Wessex Framework for Professional Support

Developed from the July 2003 version by Rosie Lusznat, Jenny King & Clair du Boulay

Revised April 2013 by

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The key differences in this 2013 revision are:

- Reference to the national implementation of Revalidation for all doctors
- Integrated description of the approach for general practice which differs slightly from other specialties
- Inclusion of dental trainees
- Greater clarity about professional support that may be offered both now and in the future to doctors not covered by HEE funding
- Greater emphasis on quality assurance and evaluation
- Greater reliance on links to the HEE website rather than including all possible documents as appendices.

There was a wide consultation process to support the development of the original strategy in 2003. This revised framework has been reviewed by a number of individuals from a range of perspectives including, but not limited to, members of the Professional Support Unit, Lead Educators, doctors in training, HEE staff and managerial representatives.
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Wessex Framework for professional support

1. Introduction

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

- Those responsible for the education and training of doctors and dentists 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 and dentists, including Human Resources (HR), Medical Directors, Clinical Directors and Directors of Clinical Governance
- Doctors and dentists themselves (including trainees, specialty doctors, Consultants, GPs and any other doctors within Wessex).

Using this Framework

This document is based on the best evidence available. The 2003 original was compiled following extensive consultation within the then Wessex Deanery (now HEE Wessex) and with local education providers. This document incorporates and extends that “Strategy for Trainees in Difficulty” originally published in 2003. It is a working document that will be reviewed regularly and updated at least every 3 years.

All details of suggested documentation, contacts, networks and support services, and checklists are available on the HEE Wessex website at www.wessexdeanery.nhs.uk/professional_support_unit.aspx which brings together the wide range of resources within Wessex, as well as national agencies providing advice for doctors and dentists who need professional support and those who manage them. Any additional resources should be notified to HEE Wessex for inclusion in the list as appropriate.

2. Background

Many doctors, at some stage in their career, will encounter health, personal or professional problems which will affect their performance. Since the introduction of more structured training, 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 specialty trainees. Nationally, between 2002 and 2006, the National Clinical Assessment Service (NCAS), established to support doctors and dentists in difficulty, received 3000 calls for advice concerning doctors whose performance had given cause for concern (see Appendix D). With the increasing pressures on doctors and dentists this picture is unlikely to improve.

Due to the increasing number of trainees involved in the above, in 2002, what was then known as the Wessex Deanery, considered it essential to formalise a scheme that ensures patient safety while meeting the needs of the trainee, the education provider and the Postgraduate Dean. This resulted in the formation of the Wessex Professional Support Unit (PSU), underpinned by the publication in 2003 of a Wessex Deanery Strategy for dealing with trainees in difficulty, developed by Dr Rosie Lusznat. The strategy aimed:

1. To promote early identification of trainees requiring professional support
2. To provide clinical and educational supervisors with a clear structure for identifying and addressing these difficulties
3. To clarify lines of responsibility for other educators involved in managing trainees requiring professional support
4. To provide a network of support for educators throughout Wessex
5. To establish a group of experts who can deal with specific areas of difficulty, and where necessary, identify opportunities for targeted training

This framework 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.

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 been able to continue their training successfully.

There are, however, a small number of doctors and dentists 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. In cases where it is clear that specialty or GP training cannot be sustained without a disproportionate investment of resource or where risk to patients cannot be mitigated, then doctors may have to leave training.

The framework encompasses the whole spectrum of performance difficulties. At one end are the more minor concerns or dilemmas, presenting a potential 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 of sufficiently serious or repetitive nature to require a remedial or disciplinary approach (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 C). This document provides overarching guidance at each of these 3 levels. As such, it forms a central plank in HEE Wessex’s drive towards robust educational governance.

The specialist services developed by HEE Wessex to support doctors in training with problems at Level 3 can also be made available to doctors in other parts of the workforce but this will require separate funding.

3. Values, purpose and principles

The values of HEE Wessex 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:

- No compromise on patient care
- 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
- Consistent application of guidelines

HEE Wessex is aiming to achieve the following goals in relation to dealing with doctors who require professional support:
4. 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 available 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 number of possible contributory factors including workload, sleep loss, physical or mental impairment, education and training difficulties, personality and psychological factors. Many of the conclusions below are based on the evidence in this book but the list of factors is not complete (e.g. financial issues are becoming increasingly common).

An analysis of the caseload of the first 8 years of NCAS showed that half of referrals had a behavioural element whilst one third were predominantly related to behaviour (NCAS 2009).

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. 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”, and “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. Three 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 significant factors 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 perhaps 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.

We need to demonstrate that the resource (especially professional time) that we invest in doctors with performance problems can be justified when competing for funding that could be invested in other ways to improve patient care. We will continue to build the evidence base about the effectiveness of interventions through:

- Commissioning an evaluation of the effectiveness of this framework at all 3 levels
• Strengthening the process for gathering data about the satisfaction of doctors and referrers with the service received from the Professional Support Unit
• Greater use of “significant event reviews” for cases where the framework seems to have been particularly effective or not to have worked well.

5. 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.

Signs and Symptoms

The evidence described in section 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.

Underlying reasons and explanations

Successful remediation for doctors requiring professional support 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).

6. Checklist

The following checklist has been developed to help educational supervisors and others diagnose and manage the early signs of a doctor in difficulty.

Symptoms and Signs

Is the doctor demonstrating any of the following?

Anger, rigidity/obsessional tendencies, 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 leading to 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, poor interpersonal skills, language barriers, 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; Occupational Health and HR will be able to advise on “reasonable adjustments” as per the Equalities Act 2010.

**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 existing 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 or 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 doctor 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 doctor’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 Flowcharts.

7. The Process

The following flowcharts 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 Foundation and Secondary Care Specialty trainees the PGMDE Programme 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 HEE, Wessex and Trust level is crucial.
- For General Practice trainees the first approach should be to the Programme Director who may then escalate to the Associate Dean or GP director.
- For all dental trainees the first point of contact should be the Training Programme Director who will liaise closely with the relevant Programme Manager and inform the Associate Dean or Dental Dean.
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Process Flowcharts

Overview of Levels and Action for Doctors in Specialist Training
(Not including General Practice)

Doctor In Training

Level 1
Low Risk
Managed within training pathways
Trust/Specialty

Regular educational supervision

Concerns identified by supervisor

Educational Supervisor active management incl. documentation of concerns

Discuss with HR with referral to occupational health if appropriate

Satisfactory ARCP/RTA

Concerns resolved

Continuing or complex issues

Level 2
Moderate Risk
Escalated within Trust
Trust/Specialty

Assessment, documentation, remedial action by DME, College Tutor or Programme Director. Formal Trust Procedures by Clinical Manager if required

Refer to DME, College Tutor or Programme Director, Clinical Manager if indicated.

HR involved Occupational Health advice as appropriate

Unsatisfactory ARCP outcome

Discrepancy referral indicated if continuing or severe concerns

Level 3
High Risk
Professional Support at HEE, Wessex Level

Concerns resolved

HSU Case Manager

Continual updates to Case Manager

Serious concerns including improvements not made to acceptable level or standard

GMC

Trainee Exits Training Programme and/or affected Employment through Trust's disciplinary or health processes

Assessment, documentation, remedial action

Complex issues may generate multiple steps back into this system

NCAS

Supp Support Group

Targeted Training

Link with Trust Management, HR and Occupational Health as appropriate
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Level 1

The aim of Level 1 is to identify trainees requiring professional support 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 knowledge. 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 section 6.

Level 2

In certain situations e.g. major clinical incident/serious complaint the most appropriate course of action will be to follow the employer’s disciplinary procedures. In a Trust, this will be handled in accordance with the Trust’s policies and procedures based on ‘Maintaining High Professional Standards’. The Clinical Tutor, Director of Medical Education (DME) and PGMDE Programme Manager should be informed that such an action has been undertaken. For GP trainees the investigation should be undertaken by the practice as employer. A report should be sent to the GP Head of School.

More commonly the next step for specialty trainees would be to involve the Clinical Tutor / DME 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 GP trainees the most appropriate contact would be the patch Associate Dean.

Many problems will be resolved by local intervention by the DME, with the support of the College Tutor etc. This will include assessment of need, further documentation and where appropriate remedial action, instituted by the DME with the support of the local consultant(s) / Educational Supervisor(s) and their team(s). Similarly the patch Associate Dean may be able to resolve problems. However, because practices have less organisational infrastructure than trusts, the GP School may need to call on other resources such as independent Occupational Health input for trainees at Level 2.

A peer support group locally may be helpful for trainees and prevent an escalation of problems. Members of the Wessex Professional Support Unit are always willing to discuss individuals and to give advice or signpost to other resources.

Level 3

This level of intervention will be required for a minority of trainees who have been identified by DMEs and / or Training Programme Directors or patch Associate Deans as having difficulties, which have either not been resolved by local intervention, or which require further input which is not available locally. This will include most trainees where fitness to practise concerns have been raised by their ARCP panel. Where concerns relate solely to the outcome of a pending investigation at Trust level, the trainee need
not be considered as Level 3 unless additional support is required, or the outcome confirms concerns which warrant referral.

All trainees fulfilling these criteria should be referred as appropriate to the Foundation Programme Director, PSU or GP director who will assess what support and intervention is required. Through PSU referral and allocation of a Case Manager there is access to a range of specialist support services and in some cases, targeted training. Such interventions have resource implications. The budget for these resources is managed by the PSU.

Doctors in training have a choice about whether to accept additional support, but failure to engage would be considered in ARCP panel decision making.

**Specialist Support Services (‘Virtual Support Group’)**

HEE Wessex has developed access to a range of specialist services with the aim of providing targeted and appropriate input to trainees requiring professional support.

In principle these should be:

- Individuals / agencies that any doctor would be confident in seeing
- Experienced in dealing with the medical profession
- Independent from employers

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

Case Managers and the GP Director can refer to these services. The range of services currently available is set out on the PSU website [http://www.wessexdeanery.nhs.uk/support/support/professional_support_unit/information_for_educators.aspx](http://www.wessexdeanery.nhs.uk/support/support/professional_support_unit/information_for_educators.aspx)

At the time of preparing this framework, the supports included are

- Dyslexia assessment and coaching
- Language assessment and support
- Psychologist for interpersonal and communication skills
- Coaching for time management, communication and personal impact, work/life balance
- Assessment and advice regarding exam failure
- Assessment of occupational health issues which may affect training
- Specialist assessment and support for autistic spectrum disorder
- Career counselling
- Psychiatric and psychotherapeutic assessment
- E-portfolio support for GP trainees
- Consulting skills for GP trainees

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 the appropriate clinical and managerial individuals in the organisation. This will ensure that the systems link into systems for clinical risk management and clinical governance.

Most doctors receiving additional support in training will remain in their current post. However, in some circumstances the needs of the doctor may require that they receive targeted training in either an
alternative substantive or, rarely, a supernumerary post.

**Targeted training**

Where the best approach is thought to be a period of targeted training the following principles should apply:

- The doctor should continue to receive external support 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 that need to be considered.
- In the exceptional event that supernumerary targeted training is thought to be required, the HEE policy and process for supernumerary training applications should be followed. This can only be initiated by a HEE Programme Manager or PSU Case Manager.
- If the time is to count towards training, training approval of the supernumerary post is required. Such placements are very expensive; both the doctor’s progress and expenditure will be closely monitored as set out in HEE’s process.
- Stigmatisation of the doctor as a "problem" should be avoided; the doctor’s wish for confidentiality needs to be balanced with the need for members of the educational and clinical teams to provide the appropriate support for the doctor and safeguards for patients.

**8. 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. Concerns by the doctor and their colleagues about the long term impact on career and reputation or sometimes lack of insight may lead to issues being avoided with 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 5) 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 educational and other roles which contain differing responsibilities for doctors requiring professional support – these are set out in Appendix A.

**Professional Support Unit**

The Wessex PSU offers advice, support and education to educators at every level of this framework and works directly with doctors at Level 3.

**Associate Dean for Professional Support**

The Associate Dean with specific responsibility for Professional Support provides strategic lead and direct support to educators on this matter, on behalf of the Postgraduate Dean, supported by a Consultant for Professional Support.
Consultant for Professional Support

Supports the Associate Dean, and case manages a proportion of individuals referred to Level 3 of the strategy. Other aspects of this role include on-going strategy development and Case Manager supervision.

Quality & Governance Group

The membership of this group includes PSU staff, HEE Wessex management, Programme Managers, PSU Case Managers, and Lay representation.

The Wessex Professional Support Unit Quality and Governance Group is responsible for the ongoing monitoring of quality and governance aspects of the work of the Professional Support Unit (PSU) including:

- PSU Activity and Outcomes
- Quality of PSU Management
- Risk Management
- Information Governance
- Financial and Resource Management

Reference Group

This group has a wider membership including trainee, HR, Medical Director, NCAS and Lay representation and meets annually.

Its responsibilities are:

- Shape the HEE Wessex framework for Professional Support
- Ensure that the interests of all parties are met by the framework
- Validate and quality assure the work of HEE in this area, through review of cases and experience of last 12 months

Case Managers

A number of Consultants working in Trusts within Wessex and GPs have been appointed to manage individual cases referred to Level 3 of the strategy. These are Consultants and GPs with experience of managing doctors requiring professional support at Level 1 and Level 2 of the strategy, and of working with trainees within the region. Regular peer supervision is available and expected, as well as individual supervision from the Associate Dean or Consultant for Professional Support whenever required.

A needs analysis should be undertaken to assess if further development of peer supervision for dentists in difficulty is required.

Revalidation & Professional Support Unit Manager

The role of the Manager for Professional Support is primarily to provide an internal interface between the programme management teams and the PSU. The role is directly linked with revalidation, the view being that the work of responding to concerns and remediation arising from revalidation will fall to the PSU in many instances. The Manager role is also designed as a project and development management position, to allow progression of specific work streams seeking to improve and build upon the successes of the unit. This is still a relatively new post and will be developed in response to need.
Deputy Business Manager for Finance

The Deputy Business Manager’s main role within the PSU is to support the team in terms of effective budget management, including reconciliation of monthly expenditure, accurate forecasting of costs, and budget setting. The Deputy Business Manager also has in depth involvement in the management and monitoring of referred doctors who require training in supernumerary posts as well as a more permanent move to less than full time training where appropriate, which includes the management and supporting the negotiation of funding to LEPs in the region.

Administrator for Professional Support

The Administrator for Professional Support is primarily responsible for the day to day running of the Unit and management of incoming cases. The Administrator also provides advice and support to doctors being referred, those making referrals, as well as Case Managers and VSG members. The Administrator facilitates the triage of cases with the Associate Dean for Professional Development and the Consultant for Professional Support. The Administrator is often the first point of contact for anyone seeking information about or from the PSU.

Training and Development

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

- Trainees
- Clinical and Educational Supervisors
- Lead Educators
- Postgraduate Education Centre 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 HEE Wessex website but will be brought to the direct attention of the relevant groups as appropriate.

9. 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
  
  http://www.wessexdeanery.nhs.uk/support/support/professional_support_unit/information_for_educators.aspx

- Continuity and communication
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 considered: the GMC (or GDC), NCAS or the medical royal college covering the relevant clinical specialty. What 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, the regulator's (GMC/GDC) advice should be sought. This approach will therefore only be used in the most serious circumstances.

- On the other hand, if the concern is 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 these 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 B lists the major organisations with website details. The list includes:

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

In addition to the local specialist support available within Wessex, NCAS has produced a national Directory of Resources [http://www.ncas.nhs.uk/resources](http://www.ncas.nhs.uk/resources) for doctors who may require specific forms of support – including behavioural coaching, cognitive behaviour therapy, communication skills training, career counselling, coping with change, etc.

10. Documentation and Information Governance

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 12 below).

Example record forms for documenting conversations with doctors in need of support are shown on the website [http://www.wessexdeanery.nhs.uk/support/support/professional_support_unit/information_for_educators.aspx](http://www.wessexdeanery.nhs.uk/support/support/professional_support_unit/information_for_educators.aspx)
It is recommended that completing forms is considered even at the early informal stage in case future evidence is required, and to act as a basis for the management plan.

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.

All documentation is subject to the requirements of the Data Protection Act and the Freedom of Information Act (FOIA).

Supporting documentation

There are several publications providing guidance concerning support for doctors – particularly The New Doctor which sets out guidance on monitoring the progress of Foundation trainees. These can be found on the UKFPO website: [http://www.foundationprogramme.nhs.uk/](http://www.foundationprogramme.nhs.uk/)

11. Success Criteria

Effective management of doctors in need of support 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 patients, the organisation (i.e. HEE Wessex), for the individual doctor and for the team in which the doctor works. Ideally, success would mean the doctor returned to safe practice in their team. However, a successful outcome may also be that a doctor returns to safe practice in another team or organisation or that a doctor leaves a particular specialty or, rarely, medicine altogether.

Success for patients means:

The quality of their treatment and care is optimised by the support needs of individual doctors being positively addressed in a timely way.

Success for HEE Wessex means:

- Everyone feels competent and capable of dealing with doctors requiring professional support
- Educational Supervisors have a proper programme for their own development
- Proof of probity, efficiency and effectiveness i.e. robust and defensible practices (including documentation)
Wessex Framework for professional support

- There is evidence of early intervention
- Every Wessex 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 means:

- The individual doctor shows improved behaviour and/or performance
- The problem is resolved within a reasonable time-scale
- The doctor feels fairly treated and supported
- The doctor is better equipped with skills to deal with difficulties in the future with less support
- The doctor can make a successful change of career

Success for the team means:

- Patients are safe
- The pressure on the team is reduced or eliminated
- The team functioning improves

Revalidation

From April 2013 all doctors with a licence to practise in the UK will be required to undergo regular revalidation (5 yearly in the long term) to ensure they are up to date and fit to practise. The Postgraduate Dean is the Responsible Officer (RO) for doctors in training across the Wessex region and will make recommendations to the General Medical Council.

Revalidation will be linked to the ARCP/RITA process with additional information supplied by employers and doctors in training.

Doctors receiving additional support can still be revalidated and an ARCP outcome 1 is not an absolute prerequisite for revalidation.

Further details and information can be accessed via the HEE Wessex website:
http://www.wessexdeanery.nhs.uk/trainee_revalidation.aspx

12. 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.

Educational and Clinical Supervision are formal processes of professional support and learning which enable 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, educational and clinical supervision support some of the central requirements of clinical governance and are also central to educational governance.

The main roles of the Educational and Clinical Supervisors in relation to trainees are defined in Appendix A.
The management of doctors requiring professional support needs to be underpinned by clear governance arrangements. These include a quality improvement, control and assurance process, as well as risk assessment and risk management. 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 PSU with such doctors 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 process. An organisational risk register is currently being developed to ensure risks are identified, reviewed and managed appropriately.

Appendices

APPENDIX A: Roles and Responsibilities of Educators and others

**HEE Staff (HEES)**
- Postgraduate Dean
- Associate Postgraduate Dean
- Consultant for Professional Support
- Programme Manager

**GP School (GP)**
- Director of GP education
- Patch Associate Deans
- Programme Manager
- Training Programme Directors

**Hospital Trust (HT)**
- Director of Medical Education
- Foundation Programme Director
- College Tutor
- Educational Supervisor
- Clinical Supervisor
- HR

**Specialty (S)**
- Head of School
- Training Programme Director
- Programme Manager
- Specialty/College Tutor
- Educational Supervisor
- Clinical Supervisor
1) Clinical Supervisor (HT & S)

Usually Consultant or GP principal (but can be senior trainee, Trust Grade Doctor, 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 requiring professional support

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.

2) Educational Supervisor (HT & S)

The Educational Supervisor is responsible for ensuring overall progress of the doctor through training.

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

Responsibility for Doctors Requiring Professional Support

- 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 multidisciplinary 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 (Foundation Programme Director or Director of Medical Education) 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.

3) College Tutor (HT & S)

The College Tutor is appointed by a Specialty College but based in a Trust and is 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 Requiring Professional Support

- 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 in Specialty
Programme Director (GP, HT & S)

The Programme Director is appointed to manage Training Programmes at HEE local office level within a given specialty.

Responsible for allocation of STs to posts and training rotations, supervision of individual training programmes, regular formal assessment including ARCP process, problem solving and feedback on progress.

Responsibility for Doctors Requiring Professional Support

- 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 ARCP review
- Ensure that Professional Support 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 PGMDE Team (e.g. if implications for training programme and additional resources required i.e. Virtual Support Group, NCAS).

5) Programme Manager (GP, S & HEES)

The Programme Manager is employed by HEE Wessex to provide all of the administrative and practical management to the training programme. Responsible for organising and administering the ARCP process as well as recruitment to their specific training programmes.

Reports directly to the Business Manager and Postgraduate Dean.

Responsibility for Doctors Requiring Professional Support

- Provide advice and support as the first port of call for all those involved with managing doctors requiring professional support
- Act as a conduit for information feeding into and out of the Professional Support Unit
- Liaise directly with the Case managers and PSU team
- Attend Operational Panels as appropriate
- Ensure that all “unsatisfactory” ARCP and RITA outcomes are communicated with the unit
- Work with the TPD to manage the training rotation to accommodate doctors requiring a change of training unit wherever possible

6) Head of School (S)

Oversees, on behalf of HEE Wessex the activity and proper functioning of the Postgraduate School; liaises with the relevant College, Faculty or Specialty Advisory Committee; and supports the Programme Directors.

Responsibility for Doctors Requiring Professional Support

- 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 School, to raise awareness and learn from the case
Regional/Specialty Adviser

Appointed by College in consultation with HEE Wessex; may provide link between College and the HEE local office on education and training in the specialty but this role differs significantly between Colleges.

Responsibility for Doctors Requiring Professional Support

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

8) Clinical Tutor/Director of Medical Education (HT)

Appointed by Postgraduate Dean together with Trust; manages the educational contract between HEE Wessex 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 Requiring Professional Support

- 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 HEE Wessex on progress of doctors requiring professional support
- Should work closely with HR Dept on issues regarding doctors with difficulties, especially where patient safety may be compromised
- Should refer to the HEE local office those problems that cannot be resolved within the Trust
- Should involve Human Resources Department and invoke Trust procedures as required

9) Foundation Programme Director (HT)

The FPD works in a similar role to the DME but with particular responsibility for Foundation trainees. They must also work closely with CT/DME Head of Foundation School on all issues regarding Foundation Programme trainees.

10) Associate Postgraduate Dean (HEES)

Associate Dean with specific responsibility for Professional Support provides strategic lead and direct support to educators on matters concerning Professional Support, on behalf of the Postgraduate Dean.

Responsibility for Doctors Requiring Professional Support

- Develop, manage and inform on framework for dealing with such doctors
- 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 requiring professional support are appropriately trained and supported
- Provide advice to educators on individual doctors
- Assess and support those doctors who require specialist input at HEE level
Consultant for Professional Support (HEES)

Supports Associate Dean and acts as Case Manager to a proportion of individuals referred to Level 3 of the Framework. Responsible for further development of the framework and supervision of Case Managers.

12) Postgraduate Dean (HEES)

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

Responsibility for Doctors Requiring Professional Support

- Support and advice to Associate Dean for Professional Support
- Provide direct input to those cases where training may need to be terminated, or where appeals procedures need to be invoked

13) Director of GP Education (GP)

As for Associate Dean/Postgraduate Dean but sole responsibility for trainees in General Practice.

14) General Practice Patch Associate Deans (GP)

Patch Associate Deans are responsible for the management of Programme Directors and GP trainers in each patch. Appoint, approve and quality assure training placements.

Responsibility for Doctors Requiring Professional Support

- The Patch AD oversees and helps manage issues at Level 2 of the framework.

15) HR in a Trust (HT)

The HR department in a Trust or provider organisation will advise on the organisation’s policies and procedures and how to use them in managing the employment of an individual doctor, for example for disciplinary issues or management of sickness absence.

16) General Support Services

Doctors and dentists should be encouraged to access support provided by their employer, professional or other body. Many large employers offer their employees access to free counselling and advice services e.g. financial advice.

APPENDIX B: Role of external agencies (taken from their websites)

National Clinical Assessment Service (NCAS)

NCAS promotes public confidence in doctors and dentists by helping to address concerns about the performance of individual medical and dental practitioners. It provides confidential support in managing practitioners whose performance gives cause for concern. If a concern comes to light, the employer / contracting body, or indeed the practitioner themselves, can contact NCAS for help. Their aim is to work with all parties to clarify the concerns and make recommendations to help the practitioner continue to deliver a high-quality and safe service to patients.

NCAS, previously the National Clinical Assessment Authority (NCAA), was established as a special health authority in April 2001. In April 2005, the NCAA became the National Clinical Assessment Service (NCAS), part of the National Patient Safety Agency. On April 1 2013 it joined the NHS Litigation Authority.
The support which NCAS provides can range from advice over the phone, through more detailed and on-going support, to a full assessment of the practitioner’s performance. NCAS does not take the role of the employer, nor does it function as a regulator. It is established as an advisory body, and the referrer retains responsibility for the handling of the case throughout the process.

The functions of NCAS

NCAS’ principal functions, as set out in Directions from the Secretary of State for Health, dated 1 April 2005, are:

- supporting NHS bodies who are concerned about the performance of an individual practitioner
- providing advice, support and agreeing action plans in relation to practitioners referred to the service
- carrying out assessments and related activities or to arrange for any other persons to carry out any of those functions on its behalf
- assisting in resolving suspensions and exclusions by NHS bodies of practitioners and providing advice to NHS bodies who are considering the suspension or exclusion of a practitioner

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

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

The law gives the GMC four main functions under the Medical Act 1983:

- keeping up-to-date registers of qualified doctors
- fostering good medical practice
- promoting high standards of medical education and training
- dealing firmly and fairly with doctors whose fitness to practise is in doubt.

Protecting the public

The General Medical Council is the independent regulator for doctors in the UK. Its statutory purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practise of medicine.

The GMC controls entry to the medical register and sets the standards for medical schools and postgraduate education and training. It also determines the principles and values that underpin good medical practice and takes firm but fair action where those standards have not been met.
Wessex Framework for professional support

The GMC has strong and effective legal powers designed to maintain the standards the public have a right to expect of doctors. It is not there to protect the medical profession - their interests are protected by others. Its 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 practise medicine.

**Independence and accountability**

Patients' interests are best served by independent, accountable regulation. The GMC must be independent of government as the dominant provider of healthcare in the UK; independent of domination by any single group; and be publicly accountable for the discharge of its functions.

Independent, accountable regulation must:

- Put patient safety first
- Support good medical practice
- Promote fairness and equality and value diversity
- Respect the principles of good regulation: proportionality, accountability, consistency, transparency and targeting

The GMC was established under the *Medical Act of 1858*. The GMC is a registered charity in England and Wales (1089278) and Scotland (SC037750).

[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. Its policies range from medical ethics and public health issues to the state of the NHS. It guides doctors through their careers, promotes the medical and allied sciences, seeks to maintain the honour and interests of the medical profession and promotes the achievement of high quality healthcare.

The BMA is a trade union and professional association, standing up for doctors both individually and collectively on a wide variety of employment issues and, since the inception of the NHS, has been formally recognised for collective bargaining purposes within national negotiating machinery and by individual employers at local level. It works with other bodies to achieve its objectives.

Through research and publishing the BMA leads debate on key ethical, scientific and public health matters and awards grants to encourage individual research in medicine. It produces a wide range of journals, reports, books, guides and online products and services. It contributes to all stages of medical education from admission to medical school to continuing professional development.

The BMA provides guidance to General Practitioners and Practice Managers on how to effectively involve patients and the public in healthcare planning and delivery.

The BMA does not hold the register of doctors, regulate doctors or deal with complaints. [www.bma.org.uk](http://www.bma.org.uk)
Medical Defence Organisations

Medical Defence Union (MDU)

The MDU is a mutual, not for profit, organisation owned by its members. Established in 1885, it is the world's first medical defence organisation and has led the way ever since.

The MDU defend 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.themdu.com

Medical Protection Society (MPS)

The Medical Protection Society is the leading provider of comprehensive professional indemnity and expert advice to doctors, dentists and health professionals around the world.

MPS is a mutual, not-for-profit organisation offering 270,000 members help with legal and ethical problems that arise from their professional practice. This includes clinical negligence claims, complaints, medical council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal-accident inquiries.

Fairness is at the heart of how the MPS conducts business. They actively protect and promote the interests of members and the wider profession. Equally, the MPS believes that patients who have suffered harm from negligent treatment should receive fair compensation. MPS promote safer practice by running risk management and education programmes to reduce avoidable harm.

http://www.medicalprotection.org

APPENDIX C: Examples of Risk Assessment Criteria for Doctors Requiring Professional Support

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.
Wessex Framework for professional support

- 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

APPENDIX D: References and further reading


Current publications and national guidance


National Clinical Assessment Service (NCAS). http://www.ncas.nhs.uk/