The Wessex Deanery Strategy for Dealing with Doctors in Difficulty

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1 Introduction

This document is designed to provide strategic guidance to all those within Wessex who are involved in managing and supporting doctors in difficulty:

- Those responsible for the education and training of doctors (see Appendix 1), from Foundation Year 1 (F1) through to Consultant grade and GP Principal or equivalent.
- Occupational Health doctors.
- Those involved in the management and clinical governance of doctors, including Human Resources (HR), Medical Directors, Clinical Directors and Directors of Clinical Governance
- Doctors themselves (including trainees, staff grades, Consultants, GPs and any doctor in difficulty within Wessex).

Using this Guidance

This document is based on the best evidence available. It has been compiled following extensive consultation within the Wessex Deanery and the Trusts and PCTs. The document incorporates and extends the original Strategy for Trainees in Difficulty published in 2003 and updated in 2005. It is a working document that will be reviewed regularly and updated in two years.

This document is designed to be read in conjunction with a series of detailed practical guides that will be provided for those with specific educational roles.

All details of suggested documentation, contacts, networks and support services, and checklists have been included in the APPENDICES which brings together in one place the wide range of resources within Wessex, as well as national agencies providing advice for doctors in difficulty and those who manage them. Any additional resources should be notified to the Wessex Deanery for inclusion in the list as appropriate.

1.1 Background

Most doctors, at some stage in their career will encounter either personal or professional problems which will affect their performance. Since the introduction of Personal Development plans, Appraisal, Annual Assessment, Learning Agreements and Clinical Governance, there has been an increase in the number of trainees struggling to achieve their goals within the expected timescale. This now applies to all grades and specialties from Foundation doctors to final year Specialist Trainees. Nationally, since 2002, the National Clinical Assessment Service, established to support doctors in difficulty, has received 3000 calls for advice concerning doctors whose performance has given cause for concern (see Appendix 2). With the increasing pressures on doctors this picture is unlikely to improve.

Within Wessex, where early identification of difficulties has been made and these have been addressed, either within the specialty or by targeted training outside the Trust, in most cases the Trainee has succeeded.

Due to the increasing number of trainees involved, in 2002 the Wessex Deanery considered it essential to formalise a scheme that meets the needs of the trainee, the NHS Trust and the Postgraduate Dean, and ensures patient safety. This resulted in the publication in 2003 of a Wessex Deanery Strategy for dealing with trainees in difficulty, developed by Dr Rosie Lusznat. This strategy had several clear aims:

- To promote early identification of trainees in difficulty
- To provide clinical and educational supervisors with a clear structure for identifying and addressing these difficulties
- To clarify lines of responsibility for other educators involved in managing trainees in difficulty
- To provide a network of support for educators throughout Wessex
- To establish a group of experts who can deal with specific areas of difficulty, and where necessary, identify opportunities for targeted training
This strategy is widely considered to have been successful in providing a supportive and developmental framework, culture and climate in which to help trainees resolve their identified problems.

There have, however, been a small number of doctors who have serious and chronic performance problems, that not only pose potential risks to patients but have involved considerable investment of resources in trying to remedy these problems, with varying degrees of success. This Strategy encompasses the whole spectrum of performance difficulties. At one end are the more minor concerns or dilemmas, presenting a potentially low risk to patients or others, for which a formative developmental approach will be appropriate (Level 1). Next come the problems that, if left undetected or untreated could pose a moderate risk to the individual doctor, the patients or the organisation, but are not yet sufficiently serious to warrant disciplinary action (Level 2). At the other end of the spectrum are the serious and/or repetitious performance problems that present a high level of risk to patients and others (Level 3), and which require a skilled and possibly disciplinary approach. (For examples of risk assessment Criteria, see Appendix 9). This document provides overarching guidance at each of these 3 levels. As such, it forms a central plank in the Deanery’s drive towards robust educational governance – that is, the link between clinical governance and clinical supervision (Du Boulay, 2006).

1.2 Values, purpose and principles

The values of the Wessex Deanery are: “to promote and foster a proactive, strategic and professional approach to ensure all postgraduate education results in better patient care and services”.

The aim of this guidance is to help ensure that doctors who may be getting into difficulty are identified and supported as early as possible, in order to avoid escalation into a more serious problem requiring major intervention. Building on the original aims of the 2002 Strategy document, this guidance provides a formalised approach to managing poorly performing doctors and doctors in difficulty, based on the following underlying principles:

- Transparent and understood by all
- Evidence based
- Clear criteria for assessment and decisions
- Responsible use of funding and resources
- A culture of support and development
- No compromise on patient care
- Consistent application of guidelines

The Institute is aiming to achieve the following goals in relation to dealing with doctors in difficulty:-

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<th>Quality-assured process</th>
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<td>Clear standards and a code of practice, with accountability</td>
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<td>Comprehensive and accurate assessment that:</td>
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<td>- Recognises the influence of context on an individual’s performance</td>
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1.3 The evidence base

There is a substantial evidence base relating to the identification, assessment and underlying causes of performance difficulties in doctors. Highlights of this evidence are described below.

Much of the evidence about influences on a doctor’s performance is captured in a book published under the auspices of the National Clinical Assessment Service (Cox, King, Hutchinson and McAvoy, 2005). Evidence from a wide range of sources identifies behaviour as the tip of the performance iceberg; underpinned by a range of possible contributory factors including workload, sleep loss, physical or mental impairment, education and training difficulties, personality and psychological factors, etc. Many of the conclusions below are based on the evidence in this book.

An analysis of the first 50 cases referred to NCAS for a full assessment (occupational health, clinical and behavioural) revealed that 47 out of 50 cases had a significant behavioural element (Berrow et al 2005).

Work by Elisabeth Paice and others at the London Deanery (Paice, 2005) has also highlighted the early warning signs of trainees in difficulty, all of which relate to behavioural and attitudinal factors. These early signs are described in more detail below (para. 3.1.1) Many of the themes found in this work are reinforced in the findings emerging from the behavioural assessment data from NCAS, in which themes such as rigidity, poor insight and poor conflict management skills are highlighted.

Evidence from work by Papadakis et al (2004, 2005) shows that medical students who had concerns expressed about their “unprofessional behaviour” at medical school were more than twice as likely to be disciplined by the State Medical Board later on in their professional career. Unprofessional behaviour included such things as “resistant to accepting feedback”, “inappropriate behaviour in small groups”, “needs continuous reminding to fulfil ward responsibilities”.

McManus et al (2004) found that stress and burnout in medical students was less related to their working environment and more to do with their personality. 3 large-scale prospective studies of medical student selection and training in the UK Data found that doctors with the highest stress were:

- More neurotic
- More introverted
- Less conscientious
- Less agreeable

Hays et al (2002) explore the determinants of a doctor’s capacity to change performance, with particular focus on insight. They cite evidence that a) many doctors become isolated professionally and can become unaware of their poor performance, including substantial gaps in knowledge and skills and b) such doctors have proved difficult to remediate and usually leave medical practice. They suggest that capacity to change can be measured through such factors as professional and social networks (e.g. the degree of isolation), learning style, motivation and personality (including locus of control).

Conclusions from the evidence

- A doctor’s performance is affected by a complex array of issues
- Behavioural factors play a significant part in the majority of performance problems
- The influence of work context and environment should not be underestimated and needs to be fully explored alongside factors in the individual (e.g. bullying/harassment)
- Educational factors, both before and after qualification, have an impact on doctors’ performance
- Early signs of performance problems are possible to detect and, in most cases, potentially amenable to early intervention
- Physical and psychological health problems are a significant factor in underperformance, but are often under-diagnosed and poorly managed
- The evidence on prevention is weak but suggests that properly constituted teams may be one important factor, together with effective transfer of information from universities to educational supervisors
• Stress and depression are important factors in performance problems and require the cooperation of HR managers, general managers and educationalists to identify and understand the pressures on doctors and manage them accordingly.
• Evidence on effective remediation of problems is limited. Improved cooperation is required between different professional disciplines e.g. occupational medicine specialists, neuropsychologists, employers.
• Evidence of the ability to change behaviour is poor. Behaviour and cognitions are thought to be easier to change than personality.
• In education and training, remediability is more clear-cut. Evidence centres on helping poor performers to develop deeper learning styles, better coping strategies for stress and improving insight through training.
• Poor insight is difficult to remedy.

All of this evidence is crucially important in emphasising that problems in a doctor’s performance can be detected as early as medical school and suggest that early detection could help to prevent more serious difficulties occurring later on in the doctor’s career.

1.4 The consultation process

The work in this document was informed by a consultation process involving individual interviews between Dr Jenny King (Edgecumbe Group) and key people within the Deanery, nominated by Clair du Boulay, followed by a workshop inviting further stakeholders to help formulate the guiding principles, parameters within which poor performance should be handled, key priorities, and success criteria. A draft document was produced and the themes presented at the 2006 Haven Conference where opinions were sought from a larger group before writing the final guidance. Some clear common themes emerged - that there should be:
• greater clarity about who is responsible and accountable for doctors in difficulty
• a clear and universally adopted Code of Practice
• a more consistent approach across Wessex
• standard documentation
• systematic routes of communication between the Deanery and the Trusts
• more effective early detection of difficulties
• defined success criteria
• robust audit, evaluation and quality assurance

2 The Parameters

2.1 Roles and Responsibilities

In an ideal educational environment, all doctors would have both the skills and the confidence to reflect on their own performance and to identify when it was consistently or regularly falling short of anticipated professional standards. This is often prevented by factors including the blame culture within clinical medicine and the current high public expectations. These factors can cause errors and lead to problems being driven underground where they have the potential to cause more lasting and frequent damage. It is therefore essential to actively encourage an open and supportive process for dealing with identified educational problems.

Clinical supervisors, educational supervisors and clinical tutors have a vital role to play in identifying potential poor performance early (see Section 3.1) and putting in place an agreed plan to manage the identified weaknesses. This not only involves direct contact with the trainees themselves, but also requires the supervisor to seek views from other members of the clinical care team including other doctors in training, nurses and, where relevant, patients and their relatives.

There are many other educational roles, each with differing responsibilities for doctors in difficulty— these are set out in Appendix 1.
2.2 Supporting infrastructure

The Wessex Deanery has developed the following infrastructure for dealing with doctors in difficulty:

2.2.1 Associate Dean for Doctors in Difficulty

Associate Dean with specific responsibility for Doctors in Difficulty provides strategic lead and direct support to educators on matters concerning doctors in difficulty, on behalf of the Postgraduate Dean (Appendix 1).

2.2.2 Operational Panel

Group of Wessex Institute members who deal directly with DiDs and includes AD for DiDs (Chair), PGD, Business Manager, AD for FP, AD for Overseas Doctors, AD for SAS Doctors, GP Deputy Director, Secretary, Project Worker.

Responsibilities

- Ongoing monitoring of those DiDs referred to Institute, with regard to progress and costs.
- Monitoring RITA and ARCP outcomes.
- Ensuring that all aspects are covered and all resources mobilised in individual cases.
- Ensuring that risks are identified and managed appropriately including risks to individual doctor, their colleagues, their employers and patients under their care.
- Deciding when to refer on to NCAS or GMC.
- Deciding when to terminate training if required.

Panel meets approx every 3/12.

2.2.3 Reference Group

This group will have wider membership including trainee, HR and lay representation and meet annually.

Responsibilities

- Shape the Deanery framework for DiDs.
- Ensure that the interests of all parties are met by the framework.
- Validate and quality-assure the work of the Deanery with DiDs.

2.2.4 Project Worker

A senior trainee has been appointed to analyse data on DiDs referred to the W.I. over the past three years to inform on e.g.

- Referral sources and patterns
- Type of problems referred
- Action taken
- Outcomes

This information will further inform the Deanery framework for DiDs.

2.2.5 Information

The revised framework will be published on the Deanery website and updated as required. Information regarding the framework will also be distributed via existing educator networks and during specific workshops with trainees and groups of educators.
2.2.6 Training and Development

A rolling programme to inform and develop knowledge and skills of all those involved in dealing with DiDs has been commenced and will continue indefinitely. It includes:

- Trainees
- Clinical and Educational Supervisors
- Lead Educators
- PGC Managers
- Medical Personnel Specialists
- HR Directors
- Medical Directors

This will include written information as well as workshops and conferences. Dates will be accessible via the Deanery website but will be brought to the direct attention of the relevant groups as appropriate.

3 Assessment

The goals of a rigorous assessment process must include:

- Comprehensive and accurate assessment that:
  - Recognises the influence of context on an individual’s performance
  - Sets clear objectives
  - Agrees a defined and finite time-scale with outcome measures
  - Monitors and reviews
- Systematic documentation (see Appendices 3, 4 and 5)
- Continuity and communication

3.1 Early identification

All possible steps should be taken to identify and act on early signs and symptoms of difficulty. This helps to prevent problems escalating to a more serious situation that may pose greater risks to the doctor, to colleagues, to patients and/or to the organisation in which the doctor works.

3.1.1 Signs and Symptoms

The evidence described in section 1.4. highlights the factors that can signal the early signs and symptoms of difficulty. The majority of these are behavioural but also include signs of clinical incompetence – e.g. poor record-keeping; poor clinical decision-making and judgement; inappropriate referrals; etc.

3.1.2 Underlying reasons and explanations

Successful remediation or support for doctors in difficulty requires an accurate understanding of the underlying reasons for the difficulty. This increases the likelihood of being able to tailor subsequent intervention to the individual’s circumstances, personality, abilities or learning style (e.g. McManus et al, 2004).

The following checklist has been developed to help educational supervisors and others diagnose and manage the early signs of a doctor in difficulty.
3.1.3 Checklist for educational supervisors - how to diagnose and manage a trainee in difficulty

Symptoms and Signs

Is your trainee demonstrating any of the following?
- Anger, Rigidity/Obsessionalism, Emotionality, Absenteeism, Failure to answer bleeps
- Poor time keeping or personal organisation, Poor record-keeping, Change of physical appearance
- Lack of insight, Lack of judgement, Clinical mistakes, Failing exams, Discussing a career change,
- Communication problems with patients, relatives, colleagues or staff?
- Have there been complaints from patients or staff about any of the following?
- Bullying, Arrogance, Rudeness, Lack of team working (e.g. isolation; unwilling to cover for colleagues; undermining other colleagues; (e.g. criticising or arguing in public/in front of patients),
- Defensive reactions to feedback, Verbal or Physical Aggression, Erratic or Volatile behaviour

Underlying reasons/explanations

Can you identify any reasons for the above signs and symptoms – for example:
- Poor approach to studying, Lack of knowledge, Lack of skills, Lack of confidence, Deficient interpersonal skills, Language barrier, Attitudinal/personality problem; Stress due to life events;
- Stress due to work (e.g. dysfunction in the team; problems with trainer/supervisor or the training process; a specific critical incident affecting confidence); Poor motivation;
- Health problems, Drug or alcohol abuse, Physical illness, Psychiatric illness
- Workload; sleep deprivation

Is the problem due to any of the following factors within the individual.

- **Capacity** – a fundamental limitation that will prevent them from being able to do their job (e.g. mental or physical impairment). If so, then a change of role or job may need to be considered.
- **Learning** – a skills deficit through lack of training or education. In these cases, skills-based education is likely to be appropriate, provided it is tailored as closely as possible to the individual learning style of the doctor and is realistic within exiting resources.
- **Motivation** – a drop in motivation through being stressed, bored, bullied or overloaded – or conversely being over-motivated, unable to say no, anxious to please, etc. In these cases some form of mentoring, counselling or other form of support may be appropriate and /or addressing organisational issues like workload, team dysfunction or other environmental difficulties that may be affecting motivation
- **Distraction** – something happening outside work to distract the doctor; or a distraction within the work environment (noise or disruption; team dysfunction). The doctor may need to be encouraged to seek outside professional help if the problem is outside work.
- **Health** – an acute or chronic health problem which may in turn affect capacity, learning or motivation. Occupational health may have a role here; or the doctor may need to be encouraged to visit his or her GP.
- **Alienation** – a complete loss of any motivation, interest of commitment to medicine or the organisation, leading to passive or active hostility, “sabotage” etc. This cannot generally be rectified and damage can be caused to others (patients and colleagues) and to the organisation if allowed to continue for too long. The doctor should be moved out of the organisation, with whatever support or disciplinary measures may be deemed appropriate.

Investigation

- Have you talked to the trainee to gain their perspective?
- Have you talked to staff/colleagues confidentially to verify your findings?
- Is there any documentary evidence?
- Can you talk to other professionals concerned with the trainee’s welfare e.g. GP (with their permission)?

Management

- Have you clearly documented any information or evidence you have discovered?
• Have you discussed the purpose of this documentation with the trainee?
• Does the trainee understand that the appraisal process is confidential but that some documentation of problems is necessary for regulatory purposes and can you agree on this?
• Can and should the trainee remain at work?
• Is this a case for a trust disciplinary procedure or referral to the GMC?

Management Plan
• Have you developed and agreed a suitable learning plan with the trainee?
• Can you organise and commit to increased and regular supervision?
• When will re-appraisal and reassessment take place?
• If problems are not or cannot be resolved should this be referred on to the clinical or college tutor/training programme director?

Further guidance about how and when to act on these concerns is provided below in the Process Flowchart (section 3.2).

3.2 The process

The following flowchart and the short guides for different groups involved in the process (see Appendix 8-12) illustrate the process for doctors in difficulties at the different stages of training and depending on the differing nature of the problem.

As general principles

• Good communication should be maintained at every stage
• For Specialist Trainees the Wessex Deanery Specialty Manager should be informed as appropriate and as early as possible
• The educational processes need to link closely with Trust internal procedures, and close communication between the responsible individuals at Institute and Trust level is crucial.
Trainees in difficulty – Process Flowchart

Level 1

The aim of Level 1 is to identify trainees in difficulty as early as possible in order to avoid difficult situations where problems have developed to such an extent that their solution requires major intervention. Regular appraisal and assessment of a trainee’s performance by educational supervisors is an important opportunity to identify and deal with the majority of problems within the trainee’s current educational setting.

Where concerns are identified by a supervisor these should be discussed openly with the trainee and further information gathered from other members of the team.

Documentation of these concerns should be undertaken with the doctor’s consent (see section 3.4. below and Appendices 3-5). Where subsequent assessment reveals no improvement or where problems are more severe the educational supervisor should seek further help and support. Supervisors are referred to the checklist in Appendix 3.
Level 2
In certain situations e.g. major clinical incident the most appropriate course of action will be to follow the disciplinary procedures of the trust (in accordance with the ‘Maintaining High Professional Standards’ framework). However the clinical tutor and deanery co-ordinator should be informed that such an action has been undertaken.

More commonly the next step would be to involve the clinical tutor (see Appendix 1). Depending on local circumstances or whether the problems may have implications for progress in training for that trainee it may also be appropriate to seek the advice of the college tutor, specialty training programme director and/or regional advisor. For General Practice trainees the most appropriate contact may be the Associate Director of GP Education (see Appendix 1 and 7).

Many problems will be resolved by local intervention by the clinical tutor, with the support of the college tutor etc. This will include assessment of need, further documentation and where appropriate remedial action, instituted by the clinical tutor with the support of the local consultant(s)/educational supervisor(s) and their team(s).

A peer support group locally may be helpful for trainees and prevent an escalation of problems. To help support lead educators undertaking this work an informal network of key individuals, with particular expertise and experience in dealing with trainees in difficulty, have been identified. These people are available to give informal advice and support and a list of contacts appears in Appendix 7.

Level 3
This level of intervention will be required for a minority of trainees in difficulty who have been identified by clinical tutors and/or training programme directors as having difficulties which either have not been resolved by local intervention, or which require further input which is not available locally.

All trainees fulfilling these criteria should be referred to the deanery coordinator (see Appendix 7) who will undertake further assessment of the needs of the particular trainee.

Where appropriate the trainee can be either referred on to the virtual support group (see 3.2.1 below) and/or arrangements can be made for targeted training with a selected educational supervisor.

Such interventions will have resource implications. Access to these services is likely to require the involvement of the deanery coordinators. Not all trainees will wish to move through this formal process and individual solutions to trainees' problems at local level may and should still be encouraged.

3.2.1 Virtual Support Group

The concept of a virtual support group is that it provides guidance, support and counselling to trainees in difficulty. As not all of these services will be utilised at any one time or by any one trainee the group will remain virtual in that key services and individuals will be identified and available for use by trainees where appropriate.

In principle these should ideally be:

- individuals/ agencies that any doctor would be confident in seeing
- experienced in dealing with the medical profession.
- seen as independent from the trusts.

In all cases greater success in problem resolution would be anticipated where a holistic approach is undertaken (personal and professional problems)

Within Wessex, there are agencies and individuals who have been identified to undertake work in agreed areas. These are listed in Appendix 7.

Referral to a member of the virtual support group will be via the responsible Deanery Co-ordinator. The services provided by the virtual support group may be used to support a trainee in their current post. However, in some circumstances the needs of the trainee may require that they be removed from their
current post and targeted training (3.2.2) implemented. We have also recruited general practitioners who would provide support and co-ordinate care of trainees in difficulty at a local level, where appropriate (see 4. in Appendix 7).

3.2.2 Targeted training

Where the best solution to a trainee’s problem is removal from their current post to a post for targeted training the following principles should apply:

- Trainees may require the help/support of the other individuals in the guidance group as well as targeted training in an identified post. Selection of an appropriate educational supervisor is a key requirement. Inevitably there will be implications for the individual supervisor in terms of time and ability to deal with their usual clinical commitments and these need to be considered.
- Consideration should be given as to whether a trainee should be supernumerary or in a substantive post and this will be decided after discussion between the deanery coordinator and trust representative. There may be resource implications with regard to trainee and trainer which must be resolved prior to any approval of targeted training.
- Finally, stigmatising of the trainee as a “problem” should be avoided and the process should ideally remain confidential.

All attempts at targeted training will need to be recorded and monitored with clear indications of how progress has been assessed. Such systems as are agreed and planned for implementation may need to be discussed with Chief Executives, Medical Directors and Clinical Tutors. This is not just a matter of courtesy but to ensure that the systems link into Trust based systems for clinical risk management and clinical governance.

3.2.3 The role of external agencies

Where a concern about a doctor's or dentist's performance arises and the employer or contractor feels they need help, the question is often asked: Whom should we contact? Three different organisations are often then considered: the GMC (or GDC), NCAS or the medical royal college covering the relevant clinical specialty. What then guides the approach taken is broadly as follows.

If the concern, whether of performance, health or conduct, is so serious as to call into question the doctor or dentist's license to practice, then the regulator's (GMC/GDC) advice should be taken. This approach will therefore only be used in the most serious circumstances.

On the other hand, if the concern is more broadly based about a whole clinical service rather than about one or more individuals within a team, or where the organisation is unsure whether the treatment of a specific group of patients has met accepted standards, the colleges are often contacted for advice.

In all other circumstances, such as immediate concerns that might require exclusion or suspension, general concern about a practitioner’s performance, conduct or competence, and in any situation where the local organisation is unsure how to proceed, NCAS should be contacted.

In any event, all of those organisations work closely together and have published memoranda of understanding outlining how they work together. Contact with any of them will enable a discussion of how a concern is best handled and which agencies should be involved.

Appendix 2 lists the major organisations with website details. The list includes:

- The National Clinical Assessment Service (NCAS)
- The General Medical Council (GMC)
- The British Medical Association (BMA)
- The Medical Defence Union (MDU)
- The Medical Protection Society (MPS)

In addition to the local specialist support available within Wessex, NCAS has produced a national Directory of Resources (see Appendix 2) for doctors who may require specific forms of support – including
behavioural coaching, cognitive behaviour therapy, communication skills training, career counselling, coping with change, etc.

3.3 Documentation

3.3.1 Keeping records

All educational contacts relating to potential poor performance, whether it is specific or generic should be contemporaneously recorded and copies given to the doctor. Documentation should commence as soon as a performance concern comes to light. Whilst only a small minority of performance difficulties escalate into a disciplinary situation, records should nevertheless be kept from the earliest stage to help ensure continuity (e.g. a trainee who changes educational supervisor) and to avoid duplication of effort. Good documentation is an essential part of educational governance (see also section 4 below).

Example record forms for documenting conversations with doctors in difficulty are shown in Appendices 3-5. It is recommended that this form is completed even at the early informal stage in case future evidence is required, and to act as a basis for the management plan. Educational supervisors of specialist registrars are referred to the educational supervisor’s report produced by the deanery (see www.nesc.nhs.uk), which provides a format by which generic skills can be assessed and recorded as part of the RITA process including aspects of professional behaviour.

Should a problem with a doctor become more serious or repetitious, it may be advisable to seek guidance from the local HR Manager or Director who can advise on any further specific documentation.

Doctors need to have confidence that this documentation is intended to support and help them to address their difficulties rather than as a punitive or legalistic activity. Transparency is paramount to retain the doctor’s trust and cooperation. The following will help to ensure openness as well as rigour:

- Educators should avoid recording and keeping information about discussions with doctors without their knowledge or consent.
- Records of conversations should be held confidentially, with the doctor’s knowledge and consent, by the person who has conducted the assessment of the problem with the doctor in difficulty.
- The doctor should be given a copy of any documentation concerning his or her performance and encouraged to keep such copies in his or her portfolio for discussion at appraisals.
- Should the doctor move to a different job, or in the event that the problem escalates or others become involved, it may become necessary to pass the record to other parties, again with the consent of the doctor where possible. Transfer of information about trainee doctors’ progress from post to post should become standard procedure including areas of concern (see Proforma in Appendix 6).
- All documentation must comply with the requirements of the Data Protection Act and the Freedom of Information Act (FOIA).

3.3.2 Supporting documentation

There are several publications which provide guidance concerning support for doctors – particularly The New Doctor which sets out guidance on monitoring the progress of foundation trainees. These can be found in Appendix 8.

3.4 Success Criteria

Effective management of doctors in difficulty requires being clear about the criteria for success. This also facilitates audit and evaluation of the whole process.

We have drawn a distinction between success criteria for the organisation (i.e. the Wessex Deanery), for the individual doctor and for the team in which the doctor works. The overarching success criteria is a ‘return to safe practice’
Success for the Wessex Deanery would mean that:
- Everyone feels competent and capable of dealing with doctors in difficulty
- Educational supervisors have a proper programme for their own development
- Proof of probity, efficiency and effectiveness i.e. robust and defensible practices (including documentation)
- There is evidence of early intervention
- Every Wessex Deanery trainee clearly understands the boundaries and knows they will be treated fairly but firmly
- There is an increase in early reporting and a decrease in serious cases through a reporting system
- Problems are being dealt with earlier (Level 1)
- There is local resolution wherever possible

Success for the individual doctor would mean:
- The individual doctor shows improved behaviour and/or performance
- The doctor can make a successful change of career
- The problem is resolved within a reasonable time-scale
- The Trainee feels fairly treated, relieved, supported and that the outcome was acceptable

Success for the team would mean:
- The patient would be safe
- The pressure on the team would be reduced or eliminated
- The team functioning would improve

4 Educational Governance

Clinical Governance is the means by which organisations ensure the provision of quality clinical care by making individuals accountable for setting, maintaining and monitoring performance standards.

Clinical Supervision is a formal process of professional support and learning which enables trainees to develop knowledge and competence, assume responsibility for their own practice and enhance patient safety in complex clinical situations.

By focusing on clinical work and skills development, clinical supervision supports some of the central requirements of clinical governance and is the central plank of educational governance.

The main role of the clinical supervisor in relation to trainees is:
- To provide appropriate clinical learning opportunities for students in their clinical setting
- To give students appropriate feedback in order for them to learn and develop clinical skills
- To participate in the assessment of trainees’ clinical skills.

The management of doctors in difficulty needs to be underpinned by clear governance arrangements. These include a quality improvement, control and assurance process, as well as risk management and risk assessment. There must also be robust and systematic documentation, supported by audit and risk assessment at each stage of the decision making processes.

The work of the Wessex Deanery with doctors in difficulty will be audited regularly. Both the Operational Panel and the Reference Group will ensure that the risks are managed appropriately and that the framework continues to meet the needs of all parties involved in the processes.
APPENDIX 1 - Roles and responsibilities of educators

1) Clinical Supervisors
2) Educational Supervisors
   • Lead Educators

   Specialty
   3) College Tutor
   4) Programme Director
   5) STC Chair
   6) Regional Adviser

   Trust
   7) Clinical Tutor/DME
   8) FP Director
   9) Associate Postgraduate Dean
   10) Postgraduate Dean
   11) Director of GP Education

Clinical Supervisor

Usually Consultant (but can be SpR or non-medical team member) with whom the doctor works clinically, and who assesses whether that doctor is safe to carry out the clinical work he/she is expected to do within the department, and that he/she progresses within the particular training post/module. This will include direct input to workplace-based assessment.

Responsibility for Doctors in Difficulty
This direct contact with the doctor puts the clinical supervisor in an ideal position:

- To detect problems with regard to clinical knowledge and skills, team working, communication, attitude, time keeping, etc.
- Any problems observed should be documented, discussed with the trainee and brought to the attention of their educational supervisor.
- Trust policies and procedures should be followed as appropriate.

Educational Supervisor

Responsible for ensuring overall progress of the doctor through training.

Includes responsibility for regular appraisals, collation of workplace-based assessment outcomes and the provision of career advice and support as required.

Responsibility for Doctors in Difficulty
- Should be made aware of and gather evidence about concerns from other team members.
- Should discuss these concerns with the doctor during regular appraisals and consider ways of addressing them, with the help of the MD team.
- If problems cannot be resolved within educational supervision context, or in current post, Educational Supervisor needs to access help from Level 2, either within the Trust (FPD or Clinical Tutor) or within Specialty (College Tutor or Programme Director), depending on the grade of the doctor and the nature of the problem (i.e. health, capability or conduct).
- Careful documentation is crucial at all stages.
**College Tutor**

Appointed by Specialty College but based in Trust and responsible for advising and supporting doctors within a particular specialty in a Trust.

Mostly responsible for ensuring that trainees and supervisors adhere to College standards with regard to local educational programmes, regular appraisals and assessment, logbooks/portfolios in that particular specialty.

**Responsibility for Doctors in Difficulty**
- Mostly deal with SHOs at present (role may change under MMC)
- Career advice about their specialty
- Advice on exam procedure and requirements e.g. for doctors repeatedly failing exams
- Advice on specialty-specific issues
- Support for Educational Supervisors

**Programme Director**

Jointly appointed by College and Deanery/Institute to manage Specialty Training Programmes at Deanery level within a given specialty.

Responsible for allocation of SpRs (specialty trainees) to posts, supervision of individual training programmes, regular formal assessment including RITA process, problem solving and feedback on progress.

**Responsibility for Doctors in Difficulty**
- Support trainees within their programme and deal with individual issues
- Support Educational Supervisors within their programme and provide advice on issues with individual doctors
- Identify issues at annual RITA review
- Ensure that Doctors in Difficulty Strategy is implemented
- Resolve issues within programme (e.g. by moving individual doctor to different post/supervisor) wherever possible
- Bring more serious problems to attention of Trust (e.g. if patient safety at risk) or Deanery/Institute (e.g. if implications for training programme and additional resources required i.e. Virtual Support Group, NCAS.

**Chair of Specialty Training Committee (STC)**

Oversees, on behalf of the Deanery/Institute the activity and proper functioning of the STC; liaises with the relevant College, Faculty or SAC; and supports the Programme Directors.

**Responsibility for Doctors in Difficulty**
- No direct responsibility but can act as general source of advice for specialty and may decide to bring a particular problem to the attention of the STC, to raise awareness and learn from the case.

**Regional/Specialty Adviser**

Appointed by College in consultation with Deanery/Institute; provides link between College and Deanery on education and training in the specialty.

**Responsibility for Doctors in Difficulty**
- General support to doctors in difficulty and those who have to deal with them, particularly when advice is required on mandatory requirements of training.

**Clinical Tutor/Director of Medical Education**
Appointed by Postgraduate Dean together with Trust; manages the educational contract between Deanery and Trust and provides main link between PGD and individual Trust with regard to training and education of doctors in all grades within a particular Trust.

Responsibility for Doctors in Difficulty
- Should be made aware of all issues with individual doctors in training in the Trust
- Should provide advice and guidance to trainees, clinical and educational supervisors on matters relating to health, capability and conduct
- Should monitor and inform the Deanery on progress of doctors in difficulty
- Should work closely with HR Dept on issues regarding Doctors in Difficulty, especially where patient safety may be compromised
- Should refer to Deanery those problems that cannot be resolved within the Trust
- Should involve Human Resources Department and invoke Trust procedures as required

Foundation Programme Director
As above but with particular responsibility for FP trainees.

Needs to work closely with CT/DME and Associate Dean for Foundation Programmes on all issues regarding FP trainees.

Associate Postgraduate Dean
Associate Dean with specific responsibility for Doctors in Difficulty provides strategic lead and direct support to educators on matters concerning doctors in difficulty, on behalf of the Postgraduate Dean.

Responsibility for Doctors in Difficulty
- Develop, manage and inform on framework for dealing with Doctors in Difficulty
- Ensure that resources are available to support the framework including Virtual Support Group, remedial training, referral to NCAS, etc.
- Ensure that those dealing with Doctors in Difficulty are appropriately trained and supported
- Provide advice to educators on individual Doctors in Difficulty
- Assess and support those Doctors in Difficulty who require specialist input at Deanery/Institute level

Postgraduate Dean
Overall responsibility for postgraduate training and education within a geographical area.

Responsibility for Doctors in Difficulty
- Support and advice to Associate Dean dealing with Doctors in Difficulty
- Provide direct input to those cases where training may need to be terminated, or where appeals procedures need to be invoked

Director of GP Education
As for Associate Dean/Postgraduate Dean but sole responsibility for trainees in General Practice
APPENDIX 2 - Role of external agencies

National Clinical Assessment Service (NCAS)

The National Clinical Assessment Service (NCAS), formerly National Clinical Assessment Authority (NCAA), was established as a special health authority in April 2001. It became a division of the National Patient Safety Agency (NPSA) in April 2005.

NCAS provides confidential advice and support to health services on how to deal with the situation where the performance of doctors or dentists gives cause for concern. If a difficulty becomes apparent, the employer, contracting body or the practitioner can contact NCAS for help. The aim of NCAS is to work with all parties to clarify the concerns, understand what is leading to them and make recommendations for how they may be resolved.

The expert support which NCAS provides is wide ranging and includes not only advice over the telephone but also more detailed and ongoing support. This support includes specific responsibilities for NCAS to advise the NHS on the use of disciplinary procedures in doctors and dentists, in particular where suspension or exclusion of the practitioner from their work is being considered, and also where disciplinary action on the grounds of capability are being considered.

Where the performance problem is sufficiently serious or repetitious and attempts to resolve the problem at local level have failed, a doctor may be asked to undergo a full NCAS assessment. This comprises three main components: an occupational health assessment (by an occupational health doctor), a behavioural assessment (by an occupational psychologist) and a clinical assessment (by a team of clinical assessors). A report is produced by a panel of assessors (including a lay assessor) containing the findings, conclusions, and recommendations. NCAS will then work with the doctor and the Referring Body to agree an action plan to resolve the concerns.

NCAS does not take on the role of an employer, nor does it function as a regulator. It is established as an advisory body, and the referrer retains responsibility for handling the case throughout the process.

NCAS presently covers the NHS in England, Wales and Northern Ireland, and also defence medical services and the prison medical and dental service.

NCAS has published a Directory of Resources which is intended to help with the implementation of recommendations following an NCAS assessment of a doctor.

In addition, it should also be useful in supporting educational programmes for doctors generally and for identifying further training / programmes following determinations made by the General Medical Council or General Dental Council.

The Directory of Resources is available through its website:
http://www.ncas-resource.npsa.nhs.uk

Full details of how and when to use the services of NCAS can be obtained through its website:
http://www.ncas.npsa.nhs.uk

General Medical Council (GMC)

The purpose of the General Medical Council (GMC) is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

The law gives the GMC four main functions under the Medical Act:
- keeping up-to-date registers of qualified doctors
- fostering good medical practice
- promoting high standards of medical education
- dealing firmly and fairly with doctors whose fitness to practice is in doubt.

The GMC has legal powers designed to maintain the standards the public have a right to expect of doctors. Their job is to protect patients.

Where any doctor fails to meet those standards, the GMC acts to protect patients from harm - if necessary, by removing the doctor from the register and removing their right to practice medicine. The employing NHS
Trust has an obligation to make an appropriate referral to the GMC but all doctors have a duty to take action if they have concerns about a doctor's fitness to practice. This should normally be done through the Medical Director, or Postgraduate Dean or other appropriate person in authority.

The publication Good Medical Practice, underpins all the GMC’s work and embodies the values of the medical profession.

The GMC focuses on fitness to practise (whereas NCAS focuses on fitness for purpose). [http://www.gmc-uk.org](http://www.gmc-uk.org)

British Medical Association (BMA)
The British Medical Association represents doctors from all branches of medicine all over the UK. It has a total membership of over 137,000, rising steadily, including more than 3,000 members overseas and over 19,000 medical student members.

The BMA:

- is a voluntary professional association of doctors
- speaks for doctors at home and abroad,
- provides services for its members
- is an independent trade union
- is a scientific and educational body
- is a publisher
- is a limited company, funded largely by its members.

It does not

- register doctors – that is the responsibility of the General Medical Council (GMC)
- discipline doctors – that is the province of the employer/primary care trust and/or the GMC
- recommend individual doctors to patients.

Its policies are decided by elected members, mainly practising doctors.

It is supported by a professional staff and works with other bodies to meet its objectives. [http://www.bma.org](http://www.bma.org)

Medical Defence Organisations

Medical Defence Union (MDU)
The MDU is a mutual, non-profit organisation, owned by its members - doctors, dentists and other healthcare professionals.

The MDU defends the professional reputations of its members when their clinical performance is called into question. On their members’ behalf they may pay legal costs in the civil courts, professional tribunals and criminal courts. They may also pay compensation to patients who have been harmed by medical negligence during their treatment. [http://www.the-mdu.com](http://www.the-mdu.com)

Medical Protection Society (MPS)
The Medical Protection Society is a leading indemnifier of health professionals. As a not-for-profit mutual organisation, MPS offers support to members with the legal and ethical problems that arise from their professional practice.

MPS members commonly seek help with clinical negligence claims, complaints, medical council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries. They have access to expert advice from a 24-hour emergency helpline and, where appropriate, legal assistance and compensation for patients who have been harmed through negligent treatment. MPS also runs risk-management and education programmes to reduce adverse incidents and promote safer practice. [http://www.medicalprotection.org](http://www.medicalprotection.org)
**APPENDIX 3 - Record of Assessment/Performance Review Pro forma**

**Interview date:**

<table>
<thead>
<tr>
<th>Name :</th>
<th>M</th>
<th>F</th>
</tr>
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<tbody>
<tr>
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<td>Referral date:</td>
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<tr>
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<td>telephone</td>
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<tr>
<td>Name of referrer:</td>
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<td></td>
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<tr>
<td>Nature of problem:</td>
<td>Health</td>
<td>Capability</td>
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<td>Issues identified:</td>
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**What has already been done?**

**Summary of main issues:**
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<th>Degree of risk to doctor:</th>
<th>low</th>
<th>medium</th>
<th>high</th>
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<tr>
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<tr>
<td>Degree of risk to employer:</td>
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<tr>
<td>Degree of risk to colleagues/team:</td>
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<td>medium</td>
<td>high</td>
</tr>
<tr>
<td>Degree of risk to Wessex Institute:</td>
<td>low</td>
<td>medium</td>
<td>high</td>
</tr>
</tbody>
</table>

**Action plan for trainee:**

**Action plan for assessor:**

**Further referral:**
- Virtual support group:
  - Career Counselling
  - Communication Skills
  - Dyslexia
  - Exam Failure
  - General Practice
  - Language Difficulties
  - Mental Health Problems
  - Professionalism
  - Time Management

- NCAS
- GMC
- Other

**Review date:**
# APPENDIX 4 - Record of Assessment/Performance Review Example 1

**Interview date:** 13/03/06

<table>
<thead>
<tr>
<th>Name</th>
<th>Dr A</th>
<th>M ✓</th>
<th>F</th>
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</thead>
</table>

**Age:**

**Employment status:** SpR Specialty X Year 3

**DOB:**

**Address:**

**Tel:**

**e-mail:**

**Referral date:**

**Mode of referral:** letter ✓ telephone e-mail other (specify):

**Name of referrer:** Dr Z Programme Director

**Nature of problem:** Health Capability ✓ Conduct

**Issues identified:**

- **RITA E Awarded**
  - Concerns re Clinical judgement, communication including language skills, progress with audit and research, time management.
  - Trainee concerned re decision and possible racial discrimination

**What has already been done?**

- RITA documentation received
- Action plan agreed with Programme Director including Direct observation of practice and feedback Feedback on selected written communication Improve language skills

**Summary of main issues:**

- Poor organisational skills including time and workload management
- Poor language skills – oral and written
- Clinical judgment needs improving i.e. decisions need to be based on structured history and examination
- Lack of progress with audit and research
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<th>medium</th>
<th>high ✓</th>
<th>may not complete CCT</th>
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<tbody>
<tr>
<td>Degree of risk to patients:</td>
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<td>medium</td>
<td>high</td>
<td></td>
</tr>
<tr>
<td>Degree of risk to employer:</td>
<td>low ✓</td>
<td>medium</td>
<td>high</td>
<td></td>
</tr>
<tr>
<td>Degree of risk to colleagues/team:</td>
<td>low medium ✓</td>
<td>high not managing workload</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Degree of risk to Wessex Institute:</td>
<td>low medium ✓</td>
<td>high appeal/ complaint</td>
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<td></td>
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</table>

**Action plan for trainee:**
- Attend Time Management workshop and apply principles to daily work
- Direct observation and assessment of practice by Educational Supervisor
- Complete audit and research project

**Action plan for assessor:**
- Referral to VSG for linguistic assessment and tuition
- Attend next RITA review to ensure fair process and review capability
- Review re need for individual help with time and workload management

**Further referral:**
- Virtual support group:
  - Career Counselling
  - Communication Skills
  - Dyslexia
  - Exam Failure
  - General Practice
  - Language Difficulties
  - Mental Health Problems
  - Professionalism
  - Time Management

**Review date:**
- Next RITA
APPENDIX 5 - Record of Assessment/Performance Review Example 2

**Interview date:** 24/09/04

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<th>Dr B</th>
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<td>Mode of referral:</td>
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<tr>
<td>Name of referrer:</td>
<td>Dr A (College Tutor)</td>
</tr>
<tr>
<td>Nature of problem:</td>
<td>Health √ Capability Conduct √</td>
</tr>
<tr>
<td>Issues identified:</td>
<td>Tearful, odd affect Family bereavements Repeatedly absent from work, ? Lying about reasons for absence Has disappeared from work at short notice, leaving colleagues to cover. When confronted, appears unconcerned Poor communication with colleagues Behaviour ‘out of character’ (Detailed examples attached)</td>
</tr>
<tr>
<td>What has already been done?:</td>
<td>Seen by College Tutor and Clinical Tutor Seen by Occupational Health Removed from on-call rota Informed of departmental protocol for sickness and absence Individual work pattern agreed with College and Clinical Tutor</td>
</tr>
<tr>
<td>Summary of main issues:</td>
<td>? Unresolved grief Socially isolated ? Depressive illness ? Attitudinal/personality issues</td>
</tr>
<tr>
<td>Degree of risk to doctor:</td>
<td>low</td>
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<td>--------------------------</td>
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<tr>
<td>Degree of risk to patients:</td>
<td>low</td>
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<tr>
<td>Degree of risk to employer:</td>
<td>low</td>
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<td>Degree of risk to colleagues/team:</td>
<td>low</td>
</tr>
<tr>
<td>Degree of risk to Wessex Institute:</td>
<td>low</td>
</tr>
</tbody>
</table>

**Action plan for trainee:**
- Bereavement counselling
- Improve social network
- Attend Occ Health Review
- Adhere to agreed work pattern
- Communicate clearly any absences from work

**Action plan for assessor:**
- Communicate with all parties involved
- Regular reviews of progress
- Seek info re performance in previous posts and medical school
- Inform HR Dept
- Refer to Clinical Psychologist

**Further referral:**
- Virtual support group:
  - Career Counselling
  - Communication Skills
  - Dyslexia
  - Exam Failure
  - General Practice
  - Language Difficulties
  - Mental Health Problems
  - Professionalism
  - Time Management
  - NCAS
  - GMC

**Review date:** 1/12
APPENDIX 6 - Transfer of Educational Plan for doctors in training (all grades)

Name ..............................................................................................................
Specialty .................................................. Year of training ..................
Current post ..................................................................................................
New post ........................................................................................................
Date of last appraisal with current educational supervisor .....................

Educational supervisor’s report detailing strengths and weaknesses of trainee and agreed
areas for improvement attached
(please tick) Yes No

If no report is attached the following sections must be completed

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<th>Strengths of trainee</th>
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<table>
<thead>
<tr>
<th>Areas in need of development</th>
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<table>
<thead>
<tr>
<th>Areas of concern</th>
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<td></td>
</tr>
</tbody>
</table>

*(For specialist trainees only)* Date of last RITA interview ...................
RITA form given (please tick) C D E F G

Signature of trainee ................................................................. Date ........

Signature of educational supervisor ........................................... Date ........

PLEASE GIVE A COPY TO THE TRAINEE AND SEND A COPY TO THE NEXT
EDUCATIONAL SUPERVISOR. IF THE TRAINEE IS LEAVING THE DEANERY PLEASE
SEND A COPY TO THE NEW DEANERY.

---

I confirm I have received and read the report/the above summary from the previous
educational supervisor/consultant.
Signature of new educational supervisor .............................................
Date ..............................

PLEASE SEND COPY TO DEANERY
APPENDIX 7 - Wessex Deanery Resource Directory

The following individuals have experience of dealing with trainees in difficulty and may be happy to be contacted for informal advice and support.

Wessex Deanery Members of Original Working and Steering Group

Dr Rosie Lusznat  Associate Postgraduate Dean
Dr Malvena Stuart Taylor  Associate Postgraduate Dean (PRHOs)
Dr Jo Mountfield  Flexible Training Co-ordinator
Professor Colin Coles  Education Advisor
Dr Elizabeth Donovan  Consultant Neonatologist St Mary’s Hospital Portsmouth and Educational Advisor for Paediatrics
Dr Edward Wozniak  Consultant Paediatrician St Mary’s Hospital Portsmouth and Chairman of Paediatric STC
Dr Robin Clarke  Consultant Physician St Mary’s Hospital Portsmouth
Miss Vicky Osgood  Director of Medical Education St Mary’s and Queen Alexandra’s Hospitals Portsmouth and Consultant Obstetrician
Dr Jeremy Nightingale  Consultant Anaesthetist Chair STC Anaesthetics
Dr James Adams  Associate Director of Medical Education and Consultant in Elderly Medicine
Dr Tim Battcock  Clinical Tutor Poole and Consultant in Elderly Medicine
Mr Adel Resouly  Consultant ENT Surgeon Queen Alexandra Hospital Portsmouth and Regional Advisor for ENT
Dr Ian Kendall  Consultant in Accident & Emergency Medicine Swindon and Chair STC Accident & Emergency Medicine

Clinical Tutors

Associate Directors of Postgraduate GP Education

General Practitioners

Dr W Fitzpatrick  The Surgery, 6 Stoneham Lane, Southampton
Dr S Goodison  Blackthorn Surgery, 73 Station Road, Netley Abbey Southampton
Dr S Hill-Cousins  Forestside Medical Practice, Old Malthouse, Main Road, Marchwood, Southampton
Dr D J Parker  Barton Surgery, 1 Edmunds Close, Barton Court Avenue, Barton on Sea, New Milton
Dr V Hartley-Brewer  Weston Surgery, 36 Combe Park, Bath

Specialist support services (Virtual Support Group)
The following individuals and agencies have been identified to undertake work in agreed areas (see section 3.2.1 above):
1. Communication/Interpersonal skills  
   Nick Maguire/Catherine Emmerson
2. Time management  
   Martin Clarke
3. Psychiatrist/counsellor for the crisis situation – John Hook?
4. Language difficulties  
   Angela MacTavish
5. Professionalism/Coaching  
   Judy Curson
   Peter Lees
6. Career counselling  
   Sonia Hutton-Taylor (Medical Forum)
7. Occupational health issues  
   Trust Occupational Health
8. Exam failures  
   Colin Coles
9. Dyslexia  
   Mrs Gail Alexander
10. Cultural aspects  
    Rosslynne Freeman

**Wessex Deanery Co-ordinators**
These individuals can undertake Level 3 assessments (see section 3.2 above):
Foundation Programme Malvena Stuart Taylor
GP SHOs  
TBC
Career SHOs / SpRs  
Rosie Lusznat / Tanzeem Raza / Sarah Beaney
APPENDIX 8 - References and further reading


Current publications and national guidance


Modernising Medical Careers: Operational Framework for Foundation Training.
http://www.mmc.nhs.uk


http://www.dh.gov.uk/PublicationsAndStatistics/fs/en

National Clinical Assessment Service (NCAS).
http://www.ncas.npsa.nhs.uk
APPENDIX 9 - Examples of Risk Assessment Criteria for Doctors in Difficulty

Health Issues
Low Risk
Insight into difficulties.
Takes appropriate time off sick.
Insight into limitations caused by health issue.
Seeks help and advice appropriately (from own GP or occupational health or appropriate colleagues) and follows this advice.
Responds to concern raised by colleagues and modifies behaviour appropriately.
Complies fully with all treatment and reasonable adjustments to workplace roles/conditions.

Medium Risk
Limited insight into difficulties.
Continues to work whilst moderately unwell.
Limited awareness into limitations caused by health issue.
Seeks advice appropriately but appears reluctant to follow this.
Some appropriate response to concerns raised by colleagues.
Complies on the whole with all treatment and reasonable adjustments to workplace roles/conditions.

High Risk
No insight into health problem.
Continues to attend work even when obviously unwell.
No insight into clinical limitations caused by health issue; may jeopardise patient care.
Does not seek help or advice for health issue.
Unwilling or unable to respond appropriately to concerns raised by colleagues.
Does not comply with treatment or reasonable adjustments.

Capability
Low Risk
Insight into capability issues.
Performance difficulties are not serious or repetitive.
Does not attempt to perform tasks when not capable.
Takes responsibility for the task, and ensures that it is completed under supervision or completed by an appropriate colleague.
Seeks advice and supervision appropriately.
Demonstrates expected improvement in areas of weakness.
Demonstrates the ability to learn from experience.

Medium Risk
Limited insight into capability difficulties.
May attempt to perform low risk or simple tasks when not capable, but then seeks advice and supervision.
Demonstrates some improvement in areas of weakness.
Demonstrates some ability to reflect and learn from experience, but there are still concerns in this area.
Repeated sick leave often of short duration and possibly associated with on-call.
Repeated avoidance of acute situations.

High Risk
No insight into lack of capability.
Performance difficulties are serious or repetitive.
Attempts to perform high risk task(s) when not capable.
Inability to communicate effectively.
Repeated inappropriate delegation of clinical responsibility.
Repeated inadequate supervision of delegated clinical tasks.
Ineffective ingrained clinical team working skills.
Does not seek appropriate advice or supervision, therefore putting patients at risk.
If unable to complete the task, does not ensure that it is completed by a colleague.
Seems unable or unwilling to improve in areas of weakness.
Does not demonstrate the ability to reflect and learn from experience. May make formal complaints about colleagues who express concern about capability.

**Conduct**

**Low Risk**
One episode of minor misconduct only (N.B. need to check that there have not been any episodes in previous posts).
Individual agrees when challenged that conduct was inappropriate.
Demonstrates remorse for misconduct.
Demonstrates the ability to reflect and learn from experience and there is no evidence of further misconduct.
Seeks advice appropriately on conduct and associated issues.
External factor present (family/financial/work related/evidence of stress).
Detailed work history available and no concerns.

**Medium Risk**
Two or three episodes of minor misconduct (check back to other posts).
Individual agrees when challenged that conduct was inappropriate.
Demonstrates appropriate remorse for misconduct.
Demonstrates the ability to reflect and learn from experience, but some very minor concerns about conduct may remain.
Sometimes seeks advice on conduct and associated issues.

**High Risk**
Repeated episodes of minor misconduct, or one or more episodes of serious misconduct.
Individual does not agree that conduct was inappropriate, or denies misconduct.
No expression of remorse.
Unable to demonstrate the ability to reflect and learn from experience.
Unable or unwilling to accept advice on conduct-related issues.
No external contributory factors.
Work history difficult to verify/previous concerns.