of support

Responsible officers should give due consideration to the types of intervention and support that can be offered through existing capacity and resource; and where strategic delivery of remediation and support may result in more effective outcomes and better value for money:

- utilising the skills and experience of senior clinicians in developing clinical skills of junior staff
- working across professional groups to collaborate on learning sets and support for handling of complex issues, for example, clinical ethics committees to advise on ethical dilemmas
- reciprocal or networked arrangements with other organisations, for example, for placements, supervision and clinical expertise
- shared arrangements with other organisations for commissioning and delivery of support and interventions
- use of routine and mandatory training and development opportunities to ensure that these are used to the full benefit of the medical workforce
- co-ordinating support and running regular updates or sessions for common concerns rather than commissioning these on an individual basis
- group support for doctors who have fallen into difficulties when supporting one another through a common approach

- recognising that individual doctors who are going through a process of remediation and those who have completed a process may be willing to act as a mentor or in another supportive capacity.

Discussions are underway in some places to develop regional hubs of expertise for professional support, either across the medical workforce or incorporating wider professional groups. Responsible officer networks should consider the capacity requirements and range of interventions that would be appropriate through a regional hub and consider how current funding of remediation and targeted support could be better utilised in a collaborative way.

Support for the responsible officer

The responsible officer role is both rewarding and challenging; concerns around the performance of doctors can be complex. Responsible officers will benefit from seeking expertise, advice and opinions from others. Regional responsible officer networks therefore provide a particularly valuable source of support.

The benefits of these networks include:

Personal support and development

- ongoing support and development in the role
- confidential discussion of difficult issues and cases with peers
- improved responsible officer job satisfaction and increased confidence for the doctors the responsible officer manages.

Organisational support and development

- sharing of local and national good practice in relation to responding to concerns processes
- improved information sharing and communication
- applying GMC guidance consistently on intervention or action in fitness to practise issues
- accessing regional and national expertise (from the RST, GMC, National Clinical Assessment Service and medical royal college advisers)
- considering development of comprehensive local performance support function to address remediation, rehabilitation or re-skilling of doctors where concerns are identified early at a local level.

Strategic support and development

- ensuring consistency and equality in decision-making and applying thresholds for intervention
- providing intelligence on the overall system
- providing assurance (validation and calibration) to the responsible officer that the Organisational Readiness Self-Assessment (ORSA) gives an accurate picture of the organisational systems.

Section 5: Steps taken since version 1, and further steps remaining

This section describes the steps taken since the release of version 1 of this document in March 2012. These include the development of advisory groups at SHA cluster-level to consider local priorities and stimulate collaborative approaches such as the evolution of the professional support unit concept and training for case investigators involved in responding to concerns. It also describes steps identified in version 1 which remain in progress: work on the responding to concerns pathway and use of information for early identification and prevention of concerns.

In 2012-13 the RST supported further development of this agenda through the SHA clusters.

In particular, the RST:

- facilitated the establishment of SHA cluster-level groups to co-ordinate regional strategies and delivery plans for responding to concerns. These groups broadly confirmed the key themes listed in Box A on page 9. They identified some additional areas of importance, including: availability of effective occupational health expertise, consistency of process for doctors in training emerging into independent practice, and clarity of expectation around language and cultural competence. The four SHA cluster-level groups have subsequently developed complementary strategies and action plans.
- through the SHA cluster-level groups, continued to establish consensus on the benefits of combining resources to concentrate skills in professional support units
- through the SHA cluster-level groups, continued to develop a generic specification for responding to concerns for designated bodies
- undertaken a programme of training for approximately 400 case investigators in England
- developed an additional training module for responsible officers (Module 4 - advanced responding to concerns)
- continued to work on a benchmarking tool for predicting the volume of concerns based on 2012 survey data to be used for resource planning or benchmarking
- developed links to the NHS Commissioning Board medical remediation working group

The need for further work in a number of key areas remains, and it is the RST's intention to deliver this during 2013-14, making full use of the expertise in the newly established cluster-level groups.

Work proposed for 2013-14

1. Working with the national remediation working group chaired by the NHS Commissioning Board

Matters that this group will consider include:

- the types of contracts that the NHS Commissioning Board will need to put in place for support
- the nature of a proposed contract to provide oversight of placements
- the funding flows to support the establishment of training practices where remediation placements could be based
- the content of the common operating procedure on remediation.

2. Further work on the concept of professional support units

The DH report, *Remediation report – Report of the Steering Group on Remediation* (Steering Group on Remediation, 2011) identified a need for a single point of expertise in relation to remediation. A professional support unit providing access to an expert shared service to support designated bodies in responding to concerns within their medical workforce will deliver on this aspiration. In some areas of the country variations on a shared resources are developing – some offering assessment services, some offering interventions and support, and others offering a blend of the two.

As described above, there is growing agreement around the value of this approach. There are two areas which would benefit from further work:

- Firstly, consideration of the best model and approach for these emerging units, in terms of delivery, range of interventions and generic specification for the service.
- Secondly, development of the business case, funding model and metrics for evaluation.

3. The responding to concerns pathway

The topics of good practice pathways, interventions and models of support require further research and evaluation, including the specific area of assessing the level of a concern. In particular there is an imperative to understand the cost-effectiveness and outcome measures for the differing interventions and models.

4. Early identification and prevention

The use of available data and research to support early identification of concerns and to identify patterns and recognition of potential triggers to enable early intervention and prevention of concerns is an important area for further development.

Appendix 1

Glossary

Behavioural coaching – a method for identifying and modulating emotional, behavioural and psychological blocks and their resultant behaviours.

Boundary awareness – an understanding of the difference between a professional relationship and a personal relationship, to ensure that openness and vulnerability are not exploited.

Case based reviews – a structured review of clinical records and case notes designed to explore professional judgement exercised in clinical cases.

Cultural competence – an ability to interact effectively with people of different cultures.

Mini-clinical evaluation exercise (Mini-CEX) – a structured assessment of an observed clinical encounter.

On-site assessment and training (OSAT) – the assessment of practical skills and knowledge carried out in the workplace.

Objective structured clinical examination (OSCE) – an examination or assessment process designed to test clinical performance and competence in skills such as communication, clinical examination, medical procedures; usually comprises a circuit of short stations using either real or simulated patients (actors).

Simulation – the imitation of a process or clinical technique in real time using either actors or equipment to represent patients.

Triangulation – the process of obtaining data from different sources, with the intention of adding to the validity of an assessment.

Appendix 2

Useful documents

Good Medical Practice (GMC, 2013)

How to Conduct a Local Performance Investigation (National Clinical Assessment Service, 2010)

The Medical Profession (Responsible Officers) Regulations 2010

The Medical Profession (Responsible Officers) (Amendment) Regulations 2013

Maintaining High Professional Standards in the Modern NHS (Department of Health, 2003)

The National Health Service (Performers Lists) (England) Regulations 2013

Primary Medical Performers Lists – Delivering Quality in Primary Care, (Department of Health, 2004)

Remediation report – Report of the Steering Group on Remediation (Steering Group on Remediation, 2011)

Tackling Concerns Locally (Department of Health, 2009)

Use of NHS Exclusion and Suspension from Work amongst Doctors and Dentists 2011/12 (NCAS, 2011)