NHS England

A practical guide for responding to concerns about medical practice

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Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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Contents

1 Purpose of this guide

When a concern arises about a doctor's practice it presents a three-fold opportunity to protect patients, support professional behaviours by the doctor and improve quality in the organisation. These are achieved through reflection and learning by all involved in an open, fair and effective manner. To realise all three is a challenge requiring skill, wisdom and leadership on the part of the responsible officer. The circumstances in which potential concerns come to light commonly increase this challenge.

This guide provides generic, practical advice for responsible officers in all designated bodies in England to address a potential concern about a doctor's practice in a manner consistent with existing literature and previously established principles (Box 1). While there are a wide variety of designated bodies, the duty to protect patients is the same for all. The aim is to help all responsible officers to follow a methodical process, to deliver constructive and timely outcomes within local processes and avoid unnecessary recourse to regulatory and legal actions.

This guide is of primary importance to responsible officers, medical directors, chief executive officers and non-executive board directors. It is also of relevance to appraisal leads, appraisal managers, relevant managers/administrators, appraisers and doctors. It will also be of interest to patient and public representatives and other groups with an interest in the quality of healthcare.

When a potential concern arises the immediate response sets the direction for that which follows. Engagement of the doctor as a professional participant is a key factor for successful resolution within local processes. Another is to distinguish common variation of practice from that which veers significantly from accepted standards and respond accordingly.

Box 1: Guiding principles for responding to a concern about a doctor's practice

- Patients must be protected.
- Clinicians too must be safeguarded.
- 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.

Adapted from Supporting Doctors to Provide Safer Healthcare
(NHS Revalidation Support Team, 2013 (revised))

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2 Roles, professional responsibilities and the nature of the organisation

Every *doctor* has a professional duty to maintain their fitness to practise. This includes the duty to be proactive about raising a concern about their practice, to acknowledge a concern if one is raised and to engage constructively with steps to address it.

A *responsible officer* has statutory duties in relation to doctors with whom they have a prescribed connection (Box 2). These include the provision of processes to respond to concerns about a doctor's practice. A responsible officer is appointed by a *designated body,* which in turn has a duty to support the responsible officer.

'[We need to be] clear about putting patients first and the overriding duty to take appropriate action to raise and act on concerns.'

Responding to Concerns
Core Group Member

In this guide the term *'person with governance responsibility for the doctor's practice'* refers to such a person in a place where the doctor is working other than the doctor's designated body. For example, if a doctor works as a general physician in an NHS hospital, their prescribed connection will be to the NHS hospital and the responsible officer in the NHS hospital will be their responsible officer. If the doctor also undertakes sessions in a clinic in the independent sector, the clinic medical director (who may also be the responsible officer for other doctors in the clinic) is a person with governance responsibility for the doctor's practice in the clinic. An individual doctor may relate to a number of such persons depending on their scope of work. A person with governance responsibility for a doctor's practice has a duty to cooperate with the doctor's responsible officer in addressing a concern about the doctor's practice. The information flows which support this are described in the NHS England guidance *Information flows to support medical governance and responsible officer statutory function* (see References section).

Box 2: Summary of the key statutory duties of the responsible officer

To ensure the provision of:
- medical appraisal;
- processes to monitor a doctor's performance;
- processes to respond to concerns about a doctor's performance;
- processes to verify a doctor's suitability for the work they are engaged to do.

And also to:
- make a recommendation to the GMC about fitness to practise (revalidation recommendation);
- refer concerns to the GMC when necessary, and monitor compliance with GMC conditions or undertakings.

From the Medical Profession (Responsible Officers) Regulations 2010

In larger healthcare organisations there is commonly a governance structure supporting the responsible officer. This may include colleagues such as associate medical directors, clinical directors, appraisal leads, relevant managers, administrative staff and others. While members of this structure collectively may

undertake some of the responsible officer's duties, they do so as *'persons with appropriately delegated responsibility'* and the responsible officer retains the statutory duties set out in the regulations. Taking the example above, it would be usual for the clinical director of the medical department to be a person with appropriately delegated responsibility for the governance of a doctor's practice.

As the example above illustrates, the governance network around a doctor can vary in scale and complexity, depending on the number of places where they work and the nature of these organisations. The direct involvement of a responsible officer with managing a concern may therefore vary, from being supported by a team and other departments such as HR in a large designated body to doing all the work personally in a small one. In this guide the term 'responsible officer' therefore refers to a 'responsible officer', 'person with appropriately delegated authority', or 'person with governance responsibility for the doctor's practice' as appropriate to the context.

3   A process for responding to a concern

Breaking down the process of responding to a concern into its constituent stages permits better understanding of each and its contribution to the overall process. It also helps us see that if the process stalls at any stage this may be due to failure to complete an earlier stage effectively.

The key stages and sub-stages of a process to address a concern are set out in this section and illustrated in Figure 1 below. The process is dynamic rather than linear. Various factors such as the occurrence of new incidents, the discovery of new information and failure of agreed action to achieve the desired outcome may necessitate repeating one or more loops of the process.

3.1   Key stages:

Stage 1: Presentation

Stage 2: Exploration:

> a: Immediate response
> b: Initial enquiry
> c: Full investigation

Stage 3: Actions[1]

Stage 4: Review[1]

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[1] The term 'remediation' is not used in this document because it carries a different meaning in different publications and for different groups. Broadly speaking, stages 3 and 4 above equate to 'remediation' as that term is most commonly employed, i.e. the actions undertaken to address an identified concern, and their review.

Figure 1: The process for responding to a concern about medical practice from initial exploration to action and review
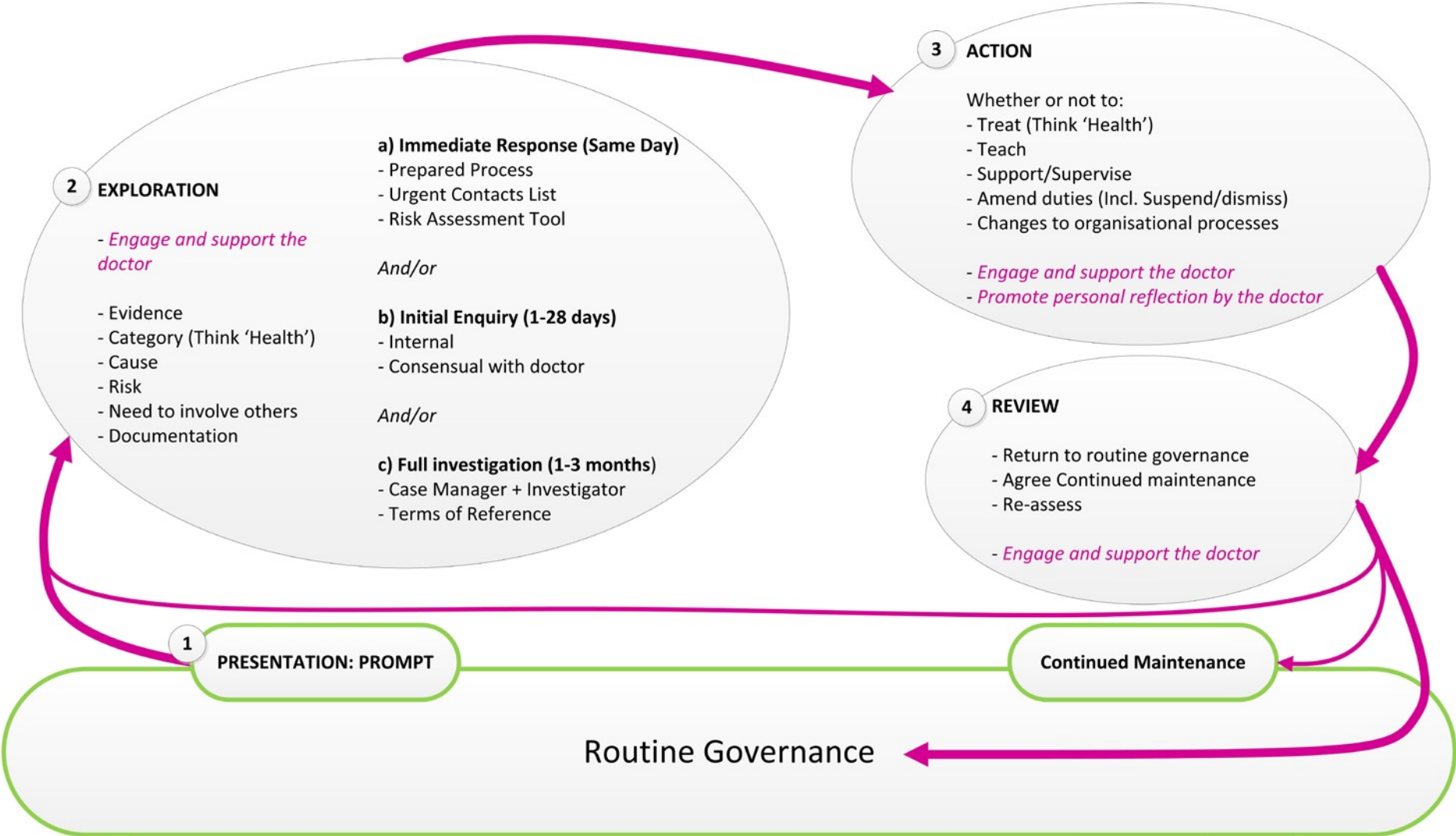
3.1.1 Stage 1: Presentation: the prompt

Key question:
- Is the incident attributable to an individual and might it constitute a concern?

Principle:
- Effective clinical governance processes should mean only those matters that need to be are brought to the attention of the responsible officer

Discussion:

For the purpose of this guide, the prompt is defined as the point at which a potential concern about a doctor's practice comes to attention. A concern could arise from any source, such as a patient complaint or colleague concern, for example. Not every prompt will be classified as a concern when it is explored. The number and level of prompts that a responsible officer will be presented with directly is dependent, among other things, on the scale of the organisation, the structure and effectiveness of local clinical governance processes as discussed in Section 2 and the culture within which this operates. Such systems help to protect the capacity of a responsible officer to exert their best professional judgement when serious matters do come to light unexpectedly.

A measured professional approach by the responsible officer will benefit subsequent stages significantly, bearing in mind that a prompt may arise without warning, with limited information and in an emotionally charged context. It is therefore desirable for a responsible officer and their team to have in place an agreed mechanism for receiving a prompt, whether trivial or serious, and for undertaking an immediate exploration in an efficient, objective, timely and proportionate manner. As a minimum the responsible officer should have a list of readily accessible resources and contacts (Box 3, on page 11).

3.1.2 Stage 2: Exploration

The prompt, having presented, requires exploration. There are three levels of exploration, any or all of which may be appropriate:

- **2a: Immediate response**
- **2b: Initial enquiry**
- **2c: Full investigation**

Regardless of whether level 2a, 2b or 2c is being undertaken, the following are common to all:
- Gather information to clarify the concern
- Consider the category of the concern (Health, +/-Conduct, +/- Capability; also fitness to practice vs fitness for purpose – see page 16 for more detail)
- Reach a conclusion about the cause of the concern
- Establish the risk (and review it in light of new information (Appendix A)).

2a: Immediate response (approximate timescale: immediate - same day)

Key questions:
- 'What immediate action is required?'
- 'Is there enough information to resolve this now?'

Principles:
- Never do nothing, but avoid over-reacting - do only what is essential to safeguard patients until the facts can be established.
- Be prepared to seek advice, with a clearly understood and practised local process, and important contact details to hand.
- Begin by assuming the doctor will engage professionally and that the matter can be resolved, whilst retaining awareness that some doctors are capable of deliberately unprofessional and criminal actions.

Common actions:
- Divert from current activity as required to give the prompt correct attention.
- Make an initial risk assessment of the prompt on the available information.
- Decide whether the matter constitutes a concern (see Box 4).
- Consider if suspension/exclusion or amendment of duties is necessary (Box 5).
- Decide whether an initial enquiry or a full investigation is required, or whether the matter can be resolved immediately.
- Speak with the doctor if possible (it is nearly always appropriate – see discussion below).
- Consider whether it is necessary or possible to speak with other persons (Box 3), whether for advice or to inform them of the matter.
- Put in place any necessary support for the person who is the source of the prompt.
- Delegate the next steps to others if you conclude from your immediate response that this is safe and appropriate.
- Document the matter and the actions taken.

Discussion

The immediate response to a prompt can have a significant impact on how the matter proceeds. In particular, facilitating the professional engagement of the doctor at the earliest stage may have a major benefit.

A key consideration is: what is the least action needed to create the space necessary to establish the facts well enough to support robust decisions. It is necessary to decide if immediate action is required to protect patients or other persons or to investigate or prevent criminal actions. Whilst a responsible officer needs to retain the option to remove a doctor from the workplace or to inform the authorities immediately, such a step should be uncommon and it is usually justifiable to take some time to explore the situation. This again is a matter of professional judgement on the part of the responsible officer. Familiarity with a suitable risk scoring matrix, such as that set out in Appendix A, is likely to be helpful here. Discussing the matter urgently with a colleague such as those listed in Box 3 is also likely to be beneficial.

At the other end of the spectrum, it is possible that the immediate response of the responsible officer is that the matter is of low risk, does not constitute a concern (Box 4) and may be addressed as a simple incident, either by handling it within routine governance processes or without any further action other than recording that it has occurred. This approach can both minimise over-reaction to a prompt, whilst safeguarding the situation by making a record to take into account should a further prompt arise.

Box 3:
Important resources to have readily to hand

General:
> Risk assessment matrix (Appendix A)
> Administrative support
> Local responding to concerns policy
> Relevant HR and disciplinary policies
> Local advisory group

Contacts (including deputies for each):
> GMC Employer Liaison Adviser
> HR Director
> CEO
> Associate Medical Director
> Media lead
> Higher Level Responsible Officer
> RO advisory group member(s)
> Person with governance responsibility in other places where the doctor is working
> NHS Resolution contact
> NHS Litigation Authority contact
> NHS Protect contact
> Other regulator
> Police
> Organisation legal adviser
> Medical Royal College advisor
> BMA contact
> Medical defence organisation
> 'Buddy' responsible officer
> Mentor or other trusted colleague

Box 4: Defining a concern

Where the behaviour of a 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*.

Supporting Doctors to Provide Safer Healthcare
(NHS Revalidation Support Team, 2013 (revised))

In all cases, when a prompt occurs, the immediate response should be recorded and agreed actions documented (including a decision to take no further action), with timings.

The source of the concern may be someone who needs support on having raised the prompt. Their needs must be considered simultaneously with the exploration of the prompt. In this context matters of equality and diversity may be relevant. Issues relating to protected characteristics must be taken into account in accordance with statutory requirements and the organisation's policies relating to these. These matters may apply to the person raising the concern, the clinician involved, or both.

Box 5: Suspension/exclusion or amendment of duties:

- Usually: permit normal duties.
- Relatively commonly: offer voluntary temporary withdrawal, restriction of duties or redeployment.
- Unusually: make a decision to suspend/exclude or dismiss instantly.

Rules of thumb when considering suspension/exclusion or amendment of duties:

1. Is any person's safety at risk?
2. Is evidence at risk (particularly criminal)?
3. Is suspension/exclusion necessary and proportionate to these risk(s)?
4. Is voluntary withdrawal/amendment a legitimate option?

2b: Initial enquiry (approximate timescale: 1-28 working days)

Key question:
- Is there agreement between the doctor and the responsible officer that the facts can be established sufficiently by initial enquiry within an acceptable timescale, to allow a safe and fair conclusion?

Principles:
- The doctor and the responsible officer have distinct but complimentary responsibilities to protect patient safety and to exhibit professionalism.
- The doctor should be included as a partner in the process.
- Involvement of resources such as the doctor's defence organisation or supports will usually aid this.
- Time efficiency is important, but it is also important to allow enough time to reach the right conclusions.
- If either the doctor or the responsible officer are not in agreement, then Stage 2c: Full investigation should be undertaken.

Discussion

Assuming that the matter does not require immediate removal of the doctor from work or notification of the authorities, but that it cannot be resolved without further exploration or action, the responsible officer needs to make an initial enquiry.

Generally, an initial enquiry will take a number of days. This should normally take no longer than 28; most should be complete within 14. One factor which can relieve time pressure is when the engagement of the doctor is effective and there is agreement that added time to reach the best outcome is appropriate in the circumstances.

Another is when the doctor can be permitted to continue in their normal duties as suspension/exclusion or amendment of duties will inevitably increase time pressure.

The initial enquiry may necessitate the cross-referencing of information from those with governance responsibility for the doctor's practice in other places where the doctor works. The mechanisms for doing this are described in the NHS England document *Information flows to support medical governance and responsible officer statutory function* (see References section) and the decision to do so should be shared with the doctor in almost all cases.

It may also be appropriate for the responsible officer to engage another person to lead the initial enquiry, and for terms of reference on the scope of the enquiry exploration to be agreed. While it may be appropriate for this to occur within the context of an initial enquiry, the more such things are necessary, the more likely it will be that a full investigation is required (Stage 2c).

2c: Full investigation (estimated timescale: 1 – 3 months)

Processes for full investigation should be described in the organisation's policy for responding to concerns and are outside the scope of this document. Various models also exist and provide useful reference even outside their target sector, such as Maintaining High Professional Standards in the Modern NHS, the NHS England Framework for Managing Performers' Concerns and the National Clinical Assessment Service. Principles of a good investigation from the perspective of the GMC are set out in Appendix B.

General considerations about Stage 2: Exploration
The following discussion points relate to Stage 2: Exploration, whether 2a, 2b or 2c:

Level of exploration
Various factors contribute to the selection of 2a: Immediate response, 2b: Initial enquiry or 2c: Full investigation as the best approach to explore a concern:
- level of risk: if the risk is high then a higher level of exploration may be necessary to maximise likelihood of successful resolution;
- complexity of the issue such that a lower level of exploration is unlikely to sufficiently establish the facts;
- whether the concerns are of a nature that interact with the functions or responsibilities of other key agencies e.g. police/home office/NHS Protect/ Healthcare Medicines Regulatory Authority;
- presence or absence of agreement between the responsible officer and the doctor on whether the facts can be established sufficiently at a lower level within an acceptable timescale, to allow a safe and fair conclusion.

Whilst it may be possible to accept that the first three of these may be relatively objectively decided, it is reasonable to believe that an effective professional rapport between the doctor and the responsible officer will minimise the frequency with which disagreement is the reason for needing a higher level of exploration.

Whilst it is commonly the case that the immediate response will be followed by either an initial enquiry or a full investigation, it should not be presumed that this is always necessary. Nor should time be spent in initial enquiry if it is clear that a full

investigation is needed.

At the end of the exploration stage, there should be agreement between the doctor and the responsible officer:
- that the relevant facts have been established, including precipitating factors;
- about the risk relating to the matter;
- about the conclusions that have been drawn.

It is only legitimate to proceed to stage 3 (defining actions to address the cause) when agreement exists on all of these. This is because the success of any action is dependent on the engagement of the doctor and likely to be unproductive if the doctor is not in agreement. If there is disagreement, then the next level of exploration (2b or 2c) should be undertaken. If disagreement persists following a full investigation (2c), then the matter will require escalation beyond the process described in this guide.

Health
In all concerns it is helpful always to consider the possibility of a health issue. Health issues are a common component of concerns and are commonly unrecognised. Where health issues are present, actions to correct a conduct or capability issue are more likely to be effective if the health issue is recognised and treated.

Further assessment and treatment of an ill doctor should not be attempted by the responsible officer or their team. If a health issue is identified as the sole cause of a concern, the matter should be addressed within other processes, for example by Occupational Health assessment (see Appendix C) and not the performance framework of the organisation.

The responsible officer should also remain vigilant for the possibility that a health problem might arise during the course of dealing with a concern, and that this may occur during or even after the matter has otherwise been resolved. There is published literature about the risks posed to professional health and wellbeing by medical error – the so-called second victim phenomenon (Appendix D). Whilst the safety of patients is paramount, the duty of care to the professional is also important and in turn can have a bearing on safety in itself.

Engaging the doctor
The responsible officer should proactively seek to develop a productive rapport with the doctor, based on professional values of trust, honesty and commitment to patient safety and quality of care. Engaging the doctor in this way indicates to them that they are involved as a professional in the process. It also forms an important component of the duty to support them in what is invariably a stressful matter, which in turn further enables their engagement.

Aspects which help build trust include clear policies and processes, and for these process to be followed efficiently in a timely and professional manner.

'I always feel that if I can keep the doctor on board and work with them, then progress is possible. The doctor is always more stressed [about the concern] than me.'

Medical Director

Engagement of the doctor is important in the information gathering process, as their perspective is a component of the evidence. An early conversation with the doctor may reveal their awareness of the issue in question and that they have already planned action to address it, thereby giving immediate reassurance to the responsible officer.

Conversely, failure to maintain adequate professional rapport between a doctor about whom there is a concern and those who are handling that concern is regarded as one of the most common reasons causing resort to legal or regulatory processes.

Formation of rapport is a two-way process. It may be helpful to bear in mind that in a conduct-related concern the level of insight by the doctor and hence their readiness to engage may be less than, for example, in a concern related to performance or health.

There are a very small number of situations where the ability of the responsible officer to communicate with and engage the doctor is limited. Chief among these is where a criminal act may have been committed, where informing the doctor may create a risk of obstructing the course of justice. Even in these situations a conversation explaining this in general terms is often possible with the doctor, after taking suitable advice from, for example, legal colleagues or the police. Such circumstances, whilst important, are rare. It is desirable to develop confidence and skills of open communication with the doctor in the vast majority of cases.

In other circumstances it may be advisable for the responsible officer not to communicate directly with the doctor, so as to preserve the responsible officer's objectivity at a later stage. In these circumstances it is desirable for the responsible officer to delegate a team member to lead on the engagement of the doctor.

Another valid benefit of engaging the doctor is to discharge the duty of care of the organisation towards the doctor. Whether or not at fault, medical professionals commonly experience feelings of guilt and shame in relation to professional incidents as mentioned above (Appendix D). Whether undertaken by the responsible officer personally or delegated to a colleague, maintaining effective communications with the doctor is one important way of mitigating this.

Similarly, as part of the process of involving the doctor, they should be invited to consult with their own sources of advice and support such as their medical defence organisation, their representatives e.g. their professional body or the BMA. The identified level of risk can be helpful in the decision about what level of support a doctor might require.

Finally, early engagement with the doctor supports the principle of professionalism, given that both they and the responsible officer share the same duty to protect patient safety by responding to concerns in a professional manner. This in turn supports constructive interactions between the doctor and their responsible officer in the future, and can benefit the culture in the organisation as a whole.

Further guidance on engaging and supporting the doctor can be found in Appendix E.

Seek input, advice and support from others

It is usually possible to consult with others even in an urgent situation and this is to be encouraged. A responsible officer should have a clear idea of the resources they can call on to help inform their professional judgement as they explore a concern. These may be internal or external to the organisation. A responsible officer may use some resources more frequently than others; by the same token they may need to contact an infrequently used resource urgently hence the need to keep their list up to date. Every case needs to be handled on its own merits and using the expertise and insights of a variety of resources can support the responsible officer and the doctor to reach the best outcomes. The options for supportive advice and input include but are not limited to those listed in Box 3 above.

Inform/communicate with others

As well as seeking input, it may be necessary or helpful proactively to provide information to others when a concern has been identified. These may include but not be limited to: senior persons in the organisation such as a chief executive officer, persons with governance responsibility for the doctor in other places where they are working, other statutory bodies such as the police, regulators such as GMC and CQC, affected individuals including patients, relatives and carers, and the media.

Communications with patients, their relatives and carers about notifiable safety incidents are set out in the duty of candour regulations (see References section).

Communications with the media should be governed by local policy. The underlying principle is that proactive, open and effective communication increases the potential for a constructive outcome. Media handling skills on the part of the responsible officer and/or access to colleagues with such expertise are of value in this regard.

Fitness to practise vs fitness for purpose

This phrase is commonly used to distinguish behaviours which are not in keeping with GMC requirements on good medical practice and therefore may have an impact on a doctor's licence or registration, from those which are not in keeping with the doctor's ability to practise in a particular professional role but do not breach the threshold for GMC action. An example of a fitness to practise issue is a doctor who fraudulently amends medical records to cover up a clinical error, and an example of a fitness for purpose issue is a doctor who takes on a role as a clinical director but is unable to develop the necessary skills to discharge this role effectively. In the first example the breach of good medical practice relates to professional integrity and is likely to be an issue in all areas of practice, whereas in the second, recognition of the issue could conceivably lead to the doctor relinquishing their management role, reverting to normal clinical work and functioning productively again.

A discussion with the GMC Employer Liaison Adviser can help to clarify which concerns raise a question about fitness to practise as well as advice about whether and when to refer the doctor to the GMC. Additionally, the Practitioner Performance Advice team (part of NHS Resolution and formerly known as the National Clinical Assessment Service (NCAS)) can provide further support and advice in relation to the management of fitness for purpose concerns.

Maintain documentation; share this with the doctor
Good documentation is a necessary component of any process of governance, whether routine personal activity data at one end of the spectrum or discussions of a concern at the other. A secure record of all prompts which arise in the process described in this document should therefore be kept whether these are ultimately defined as low risk and addressed via routine governance mechanisms, or as higher risk and addressed via the process for responding to concerns. This should include timings, narrative and associated documents. It can also be helpful to store relevant e-mail and other electronic correspondence in a designated place, as it can be a difficult matter to retrieve and assemble these from personal e-mail archives retrospectively.

Such records should be shared with the doctor unless there are legal or statutory reasons not to, and it is good practice to invite the doctor to contribute appropriately to their content and to have any dispute about the content recorded.

A doctor has right of access to all documentation relating to them in all but a very few situations, through data protection and freedom of information legislation. Such right of access extends to documentation including emails and text messages whether directly or indirectly related to the matter in hand. This reinforces both the principle of sharing documentation with the doctor, and the importance of maintaining a professionally respectful and objective style in all communications.

Supporting responsible officer decision making
Depending on the scale and resources of the organisation, the responsible officer will often find support in decision-making helpful, and adds objectivity to their decisions. This can be achieved ad hoc with input from the sorts of resource listed in Box 3, or via a formally constituted advisory group (Appendix F).

'Our [small group for discussion of concerns] is in effect a MDT (multi-disciplinary team) meeting. It is invaluable as it offers me assurance that I am acting in a reasonable way.'

NHS England Responsible Officer

Other actions
The exploration of a prompt may or may not identify that the cause resides solely with the doctor's practice. Exploration may confirm that the behaviour of the doctor played no part and that the prompt was simply the trigger bringing a wider issue to light. Where other factors are identified as relevant, such as team or systems issues, there is a separate need to look into these and identify actions to address them within the organisation's clinical governance and assurance systems.

3.1.3 Stage 3: Define and undertake suitable actions to address the cause

Key question:
- Is the action appropriate to the cause of the concern?

Principles:
- Accurate exploration of the cause will help identify the best actions to improve practice.
- All actions are one of:
  - treatment of a medical condition,
  - learning,
  - supervision/support,
  - amendment of duties,

  or a combination of these.
- The intensity of the action(s) is determined by the risk associated with the concern and its cause.
- A decision support group may help identify suitable actions.
- Actions may relate to the doctor only or may relate to other individuals, teams or the organisation as well/instead.

Discussion

The actions to address the cause of a concern will flow from the accuracy of the exploration of that cause and the associated risk. The nature of the actions will thus vary accordingly. Other factors affecting the options available include levels of resource and availability of skills and facilities. All of these mean that it is not possible to present a defined list of actions here. However, it is possible to consider that in most cases where the concern relates to professional behaviours there is a small number of broad categories of intervention and that all actions therefore are based on these:

- **Treatment**

  The doctor can receive treatment for medical conditions affecting their medical practice. As observed above it is important to identify whether health issues form any part of the cause of the concern in question, because it is almost always preferable to address these first.

- **Learning**

  The doctor can undertake learning or retraining to increase or refresh knowledge or skills (including behavioural interventions).

- **Supervision/support**

  Additional supervision/support can be put into place. Whilst there is a clear distinction between supervision (which implies observation to assure practice) and support (which implies the presence of a colleague to observe/mentor/coach the doctor to practise in an improved way) the two functions are commonly discharged by the same person or team, hence their being listed them in the same section here.

  Whilst appraisal is not the forum for a concern to be explored, review at appraisal is one of the options for supporting a doctor and supervising actions, particularly

for concerns at the lower end of risk. This can also be a relatively less intense option for a doctor when appropriate, given the universal nature of appraisal.

- **Amendment of professional duties**
  The doctor can amend their professional activities, whether in relation to the nature of their work (e.g. withdrawing from the undertaking of certain procedures) or volume (e.g. by withdrawing from a role, to be more effective in their remaining roles).

  At times it may be appropriate to explore the potential to return to practice but in a different role. For example a consultant may become a staff grade doctor, a locum general practitioner may become a salaried doctor in a single practice or a clinician can move to a non-patient-facing role. Such actions can be challenging to negotiate and navigate, and the professional rapport between the parties and shared commitment to patient safety crucial to success.

Within each of these categories, the action can range from low to high intensity and from self-directed to externally managed, depending on the risk of the original concern and nature of the identified cause. This is set out in Figure 2 below. It is noted that availability of the options described may be dependent on factors such as the nature of the organisation, resources available and the provision of a particular intervention in a given place.

Where possible, the actions should be agreed between the responsible officer and the doctor (in the vast majority of cases). They should be clear and specific, and include description of responsibility for participation and, where appropriate, funding arrangements, as well as agreed timescales and arrangements for review. All of this should be clearly documented so that it can be reviewed effectively in the next stage.

The actions agreed should contain details of whether subsequent review will take place within other processes such as medical appraisal or local governance systems, or within the concerns process. Broadly speaking, for matters of lower risk, review within appraisal/governance processes is likely to be appropriate and matters of higher risk may require review within the responding to concerns process.

An additional action may be necessary on occasion, of engaging another agency to deal with the matter appropriately. For example the police will need to be involved if criminal activity is identified or suspected, or the GMC may need to investigate if the matter crosses the threshold for fitness to practise referral. A conversation with the local GMC employer liaison adviser will help establish this latter aspect before making a formal referral to the GMC.

Funding
Healthcare organisations should have agreed arrangements for the funding of actions in response to concerns about a doctor set out in policy. These may take into account, among other things, the nature of the concern, the contractual relationship with the doctor, the amount of work the doctor does within the organisation, and relevance of the concern to that work.

Figure 2: Options for action

	Risk	Options for action At all levels personal reflection by the doctor is an important action			
	Risk	Educate	Supervise	Support	Define practice
Not a concern	Low (Insignificant)	• Standard PDP (doctor-led), • College-defined standard CPD	• Normal, by line manager	• Informal support (e.g. mentoring, coaching) optional/self-directed	• Normal practice within scope of work presented at appraisal
Not a concern	Low (Minor)	• PDP contains appraiser-led items. • CPD may contain items directed by appraiser	• Normal, by line manager • Responsible officer aware via appraisal	• Informal support (e.g. mentoring, coaching) optional/may be specified by appraiser	• Normal practice +/- minor adjustments to scope of work
Concern	Medium (Moderate)	• Expert (in-house or local external, +/- NHS Resolution/College) assessment of development needs to create targeted PDP and CPD requirements	• Responsible officer aware separately to appraisal • Supervision in practice optional	• Informal support (e.g. mentoring, coaching) desirable	• Normal practice +/- adjustments to scope of work
Concern	Medium (Significant)	• Expert external assessment (+/- NHS Resolution/College) of development needs to create targeted PDP and CPD requirements	• Responsible officer aware separately to appraisal • Supervision in practice likely	• Informal support (e.g. mentoring, coaching) • Desirable	• Significant restrictions to scope of work likely • Exclusion from workplace may be necessary • GMC investigation possible including potential interim restrictions on the doctor's registration.
Concern	High	• GMC-led investigation of fitness to practise leading to targeted PDP and CPD requirements	• Responsible officer aware • Supervision essential if not excluded	• Informal support (e.g. mentoring, coaching) desirable	• Significant restrictions to scope of work highly likely • Exclusion from workplace likely • GMC investigation probable including potential interim restrictions on the doctor's registration.

3.1.4 Stage 4: Review

Key question:
  - Have the actions resolved the concern?
Principles:
  - A concern which has not resolved requires re-exploration.
  - Not all concerns can be resolved; continuing management may be necessary to assure patient safety.
  - It does not serve patients, a doctor or the service to maintain the doctor in a role in which they are not maintaining good medical practice.

Discussion:
Details of the process for reviewing the outcomes of actions taken to address a concern should be set out in the designated body's policy for responding to concerns. Arrangements specific to the individual situation should also be described in the documentation of the actions agreed in Stage 3 above.

If there is agreement at review that the actions have resolved the concern then the concern should be closed.

If there is not agreement that the concern is resolved then the reasons for this must be explored. These may be complex but include:

- failure to complete the actions,
- incorrect exploration of the cause in Section 2,
- selection of unsuitable actions,
- failure to successfully achieve engagement with the doctor,
- inability of the doctor to change their practice,
- organisational factors.

If the process stalls at any stage this may be due to failure to complete an earlier stage effectively. For example, if, following unacceptable behaviour to patients and colleagues, a doctor undertakes an action to re-train in interpersonal skills but their unacceptable behaviour continues, this may be due to a failure at the exploration stage to recognise that they were suffering from stress and burnout.

It may be sensible to consider repeating Stage 2 at least once, as fresh exploration may permit new understanding of the relevant factors. The decision to repeat the cycle subsequently will need to be balanced with the cost to all parties of going through the process another time; with each cycle the likelihood of identifying a resolvable cause probably lessens. In such situations, where safe practice cannot be maintained in a proportionate and sustainable manner, a different solution may need to be sought.

Striving for success; recognising and addressing failure
When addressing a concern about medical practice the prime focus is to support patient safety by ensuring the continuing delivery of safe, high quality practice by the doctor. The rate at which this is achieved is an important marker of the effectiveness

of the process, and should be measured within the quality assurance of the organisation's policy for responding to concerns (Appendix G).

At the same time it is not possible on every occasion to achieve resolution of a concern or its management in a proportionate and sustainable manner. This may be true even with sincere intent to behave professionally from all parties involved. It is therefore necessary to retain the option of the doctor withdrawing from their role and even from practice completely. Clearly this is a difficult area to be approached with sensitivity by the responsible officer. At the same time it is a disservice, not just to patients but to the doctor in question, to persist with a situation where disproportionate and unsustainable actions are required to maintain patient safety because of the needs of the doctor. Working in such a context is commonly stressful. It may be harmful for that individual as well as to the team, and thus to the quality of patient care.

When such a situation arises it is therefore legitimate for the responsible officer to address it openly and sensitively, to consider how to support the doctor in withdrawing, and to offer an appropriate level of assistance in identifying suitable alternative employment. It should also be noted that the ending of the relationship between a doctor and their organisation in such circumstances is very different to that in which a doctor is dismissed under the terms of their contract.

Appendices

4 Appendices

Appendix A - Assessing the risk

This appendix aims to promote assessment of an incident for its risk. Commonly, by identifying that the risk associated with a trigger is low, sufficient reassurance can be gained that the issue is not a concern and can be dealt with as a learning incident. Low rated incidents should be more common; by becoming familiar with addressing these, the conversations and process become generally more comfortable for all so that incidents identified as moderate and high, whilst being recognised as concerns, can be less threatening too.

In this way it is possible to establish the concept of dealing with low risk prompts not as concerns but as incidents, within normal governance processes. An important advantage of this is that such processes are commonly system - or team - rather than individually-focussed. This helps destigmatise the issue and facilitate engagement. It is preferable to operate in the realm of governance processes where possible, only moving to the concerns handling processes when the risk is identified as medium or high.

It should be noted that, as facts are clarified or further events occur, the risk may vary, so a trigger initially classed as 'high' may revert to 'low' as the investigation progresses and it becomes clearer that the doctor is fully engaged with the process, or a low risk incident may rise to medium or high if, for example, other instances come to light on involving the responsible officer. The risk should therefore be reassessed as often as is necessary.

There is currently no single agreed model for assessing incident or concerns risk. The matrix which follows is offered as a suitable basis on which to proceed. It has been created from a matrix used in an NHS secondary care setting, and subsequently after adaptation, in an NHS primary care setting. It may be suitable for use in a designated body where no tool is currently in use. Whilst it may be used by an organisation to develop their existing tool it is not intended to replace an existing tool where that tool is effective.

Risk assessment matrix

Using this risk assessment matrix

This risk assessment matrix is a tool to support and to provide a degree of objective backing to professional judgement. It is not a validated tool and does not replace professional judgement. The recommended approach is as follows:

1. *Before looking at the matrix*, consider the issue and form an opinion as to whether the associated risk is low, medium or high using your professional judgement.

2. Only after you have done this, refer to the matrix.
    i. Consequence: Use Sections A or D to determine the consequence score[2] based on whether the consequence listed can reasonably be viewed as having resulted from the actions of the doctor. You should do this in terms of both the prompt which has occurred and the potential consequence should the same prompt occur again. All events, actual or future, may have one consequence or several consequences (e.g. affecting patient care, adverse publicity, etc.). The score used to calculate the overall consequence is the row from which the highest numerical score is achieved, whether considering the initial prompt or potential future consequences.
    ii. Likelihood: Use Section B to determine the likelihood score. This is the chance that the consequence described above will recur, or the frequency with which a similar incident has occurred in the preceding 12 months, whichever gives the greater score.
    iii. Risk Score: Section C. Multiply the consequence score with the likelihood score to obtain the risk rating, which will be a score between 1 and 100. A score of 0-8 = low risk, 10-18 = medium risk, 20-100 = high risk.

3. Compare the risk rating you arrived at in 1 above with the rating you reached in 2. If they concur, accept the risk. If they do not, revisit both ratings until you are satisfied that the risk is correct. If you cannot reconcile your professional judgement with the score obtained using the matrix, you should discuss with others until you are satisfied that the risk rating you are applying is that which is most appropriate to the circumstances.

4. The matrix is designed to measure the risk associated with an incident, not an individual. Once the incident risk is established, a further judgement is needed to establish the extent to which the incident is attributable to the actions of an individual and hence whether or not it should be regarded as a concern about medical practice.

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[2] Consequences relating to persons and quality of care are set out in Section 1, for ease of using the matrix because most concern prompts arise in these areas. The less common consequences are set out in Section 4.

Section A Common consequences

(see Section D for other consequences)

Actual Severity = Concerns/Incidents/Complaints/Claims   Potential Severity = Risk Assessments/Near Miss

Descriptor	2 Insignificant	4 Minor	6 Moderate	10 Major	20 Catastrophic
Impact on the safety of patients, staff or public (physical/ psychological harm)	No or trivial impact on patient health No or trivial impact on staff	Minimal impact on patient health requiring no intervention or treatment Staff distress or injury not requiring time off work	Minor impact on patient health, or intervention/treatment required, resolves within one month Staff distress or injury requiring time off work or light duties for 0–35 days	Moderate impact on patient health, or impact lasts longer than 28 days – patient recovered Staff distress or injury requiring time off work or light duties for >35 days with eventual recovery Major injuries/Dangerous Occurrences reportable under RIDDOR	Major impact on patient health, or impact is permanent or unexpected death Staff distress or injury which prevents work for the foreseeable future. All Never Events (Defined elsewhere)
Quality/ Complaints	Little or no patient dissatisfaction	Unsatisfactory patient experience relating to attitude or patient expectations of care where care has been within the normal surgery protocols Justified formal complaint peripheral to patient care Error of process – minimal potential for patient harm	Unsatisfactory patient experience relating to attitude or patient expectations of care, where the care has been outside normal local protocols Justified formal complaint involving lack of appropriate clinical care, short term effects Error of process with potential for patient harm	Non-compliance with widely agreed national standards Justified multiple formal complaints. Serious mismanagement of care, long term effects Potentially criminal behaviour Legal Claim Ombudsman Inquiry	Totally unacceptable level or quality of treatment/service, or overtly negligent or malicious behaviour by member(s) of team Probable or overt criminal behaviour
Fitness to practise	No indication of breach of GMP	Possible minor breach of GMP	Minor breach of GMP	Moderate breach of GMP	Major breach of GMP

Section B – Likelihood

	1	2	3	4	5
% Chance of recurrence of consequence in identified group in next 12 months	1-5%	6-25%	26-50%	51%-75%	76-100%
Number of times this has happened in the last 12 months	0-2	3-6	7-14	15-30	31+

Section C – Risk Score

Likelihood	Consequence				
	2	4	6	10	20
1	2	4	6	10	20
2	4	8	12	20	40
3	6	12	18	30	60
4	8	16	24	40	80
5	10	20	25	50	100

Section D – Less common consequences:

Descriptor	2 **Insignificant**	4 **Minor**	6 **Moderate**	10 **Major**	20 **Catastrophic**
Objectives / Projects	Insignificant project slippage Barely noticeable reduction in scope or quality	Minor project slippage Minor reduction in scope or quality	Serious overrun on project Reduction in scope or quality	Project in danger of not being delivered Failure to meet secondary objectives	Unable to deliver project Failure to meet primary objectives
Service / Business Interruption Environmental Impact	Threatened Loss / Interruption of service Minimal or no impact on the environment including contamination, not directly coming into contact with patients, staff or members of the public	Loss / Interruption of service Up to 1 hour Minor impact on the environment	Loss / Interruption of service 1 to 4 hours Moderate impact on the environment	Loss / Interruption of service 4 hours to 2 days Major impact on the environment including partial closure	Loss / Interruption of service More than 2 days Major impact on the environment including full closure
Statutory duty/ inspections	No or minimal impact or breach of guidance/statutory guidance	Breach of statutory legislation reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices low performance rating. Critical report	Multiple breaches in statutory duty Prosecution Complete system change required Zero performance rating Severely critical report
Adverse Publicity / Reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Element of public expectation not being met	Local media coverage – long term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the house) Total loss of public confidence
Finance including claims	No obvious / small loss < £50	£50 - £500	£500 to £5000	£5000 to £50000	Over £50000

Appendix B – GMC principles of a good investigation

The emphasis of this guide is on the initial phase of responding to a concern is on local exploration and resolution of concerns about a doctor's practice, before any formal investigation takes place, and minimising progression to formal investigation.

Accepting that local early resolution is not always possible and some concerns do require formal investigation, this annex outlines the General Medical Council's (GMC) principles of a good investigation that reflect the key elements they believe help to ensure that investigations into concerns about doctors are objective and effective. The principles are intended to supplement and complement existing requirements and guidance in place at a national level.

Responsible officers might find it useful to assess their policies and procedures for conducting an investigation into concerns about a doctor to consider the extent to which the principles are applied. They may also wish to think about any changes they could make to the way they run investigations to ensure the principles are embedded in local responding to concerns systems. Application of the principles across the health sector will better enable us to protect patients and uphold confidence in the profession.

1. **It's best for everyone if concerns can be dealt with locally, and escalated promptly where necessary.**

It is better for all involved if concerns can be dealt with locally, ensuring faster, focussed and fair resolution. If there is an immediate or serious potential risk to patient safety or public confidence in the profession, a referral to the regulator can be made at any stage of an investigation and interim measures to mitigate this put in place. Advice on thresholds for referral to the GMC should be sought from the Employer Liaison Service.

2. **Concerns can be explored before commencing a formal investigation if decisions are subject to clear, transparent criteria and the two stages are clearly defined.**

A decision to investigate concerns about a doctor, and how to investigate those concerns, should be made in accordance with clear, transparent criteria There should be a clear boundary between an initial stage of exploring concerns and any subsequent formal investigation, supported by a transparent decision making process.

3. **Investigations should have a clear scope and follow a clear process.**

Investigations must be conducted within an appropriate governance system, and reflect the approach of relevant national frameworks. Relevant policies and procedures should be kept up-to-date to reflect changes in legislation and best practice. An investigation plan with clear terms of reference must be produced, and this should set out the scope of a formal investigation and clearly identify all relevant issues.

4. **Investigators should be objective, properly trained and receive appropriate support and guidance.**

Investigators should be properly trained, receive appropriate support and guidance and be objective in their approach to exploring any concerns and establishing the facts. Where possible they should be independent of the environment in which concerns arose to ensure fairness for all involved and to minimise the risk of actual or perceived conflict of interest. We recognise that in some contexts this may be difficult (e.g. small doctor surgeries with limited staff) and, in these circumstances, alternative arrangements (e.g. investigation to be undertaken by staff from another practice) or other mechanisms to secure objectivity should be explored.

5. **Doctors under investigation should be given information to help them understand what is happening, what is expected of them, and where to access independent advice.**

To ensure fairness and transparency, anyone who is the subject of a formal investigation should be promptly informed and provided with a copy of the terms of reference for the investigation, contact details for those undertaking the investigation and signposted to sources of independent advice. There may be exceptional circumstances where this is not appropriate for example due to concerns that a police investigation may be compromised. Steps should be taken to mitigate the risk of unfairness to doctors who do not have access to legal advice or other representation.

6. **Information about an investigation should be kept securely and handled under a fair, transparent and proportionate disclosure policy which balances the need to assure patient safety, treat sensitive information in confidence and keep relevant parties informed of progress.**

Information must be handled in line with the requirements of relevant data protection legislation. Relevant parties may include the doctor under investigation and other colleagues such as senior staff involved in assessing risk to patient safety, the complainant and witnesses. Appropriate updates should also be shared with patients whose quality of care is the subject of concerns, and the relatives and carers of those unable to represent themselves (this may include patients with diminished capacity, children and the deceased).

7. **Relevant evidence must be identified, collected and efforts made to triangulate information.**

All relevant witnesses must be identified, thoroughly interviewed, appropriate records made, statements taken and consent sought for use of information. Where potential witnesses decide to leave employment during the course of an investigation, efforts should be made to take a statement and keep in touch with them to ensure concerns can be fully explored. The original documents relating to concerns should always be retained.

8. **Independent expert opinion should be obtained where concerns relate to specialist matters.**

Where there are relevant performance concerns, a review of the clinical care/actions should be sought from an independent source that has the necessary understanding of the area(s) of clinical practice. In cases involving health issues which may impact on a doctor's fitness to practise, a referral to an occupational health professional or other independent expert should be offered at an early stage to provide an objective assessment.

9. **The facts established by the investigation should be summarised in a clear, accurate report.**

The report should reflect the terms of reference of the investigation, outline the issues which were investigated and the evidence collected including any response from the doctor under investigation.

10. **The outcome, recommendations and decisions following an investigation should be summarised in a concise, accurate report which demonstrates that an open and fair approach has been taken.**

Recommendations and decisions at the outcome of an investigation should be supported by clear and objective reasoning that is based solely on the facts and evidence gathered and reflects clear criteria. They should also take into account any relevant context such as mitigating or aggravating factors. The action taken as a result of an investigation should be communicated to all relevant parties without disclosing any sensitive personal information such as the doctor's health unless consent is provided.

Appendix C - The role of others

1. Human Resources

Whilst recognising that the scale of many designated bodies is not compatible with having a formal Human Resources (HR) department, where there are sufficient resources to support one, it can be very beneficial in managing concerns about a doctor's practice. In such organisations the relationship between the responsible officer and the director of human resources is a key interaction. It is more than just providing guidance about the HR process within the organisation but is part of the strategic discussion on how to manage a doctor and deciding the options available and the manner and tone that is employed.

In an organisation with an HR department therefore, the HR director should be consulted, possibly with the CEO, when dealing with initial concerns regarding a doctor. These preliminary discussions often balance and provide in-sight to a problem that may not arise when considering an issue in isolation. Inclusion of a person with HR expertise in the responsible officer decision support group adds to the range of perspectives, minimising risk, ensuring that concerns are dealt with in a timely manner, actions are agreed, and momentum is maintained.

It is important that persons with governance responsibility for a doctor's practice at a level below the responsible officer such as clinical directors also have access to expert senior level HR advice, to allow them to address minor concerns with a doctor informally in a timely manner, and to help identify when more serious concerns should be escalated to the responsible officer. It can be helpful to involve persons with governance responsibility for the doctor at a lower level, such as a clinical director, and significant others, in the decision making process with the responsible officer and HR director when serious concerns first come to light.

The HR director should provide timely advice to both the responsible officer and organisation to provide the best options available and to minimise the risk to individuals carrying out these disciplinary roles. The worry about downstream liability and consequences to the responsible officer can sometimes be an unconscious concern that clouds decision making, adding to the stress of discharging these roles.

Although the HR department may be able to point to the policies and mechanisms available, the HR director can also highlight the different solutions that could be used. For instance, although maintaining high professional standards (MHPS) is often used, the other policies in an organisation may still be applicable and used as an alternative e.g. staff bullying and harassment policy. Mechanisms such as coaching, mediation and team development are examples of approaches that the HR department can advise on. These may often provide an option that helps resolve an issue in a less formal manner. On the other hand, appropriate use of a formal approach involving less serious outcomes can achieve improvement and avoid matters developing into more serious matters. Whichever route is adopted to resolve an issue, the role of HR also helps ensure consistency and fairness of approach with regard to how other staff in the organisation are treated.

Expert knowledge of employment law is critical. This is particularly important in the initial phases of a serious investigation that may lead to a dismissal. Conduct or capability issues are usually managed through MHPS but the other 3 reasons (redundancy, breach of statutory restriction and some other substantial reason 'SOSR') may apply and the HR director will be able to advise. SOSR is the more common third reason that applies to medical staff but is often unknown outside HR circles.

The HR lead has an important role in the management of any panel hearing. The role includes not just discussing and advising on issues of procedure and law, but the level of appropriate sanctions with a view to achieving consistency. Specifically, this includes ensuring fair play and that the employee has a proper opportunity to state their case and know exactly what charges they face. HR can support the chair of any hearing and that support ought to ensure that the organisation acts reasonably, has carried out a reasonable investigation and has a reasonable belief that the employee has done whatever they are accused of. Given 50% of cases are lost at Employment Tribunal on procedural unfairness, an expert in procedures is important. Likewise, where it is available, HR expertise should be used at all parts of processes to provide expert procedural advice and to ensure appropriate recording and documentation of processes.

There are other statutory instruments that may be useful that may not be known to responsible officers. The role of the 'protected conversation' (S111A, Employment Rights Act 1996) allow for pre-settlement agreements to be discussed that may be protected from disclosure to a subsequent Employment Tribunal.

There will be circumstances when expert external legal advice is required. This should be readily available to responsible officers by their organisations. This advice will not necessarily prescribe what option to take but should help inform decision making and is a vital corroboration tool.

Ultimately, a degree of personal decision making is required. However the senior members of the organisation should help share this burden and provide support and guidance.

2. Occupational Health

In order to get the most out of an Occupational Health (OH) referral and future support from OH it is important to provide appropriate and detailed information on the Management Referral form. Before making a referral consider what exactly you are trying to achieve and how will it help you manage the doctor.

The role of occupational health is to provide advice guidance about how to manage an individual where work may be impacting on their health or their health is impacting on their ability to work or their performance. You may be unsure whether there is an underlying health issue impacting on their performance or ability to work. If that is the case, it is legitimate to refer the individual to OH with their consent. If there is no clear health problem, then occupational health is unlikely to be able to provide advice.

Once a referral is submitted to OH, it will be triaged to assess the appropriate assessment process. Some doctors may be seen initially by an OH Practitioner and some directly referred to the OH physician (OHP) depending on the complexity of the issues. If the assessment is urgent, then please consider contacting your OH service prior to making the referral to explore the possibility of expediting the appointment. You may also choose to discuss a challenging case with the OHP prior to the referral being submitted. It may be that the OHP can guide you as to the detailed questions you may need to ask to obtain an appropriate response from OH. Remember you will only get responses to the questions you specifically ask. In some cases the OHP may advise you that further medical evidence will need to be sought, for example a report from the GP or treating specialist

In terms of background information, please provide the reason(s) for referral and a brief synopsis of the medical condition if available to you. This includes timescales, serious incidents, concerns and previous absences or performance issues. The more detail you provide the easier it is for OH to provide an appropriate response (see sample referrals). This is the chance to describe the employer's perspective in relation to the employment situation. Include any support mechanisms that have been implemented, or adjustments that have already been provided is important.

It is vital that the Doctor is aware of the reason for referral, and preferable that they agree to the referral. It is good practice to confirm that the content of the referral has been discussed with the Doctor being referred.

It is important to note that the Doctor has the right to request access to their full OH records, and this will include the referral letter. Furthermore, some OH clinicians' style of consultation dictates that the referral background information is discussed word for word with the Doctor at the time of assessment to set the scene for the consultation. In other words, the Doctor can have access to any information you include in the referral paperwork. If there is information the employer does not wish to be shared with the Doctor then it is strongly advised that such information is not included. However, please be aware that what is not documented on the referral letter cannot be discussed during the consultation or advised on in the report.

Please provide additional documentation with the referral if it is available e.g. fit notes, GP or Treating Specialist reports. If a doctor has been seen by OH before, it is probably worthwhile attaching the previous report to the referral. The OHP may in some cases wish to refer the doctor for a specialist opinion so any previous reports can help with these cases.

The GMC's guidance on confidentiality dictates that the doctor being assessed would need to be offered the chance to view the report prior to it being sent to the employer. The doctor has the right to not agree to the content of the report and withdraw consent for it to be released, or may request that parts are changed or withheld. It is up to the OHP to work through the report with the doctor and provide a report that is helpful, independent and provides the employer and the doctor with a fair and balanced view as to the difficulties and concerns that may have been raised. If the report is withheld (which should be rare if the OHP work carefully with the doctor) then the employer may need to consider managing the case based on the available information, under the guidance of relevant policies and procedures.

Figures 1 and 2 provide an illustration of an inadequate and a helpful referral respectively. Each figure refers to the same hypothetical case of a doctor with a mental health condition.

Figure 1: Inadequate Occupational Health referral		
From: Position: Tel No: Date:		To: E-mail:
Doctor's name: Home Address: Contact Telephone Number: Dept:	D.O.B**:** Email:	
Description of current problem: Bipolar Affective Disorder with psychosis. Generally been well.		
Is the problem affecting their ability to work? Has had time off. **How long has the problem been present?** Several months on and off. **What remedial action has been taken?** Under their local CMHT I believe.		

What specific questions do you want answered?
     1. Does Dr A's condition fall under the Equality Act?
     2. Any recommended adjustments we need to make?		

Is the person currently working? Yes **If NO, How many days lost in the last year?** About 3 weeks **Length of current continuous absence?** About 3 weeks **Is there a return or certified until date?**		
I have discussed this referral with the doctor concerned. Signature of Referrer: Dept:		
Please return completed form to: **email@address.uk**		

Figure 2: Helpful Occupational Health referral		
From: Position:		To:
Tel No: Date:		E-mail:
Doctor's name:		**D.O.B:**
Home Address:		
Contact Telephone Number:		**Email:**
Dept:		

Description of current problem: Bipolar Affective Disorder affecting training

Thank you for seeing Dr A, a XXy old XXy trainee in [specialty], currently working in a 6 month placement in [department] (date of commencement: dd/mm/yyyy).

On dd/mm/yyyy, Dr A made contact by phone, and agreed to call in later the same day. Dr A disclosed that they suffer from Bipolar Affective Disorder with psychosis, and that they were experiencing a particularly distressing deterioration in their mental health. They confirmed that they were being managed by the Community Mental Health Team, and that they had largely been well. However, in the run–up to their most recent postgraduate exams and immediately after, their health deteriorated significantly. They also disclosed suicidal ideation.

At this point, an emergency appointment was made at the CMHT on the same day (dd/mm/yyyy). Dr A then took immediate leave. We were informed on (dd/mm/yyyy) that Dr A may be fit to resume their training.

Dr A first had difficulties during their undergraduate studies on dd/mm/yyyy. The reason stated at the time was stress-related illness. However they have now had a sustained period of good health.

Is the problem affecting their ability to work? Dr A is largely able to work and has not missed clinical duties, teaching or assessments.

How long has the problem been present? Dr A was diagnosed in (dd/mm/yyyy). Note that it is not clear if this diagnosis always included psychosis, or if this is a more recent consideration.

What remedial action has been taken? As above, Dr A is being managed by their CMHT and is engaging with this well.

What specific questions do you want answered?

In your opinion:

1. Is Dr A fit to return?
2. If No, how much longer would you recommend they stay off?
3. If Yes, are there any recommended reasonable adjustments to support them with their role*?
4. Does Dr A's condition fall under the Equality Act*?

Is the person currently working?	No
If NO, How many days lost in the last year?	X weeks
Length of current continuous absence?	X weeks
Is there a return or certified until date?	Certified until dd/mm/yyyy, but awaiting your opinion before making a final decision.

I have discussed this referral with the doctor concerned.
Signature of Referrer: Dept:

Please return completed form to: **email@address.uk**

* The Equality Act (2010) sets out a legal requirement to avoid discrimination. This covers unfavourable treatment on the grounds of protected characteristics including disability and long term health conditions. Discrimination can also extend to people with an association, like caring responsibilities, for others with a disability or long term condition. Reasonable adjustments may need to be made at any point in a person's working life and where appropriate should be put in place to help create an environment where everyone can do their best. Improvements made through reasonable adjustments benefit individuals, teams and ultimately help an organisation work more effectively and retain talent.

3. British Medical Association

The British Medical Association (BMA) is the trade union and professional body for doctors in the UK. The BMA offers expert advice for members on issues such as contracts, pay and discrimination. For support with revalidation and appraisals please visit https://www.bma.org.uk/.

4. NHS Employers

NHS Employers is an organisation which acts on behalf of NHS trusts in the National Health Service in England and Wales. It negotiates contracts with healthcare staff on behalf of the government.

NHS Employers may be able to advise on employment policy and practice, staff engagement, equality and diversity and healthy and productive workplaces amongst other areas. For example, a trust medical director/responsible officer or HR department might contact NHS Employers to ask advice about consultant contract terms and conditions or the MHPS process. For further information please contact: enquiries@nhsemployers.org.

5. NHS Resolution (formerly known as National Clinical Assessment Service)

The role of NHS Resolution is to provide impartial advice to healthcare organisations to effectively manage and resolve concerns raised about the practice of individual practitioners. NHS Resolution provides expertise to the NHS on resolving concerns fairly, shares learning for improvement and preserves resources for patient care.

NHS Resolution's functions are set out in *The National Health Service Litigation Authority Directions 2013*, issued by the Secretary of State for Health. We provide a range of services to NHS organisations and other bodies in England, Wales and Northern Ireland, including:
- Advice service
- Assessment and intervention services
- Other expert services including education and evaluation and research.

Advice service
Each year, NHS Resolution receives around 1,000 requests for advice from healthcare organisations with concerns about the practice of individual practitioners. The advice we offer focuses on:
- the fair and effective application of the healthcare organisation's own local performance management and associated procedures

- good practice in relation to local case management and investigation
- helping to identify and consider options available to the healthcare organisation to address and resolve concerns raised about an individual's practice, including for exclusion and suspension
- signposting available avenues of professional support and other resources.

We are also able to provide advice directly to practitioners. Our advice is provided by an established team of Advisers, comprising senior staff who are aligned to specific trusts and NHS regions across England, Wales and Northern Ireland.

Assisted mediation
Assisted mediation involves NHS Resolution accredited mediators working with the parties in dispute on a confidential and impartial basis to help resolve difficulties which are impacting on professional relationships at work and service delivery.

Assessment and intervention services
In some cases, NHS Resolution can offer more detailed input to support the management and resolution of the concerns raised about a practitioner, through our assessment and intervention services. These services include:
- detailed, comprehensive and evidence-based assessments of an individual practitioner's health, behaviour and/or clinical performance in the workplace. Our assessments provide findings and conclusions aimed at informing a clear way forward to bring the case to a resolution
- professional support and remediation services to develop, implement and monitor actions plans to address concerns and help return an individual practitioner to safe and valued clinical practice
- multi-source feedback tools to further understand the views of colleagues and patients on an individual practitioner's work
- management of the Healthcare Professional Alert Notices (HPANs) system. This is a system where notices are issued by NHS Resolution to inform NHS bodies and others about health professionals who may pose a significant risk of harm to patients, staff or the public.

Where NHS Resolution has offered to undertake an assessment or other intervention, we will only proceed with the explicit agreement of both the practitioner and their healthcare organisation.

Other expert services
We also provide other expert services including education programmes on a diverse range of subjects such as good practice in case management and case investigation. These can be specific to your organisation and details are on the website. In addition, we offer a range of expert casework and consultancy services commissioned directly by regulators and other professional bodies.

Access
Access to NHS Resolution is free to NHS organisations. Non-NHS organisations can contact NHS Resolution free of charge for initial advice, with a fee payable for further involvement. NHS Resolution must be engaged if a case is progressing through the Department of Health framework for maintaining high professional standards in the modern NHS (MHPS). For a case progressing through the NHS England Framework for managing performer concerns NHS Resolution engagement is optional at the discretion of the responsible officer.

In this appendix we explore the concept of a 'spectrum of safety'. The value of this is to help de-stigmatise error and support a professional and balanced approach to professional imperfection by the doctor, the organisation and society. This not only nurtures shared insight in individual cases but also a culture of excellence in the system as a whole.

The spectrum of safety
Figure 1.Considering the variability of medical practice
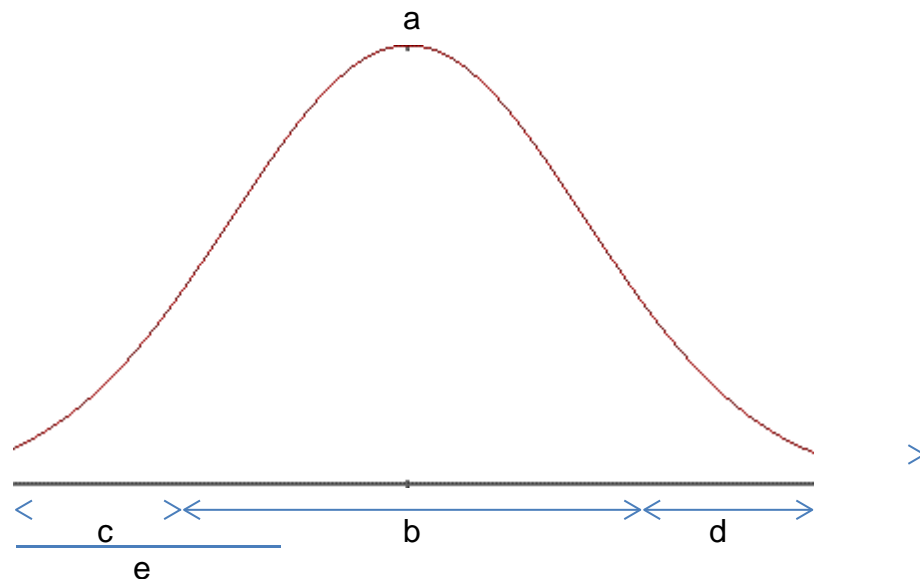
To recognise the inevitability of imperfection is essential to the pursuit of quality in any area. Every error does not amount to a concern; every failure does not indicate unprofessional practice; every mistake is not negligent. By recognising error as a routine component of professional life it is possible to engage with it as a vital source of learning. Indeed it can be argued that not to do so is deficient.

In professional life as in any area of human activity there is inherent variability in practice. For the purpose of the discussion this is shown as a normal distribution in Figure 1. Every professional fluctuates around a personal mean in the course of their work (a). In statistical terms within a population of similar professionals most oscillate within two standard deviations of average practice for that population (b). For the sake of illustrating the concept we can view this common range of practice as representing behaviour within acceptable limits – 'good' doctors. However, almost all individuals will occasionally undertake actions which are outside these usual ranges, whether these are unacceptable (c) or exemplary (d). This is important: 'good' and 'exemplary' doctors can undertake actions below the accepted standard. Furthermore it is a statistical fact that half of all actions are above and half are below the mean. This sits at odds with a professional culture in which every individual is striving for continual excellence.

The next challenge is to understand the reason why an action sits where it does on the curve before assigning responsibility to the doctor (Figure 2). For an action or

incident outside the normal range, there are a number of potential causative factors which should be considered before deciding that responsibility rests with the individual practitioner.

Learning from the full spectrum
A system which responds only to incidents which are unacceptable (c) is limiting the learning available to it, whereas a system which also identifies lesser incidents (say between one and two standard deviations below the mean) (e) not only increases the opportunity for learning but also normalises the process of addressing them, by virtue of the facts that they are more common and of lower overall risk. Indeed, the most desirable situation is to be open to identify any incident from which learning may be gained, regardless of its position on the spectrum i.e. incidents with positive learning as well as when mistakes are made.
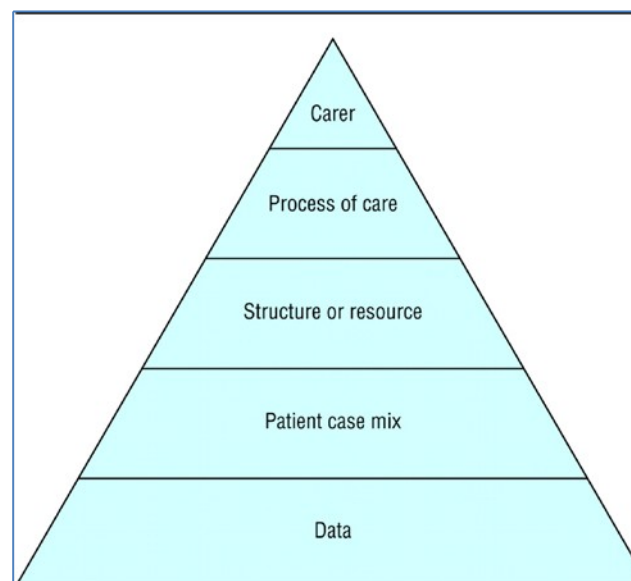
If the culture shifts from one where a clean sheet of 'no concerns' is the preferred status to one where an individual is professionally engaged in reviewing a number of incidents where most are low level, this leads to a system which is safer overall. To be treated by a doctor with a history of incidents, positive and negative to which they have responded in an open and professional manner with good insight and commitment to improving will come to be viewed by patients as reassuring, compared with being treated by a doctor who has 'no recorded concerns'.

These observations are consistent with the principles of effective clinical governance, which strives for increasing quality through the development of a healthy culture (Section 5). Nor are they new; moving from a high blame culture was discussed in 2000 in the Department of Health paper Organisation with a Memory (Section 5). Success in the area of responding to concerns depends on healthy relationships between doctors and their organisation. Where the organisation has a tolerant and proportionate approach to error, positive attributes such as professionalism, accountability, and openness on the part of individual doctors are likely to flourish.

Figure 2

Pyramid model of investigation to find credible cause for a statistical outlier.
From Mohammed M, BMJ 2004; 328:1474

A paradigm shift
It is difficult to over-estimate the depth of the culture change required in order to put these concepts into practice. Many doctors, managers, patients and members of the public believe that there is a sharp distinction between good practice and poor practice. Moving from a world of

black and white scenario to one with blurred boundaries feels instinctively uncomfortable, but is necessary if we are serious about learning from error.

Changing to a new paradigm poses a challenge, not just to doctors and their local organisation, but to national organisations, the media and society at large. All participants have something to learn and something to gain in the new arrangement. By engaging with medical appraisal and revalidation, doctors have indicated their willingness to embrace a culture shift from independent to interdependent practice. To support openness and honesty from individuals, organisations and society must recognise that the response to imperfect actions by individuals must be tolerant and fair.

Caring for the one who does harm, or who may have done harm
When a patient has been harmed as a result of the actions of a doctor, it may be difficult to advocate the need to care for the doctor. However, there is established literature about the 'second victim', where feelings of personal guilt and shame undermine the ability of a doctor to cope with a challenge to their professional ability and may reduce their future professional effectiveness.

Given that the causative relationship between the actions of an individual and a harmful outcome commonly require careful investigation, it follows that many doctors whose practice comes under scrutiny will be found to have acted without fault. This creates a risk that doctors practising correctly will be harmed if processes for investigating matters do not take this risk seriously. A process for addressing concern about a doctor's practice therefore needs to include provision for safeguarding the doctor through and beyond that process. This can present significant challenge for an investigating team, as some behaviours by an individual which might be easily interpreted as obstructive or challenging may in fact mask anxiety and distress. If recognised and addressed this can be overcome; if not, the chance to develop an effective rapport can quickly be lost.

Achieving accountability and promoting professionalism
It is important to acknowledge the role of medical professionalism in maintaining safety and quality in healthcare, and the importance of maintaining a culture in which medical professionalism and regulatory mechanisms work in synergy to achieve the desired culture. Excessive external regulation which undermines professionalism may be counterproductive in terms of quality; conversely excessive self-determination by a group of professionals may also be unhealthy. The challenge is therefore to strike a balance, such that the professional group has an appropriate degree of autonomy to pursue quality through professional behaviours whist also engaging with a tolerant and just framework of accountability.

The effective organisation
It is helpful to consider those characteristics which would typify an organisation more likely to succeed in implementing the above observations. These include:

- An open culture with a healthy environment of debate, freedom to speak up and a commitment to turning learning into improvements.
- Effective involvement of patients and public, as a counterbalance to organisational and professional influences.

- Good governance, including balanced line management of doctors.
- Clear lines of accountability and effective communications, within and between all levels of the organisation.
- Effective data processes that measure true markers of quality and distinguish true variations in practice objectively.
- Good leadership, where leaders are accessible to those they are responsible for, and willing to get involved in difficult situations.
- Effective recruitment processes with a focus on values as well as knowledge and skills.
- Use of comprehensive induction, supervision and support (such as mentoring and peer review) including for short term colleagues.

This list is not exhaustive but helps to indicate some of the aspects of the environment that an organisation should seek to create in order to allow excellence in care to flourish. Overall, a high level of emotional intelligence at an organisational level may be the most effective characteristic for an organisation to pursue. Difficult to define but easy to recognise, this is the feature which brings to life the systems and processes, strikes the balance between organisation and individuals and will replace a culture of recrimination with one devoted to protecting patients, supporting professionalism and improving quality.

Appendix E - Guidance/support for a doctor

When a prompt arises, share information about it with the doctor as soon as is practically reasonable to do so – in person or by telephone, in preference to email. At the same time, consider your timing – depending on the severity of the matter it may be more sensitive not to inform a doctor about a new concern at 4:45pm on Friday, or immediately prior to their going on annual leave.

Agree a suitable venue and mutually convenient time to meet and discuss it.

Before meeting, discuss with the doctor whether or not you meet one-to-one or with others in support. Consider the level of risk you have identified when considering this, and the degree of engagement/insight that currently exists. For an issue of low concern and where the doctor is fully engaged it would be common to meet without anyone else, whereas for high concern issues it might be necessary for both you and the doctor to have support in the form of a person to keep notes or other advisor, e.g. a colleague, defence organisation, local medical organisation (LNC/LMC) or legal representative. If you have agreed to meet alone, it is important to record this agreement in your agreed final notes of the meeting.

At the meeting, put aside time to meet with doctor and avoid interruptions. Arrange seating so you can make eye contact. Take time to set the scene, with introductions, including clarity on the role in which you are meeting the doctor.

Be polite and respectful, remain professional and avoid getting drawn in to arguments even if the doctor becomes challenging, aggressive or challenges your personal integrity. Focus on the facts. Explain how the information reached you, why you are concerned, any actual or potential risks to patient safety.

Explain the shared duty on all parties to maintain a professional approach to responding to the matter and working together to identify the cause and agree appropriate action. Refer to the professional requirements outlined in Good Medical Practice.

Explain the role of the responsible officer with regard to their whole scope of work and ask the doctor to confirm any other roles outside the organisation. You may need to make contact with persons with governance responsibility for the doctor's practice in other organisations where the doctor works or ask the doctor to share information as appropriate with other places of work.

Try to understand how the doctor is feeling having had concerns raised about their practice. Putting the incident/complaint/concern in context may be helpful. For example knowing that the matter has a low level of risk or explaining the proportion of doctors that commonly receive complaints or are involved in incidents may be helpful for the doctor.

Allow the doctor time to remember and describe their version of events.

Explore sensitively but explicitly with the doctor whether there may be any relevant health issues.

Explore sensitively but explicitly whether there need to be any amendments to the doctor's usual duties while the matter is being assessed. Make it plain that any action of this nature will be based on an assessment of risk and that any exclusion from practice or amendment to duties will only take place if absolutely necessary in the interests of patient safety. If duties are being amended, take care to confirm that this is a neutral act and that the doctor understands and accepts this. Reassure them that this matter will be sensitively handled in terms of confidentiality, with only those who need to know being informed of the minimum necessary facts. If you feel adjustment of duties is necessary, including full removal from the workplace, asking the doctor to voluntarily withdraw or amend their duties (if compatible with local policy) may receive a more positive response than the imposition of restrictions to practice. Ensure that there is clarity on exactly what has been agreed and document this.

Discuss with the doctor any requirements to inform patients/relatives in accordance with the Duty of Candour Regulations.

Take notes of the meeting and send to the doctor afterwards and ask them to confirm their agreement to the record. It may be helpful to provide a leaflet/guidance document for doctors so they have reference to written information after the meeting (Template 1).

Explain what the next steps are and ensure that there are arrangements in place to continue to meet with and communicate with the doctor at regular intervals.
If a full investigation is required, explain how this will take place, who the investigator will be (if known) and the terms of reference.

If during the discussion it is agreed that access to a mentor or coach may be helpful, provide details of how the doctor can access this.

Template 1:
Advice from the responsible officer for a doctor asked to respond to a concern about their practice

The following is intended to provide you with some initial information and advice to help you through the process in relation to the matter that has been raised with you.

The first rule is to remain calm. No doctor is perfect and we can all expect to come under some level of challenge to our professional behaviour at some stage. In fact, learning from such things is a vital component of professional life. In addition, this matter has not yet been fully explored and so at this point no decision has been made about the root cause. The key matter is therefore to focus on patient care as the most important thing, and for us to work together to understand this matter and gain the maximum useful learning.

It may help to review your emotional response, and allow yourself some time to come to terms with the fact that this concern has been raised. Remember SARA – the stages of receiving bad news (Shock, Anger, Rejection, Acceptance). Some degree of the three negative emotions is not only understandable but inevitable. Once you recognise this, you have a greater ability to put these to one side, accept the fact of the concern, and respond constructively.

In this organisation, these issues are handled by [NAMED PERSON(S)]. [NAMED PERSON] may arrange to meet you to discuss the matter (or may have already done so), or ask you to provide a statement on the issue. We may also ask for input from other persons, depending on the issue. Once all responses are gathered, we will discuss with you what the facts are and what the conclusions are. You will be invited to give your views at all stages.

For more information about how we address these matters you are encouraged to read our policy on responding to concerns [DETAILS OF HOW TO ACCESS THIS OR LINK].

When considering your response or providing a statement, the following structure may be helpful:
1. Discuss the matter with people you trust. We rate these matters according to the risk we perceive to be associated with them, and will share this rating with you. You may take this into account when considering who you might turn to for advice. For example, options include talking it through with a colleague, line manager, your medical defence organisation, BMA representative, or other professional or legal advisor. For matters which we have rated as being medium or high risk, you are also welcome to choose to invite a suitable representative to accompany you to any discussions.
2. Make sure any statement you write about this matter is composed in suitably professional terms. (Indeed this rule holds for any communications you send about it to any other person, whether on paper or electronic, and whether professional or social. All of these can be retrieved under data protection and Freedom of Information regulations.) If the matter involves patient care, constructing your statement as if you were going to send it to the patient direct can help you to view the matter from the patient's perspective.
3. Acknowledge the issue insofar as someone has felt it necessary to raise it, and work with the assumption that they have done so in the interests of high quality care and patient safety. If appropriate to the incident, express sympathy that the subject's experience or the outcome was negative.

4. Clarify the issues that you understand are under consideration. Sometimes this will have been listed for you; sometimes you may need to work them out. For example: "I understand that this concern has arisen because I decided against giving the patient a particular form of treatment." Being explicit in this way can be very helpful.
5. Set out the facts. Be clear about what is based on your notes, and what is based on your recollection.
6. Make your own professional judgement about your actions. Apologise if you believe this is appropriate; explain if you do not.
7. List your personal learning. This helps reassure those reviewing the matter that you are open to identifying positive learning even when your behaviour is being questioned. For example: 'My learning point from this complaint is that, while my actions were medically justifiable, I could have made greater effort to check that the patient/colleague understood my logic'.
8. List your personal actions, for the same reasons as 7. For example: 'I will discuss this incident at my forthcoming appraisal.', or 'As a result of this incident I will review the indications for this drug'. Be specific and make sure that this is an action you know you will be able to complete.
9. Close with an offer of further discussion. If relevant and appropriate, consider thanking the person who raised the matter for taking the trouble to do so.
10. Please respond with the timescales suggested if at all possible, so that things can be resolved as efficiently as possible. If you are unable to meet a deadline, please let us know as soon as possible.
11. If there are other factors which might be relevant, such as a health problem affecting your professional practice, it is helpful for you to share this with is at as early a stage as possible so that we can take steps to support you with this.

Timescale
We intend to complete this process as efficiently as possible. Our policy on responding to concerns is that issues of low risk are explored within XX days, issues of medium risk within YY days, with issues that proceed to full investigation taking longer, depending on the nature of the matter.

Your working arrangements
Unless we have spoken to you to arrange a period of adjustment to your duties or time away from work, you should expect to be able to continue to work as normal while this matter is being addressed. Where we have arranged for your working arrangements to be changed, we will strive to do so for as short a period as possible, and will keep you informed with regular updates.

I hope this provides you with some reassurance and help about how to approach this matter. The GMC requires us to behave professionally when addressing concerns about our practice. I therefore hope that with a shared commitment to such an approach we can explore and address this matter successfully, with a satisfactory and professionally acceptable outcome for all concerned.

Appendix F - Illustrative terms of reference for a responsible officer advisory group

While statutory responsibilities in relation to the responsible officer regulations rest with the responsible officer, their decisions can often be assisted by suitable discussions with others, in terms both of supporting objectivity and usefulness. Depending on the nature and scale of an organisation, arrangements for such discussions can be formalised by way of establishing a suitable group, comprising relevantly skilled and experienced colleagues.

For an organisation seeking to establish such a group, the following terms of reference, which set out how such a group could be constituted and its function described, may be helpful, following suitable amendment to take into account the local situation.

Terms of Reference

Purpose

The purpose of revalidation is to provide assurance to patients and the public that licensed doctors are up to date and fit to practice. The Responsible Officer (RO) has a key role in ensuring the effective implementation of the Responsible Officer Regulations in their designated body. An advisory group to support the role of the RO provides the opportunity for greater calibration of decision-making and the involvement of lay members. The group will provide input to the decision-making with regard to appraisal, revalidation recommendations, performance concerns about doctors, employment processes and any other aspects relevant to the RO Regulations.

Key objectives

The advisory group will consider key items requiring decision-making to support the role of the RO, including but not restricted to:
- Revalidation recommendations, particularly in complex situations
- Concerns regarding a doctor and the application of the organisation's Responding to Concerns policy
- Complex issues related to appraisals
- Complaints to the RO about appraisal, revalidation or performance concerns processes
- Any other issues relevant to the role of the responsible officer

Additional objectives may include:
- The provision of a forum where standards of medical practice are set and thresholds for raising and acting on concerns are monitored for consistency, both internally and externally
- The provision of a forum for discussing excellence in practice, encouraging development and identifying career opportunities for individuals

- The provision of oversight and scrutiny of medical appraisal outputs and relevant documentation to support the RO in the process of making recommendations for medical revalidation for individual doctors to the GMC
- The provision of quality assurance of the medical appraisal process and the medical appraisers
- The provision of support to the RO in the recruitment and discharge of medical appraisers
- The promotion of effective triangulation of information where there may be a number of potential sources of intelligence about an individual
- The provision of support to the RO in the oversight of remediation of doctors
- The consideration of data on appraisal, revalidation and concerns and identification of best practice, areas for development and themes for wider sharing

Membership

The advisory group includes:
- Medical Director/Responsible Officer
- Deputy Medical Director (Appraisal and Revalidation)
- Associate Medical Director (Clinical Governance and Quality)
- Revalidation Manager
- HR Director/Lead
- A doctor employed by the organisation
- A representative from another designated body (Medical Director/RO/Deputy/Associate Director)
- Lay Member

Additional members may be recruited as required for specific items / advice as required e.g. GMC Employer Liaison Advisor, Communications Lead, representative from a Royal College, NHS Resolution.

The chair will be the Medical Director/RO or deputy.

Quorum

A quorum will be four members from the above list including the chair.

Process

The Advisory Group exists within a system in the organisation for compliance with the RO Regulations. Although the RO holds the statutory responsibility for decisions gaining broader input from a wider group may be beneficial in ensuring consideration of all relevant aspects.

The Advisory Group will meet at least three times per year and on an ad hoc basis if required. Meetings may take place using technology to avoid travelling where possible e.g. WebEx, video or teleconferences. Details will be circulated with the agenda for each meeting.

Where urgent decisions are required additional meetings may be convened in a timely manner.

Discussions will be held on any issues relevant to decisions to be made by the RO. Brief notes will be made of the discussions and decisions reached. If the Medical Director/RO is not present the key points from the meeting will be communicated to the RO as soon as possible after the meeting to inform decision-making.

Documentation will be stored securely in a restricted folder. Any papers printed and used during the meetings will be disposed of by confidential shredding following the meeting. A summary of decisions and actions will be provided at the start of subsequent meetings to update the group.

At the beginning of each case discussion members will be asked to disclose any conflict of interest and as cases are presented anonymously, if a conflict of interest becomes apparent at any time members are expected to bring this to the group's attention for a decision to be made whether to exclude them from further discussions.

All discussions by the group will be treated confidentially and not discussed further outside the group except with express permission of the group.

For the purpose of calibration across designated bodies any relevant learning will be considered for sharing anonymously with others through the RO network.

Product

The product following the discussions by the group will be a recommendation for the responsible officer. The responsible officer will make decisions and determine actions based on the group's discussions and will feedback to the group at the next meeting.

Any learning identified through this process will be shared anonymously as appropriate e.g. with other responsible officers.

Review of term of reference

The term of reference for the Responsible Officer's Advisory Group will be reviewed annually.

Appendix G - Quality assuring processes for responding to concerns

All responsible officers should be aware of the *Framework of Quality Assurance for Responsible Officers and Revalidation* (FQA). This framework includes assurance standards and descriptors for a designated body's process for responding to a concern about a doctor's practice, covering areas including leadership, resources (including personnel), a clearly designed process and a supportive infrastructure. Broadly speaking these are focused on ensuring the presence of the right mechanical aspects as standard.

This appendix presents an outline framework to make explicit and also augment the FQA by describing aspects which support the principles and aims of this guide and the effectiveness of the process. It is intended to be relevant to all sectors, recognising that the relevant regulatory and legal framework will inform the specific policy of the designated body.

Components of a quality assurance framework
The areas below all need consideration to ensure a fair, open, transparent and effective process which engages the doctor whenever possible and results in continuing safe and effective practice whenever possible:

- **Recruitment and training**
  All relevant personnel in the process should be properly recruited, with a suitable role description, clearly identified competencies and a proper selection process. All such personnel should have suitable training and development in the role, including initial training, on-going training, self-assessment against competencies, annual review of performance and the opportunity to engage in networks with peers.

- **Systems**
  To ensure that all appropriate concerns are considered appropriately there is a requirement for the coordination of the management of concerns including complaints, contractual breaches, serious incidents and 'never events' within an organisation. Also where appropriate whether the management of the concern with regard to the learning and action of the doctor and the organisation has been informed by the duty of candour regulations.

- **Effective and coordinated delivery**
  In many organisations there may be an advisory group and separate decision making group to support the management of concerns about a doctor. Evidence of mutual communication/feedback between such groups, led by the responsible officer, will ensure their most effective working for the benefit of patients, services and doctors. Evidence of use of 360 feedback tool within and between the groups may be helpful. Depending on the size of the organisation it may be helpful to undertake a programme of in house networks between relevant departments to ensure effective internal coordination.

- **Equality and diversity**
  The organisation must ensure that its processes are transparent and fair and do not discriminate against individuals or groups with protected characteristics. Quality review processes should therefore measure the potential for unfair impact of this nature and mitigate against it if identified.

- **Peer review/benchmarking across organisations**
  All organisations should seek opportunities to compare experiences with other bodies for the purpose of calibration and learning. This should be supported by the system as a whole, and includes such measures as including the topic at responsible officer network meetings, maintaining and developing a focus on concerns management at supra-organisational level through, for example national audit and review processes such as the annual organisational audit (AOA) of the FQA.

- **The doctor**
  The timeliness and effectiveness of the engagement of the doctor and their supports should be assessed and confirmed.

- **Processes**
  Documentation such as assessment reports and the organisation's database for managing concerns should be reviewed and assessed for compliance with policy and process. This may be complemented by sampling individual cases to review that all appropriate actions were undertaken.

- **Outcomes**
  The demonstration of the appropriate actions and learning to address patient safety and minimise a recurrence should be assured. Where a risk assessment is used the effect of actions taken on the level of risk should be monitored and reviewed, both for individual cases and aggregated for all cases.

  As captured above, management of a concern should result in a timely and constructive outcome for the doctor whilst addressing any patient safety issues. In the majority of cases this will allow the doctor to return to unrestricted practice in due course, but in other cases an appropriate outcome may require some degree of restriction. An outcome measure therefore to explore is the conversion rate of anticipated outcome to the reality once managing the concern is closed. Another is the record of the rate with which doctors, with varying levels of concern, are successful in returning to safe and effective practice. Finally, the simple outcome of recording the time taken for the process both from beginning to end and also of each stage in turn is a valuable indicator of quality. All these measurements will gain in validity if benchmarked with peer organisations.

- **Feedback from the doctor**
  Accepting that the doctor is likely to find being under review a difficult process, and that at times this may influence their perspective, there is merit in gaining their feedback about their experience to prompt development of the management of concerns. In addition to the doctor, seeking feedback from those who have assisted them such as a BMA representative, or medical defence organisation may also be helpful. There are current examples of using internet based tools

such as 'Survey Monkey' to gain feedback of this nature, with the focus of the questions being on the actions of the reviewing team on areas including:
- o Respect
- o Communication
- o Fairness
- o Timeliness
- o Transparency.

The benefits of an oversight group to maximise learning

The method of undertaking quality assurance of processes for responding to concerns will vary between organisations, and will be informed by their governance arrangements and issues such as the opportunity for lay input. An organisation will be assured in regard to managing concerns about doctors if it can demonstrate that concerns are being managed fairly and effectively to ensure patient safety and timely and constructive outcomes for the doctor, the service and patients.

This outline framework for quality assurance provides the opportunity for an organisation's assurance/oversight team to establish suitable performance indicators to demonstrate this assurance. The vast majority of patients or their representatives who raise a concern (later shown to be proven) about a doctor seek an explanation, an apology if appropriate and assurance that the risk of recurrence will be reduced. The presence of a group to oversee the organisation's policy for responding to concerns enables the organisation to demonstrate these, both for the individual doctor and within the organisation.

The best way of managing a concern is to prevent its occurrence, and an assurance oversight group can promote this by identifying themes and trends, and how they may inform the development programme for doctors and other health professionals as well as the revision of policies and specific elements of service delivery. Such a group can also champion the benefits of the clinical governance system in addressing variation in individual and team delivery before significant arise which might compromise patient safety. An oversight group can also contribute to the reporting arrangements of the board or executive team in respect of the delivery of the statutory responsible officer function. In these functions, the oversight group acts as a barometer for the culture of the process for responding to concerns, and indeed the organisation as a whole. It also acts as a mirror; the emotional intelligence and values exhibited by the group provide role modelling to the whole organisation, promoting openness and fairness as vehicles to protect patients, support professionalism and improve quality of care.

Appendix H - Project core group

This guide has been developed after consultation with and input from all major stakeholder organisations. This included a core working group to support the development of this guidance.

Core working group	
Name	**Organisation**
Ruth Chapman	Regional Appraisal Lead, NHS England (London)
Maurice Conlon	Clinical Advisor, NHS England Professional Standards Team
Ros Crowder	Deputy Director Revalidation, NHS England (South)
Jenny Kirk	Project Manager, NHS England Professional Standards Team
Kirstyn Shaw	Principal Employer Liaison Adviser, General Medical Council
Anne Rothery	National Clinical Assessment Service Advisor, NHS Resolution
Paul Twomey	Joint Medical Director, NHS England (North) (Yorkshire and the Humber)
Jill Williams	Employer Liaison Adviser - Midlands and East, General Medical Council

We would like to acknowledge the input and thank all stakeholders and expert resources who have contributed to the development of this guidance.

5   References, links and resources

All remediation resources incl Invited Reviews (Academy of Medical Royal Colleges):

http://www.aomrc.org.uk/revalidation-cpd/remediation-resources/

http://www.aomrc.org.uk/wp-content/uploads/2017/01/Invited_reviews_Contacts_Services_011116-2.pdf

Resources in Medical Royal Colleges and Faculties

Name of College/Faculty	*Contact email address*
Royal College of Anaesthetists	revalidation@rcoa.ac.uk
Royal College of Physicians of London	revalidation@rcpl.ac.uk
Royal College of Paediatrics and Child Health	revalidation@rcpch.ac.uk
Royal College of Surgeons of Edinburgh	revalidation@rcsed.ac.uk
Royal College of Psychiatrists	revalidation@rcpsych.ac.uk
Royal College of Pathologists	professionalism@rcpath.org
Royal College of Radiologists	revalidation@rcr.ac.uk
Faculty of Public Health	revalidation@fph.org.uk
Royal College of Ophthalmologists	contact@rcophth.ac.uk
Faculty of Occupational Medicine	FOM@fom.org.uk
Faculty of Pharmaceutical Medicine	revalidation@fpm.org.uk
Royal College of Obstetrics and Gynaecologists Faculty of Reproductive and Sexual Health	revalidation@rcog.org.uk
Royal College of Surgeons of England	revalidation@rcseng@ac.uk

An introduction to revalidation (GMC)
https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/information-for-doctors-on-the-register/revalidation

Appraisal for revalidation: a guide to the process (Academy of Medical Royal Colleges)
http://www.aomrc.org.uk/publications/reports-guidance/revalidation-reports-and-guidance/appraisal-revalidation-guide-process/

A Framework of Quality Assurance for Responsible Officers and Revalidation (NHS England, 2014)
http://www.england.nhs.uk/revalidation/qa/

A guide for doctors to the General Medical Council (Licence to Practise and Revalidation) Regulations 2012 (GMC, 2012)
http://www.gmc-uk.org/Revalidation_guidance_for_doctors.pdf_54232703.pdf

Clinical governance and the drive for quality improvement in the new NHS in England (Scally G. and Donaldson L., published in the BMJ, 1998)
https://doi.org/10.1136/bmj.317.7150.61

Colleague and patient feedback for revalidation (GMC)
http://www.gmc-uk.org/doctors/revalidation/colleague_patient_feedback.asp

Doctors in society: medical professionalism in a changing world (Royal College of Physicians, 2005)
https://cdn.shopify.com/s/files/1/0924/4392/files/doctors_in_society_reportweb.pdf?15745311214883953343

Good Medical Practice (GMC, 2013)
http://www.gmc-uk.org/guidance/good_medical_practice.asp

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This document is available by emailing johnsanfey@nhs.net.

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Raising and acting on concerns about patient safety (GMC, 2012)
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Specialty Guidance for Appraisal and Revalidation (Academy of Medical Royal Colleges)
http://www.aomrc.org.uk/revalidation-cpd/appraisal-and-specialty-guidance/

Supporting information for appraisal and revalidation (GMC, 2012)
https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/guidance-on-supporting-information-for-appraisal-and-revalidation

The good medical practice framework for appraisal and revalidation (GMC, 2013)
https://www.gmc-uk.org/-/media/documents/the-good-medical-practice-framework-for-appraisal-and-revalidation---dc5707_pdf-73076920.pdf

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Optional support services for doctors

For doctors and dentists with health problems which could endanger patients, the first duty is to seek appropriate advice and follow it. Sometimes, advice will come first from a source outside the NHS, via one of the voluntary organisations set up to support doctors and dentist with health problems. These voluntary organisations also work with clinicians recovering from problems such as depression, stress and anxiety and alcohol and drug misuse, offering peer support as well as advice and counselling.

The organisations take phone calls from doctors and dentists directly and also from their colleagues and close family members. When a new problem is identified, the aim is to guide callers towards appropriate sources of help. It is not normally necessary for the caller to identify the clinician at first phone call.

Some clinicians with health problems will continue to find it hard to accept help in any other way and doctors should be aware of the role of these networks in encouraging health care professionals towards appropriate help. They can also be useful during recovery, in offering opportunities to talk to someone who has been through the same experience.

The following national groups are currently operating (this is not an exhaustive list):

Association of Anaesthetists' Sick Doctor Scheme:
provides advice for anaesthetists. 020 7631 1650 or email wellbeing@aagbi.org

BMA Counselling Service:
provides doctors and their families with 24 hour telephone counselling by qualified counsellors. Tel: 0330 123 1245

BMA Doctors for Doctors Service:
provides help for doctors in employment difficulties especially in relation to mental health problems and abuse of alcohol and drugs. The unit provides a signposting service to the area of help that is of most pertinence to the individual doctor's case. Tel: 020 7383 6739 or https://www.bma.org.uk/advice/work-life-support/your-wellbeing

British Doctors' and Dentists' Group:
a network of support groups of recovering medical and dental drug and alcohol users. Students are also welcomed. http://www.bddg.org/

British International Doctors' Association:
where cultural or linguistic differences may be a contributing factor doctors can access the health counselling panel. Tel: 0161 456 7828
http://www.bidaonline.co.uk/

DocHealth:
This is a confidential not for profit service giving doctors and opportunity to explore difficulties, both professional and personal, with senior clinicians. This service is delivered by a consultant medical psychotherapist based at BMA house in London.
http://www.dochealth.org.uk/

Doctors' Support Network and Doctors' Support Line:
self-help organisations for doctors with, or who have recovered from mental illness.
http://www.dsn.org.uk/

GP Health Service:
The GP Health Service can help doctors with issues relating to a mental health concern, including stress or depression, or an addiction problem, in particular where these might affect work. For GP's or GP trainees in England 0300 0303 300
http://gphealth.nhs.uk/

Psychiatrists Support Service:
Provides confidential support to associates and members of the Royal College of Psychiatrists. To contact the Psychiatrists' Support Service please telephone: 020 7245 0412 or email: pss@rcpsych.ac.uk

Royal College of Surgeons Confidential Support and Advice Service (CSAS):
helpline providing confidential surgeon-to-surgeon help. Tel: 020 7869 6219
https://www.rcseng.ac.uk/careers-in-surgery/csas/

Royal College of Obstetricians and Gynaecologists:
provides mentoring support for Members and Fellows in difficulties.
https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/supporting-our-doctors/support-members-trainees/

Sick Doctors' Trust:
a proactive service and self-help organisation for addicted physicians. Tel: 0370 4445163 and see
http://sick-doctors-trust.co.uk/

Samaritans:
Tel: 08457 90 90 90. E-mail: jo@samaritans.org and see www.samaritans.org.uk

http://www.support4doctors.org/ - very useful website covering many areas

http://www.hope4medics.co.uk/ - useful website doctors with disabilities

http://hphl.org.uk/ - health professionals with hearing loss

http://php.nhs.uk/ - a London based service 020 3049 4505