

Remediation report

Report of the Steering Group on Remediation

Foreword

Whilst the vast majority of doctors maintain high standards it has always been the case that a small minority of doctors have caused concern about their health, conduct, clinical competence and capability, or a combination of these. Health and conduct issues are usually appropriately dealt with locally and when required by the regulator. Clinical competence and capability issues are similarly the responsibility of the employer, the practice and the regulator. However, these have proved far more difficult to resolve, particularly for doctors no longer in training. The focus of the report is therefore to address clinical competence and capability issues occurring in doctors no longer in the training grades.

Revalidation will provide a positive affirmation that licensed doctors remain up to date and fit to practise throughout their career. As part of the annual appraisal process doctors will need to demonstrate how they are meeting the principles and values set out in Good Medical Practice (GMP), the General Medical Council's (GMC) core guidance for doctors.

This guidance is based on the GMP Framework for appraisal. Revalidation is based on this guidance and will form the basis of a standard approach for appraisal. It will demand consistent processes for appraisal, including feedback from patients and colleagues. As such, it is expected that the new system will, over time, help to raise the quality of the medical workforce, by supporting doctors in continually updating their professional skills to deliver a service to patients. However, the new processes will inevitably identify some doctors whose competence gives cause for concern and for whom, if they are to revalidate, some form of remediation will be needed.

The Department of Health asked the Remediation Steering Group to look at how well remediation of clinical competence and capability issues works now in the NHS in England. We were asked to consider whether there are options for improving the way this is managed and delivered, so that doctors can access the support they need when they need it and patient safety can be assured. The Group had a great deal of first hand experience of tackling performance issues. We were also able to draw on both existing materials and research, as well as a survey undertaken especially to support this work.

We found that whilst there was much good practice in managing clinical competence and capability concerns, it was still an area that many employers and contracting bodies found difficult to manage. Providing suitable remediation packages was also challenging and was often difficult and very expensive. Indeed, it appeared that ignoring a problem until it became a crisis, sometimes seemed to be the easiest solution.

The Group developed a set of principles that should be followed when tackling poor performance:

- Patient safety should be paramount;
- Concerns about a doctor's practice must be addressed early, systematically and proactively in all healthcare settings; and
- The appropriate competent authority must take action where a concern is raised.

We considered the factors that will support or undermine how concerns are identified and dealt with through remediation. We developed some options for the future system and for how the complex issues around funding might be taken forward. We have identified a set of practical actions that organisations can take to reduce or prevent the need for intensive remediation or crisis management. Ministers will wish to consider which of the options they wish to explore further.

I have had the privilege of chairing the Steering Group on Remediation. I believe that this report sets out a practical way for improving the current situation. I would like to thank the Steering Group for their time, effort and commitment to taking this subject forward. I am pleased to present this report, which sets out the results of its work.

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Executive Summary

The topic of remediation is one of key interest to the medical profession. Although few doctors will have need to access a formal remediation programme during their career, for those that do their ability to get the help they need may well depend on where they currently work and the network of local support their medical director is able to access. The introduction of revalidation for doctors will provide a more structured on-going assessment of clinical performance based on doctors demonstrating they are meeting the principles and values set out in Good Medical Practice framework. This work has highlighted the need to ensure the approach to remediation is more structured and consistent.

The Department of Health sent out a questionnaire to every Trust and PCT in England in December 2009 to understand the scale of the problem and the approaches currently taken to tackling performance concerns. The survey revealed a wide range in how concerns are investigated and remediation delivered. There was also a wide variation in the scale of the problem being managed in each organisation. Respondents also put forward many ideas on how tackling performance concerns could be improved, including many things that NHS organisations could do locally.

In January 2010, the Department of Health established a Steering Group to consider remediation, focussing on managing competence and capability issues. Many members of the Group had considerable personal experience of tackling clinical competence and capability problems and were able to draw upon this experience as well as the Department of Health survey and other recent work in developing their ideas.

In looking at how remediation could be better managed, the Group made six broad recommendations.

- 1 performance problems, including clinical competence and capability issues, should normally be managed locally wherever possible;**
- 2 local processes need to be strengthened so as to avoid performance problems wherever possible, and to reduce their severity at the point of identification;**
- 3 the capacity of staff within organisations to deal with performance concerns needs to be increased with access to necessary external expertise as required;**
- 4 a single organisation is required to advise and, when necessary, to co-ordinate the remediation process and case management so as to improve consistency across the service;**
- 5 the medical Royal Colleges to produce guidance and provide assessment and specialist input into remediation programmes;**
- 6 postgraduate deaneries and all those involved in training and assessment need to assure their assessment processes so that any problems arising during training are addressed.**

Associated with each of these recommendations are a number of points describing what needs to change. Some of these points are in fact already requirements for those NHS organisations employing doctors, but it would appear they are not always routinely happening. For example, there is already a requirement for the medical director and the human resources director to work in partnership when they are determining the course of action to be taken where there are concerns about a doctor's performance, but the Group noted that there were many instances where this did not happen, especially in the early stages, leading to more complexity and cost in resolving performance problems.

Prevention, as far as possible, was seen by the Group to be as important as improving the way that performance problems are remediated. There is much that organisations can do locally to minimise the occurrence of poor performance and the need for remediation. Good processes that deal with concerns as they arise and systems that support doctors to address their problems have been shown to minimise the need for exclusion and a full remediation programme.

Whilst not in the original terms of reference, the Group heard clear messages from employing and Doctors' organisations that funding for remediation should be more equitable. Currently, most doctors in secondary care have their remediation funded by their trust. Doctors in primary care often make a financial contribution to their own remediation. The Group recognised that there was unlikely to be any new money for remediation and developed a number of ideas for how more equity might be achieved. These will need to be investigated further to determine their feasibility and practicality.

Chapter 1 Introduction

- 1.1 Patients rightly expect their doctors to remain up to date and fit to practise throughout their career, and capable of undertaking the job they are currently doing. The great majority of doctors expect no less of themselves. However, despite a long and intensive training, there are occasions when some doctors develop clinical competence and capability problems and are no longer able to continue in independent practice. Getting doctors back to full and unsupported medical practice is the aim of remediation. However, whilst the ambition will be to get the doctor back to their previous role it must be recognised that this will not always be possible. Patient safety will always be paramount.
- 1.2 Representatives of the medical profession told the Department of Health that they felt the way remediation was currently being managed and dealt with across the NHS in England was variable. The need for a good and consistent approach to remediation is independent of the new regulatory process of revalidation that will be introduced by the GMC for all licensed doctors. However, improved clinical governance and the more robust annual appraisal processes which will underpin revalidation may well mean that, at least in the short-term, more doctors are identified who have a clinical competence and capability issue, and are in need of remediation.
- 1.3 In January 2010, the Department of Health set up the Remediation Steering Group to help develop some options for how remediation could be more effectively organised in the future. The Group consists of representatives from the medical royal colleges, postgraduate deaneries, employers, patient groups, defence organisations, the British Medical Association (BMA) and regulators, most of whom have extensive experience of dealing with performance issues. The terms of reference for the Group are set out in Annex 1.

1.4 Remediation is an issue that has been reviewed recently by a number of organisations including the Department of Health, National Clinical Assessment Service (NCAS), the Academy of Medical Royal Colleges and the Royal College of GPs.

1.5 The Department of Health published the Tackling Concerns Locally (TCL) clinical governance sub-group report¹ in March 2009. This set out 12 principles that should underpin the approach to remediation for health professionals. These are:

1. Remediation must ensure the safety of patients and the public while aiming to secure:
 - the well-being of the healthcare professional and the wider team;
 - the robust delivery of services based on agreed patient care pathways; and
 - consistent competence of the healthcare professional across scope of practice.
2. There should be lay and patient input into the quality assurance and delivery of remediation.
3. Primary Care Trusts (PCTs) and healthcare providers should maintain an available and accessible, quality assured process of remediation for all professional groups.
4. Decisions on remediation should be based on evidence using validated tools for assessment of performance, conduct and health.
5. Remediation should be personalised to the individual healthcare professionals and their learning style.
6. Remediation should be of high quality.

¹ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_096492

7. The performance of the professional during and following remediation should be monitored by quality assured methods.
8. The work environment for remedial placement should include adequate, quality assured supervision by a named individual.
9. There should be training and support for the whole clinical team working with the professional undergoing a remedial placement.
10. All those involved in the remediation process should uphold the NHS commitment to equality and recognition of diversity.
11. Remedial training and reskilling must be adequately resourced.
12. Healthcare organisations to define success criteria & learn from experience.

1.6 The Steering Group broadly agreed with these principles, which are set out in full in Annex 2. However, it was clear to the Group that these principles have not been widely adopted by the NHS in England and that in practice some of them would be difficult and expensive to achieve.

1.7 Some research was undertaken to support the TCL work but it was limited in scope, geographical coverage and sample size. However, it did highlight some inconsistencies in the way remediation was delivered. To better inform future policy options it was decided more detailed information was needed from NHS organisations across the country. A new survey was designed, tested and circulated in December 2009. This provided a more comprehensive picture of what was happening across England.

1.8 The findings from the Department of Health remediation survey, and the TCL report along with other recent work on remediation, helped to inform the thinking of the Remediation Steering Group.

- 1.9 On 12 July 2010 the Government published its White Paper: 'Equity and Excellence: Liberating the NHS'. This set out how power would be devolved from Whitehall to patients and professionals.
- 1.10 As the quality of information made available to patients improves, it may be that clinical competence and capability issues amongst doctors are highlighted.
- 1.11 The Remediation Steering Group focussed on how clinical competence and capability issues for qualified doctors currently in clinical practice in England could be better managed. The Group was not required to look in detail at doctors in training, because there is already a process of remediation through the deaneries. The Group did not examine what could happen in the private sector or for doctors working in non-clinical areas (for example medical management, academia or the pharmaceutical companies). These aspects could be explored in the future, although the processes may well be very similar.

Chapter 2 Steering Group

- 2.1 The Remediation Steering Group was established in January 2010 to look at how remediation might be more effectively managed. The group had a broad membership including employers, human resource departments, deaneries, medical royal colleges, SHAs, PCTs, the BMA, the GMC, the Revalidation Support Team (RST), defence organisations, patient groups, and National Clinical Assessment Service (NCAS). Members of the Group were selected for their direct experience of dealing with doctors with performance difficulties and of instigating or managing remediation programmes. The Group's remit was confined to looking at the provision of remediation in England. The Welsh Assembly, Scottish Government and Northern Ireland Department of Health, Social Services and Public Safety (DHSSPS) attended the meetings as observers.
- 2.2 A number of previous reports and research into remediation provided the background material that informed the discussions of the Group. A survey undertaken specifically to inform this work gave a picture of the current situation in England. This included the views of medical managers about how things might be improved. These are described in chapters 4 and 5.
- 2.3 The Group met on four occasions and worked in a variety of ways including formal presentations, facilitated discussion and small group brain-storming. An early task was to map out the current process and personnel involved from first raising a concern about a doctor and the many entry and exit points in remediation (see Annex 3). The Group noted that although there were very many ways that clinical competence and capability concerns might be raised, the most usual ways were through peers raising concerns and Serious Untoward Incidents (SUI). In thinking about options for the way forward in managing the remediation process, the Group were mindful of the financial climate and the fact

there were unlikely to be new resources. The conclusions and recommendations from the Group are set out in chapters 7 and 8.

Chapter 3 Remediation

- 3.1 What is remediation? Dictionary definitions vary, but at its simplest it is an action taken to remedy a situation. In relation to healthcare professionals, the Tackling Concerns Locally report published the following definitions, which the Steering Group took as its starting point:

Remediation: the overall process agreed with a practitioner to redress identified aspects of underperformance. Remediation is a broad concept varying from informal agreements to carry out some reskilling, to more formal supervised programmes of remediation or rehabilitation.

Reskilling: provision of training and education to address identified lack of knowledge, skills and application so that the practitioner can demonstrate their competence in those specific areas.

Supervised remediation programme: a formal programme of remediation activities, usually including both reskilling and supervised clinical placement, with specific learning objectives and outcomes agreed with the practitioner and monitored by an identified individual on behalf of the responsible healthcare organisation.

Rehabilitation: the supervised period and activities for restoring a practitioner to independent practice – by overcoming or accommodating physical or mental health problems.

- 3.2 The focus of the Group has been to review how clinical competence and capability issues are dealt with currently, how they could be in the future and how the remediation of doctors should be managed and options for funding. The Group recognised that clinical competence and capability problems may be the result of health or behavioural problems. Health issues should always be dealt with as a priority. Behavioural issues are primarily the responsibility of the employer and should normally be handled through the organisation's human resources and disciplinary procedures. Clarity about which process is being

deployed is necessary at the outset and senior human resource advice is required.

- 3.3 The Group acknowledged that the word remediation had negative connotations and looked to find an alternative word that might be used instead. This was not achieved largely because the problem is more related to negativity about the actions and processes that arise from a need for remediation, rather than the word itself.

Chapter 4 Development of the current system

- 4.1 It is said that 2-3% of doctors at any one time may have some sort of clinical competence and capability issue, although there is only limited evidence to support this. The only detailed study into this was done in 1994 by Sir Liam Donaldson who looked at doctors in the North East of England². This found that 6% of all medical staff were involved in some type of disciplinary problem over a five-year period and of these 40% arose largely from clinical competence and capability issues.
- 4.2 Concerns about the processes used to identify and tackle these doctors have been well documented. *“Supporting doctors protecting patients”*³ was published by the Department of Health in 1999. It highlighted a set of weaknesses that were inherent in how performance issues were being addressed:

- major problems often surface as a serious incident when they have been known about in informal networks for years;
- over-reliance is placed on disciplinary solutions to problems late in the day, whilst mechanisms to produce earlier remedial and educational solutions are particularly weak. Often the human resource function is not involved until disciplinary proceedings are unavoidable;
- NHS trusts and health authorities are often deterred from taking action because the disciplinary processes are regarded as daunting and legalistic;
- there is no clarity at local level about the interface between GMC procedures and NHS procedures so that there is confusion about who does what and when;
- mechanisms to identify and help sick doctors are unsatisfactory;
- in the past, too many problem doctors have been moved on to become another employer’s problem rather than being dealt with; and
- the timescales for dealing with serious problems can be very protracted and often last months or even years.

Source: Supporting doctors protecting patients 1999

² Doctors with a problem in the NHS workforce BMJ 94; 308:1277

³ Supporting doctors, protecting patients DoH 1999

4.3 The report analysed the impacts of the existing processes for dealing with the poor performance of doctors:

- they do not provide proper protection for patients;
- they are not always fair to doctors;
- they are cumbersome and costly to operate; and
- they do not work in support of NHS organisations in their role of delivering high quality health care to the public.

Source: Supporting doctors protecting patients 1999

4.4 It also identified a set of criteria against which the success of any changes might be measured:

- reduction in numbers of patients experiencing harm or sub-optimal outcomes of care due to poor practitioner performance;
- doctors with competency, conduct or ill health problems recognised at a much earlier stage than at present;
- Doctors willing to report their concerns about colleagues;
- confidence of public and patients that the doctor who treats them is well trained, highly competent and up-to-date in their practice;
- patients not put at risk or denied a response to their concerns because the system is finding it too difficult to assess or decide how to resolve problems with a doctor's practice;
- the workings of the regulatory bodies fulfil explicit criteria, easily understood and publicised;
- widely accepted statements on standards of conduct, performance and ethics primarily aimed at the protection of patients;
- a strong effective partnership between the NHS and medical professional bodies to prevent, recognise and deal with poor clinical performance;
- protracted, expensive disputes with uncertainty about how to resolve serious problems a thing of the past; and
- benefits for doctors in the availability of well targeted continuing professional development and support.

Source: Supporting doctors protecting patients 1999

4.5 The report recommended setting up an Assessment and Support Service with a number of centres around England, run jointly by the NHS and the medical profession. This idea then evolved into the establishment of the National Clinical Assessment Authority (NCAA) as a Special Health Authority in 2001. This was

announced in “*Assuring the Quality of Medical Practice*”⁴. The NCAA became the National Clinical Assessment Service, NCAS, in April 2005. It is a legal requirement for NHS health-care providers to contact NCAS when they are considering excluding a doctor from work. NCAS also provides an advice and assessment service to the NHS about any doctor where there are performance concerns. This is currently free at the point of delivery. Further details of the way that NCAS works are set out in Annex 4.

- 4.6 Since the publication of “*Supporting doctors protecting patients*” a number of other important changes have been introduced that have affected the way that performance issues are identified and dealt with.
- 4.7 Annual appraisal became a requirement for all NHS doctors in England in 2002/2003. Whilst essentially developmental in nature, appraisal discussions can surface issues about areas of work where there are competency problems, and where action needs to be taken. Personal development plans should include actions to remedy any minor performance issues.
- 4.8 In 2005 “*Maintaining High Professional Standards in the Modern NHS*”⁵ was published. This set out a framework to guide employers of doctors which covers:
- action to be taken when a concern about a doctor or dentist first arises;
 - procedures for considering whether there need to be restrictions placed on a doctor or dentists practice or suspension is considered necessary;
 - guidance on conduct hearings and disciplinary procedures;
 - procedures for dealing with issues of clinical competence and capability; and
 - arrangements for handling concerns about a practitioners health.
- It was developed and agreed at a national level by the Department of Health, the NHS Confederation, the British Medical Association and the British Dental Association and applies to the NHS in England.

⁴⁴ Assuring the Quality of Medical Practice DoH 2001

⁵ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103586

- 4.9 *Maintaining High Professional Standards* is embedded into doctors' terms and conditions for those working in secondary care and for those employed by primary care trusts. These organisations are obliged to use the framework to develop their own policies, procedures and guidance for managing performance concerns and remediation. The Performers List Regulations 2004⁶ set out the actions that a PCT must take when it is considering suspending or removing a contracted GP from its list whether for performance concerns or for other reasons.
- 4.10 In both primary and secondary care NCAS is a resource that the NHS can and does draw upon, although there are a number of other organisations that have also developed a role in remediation.
- 4.11 Although their main remit is doctors in training, postgraduate deaneries offer some support to registered GPs and primary care trusts through continuing professional development (CPD) programmes. A few deaneries also offer some level of support to doctors not in training but who are in difficulties. Some have confidential help-lines for doctors with health related problems. However, there is no formal basis for them doing so and no specific funding for supporting doctors not in training. Therefore, any remediation activity depends on the personal support of the Dean.
- 4.12 The medical Royal Colleges set standards and many colleges have assessor pools that carry out reviews of poorly performing teams. They provide advice to employers on standards and courses, but most do not engage directly in remediating individual doctors. However, the Royal College of Surgeons England and Royal College of Obstetricians and Gynaecologists do support employers in designing and implementing the clinical elements of further training

⁶ <http://www.legislation.gov.uk/uksi/2004/585/contents/made>

and return to work programmes where this has been recommended for an individual doctor following a formal performance assessment.

- 4.13 Medical defence organisations represent individual doctors. They seek to ensure that a member who is facing some sort of proceedings in relation to their professional work is fairly treated and so support doctors in achieving a reasonable outcome. Where members are deemed to present a high level of risk the defence organisation itself may ask them to undertake specific training, which they will have to fund themselves. Some medical defence organisations offer educational courses, open to both members and non-members, particularly focussing on behavioural and communication issues.
- 4.14 The GMC focuses on fitness to practise. A doctor may be required by the GMC, through a fitness to practise process, to undertake a course of remediation as a condition of remaining on the register. The responsibility to ensure that the remediation happens rests with the doctor and they are re-assessed after any remediation as a pre-cursor to returning to full independent practice.
- 4.15 There are two aspects to the BMA's involvement in helping doctors where concerns have been raised:
- *Doctors for Doctors* provides confidential counselling for doctors who are facing difficulties, including GMC issues; and
 - The BMA also offers a service to advise and support those doctors who have contractual difficulties.
- 4.16 The current strategic health authority structure can provide some support to medical directors who are dealing with doctors causing concerns.

Chapter 5 Is remediation working?

- 5.1 Despite the many changes that have taken place since 1999, concern was expressed to the Department by groups representing doctors, including the BMA, individual colleges and the Academy of Medical Royal Colleges, that the approach being taken to providing remediation was not consistent. The perception was that despite setting up NCAS, which assists organisations with assessments and remediation of the most severe cases, many of the underlying weaknesses appeared to be the same as they were in 1999. The success criteria that were identified in *Supporting doctors, protecting patients* as the requirements of a good approach to dealing with performance concerns had not thought to have been met. With revalidation about to be introduced, there is an urgent need for a process that is fair and equally accessible wherever a doctor is based.
- 5.2 There is a perception that low-level concerns may remain unaddressed for many years. This approach presents obvious risks to patient safety, and risks for the poorly performing clinicians who may not get the support they require until it becomes very difficult and expensive to remediate them. Even at the most severe end of the spectrum, where an organisation is considering excluding a doctor, there are perceived to be delays in the process..
- 5.3 Whilst there was much good practice, many organisations continue to struggle to recognise and deal with performance problems in a timely and effective manner and found difficulty in accessing appropriate remediation processes. There is a confused picture as to the services colleges and postgraduate deaneries provide. This confusion is thought to be extremely unhelpful, as is the difficulty in securing appropriate remedial placements.
- 5.4 The Department of Health England carried out a survey of NHS organisations in England between December 2009 to January 2010 to get a current picture of the

way in which all performance problems were managed and, if necessary remediated. The survey also attempted to assess the scale of the problem. A 50% response rate was achieved with a good coverage of all types of trust in most SHA areas. In total 75 primary care and community trusts, 93 acute trusts, and 30 mental health trusts responded. The respondent was usually the medical director or a senior medical manager.

- 5.5 With a 50% response rate, it was important to do some sort of quality assurance to check the general thrust of the response was representative of the total population of trusts and PCTs. The summary of the quantitative responses for each geographic area was returned to the relevant SHA for review. In all instances this review confirmed that the responses were in line with expectations. This enabled the total number of all doctors currently undergoing remediation in England to be estimated. In addition a large number of suggestions were made as to how existing processes should be improved. The survey is attached at Annex 5.
- 5.6 The responses confirmed a very varied picture across England as to how concerns were investigated and resolved. There was also variation in the use of different types of remediation processes and different sources of help.
- 5.7 Over 90% of organisations claimed that they had relevant policies and guidance in place. Over 90% of organisations were confident these were followed. This is in contrast to the situation described in 1999 in *Supporting doctors, protecting patients*, when only a few organisations had any such guidance.
- 5.8 The number of remediation cases with which any organisation was dealing, at the point the survey was returned, varied considerably from zero to more than 20.

Total number of current cases (at the time of the survey)

	PCT	Acute	MHT
Number:	260	212	27

In total respondents were dealing with 499 cases at the time of the survey.

Extrapolating from the 50% response rate these figures suggest that there could be about 1,000 cases being dealt with at any one time in England, covering all types of remediation.

Number of concerns actively investigated over past 12 months

	PCT	Acute	MHT
Number:	753	552	97

Over the past year the respondents reported that 1402 doctors had been actively investigated. Again, extrapolating from this figure, it would suggest around 2,800 doctors have been investigated, representing 2% of all doctors working in the NHS in England.

- 5.9 Less than 12% of organisations had any specific funds for remedial activities, although nearly 90% of them said that they would make some sort of financial contribution to the remediation of doctors. In acute and mental health trusts it is uncommon for a doctor to be expected to invest financially in their own remediation. Conversely, nearly 50% of PCTs may ask a doctor to make a financial contribution and a third reported they sometimes expected doctors to meet the entire cost. This may reflect the contractual status of a GP as compared with the employee status of a doctor in a trust.
- 5.10 Only one PCT, three acute trusts, and one mental health trust routinely chose to bring in external support to carry out an initial investigation into a concern. Provider organisations gained support in different way, including NCAS, postgraduate deaneries, medical Royal Colleges and independent companies and wherever possible, internal resources. A range of remedial approaches were used, the most common being mentoring and supervised placements within

the Trust or PCT area. Less than 33% of PCTs and mental health trusts used placements in other trusts. Under 50% of trusts and PCTs used returners' schemes as part of a remediation package.

5.11 A question was asked about the activities that staff in each organisation were trained to undertake. Most organisations had people trained to investigate complaints and assess what action was required. Trained mentors were available in 87% of mental health trusts, 80% of acute trusts and 57% of PCTs. However, only around a third of PCTs and mental health trusts had people specifically trained to provide supervised placements. Only 59% of PCTs, 41% of acute trusts and 27% of mental health trusts had staff trained to assess whether remediation was complete. Since this is an employer responsibility this is a significant issue. Nearly every trust in secondary care involved human resources when there were performance concerns. However, in primary care 33% of PCTs did not involve human resources staff or expertise.

5.12 In addition to the quantitative questions, organisations were asked to contribute ideas about what aspects of the system needed to change to deliver a better way of managing concerns and remediation. They suggested a need for much more consistency in identifying and tackling poor performance. There also needed to be clarity about the roles and responsibilities of different organisations that were active in supporting remediation.

5.13 Organisations thought that much could be done locally to improve the capability to identify and tackle concerns. Recruitment processes were not thought to be as effective as they should be in identifying candidates who had had performance problems in the past, or in picking up problems with new doctors.

5.14 Respondents felt there were still cultural barriers in reporting poor performance. The proposals contained in the recent consultation on Whistleblowing⁷ and

⁷ http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_120349

proposed amendments to the NHS Constitution should strengthen the protection given by organisations to whistleblowers. It would also strengthen the expectation placed on staff to raise concerns.

- 5.15 Organisations identified a need for clear internal processes and local guidance. Better performance data and clinical governance systems should help to produce objective evidence to both highlight concerns and aid review during the investigation of concerns. Training was needed for those dealing directly with the investigation of concerns, human resources departments and medical directors.
- 5.16 Organisations felt that a single point of external expertise would be helpful, given the relative rarity of clinical capability and competence issues. It would not be possible for every healthcare organisation to become expert in this complex area. The survey suggested that this service needed to be able to access a network of accredited placement hospitals and GP practices to provide supervised remediation placements. More details from the qualitative responses are set out in Annex 6.
- 5.17 Some other organisations also commented on remediation processes. The Academy of Medical Royal Colleges and the Royal College of GPs were concerned about equity of access to remediation in the context of revalidation. They had set up working groups to look at how the system might be improved.
- 5.18 The Royal College of GPs completed a short piece of work in autumn 2009⁸. The college supported the four stages of remediation proposed by Tackling Concerns Locally:
- Identifying issues;
 - Investigation;
 - Deciding on action; and
 - Remediation – re-skilling and rehabilitation

⁸ http://www.rcgp.org.uk/_revalidation/revalidation_documents.aspx

They set out how each of these might work in a primary care context. The paper proposed that the local primary care organisation (PCO) and deanery should share the cost of remediation themselves and the PCO should meet any other costs. Although currently GPs often contribute to the cost of remediation, the RCGP believed that GPs should be funded to the same extent as hospital doctors. Currently the RCGP does not offer direct support to PCTs dealing with remediation cases, although they are considering providing a practice review service.

5.19 The Academy of Medical Royal Colleges, which represents both medical royal colleges and faculties, set up a working group to consider the potential interrelationship between revalidation and remediation in 2008-09⁹. The group recognised that performance concerns had been unlikely to emerge for the first time at appraisal, but said that appraisers needed to be made aware of any concerns and that these should form part of the appraisal discussion. The group endorsed the principles for return to work set out in NCAS's guidance document *Back on Track*¹⁰ and the remediation principles set out in TCL. The group considered the direct role of colleges in the remediation of individuals would be limited. They felt there was a direct role for colleges in concerns relating to a team or department, but only an indirect advisory role in relation to individual cases on standards, courses and supervision.

5.20 The AoMRC group made four recommendations for further action on remediation:

1. The Departments of Health in the UK need to establish information about the existing provision of remediation;
2. The Department of Health in conjunction with NCAS should develop detailed guidance on remediation following the introduction of revalidation;

⁹ <http://www.aomrc.org.uk/introduction/news-a-publications.html>

¹⁰ <http://www.ncas.npsa.nhs.uk/publications/>

3. The Departments of Health in the UK need to explore and evaluate the potential impact of revalidation on remediation programmes; and
 4. The provision of remediation should be monitored, maintained, and quality assured to a level where it continues to support appraisal and revalidation.
- 5.21 In addition to its report on remediation the AoMRC produced a set of scenarios based on real cases, where concerns had been raised about a doctor's practice, and how these might be resolved.

Chapter 6 What does poor performance currently cost the NHS?

- 6.1 The Department of Health survey did not ask respondents directly about how much they spent on remediation. This was because very few organisations have a budget line specifically for remediation, or have attempted to quantify the full costs. Data was gathered about costs through follow-up interviews with Trusts and PCTs and from information provided by NCAS and the Welsh Assembly Government. The costs associated with dealing with a doctor with performance concerns could be very significant. An initial investigation could cost up to £20,000 per doctor. A placement in another organisation could cost around £60,000 for six months, excluding salary and accommodation costs. Increasingly organisations hosting placements expect to be paid and in addition, there are locum costs to backfill the doctor undergoing remediation.
- 6.2 The largest type of direct cost arose when a doctor had to be excluded from work. In 2009, 77 doctors in the UK were suspended by the GMC, but during 2009/10 about 108 were excluded by their NHS employer, pending GMC fitness to practice proceedings¹¹. Providing cover for excluded doctors is expensive. The cost of locum cover for such doctors could be up to £200k/doctor/year. This is in addition to the salary of the suspended doctor, which in primary care is often paid at 90% of the usual rate and at full cost in secondary care. Waiting for the GMC to reach a decision could push up costs significantly. The sooner problems are identified and successfully tackled the better – both in terms of reduced cost and successful outcome. Annex 7 sets out some indicative costs for remedial

¹¹ NCAS: Use of NHS exclusion and suspension from work amongst dentists and doctors - 2009/10 mid year report

interventions in primary care and has some case studies to illustrate the problems facing employers and contractors, and the costs involved in difficult cases.

The indirect costs of poor performance

- 6.4 Department of Health statistics show that about 500,000 patients a year are accidentally harmed in the NHS. The most common cause is patient accidents, such as falls, but there are around 140,000 incidents per year arising from treatments and procedures, or clinical assessment. Although there is no breakdown of why these are happening, some of these are caused by doctor error. 30,000 incidents lead to formal complaints and around 6,500 to litigation.
- 6.5 The NHS Litigation Authority (NHSLA) was set up as special health authority in 1995 with the principle task of administering schemes to help NHS bodies pool the costs of any loss of or damage to property and liabilities to third parties for loss, damage or injury arising out of the carrying out of their functions. All trusts and PCTs contribute to the NHSLA. In 2009/10 the NHSLA paid out £650,973,000 in clinical negligence claims. During that year 6,652 new claims were lodged with the NHSLA. Whilst by no means all of these claims can be attributed to doctor error, poor clinical performance is inevitably a factor in some cases and one with a very high cost attached.
- 6.6 Re-admissions may be an indicator of when medical care has not been achieved first time. According to Dr Foster in 2008/09 the NHS spent over £1.5bn on people being readmitted within a month¹². Reasons for this included being discharged too soon, or having an additional health problem that was not originally diagnosed. The costs of this can run into hundreds of thousands of pounds for an individual hospital, and in some hospitals readmissions amount to 10% of all admissions.

¹² Dr Foster Hospital Guide 2009

Chapter 7 Conclusions and recommendations from the Steering Group

7.1 The Group concluded that there were a number of key problems inherent in the current system:

- lack of consistency in how organisations tackle doctors who have performance issues;
- lack of clarity about where a personal development plan stops and a remediation process starts;
- lack of clarity as to who has responsibility for the remediation process;
- lack of capacity to deal with the remediation process;
- lack of clarity on what constitutes acceptable clinical competence and capability;
- lack of clarity about when the remediation process is complete and successful; and
- lack of clarity about when the doctor's clinical capability is not remediable.

7.2 In order to address these problems there are a number of actions that need to be taken which can be summarised in the following six recommendations:

- 1. Performance problems, including clinical competence and capability issues, should normally be managed locally wherever possible;**
- 2. Local processes need to be strengthened to avoid performance problems whenever possible, and to reduce their severity at the point of identification;**

- 3. The capacity of staff within organisations to deal with performance concerns needs to be increased with access to necessary external expertise as required;**
- 4. A single organisation is required to advise and, when necessary, to co-ordinate the remediation process and case management so as to improve consistency across the service;**
- 5. The medical royal colleges should produce guidance and also provide assessment and specialist input into remediation programmes;**
- 6. Postgraduate deaneries and all those involved in training and assessment need to assure their assessment processes so that any problems arising during training are fully addressed.**

These recommendations are expanded in the following paragraphs.

Performance problems, including clinical competence and capability issues, should normally be managed locally wherever possible.

- 7.3 Employers of doctors, PCTs and, probably in future, Clinical Commissioning Groups are to be responsible for ensuring that annual appraisals take place and that a personal development plan is agreed. They should manage remediation locally whenever possible. Conduct issues should also be handled locally using the local human resources procedures. The new post of responsible officer will have a key role in managing the interface with the regulator.
- 7.4 Dealing with issues locally does not just relate to the employing or contracting healthcare organisation. Crucially, the individual doctor has a personal responsibility for their conduct, clinical competence and capability and to:

- ensure that they are working to Good Medical Practice;
- working to the relevant specialty framework;
- meet any employment related standards for their current role;
- be honest about when they feel that they might have clinical competence and capability problems and seek early help and support; and
- engage constructively with their employer or contracting body when problems are identified.

7.5 All initial investigations should be carried out by the employer, practice or contracting body:

- health matters should be referred to occupational health or the relevant medical service;
- behavioural matters must be dealt with by the employer;
- clinical competence and capability issues should be dealt with locally in the first instance;
- regulatory matters should be referred to the regulator;
- any criminal matters should be referred to the police;
- there should be a consistent approach to providing remediation, locally delivered as far as possible, with active involvement, where appropriate, from 'expert' organisations.

7.6 The collective NHS has two main responsibilities whether as an employer or contractor of healthcare services:

- responsibility for patient safety, which is pre-eminent; and
- responsibility to support clinicians in meeting their personal responsibility to remain up to date and fit to practise.

Local processes need to be strengthened so as to avoid performance problems whenever possible, and to reduce their severity at the point of identification.

- 7.7 The Group recognised a large continuum of clinical competence and capability issues, from minor concerns that may be resolved through the annual appraisal and personal development plan process, to issues that require a very comprehensive training package and external assistance.
- 7.8 Organisations should put in place the following to reduce the risk of performance problems arising and where they do, to identify them at early stage:
- strong medical leadership;
 - strong human resource leadership;
 - effective recruitment procedures and processes;
 - robust annual appraisals and personal development planning;
 - consideration should be given to six-monthly review in the first two years following appointment to a career grade;
 - normal mentorship for the first two years for doctors newly recruited to career grade posts;
 - effective induction processes in place that include organisational ethos (including responsibility to raise concerns about colleagues' practice) and how performance issues are managed;
 - promotion of self-referral schemes.
- 7.9 Once a concern is raised, an organisation should:
- tackle concerns promptly, ensuring the primacy of patient safety;
 - fully assess concerns so that appropriate action is taken, following the relevant process;
 - fully involve both the human resources director and medical directors who should together lead the process;
 - follow an appropriate competent investigation process, including investigation into whether there are organisational issues that need to be addressed;
 - maintain good documentation and record keeping throughout the process;
 - provide as much information as possible to patients about the processes that are undertaken to resolve concerns that they have raised, whilst respecting

the appropriate confidentiality of the employee, in order that the patient is not lost in the process of investigating and remediating concerns;

- ensure the medical director/responsible officer and the human resources director work together to oversee the processes¹³, including reviewing whether there are organisational problems that also need to be addressed;
- make it clear to a doctor who requires remediation what they must achieve before they commit to a programme. This should include clear boundaries, the method to be used for remediation, how they will be able to demonstrate that they have been remediated, how and who will assess whether they have successfully completed the programme, and the proposed timescale;
- ensure that where a doctor causing concern has been recently appointed and promoted, the medical director / responsible officer will liaise with the relevant postgraduate dean to ensure there are no systemic failures in the deanery selection and assessment processes;
- ensure there is a clear exit strategy for any remediation case;
- ensure the remediation process remains as confidential as possible and practicable.
- The Group recognised that many positive initiatives have already been taken locally (e.g. the Wessex Insight project), to tackle clinical competence and capability problems. The approach taken in primary care across Wales gives certainty to GPs about what will happen if they are referred to NCAS and require remediation. This is described in Annex 8.

Capacity of staff within organisations to deal with performance concerns needs to be increased with access to necessary external expertise as required.

7.10 The Department of Health survey revealed that many organisations did not have staff trained to deal with all aspects of the process of remediation, from the initial investigation at the point that a concern is identified to the point of assessing

¹³ Maintaining High Professional Standards 2005 already mandates such an approach

whether remediation had been successfully completed. To deliver remediation an organisation requires:

- capacity at medical director, human resource director and clinical directors level;
- a pool of competent external investigators available to it;
- the role of responsible officers and their support teams to be closely linked with employers and contractors.

A single organisation is required to advise and, when necessary, to co-ordinate the remediation process and case management so as to improve consistency across the service.

7.11 There should be a single organisation to manage the process of remediation where it is not possible for an employer to do so, either because of the employers lack of experience or more likely, the complexity or the difficulty. This may need to include managing the assessment, retraining and reassessment. It could also include clarifying the funding arrangements, obtaining placements and co-ordinating Royal College input. The organisation would also give advice to employers, contractors and practices, and work to clarify the appropriate roles of other organisations. Clarifying the roles of different organisations in England so there is a coherent framework for managing the remediation of doctors is key to this process.

7.12 No new public organisation should be created to manage remediation processes. The detailed shape and governance of the organisation needs to be defined.

7.13 NCAS currently carries out some of the functions of the managing organisation. At the moment NCAS's services are free at the point of delivery. However, as a result of the Arms Length Body Review it will be required to become self-funding within three years. It may be that other providers will emerge who are equally

placed to carry out the role. They will need to demonstrate the requisite expertise.

- 7.14 In dealing with cases that the employing or contracting organisation cannot resolve on its own, the managing organisation should:
- provide expert advice to local organisations to facilitate wherever possible, the issue to be resolved locally.
 - develop a system for providing and accessing clinical remediation placements;
 - source a range of providers that can carry out remediation to an assured standard;
 - develop relevant relationships with colleges to provide specialist input;
 - establish the mechanisms by which it can be confirmed or not that after a programme of remediation a doctor has met the standard that is expected of them, and can return to full practice; and
 - advise on funding arrangements.

The medical royal colleges should produce guidance and provide assessment and specialist input into remediation programmes.

7.16 Few Royal Colleges currently provide full support to the remediation process. However, triggered by the revalidation process they are helpfully producing increasingly clear standards. This is of course in addition to their role in providing education and assessing clinical capability and competence issues through examinations.

7.17 To assure patient safety as well as to support their own members and fellows the Colleges all need to play a full supportive role in the remediation process (recognising that they are neither the regulator nor the employer/contractor).

- 7.18 The Colleges may also need to provide advice in supporting the remediation process.
- 7.19 There may be some issues that need to be resolved before all of the Colleges agree to take on this extended role. These include the handling of indemnity issues and the funding required to support the work. Some Colleges have made very considerable progress in addressing these issues and hopefully other Colleges can benefit from this expertise. The Academy of Medical Royal Colleges may have a useful facilitatory role in this regard.

Postgraduate deaneries and all those involved in training and assessment need to assure their assessment processes so that any problems arising during training are addressed.

- 7.20 One of the themes that recurred in the evidence reviewed was that some trainees have successfully completed their training placements despite there being unresolved performance problem involving clinical competence and capability. Clearly any problems arising during training need to be fully resolved prior to accreditation.
- 7.21 Postgraduate deans have been designated as the responsible officers for doctors in training. As such, they will need to have good exchanges of information with the responsible officer in the organisations where doctors in training are working and with those supervising trainees. In this way, any educational or professional/clinical performance concerns should be raised promptly and dealt with fully. As remediation or targeted training at an earlier stage improves there should be fewer problems later in a doctor's career.
- 7.22 Postgraduate deans and deaneries may be in a good position to assist in the sourcing of remedial placements for doctors not in training grades, particularly in primary care.

- 7.23 Postgraduate deans already supervise postgraduate training and oversee the remediation of doctors in training grades. In granting the CCT, they are providing an assurance that each doctor is clinically competent and capable.
- 7.24 Some deaneries offer advice about remediation for non-training grade doctors. This may, from time to time be helpful, but it is essential that any process should be well documented. It is particularly important that there is clear accountability for the advice offered and any decisions made about return to practise. Some Postgraduate Deans have been particularly helpful in assisting remediation processes, but they cannot act as the employer/contractor or the regulator.

Chapter 8 Funding Options

- 8.1 Although the funding of remediation falls outside of the Terms of Reference of the Group, it is an important issue that urgently needs to be resolved. In a time of constrained budgets, the case for funding any part of a doctor's remediation needs to be well made.
- 8.2 Medical training is expensive. Estimates of the total cost vary according to specialty, but a conservative estimate is £250,000 per doctor to reach the point of full registration, which for most doctors is followed by a period of specialist training. A very large sum of money has been invested in each doctor by the time they become a career grade doctor.
- 8.3 It is not just a question of cost. The time taken to qualify in a specialty is typically around 13 to 14 years after entry to medical school. We therefore have a highly trained workforce who cannot be easily replaced and a demand for doctors which historically has been hard to meet.
- 8.4 There are a number of reasons why employers have been prepared to invest in the remediation of doctors and will continue to do so in some way in the future:
- public money already invested;
 - time and cost of producing an equivalent resource;
 - workforce planning assumptions;
 - impact of recent legislation, particularly consideration of what constitutes discrimination.
- 8.5 Decisions on funding need to be fair and equitable and the investment in remediation should be proportionate to the likely outcome. Remediation is about getting back to independent practice, but not necessarily in the same role.

- 8.6 In some parts of the country, where it is traditionally hard to recruit doctors, employers have an added incentive to fund remediation. However, whether it is appropriate for employers to meet all the costs of remediation, particularly where these are substantial is questionable. There is strong evidence that where doctors have made some sort of personal investment in remediation they are more motivated to follow through to a successful conclusion. In North America it is usual for doctors to pay for both their own assessment and any remediation. In Australia and New Zealand it is the regulator that funds assessment, but clinicians that fund remediation. More information is set out in Annex 10.
- 8.7 When the Steering Group considered the options for funding remediation, they did so using the assumption that there was unlikely to be any additional money in the system. It also felt that some approaches such as money being held back for remediation by SHAs or the future NHS Commissioning Board, or Monitor were unlikely to work. The Group recognises that there is a need to explore any options in much greater detail. Therefore, it has put forward this series of possibilities for consideration and further investigation.

POSSIBLE METHODS OF FUNDING

Doctor meets all or part of the costs of their own remediation

- 8.8 Doctors often fund part or all of their own CPD. It might be reasonable to think therefore that doctors should be expected to fund all or part of their own remediation. Not keeping up with CPD might be a factor in the need for remediation so it is not unreasonable to think that an equivalent contribution should be expected to fund any required remediation.
- 8.9 If this option were routinely used, there might need to be mechanisms to allow some doctors to borrow the money they would need to fund remediation. This could be through a loan scheme, but it might need to be underwritten by the

State because doctors in this situation might be deemed high risk through normal commercial approaches.

Employer funds remediation

8.10 As described earlier in this section, there are a number of good reasons why employers and PCTs currently fund all or part of remediation. However, an open cheque book can bring its own problems. For example, no one would want to see the UK becoming an attractive venue for poorly performing doctors from overseas coming to the UK to access the support that is not available in their own country.

Doctor joins an insurance scheme/extension of indemnity provided by a medical defence organisation

8.11 There are no products currently available, but potentially there could be assistance with the funding for remediation, provided either through an insurance policy or as a benefit of membership of a defence organisation. Medical defence organisations and insurers may deem some doctors just too high risk to cover. Already, the cost of an indemnity premium varies considerably depending on the type of specialty that is practised. Currently, doctors employed in the NHS do not have to meet the costs of indemnity cover. Employers effectively do this, although the indemnity cover only applies for negligence. There might be potential for the employer and the employee to jointly pay into some form of pool, which might be insurance backed. However, this is likely to be resisted by both employer and employee, given the number of employees who might incur significant costs would probably be small and any insurance backed product could well have a prohibitively high premium.

Linking remediation to clinical negligence schemes

8.12 An option that could be explored is making a linkage between remediation and between the costs of remediation and the schemes run by the NHS Litigation Authority. The payments made to the Litigation Authority vary with the risk profile

of each organisation. There may be an opportunity to encourage robust organisation processes (e.g. recruitment, induction, clinical governance, dealing with complaints etc) by a sliding scale of fees.

Mutuals or subscription clubs

8.13 Mutuals could provide a way of funding and providing remediation in a cost effective way. Groups of organisations would enter into reciprocal arrangements with each other. These arrangements could be in terms of putting money into a pool, based on the number of doctors employed, or providing resources in kind (eg example training placements). A variant on this would be to set up a club on a subscription basis. Being a member of the club could gain you some sort of quality mark and could help to reduce your NHSLA CNST premiums. It would also gain you access to support from the managing organisation and appropriate college and deanery input. Such an approach might have attractions for the private sector too.

Contribution of the private sector

8.14 Whilst the Group did not look at the private sector in terms of access to remediation, the Group noted that currently the private sector does not make any contribution to the remediation of any doctors that worked for them who also worked in the NHS. This was something that the Group thought needed to change as the private providers were benefitting from the investment of the NHS.

8.15 It is for Department of Health to consider which of these options it wishes to explore further.

Chapter 9 Other considerations

- 9.1 The new role of responsible officer came into force on 1 January 2011. All designated organisations employing doctors, including all NHS and private healthcare providers, now have to appoint a responsible officer. The responsible officer will be accountable for managing the revalidation process when it is introduced. During 2011, the responsible officer will ensure that their organisation's clinical governance and appraisal systems are sufficiently robust to support revalidation and that there are clear processes in place for dealing with performance concerns. The designated organisations must provide responsible officers with appropriate support to carry out their functions.
- 9.2 Although most responsible officers are likely to be existing medical directors, a specific training package has been developed to help prepare responsible officers for carrying out their functions. This will be delivered from early 2011. It will provide an opportunity to help embed some of the actions proposed by the Group for improving local systems for managing the remediation of poorly performing doctors. In addition, all medical managers need training for their role as managers of other doctors. This includes training in the associated human resources and performance frameworks in operation in their organisation and in particular in regulatory and employment matters.
- 9.3 There will be occasions when, despite all best endeavours, it will be necessary to conclude that a trainee or a qualified doctor should no longer practise and that remediation cannot be achieved. The Steering Group believes that there needs to be more work with the GMC to agree how to improve the management of these situations.

Annex 1

Terms of reference for the Remediation Steering Group

- 1 To review and confirm the principles of good practice on remediation set out in the report of the Clinical Governance sub-group of Tackling Concerns Locally.
- 2 To review the research on the current approach to the provision of remediation for doctors in England and identify whether there is other information that needs to be collected.
- 3 To review evidence on the cost-benefit and value for money of early remedial interventions, at both the organisational, patient and individual doctor level.
- 4 To assess the demand for remediation including any potential impacts deriving from the processes underpinning revalidation, such as improved clinical governance and strengthened medical appraisal, and look at the potential cost and resources impacts.
- 5 To make recommendations on the models and structures for delivering remedial services in England.
- 6 To confirm that additional operational guidance is necessary for healthcare providers about how to identify the need for and ensure access to remediation for doctors, and to help develop the specification for commissioning the guidance
- 7 In taking forward its work, the Group will bear in mind the definition of remediation set out in *Tackling Concerns Locally*: “the overall process agreed with a practitioner to redress identified aspects of underperformance. Remediation is a broad concept varying from informal agreements to carry out some reskilling, to more formal supervised programmes of remediation or rehabilitation.”

Annex 2

Recommendations for the Tackling Concerns Locally Report

1. Remediation must ensure **the safety of patients and the public** while aiming to secure:
 - the **well being of the healthcare professional and the wider team**;
 - the **robust delivery of services** based on agreed patient care pathways; and
 - **consistent competence of the healthcare professional** across the entire scope of their practice.
2. There should be **lay and patient input into the quality assurance and delivery of remediation**. This could for instance involve a “lay champion” of healthcare professional performance at the level of the trust board. In addition, patients under the care of a professional undergoing remediation should be informed.
3. Primary Care Trusts (PCTs) and healthcare providers should maintain an **available and accessible, quality assured process of remediation for all professional groups** as an integral part of their local performance processes. A senior executive team member of the organisation should be responsible for the implementation and quality assurance of these processes and there should be regular reports to the board on the progress of individual practitioners. Self-referral by practitioners should be encouraged.
4. Decisions on remediation should be based on evidence using **validated tools for assessment of performance, conduct and health**. This would include assessment of behaviour at work, functioning in the clinical team, clinical competence, feedback from patients, assessment of the work and organisational environment, and any underlying health issues.
5. Remediation should be **personalised to the individual healthcare professionals and their learning style**, with explicit goals and timescales that are proportionate to the risks to patient safety. The possible need for a clinical placement away from the normal place of work should be considered. Resource needs, and the relative contribution of the healthcare organisation and the professional for funding, should be agreed out the outset.
6. **Remediation should be of high quality**. All involved in providing remediation should be competent in relation to the process as a whole and expert in their own field. There should be clear, accurate and comprehensive documentation of all processes and meetings. Processes should respect confidentiality both of patients and of the professional.
7. The performance of the professional during and following remediation should be **monitored by quality assured methods**, focussing on the attainment of

planned goals. A designated individual should be appointed by the healthcare organisation to oversee and support the professional, both during remediation and during the transition back to unsupervised practice at the end of the remediation process. The responsible person should regularly review whether the plan still adequately protects patient safety or whether other action (eg referral to the national regulator) is necessary.

8. The **work environment for remedial placement should include adequate, quality assured supervision by a named individual.** The environment should reinforce the values of patient centred care. The relative responsibilities of the placement supervisor and of the individual responsible for the general oversight of the practitioner (see principle 7) should be clearly specified, including an agreed system for reporting any concerns arising out of the placement.
9. There should be **training and support for the whole clinical team working with the professional undergoing a remedial placement**, while maintaining confidentiality over discussions between the professional and those responsible for oversight of the process.
10. All those involved in the remediation process should **uphold the NHS commitment to equality and recognition of diversity.**
11. **Remedial training and reskilling must be adequately and appropriately resourced.** Healthcare boards must have a senior member responsible for the resourcing and operation of performance procedures who can make the case for investment in remediation, including sufficient capacity for clinical placements. This will involve effective partnership working with postgraduate deaneries/higher education institutions approved by the relevant regulatory bodies, and with other local healthcare organisations.
12. Healthcare organisations should **define success criteria and learn from experience.**

Annex 3

Remediation journey

IN

1 Entry

i Triggers

- a. Monitoring clinical governance and audit data (and other relevant data)
- b. Police
- c. OH/GP (thresholds issues)
- d. Complaints etc
- e. Incidents
- f. Whistleblowing
- g. Peer review
- h. SUIs/SEA
- i. Revalidation/appraisal

ii Referrers

- a. Self-referral
- b. Colleagues
- c. Friends and family
- d. Employers
- e. PCTs
- f. ROs/MDs
- g. Medical examiner
- h. GMC
- i. Deanery system/ARCP
- j. Pharmacists/dispensers
- k. Counsellors
- l. Coroner's reports/Rule 43 letters
- m. Child protection services
- n. Social care cases
- o. Media
- p. Undertakers
- q. Schools
- r. PALs

EXIT

2 Scope the problem (most difficult problem)

- a. Context review
 - i. personal/non-personal
 - ii. Team environment/individual
- b. Identify manager

EXIT

3 Diagnostic process based on the medical model

- a. History
 - i. Personal
 - ii. Team environment
- b. Investigation
 - i. Health/clinical competence and capability/conduct?
 - ii. Is this person equipped for the job or not?
 - 1. OH (including cognitive assessment)
 - 2. Psychometric/behavioural issues
 - 3. Clinical performance
 - 4. MSF
- c. Diagnosis and prescribing

EXIT

4 Intervention (or not)

EXIT

5 Interventions (not necessarily linear)

Types of intervention

- Advice
- Education and training – including re-skilling
- Coaching – behavioural change
- Mentoring
- Supervision
- Placement
- Work based assessment/learning assessment
- Team based approaches (in isolation or with others)
- Return from ill health

Dependencies (policy environment a key factor):

- Resources
 - Capacity in all its constructs
 - Finance
 - Engagement of doctor
 - Insight of doctor
- Other identified factors (non personal)
- Institutional culture]
- Willingness to retrain doctor
- Need for 3-way contract between doctor/employer/provider

EXIT

6 Post intervention review

Needs to be an external review

Actions

- Post-intervention analysis of accumulated evidence (self-assessment included)
- Decision-making – not just either/or
- Doctor to collect evidence of progress
- Ongoing review of progress

Conclusions

- Final outcomes (several possible)
 - Back to same job
 - Back to adjusted job (new employer/role)
 - New job
 - GMC (involuntary out – at moment no honourable voluntary out)
 - Voluntary out

[Dependencies similar to interventions]

EXIT (possible re-entry)

Annex 4

National Clinical Assessment Service (NCAS)

NCAS was established specifically to help resolve concerns about a practitioner's performance for which organisations needed external support. It offers advice, specialist interventions and shared learning. In terms of direct support for individual practitioners NCAS receives around 900 referrals a year about doctors, dentists, and pharmacists. The majority of referrals are about doctors. With around 150,000 doctors and 30,000 dentists working in the UK, each year the performance of about one doctor in 190 causes enough concern to result in an NCAS referral. For dentists the one-year referral rate is about one in 290. (Pharmacists referrals are a new work strand and therefore it is too early to comment on the referral rate.) These figures have not changed significantly since NCAS was set up. About 1 referral in 17 leads to a formal NCAS assessment being undertaken.

The assessment process is an intensive examination of a doctor's practice. The validity and reliability of an NCAS assessment depend on sampling across a practitioner's practice using a wide range of instruments including:

- Occupational health assessment
- Behavioural assessment
- Review of information provided by the referring body and practitioner
- Records review
- Case based assessment
- Direct observation of practice
- Interview with the practitioner
- Feedback from colleagues and patients
- Review of the working environment
- Simulations (if necessary)

In addition to providing direct support to organisations, NCAS publishes a range of practical publications to help organisations deal with performance concerns effectively. Among these, *Back on Track*¹⁴ 2006 addresses the restoration of practitioners to safe practice and sets out seven guiding principles for employers in formulating their return

¹⁴ Back on Track NCAS 2006

to work programmes. NCAS also undertakes an extensive programme of education and training for the NHS.

Annex 5

The Department of Health would like your help in providing a full picture of how Trusts and PCTs are currently responding to the need for remediation measures when there are concerns raised about a doctor.

For the purposes of this questionnaire, "concerns" means concerns about a doctor's conduct, performance or health related issues. These "concerns" may come to light in a number of ways, for example raised by the doctor, raised by another healthcare professional, resulting from analysis of clinical information, or raised by patients or their relatives.

Remediation was defined by the 'Tackling Concerns Locally' Programme¹⁵ as the overall process agreed with a practitioner to redress identified aspects of underperformance. Remediation is a broad concept varying from informal agreements to carry out some reskilling, to more formal supervised programmes of remediation or rehabilitation.

The information you provide will help us to build a baseline picture of current remediation provision across England and what steps should be taken to ensure that all doctors have access to appropriate support when the need arises.

Completing the questionnaire will take approximately 15 minutes. Thank you so much for taking the time to contribute to this important exercise.

The first two questions focus on your organisation

1. My organization is a:

- **PCT**
- **Acute Trust**
- **Mental Health Trust**

2. My organization employs

- **0-50 doctors**
- **50-100 doctors**
- **100- 300 doctor**
- **Over 300 doctors**

The next set of statements focuses on how concerns are raised and dealt with initially

3. The Trust/PCT has a clearly defined process for health care professionals to follow when raising concerns about a doctor in this organisation.

¹⁵ Tackling Concerns Locally: report of the Clinical Governance subgroup, DH, March 2009.

- Yes
 - No
- 4. The Trust/PCT has developed a policy that describes the immediate action to take when a concern is raised about a doctor.**
- Yes
 - No
- 5. The Trust/PCT has guidance in place that helps managers to start to deal with a range of concerns.**
- Yes
 - No
- 6. I am confident that the Trust/PCT policy guidelines are followed when responding to any concerns raised by health care professionals about a doctor.**
- Strongly Agree
 - Agree
 - Slightly Agree
 - Cannot say
 - Slightly Disagree
 - Disagree
 - Strongly Disagree
- 7. Do you think that the existing appraisal systems for doctors within this Trust/PCT are sensitive enough to provide early identification of any performance, conduct or health issues?**
- Yes
 - No
- 8. Staff recruitment and selection procedures reliably identify any conduct, performance issues of doctors seeking employment within this Trust/PCT.**
- Strongly Agree
 - Agree
 - Slightly Agree
 - Cannot say
 - Slightly Disagree
 - Disagree
 - Strongly Disagree
- 9. The Trust takes swift action after a concern is raised about a doctor, if a risk is identified.**
- Strongly Agree
 - Agree

- Slightly Agree
- Cannot say
- Slightly Disagree
- Disagree
- Strongly Disagree

The next set of questions looks at how the concern is currently dealt with

10. How does the Trust/PCT carry out an initial investigation following concerns bring raised about a doctor?

- Internal resources
- Seeks external support from another specialist organisation

11. Following an initial investigation, and where further action is required, how does the Trust/PCT go about assessing what action is required?

- Internal resources, including HR
- NCAS
- Deanery
- Royal College
- Commission other external provider

12. Where a programme of remediation is identified as being necessary for a doctor, who provides this programme for your Trust/PCT?

- Internal resources
- Deanery commissioned programme
- Other external provider

13. What kind of remediation activities do you currently use in your Trust/PCT?

- Mentoring
- Returners induction schemes
- Supervised placements within your Trust/PCT
- Supervised placements in another Trust/PCT
- Deanery based schemes
- Other educational courses
- Healthcare support

14. How many remediation cases are you currently dealing with?

15. What future plans do you have for remedial services in your Trust/PCT?

Thinking about the funding of remediation in your organisation.

16. Do you have a dedicated budget for remedial activities in your Trust/PCT?

- Yes
- No

17. How are funds provided for the remediation of the doctor?

- Funds are found from within the Trust/PCT
- The Deanery pays for the remediation
- The doctor makes a contribution towards the remediation costs
- The doctor pays for their own remediation

Thinking about those within your organisation who are having to deal with concerns and remediation

18. Are people within your Trust/PCT trained to undertake:

- | | | |
|--|-----|----|
| • Investigation of complaints | Yes | No |
| • Assessing what action needs to be undertaken | Yes | No |
| • Provision of supervised placements | Yes | No |
| • Mentoring | Yes | No |
| • Assessing completion of remediation | Yes | No |

19. Is the HUMAN RESOURCES DEPARTMENT department actively involved in the process when a concern is raised about a doctor working in the Trust/PCT.

- Yes
- No

20. Is Occupational Health is actively involved in the process when a concern is raised about a health care professional working in this Trust.

- Yes
- No

We would like your opinions about important developments

21. In your opinion, what are the two most important developments that would improve the processes and outcomes for raising conduct, performance or health concerns about doctors in your Trust/PCT?

Enter your text in the space provided:

22. In your opinion, what are the two most important developments that would improve the Trust's processes for dealing with the remediation of doctors working in your Trust/PCT?

Enter your text in the space provided:

23. How many concerns have been actively investigated in your Trust over the past 12 months?

24. If you have any further comments about the issues in this questionnaire, or any issues that you believe have not been addressed, please outline your comments in the box below:

Enter your text in the space provided::

Name:

Organisation:

Thank you so much for taking the time to complete this questionnaire

Annex 6

Qualitative questionnaire ideas

Those that responded to the survey thought that there was a lot that they could do to improve patient safety and to improve their own systems by putting in place mechanisms to help identify problems early:

- improved human resources department processes, particularly at the primary care level;
- better documentation of concerns as they arise until their resolution;
- ensure that consultants were clear about their responsibilities as line managers;
- existing recruitment processes were highlighted by many organisations as inadequate in flagging up performance problems. Ideas to address this included:
 - asking for three previous appraisal summaries
 - psychological profiling of candidates
 - compulsory induction process
 - assessed probationary period;
- address cultural problems in raising concerns:
 - make it clear that all staff have a duty to raise a concern
 - protection for whistleblowers
 - organisations to have processes in place to ensure that concerns raised are taken seriously, and not dismissed because they come from more junior staff or non-medical staff; and
- try to de-stigmatise remediation:
 - reposition it by recognising that there will be times throughout most people's career when they will have a need to improve and update their skills
 - support and promote self-referral.

Lack of hard evidence was viewed as one of the main problems in the early and clear identification of performance problems. There was a need for:

- good benchmarking and quality data that could relate to individual clinicians;
- Improved clinical governance, including the development of outcome measures and monitoring of such measures; and
- For GPs having individual prescribing numbers would be a positive step. Currently, locums and many salaried GPs don't have their own number but use a partner or generic practice number.

Whilst opinion was divided about whether appraisal currently identifies poor performance, respondents felt that the introduction of a more consistent approach to appraisal in support of revalidation would routinely identify more performance problems. This needed to be linked to consistent follow-through by managers on the issues raised.

Tackling poor performance

Organisations recognised that their own staff needed to be better trained in tackling poor performance:

- specific skills training, for example how to conduct an investigation and mentoring;
- workshops for clinical directors and human resources department departments to reinforce the processes that need to be followed; and
- better alignment between medical management and HR management about how performance issues should be tackled.

Many of the external bodies that already had a role to play in remediation could do so more effectively:

- The BMA should be more available to members and liaise more closely with employers and PCTs when a concern is first raised;
- NCAS needed to be speedier, more accessible, and offer support services that do not involve a formal NCAS assessment;

- Response times from the GMC should be much faster;
- The Colleges should give a better service and provide clearer guidance about what represented unacceptable practice;
- The role of Deaneries should be strengthened, and dedicated resource available for remediation; and
- Occupational health services needed to be improved as the quality and clinical competence and capability was varied.

Respondents felt that there was a need for the development of regional expertise that organisations could call upon, as it was not cost-effective for them all to become experts in this area. This might take the form of lead hospitals and GP practices that could offer supervised placements, a pool of trained remediators, or remediation consortia being set up. Another suggestion was a network of investigating officers in each region that can be called upon as required.

It was felt that concerns should be classified, as should the approach that is taken to dealing with them, so that there is clarity about the pathway that will be taken to resolve them and which organisations will be involved. For low-level concerns, the emphasis should be on learning rather than punishment, but progress in addressing all concerns should be properly monitored.

Funding was an issue raised by many organisations. The lack of explicit funding was seen as a barrier to tackling performance concerns properly, both in terms of training staff to deal with it and in terms of access to suitable packages of remediation. Whether a doctor should contribute financially to their own remediation was not seen as so much of an issue as the fact that there was no clear central policy about whether they should do so or not.

Annex 7 – Indicative costs

Indicative costs for different types of remediation activities for GPs:

- Initial occupational health assessment by consultant specialist – circa £300
- Initial reviews- circa £2000
- Full diagnostic package including visits and preparation of the report and initial support: 1 to 1 ½ days = £1200 to £2000 (exact costs will depend on the variety of assessment tools used)
- Validated knowledge based test such as the Applied Knowledge Test which is part of the new certifying exam for GP s or Clinical Skills Assessment tests and Multiple Choice Questions this would cost an additional £400 – 500 per attempt.
- Additional support/mentoring meetings = £300 per meeting (lasting 2 hours including preparation time) or circa £2500 for a 3 month period involving 10 contacts.
- Remedial education (will depend on need eg tutorials, courses etc)
- Communication skills training circa £500
- Behavioural therapy through mentoring, role play and personal development would be variable.
- Re-assessment costs to determine improvements and if doctor or dentist is likely to be safe to practise
- Provision of placement in an advanced training practice is required in a small number of cases and has more financial significance. An example of such costs would be placement for supervised consultations with ongoing monitoring and reports. This would cost circa £15,000 for 4 months where an experienced clinician would be dedicating about 8 hours per week of their time + provide ongoing supervision and consulting surgery expenses etc.
- Training courses would incur variable costs, depending on their length and nature.

Source:
Wales Deanery

Case study: A district hospital in the north of England

“The case was prompted by a SUI report. This led to an inquiry within the hospital. It concluded that there was a case to answer by one of the doctors. The medical director then took advice from NCAS and the doctor was removed from out-of-hours duties. A locum covered the out-of-hours work over a period of two years with an associated cost of c£150,000. After the NCAS assessment it was agreed that the doctor should have a six month placement in a neighbouring teaching hospital. The trust paid for this at a cost of £50,000. The placement was successfully concluded, but on return the doctor felt the other consultants were hostile towards him and the doctor has now gone to a neighbouring trust on a six-month contract. After this he will have to return, or attempt to find a job somewhere else. The indirect management costs associated with this case have not been quantified. “

Case study: A PCT in the north of England

“There are a number of GPs in performance procedures who need to work in a practice where they can be supervised. At the moment the PCT funds this as there are severe recruitment problems in the area. Such GPs are paid at the lowest rate for GPs which amounts to about £90,000 per year with on-costs. Normally placements last three to six months. The clinical supervisors overseeing the placements feel they should be additionally rewarded and they are paid about £9,500 for six months. If the GP then needs to have a local action plan, this will require an educational supervisor (paid at training grant level), a mentor (£60/hr) and a PCT supervisor. The overall package for six months can be £75,000.”

Case study: A London hospital

“One doctor has recently been through a five-year programme, which has still not ended. There were issues around competency and behaviour. Eventually a placement was found for him at a neighbouring hospital. It was not a very good experience for them and they are unlikely to take anyone else from our hospital. Working with this doctor has cost us hundreds of thousands of pounds. There is another surgeon that we can't find anyone else to take. There needs to be a more formal system to take people for retraining.”

Annex 8 - Best practice examples

Welsh model

In Wales, when GPs are referred to NCAS or the GMC and have restrictions placed upon their practice and an action plan, this may include a placement in an advanced training practice. These are practices that have been rated as excellent in terms of the training they provide and that have trainers who have undertaken specialised training. The advanced trainer will be a dedicated resource for the GP in difficulties and will not be supervising trainees at the same time.

There are 18 ATP Practices and 33 ATP trainers. Money flows directly from the Welsh Assembly to the Deanery for the training of the trainers. A placement in an advanced practice usually last six months. The money for the placement will come from the Local Health Board (LHB) and/or from the doctor. The patients are told that there are being seen by someone who is re-skilling, but they are very carefully supervised so it seems to be accepted. In addition, the doctor will be expected to spend a day a week undertaking clinical audit or CPD related activities.

Regular monthly reports are made on each doctor under supervision. At the end of the placement the trainer makes a report to the LHB and to the Performers Group. If the conclusions is that they should not be working they are removed from the Performers List. If the assessment is satisfactory they go back into their practice.

The system normally works well and doctors are motivated to return to full practice. The same approach is also used for returners in primary care, this is deemed to be someone who has been away from work for at least two years. There is recurrent funding for a combination of UK returners and EEA inductees (up to a maximum of 9 at any one time) from the Welsh Assembly Government.

Tiered approach in a London hospital

The Trust takes a tiered approach to dealing with performance concerns:

- Low end – agree a care plan with the doctor.
- Medium severity - a structured learning contract must be committed to by the doctor.
- High-end more formal disciplinary procedures commenced.

Concerns are dealt with as they arise which means that very few need to be escalated to the GMC and fitness to practice procedures. Where people remediation it is usually repositioned from a disciplinary procedure to a supportive one to positively drive improvements. A pastoral philosophy underpins the way underperformance is managed, whilst ensuring that patient safety is the top priority.

Junior doctors in difficulty are looked after by the Deputy Director of Education and where necessary Deanery support is sought. A confidential service has been put in

place to encourage juniors to come forward where they think they have difficulties. Every six months the Deputy Director of Education makes a report to the Board about the outcomes of remedial interventions for junior doctors.

The medical director deals with consultant graded. Most cases are dealt with through local management, although on occasion it is necessary to seek an external placement.

The Trust believes that strong leadership is required to make remediation work. The medical director must make a record of soft intelligence so that it can be linked with hard data from of Serious Untoward Incidents (SUIs), complaints, other incidents and audits.

The routine analysis of SUIs and complaints is a really important part of managing performance. When there is a problem the Medical Director has an initial chat with those involved. If a lack of proper process in the system is identified, which exposes junior staff, the consultant in charge of that area will be given the task of resolving the process gap and given a learning contract to complete this.

Within the Trust there is considerable investment in medical leadership with a consultant leadership programme in place. This helps to create a supportive community with the long-term interests of the organisation at its heart.

A clear grievance and disciplinary policy is in place setting out exactly what will happen when. Everything is fully documented so that there is a clear audit trail. A medical workforce clinical manager is in post to manage the processes.

This very systemised approach has led to savings with most of the remediation either being provided through in-house mentors or through the organisational commitment to providing further education.

Wessex Insight

A proactive approach to performance issues has long been part of the way Wessex Deanery works. Through this it was recognised that a number of doctors in the area had in fact been struggling for some time. It was felt that something more was needed to support individuals to address their problems before they became formal performance matters. This has been taken forward through a virtual organisation "Wessex Insight". The LMC is prepared to fund 50% if doctor agrees to put in the other 50% so that they have both made some investment in the future. This fund covers brief non-health related interventions and covers both knowledge gaps and organisational matters such as time management, consultation skills and decision-making skills. There is a set format for the intervention, an assessment with the medical director followed by an educational assessment with the Deanery and then developing an action plan. An SLA is in place with the Deanery. "Wessex Insight" started on 1 April, and doctors are engaged in the process. Literature has been sent to appraisers, as it is felt that many of the problem areas are likely to emerge through the appraisal discussion. The scheme has been promoted by e-mail to individual doctors. The LMC will use income generated

through its appraisal contracts with the Channel Islands to fund this initiative. A cap of £2k per doctor is envisaged. The project will be evaluated on an on-going basis. A questionnaire has been developed for participants to be used at the beginning and end of the process.

Zero tolerance – a PCT in the West Country

“We have a relatively high number of concerns because there is a very good system in place to pick them up, including behavioural issues. Attitudinal problems are simply not tolerated. The PCT has a very low threshold compared with other areas and this has been confirmed through case reviews with neighbouring PCTs. There is some hostility amongst practices for the robust approach taken by the PCT, but a very good response from patients. Leaflets are sent out about how to raise a concern to all those who are joining the performer’s list. At the PCT level, there are clear policies and guidance which is followed when we investigate a concern, and the policies are frequently reviewed. Our approach is helped by the stable team at the PCT. If required the Deanery helps doctors to find suitable placements.”

Annex 9 - Practitioner Health Programme

In 2008, a pilot scheme called the Practitioner Health Programme was set up in London. It derived from the Chief Medical Officer's report on medical regulation *Good doctors, safer patients* (2006)¹⁶. The Practitioner Health Programme is a free and confidential service for doctors and dentists living or working in the London area (within the M25) and who are suffering from mental health, addiction or physical health problems that are affecting their work. These groups may face a number of barriers when dealing with health difficulties, particularly mental health and addiction problems. For example:

- the insight of sick practitioners into their condition and the impact that it has upon their performance may be severely compromised
- illness in practitioners may be poorly managed and appropriate assistance may not be sought for a variety of reasons
- practitioners may be able to disguise their illness from others (perhaps through self-prescription)
- where illness is recognised to adversely affect performance, there may be a reluctance to refer a practitioner into a system that is perceived as “disciplinary”, particularly where there is a lack of knowledge as to alternatives
- an excessively stressful work environment may have a significant impact on a practitioner's health and wellbeing.

Practitioners may not wish to access mainstream services for a variety of reasons, including an unwillingness to admit to illness, concerns about confidentiality, opportunities for self-medication and inappropriate treatment when they do access services.¹⁷ Studies show high rates of depression, anxiety and substance misuse in healthcare professionals, especially doctors. Suicide is higher in doctors and dentists than in the general population¹⁸. In the first year of operation the NHS Practitioner Health Programme helped more than three in four of the 184 clinicians seen by the Programme to stay in or return to work.

¹⁶ Good Doctors safer Patients

¹⁷ National Clinical Assessment Service (NCAS), 2007

¹⁸ Harvey et al, 2009

Annex 10 Approaches in other countries

- Canada and USA have a very different approach to managing the performance of doctors. Both countries not only have a system of state regulation but also a very tight set of rules connected with the appointment of doctors in hospitals. Contracts and clinical privileges are renewed either annually or biannually and a pre-scribed set of evidence needs to be produced in support of an application to continue practice within the hospital or to work there for the first time. Most doctors who work in the community also have some sort of hospital post.
- Assessment and remediation programmes are offered by a range of providers, both in the university and private sectors. It is usual for the doctors to meet the cost of any remediation programme themselves and for some or part of the assessment process
- The Vanderbilt distressed physicians programme is a well-established 5-day programme to help doctors learn to manage their workplace behaviour. It costs \$4000, following an assessment. The programme is run in other centres in North America and will be piloted this year by Oxford Deanery
- The Queensland Government in Australia has set up the the Clinician Performance Support Service (CliPSS) to provides support and advice for the management of concerns about the safe clinical practice of individual clinicians. CliPSS has been established as the primary referral pathway when there are concerns regarding patient safety as a result of job performance. It was designed as an alternative non-adversarial method for the management of serious clinical performance issues, but does not cover health related issues
- In New South Wales the Performance Program, was introduced in October 2000. The Medical Council of NSW aims to ensure practitioners' fitness to practise, and the Performance Program is central to this aim. The Program is designed to complement the existing conduct and health streams by providing an alternative pathway for dealing with practitioners who are neither impaired nor guilty of professional misconduct, but for whom the Council has concerns about the standard of their clinical performance. The program is designed to provide an avenue for education and retraining where inadequacies are identified, while at all times ensuring that the public is properly protected. It is designed to address patterns of practice rather than one-off incidents unless the single incident is demonstrative of a broader problem.

Annex 11

Remediation plans in the Devolved Administrations

Remediation support in Scotland for Doctors and Dentists

At the moment a service level agreement exists between the Scottish Government and NCAS to facilitate the provision of confidential assistance and independent advice, support and assessment to NHS Scotland boards in respect of medical or dental practitioners for whom performance concerns have been identified. This SLA has been operating since 2008, and is presently under review to ascertain if it remains appropriate for the future needs of NHS Scotland.

In preparation for medical revalidation, pilot activity to enhance appraisal of doctors is well-developed, including scoping what remediation support may need to be provided to support this process. The intention is to discuss emerging proposals at the SGHD-led Regulation event in October with a view to achieving consensus on such support to support enhanced appraisal systems in time for implementation in 2011 [DN need to update after the event].

NHS Lothian are currently undertaking a pilot project in Edinburgh in relation to remediation called "Tackling Concerns Locally". The purpose of the pilot is to test out an approach to the investigation and management of concerns locally with a view to producing a framework for use across NHS Scotland. This pilot is due to be completed in December 2010. However, an update will be provided at the Regulation event in October.

Wales

The Wales Revalidation Delivery Board is Chaired by Dr Jane Wilkinson, the Deputy CMO and reports to the UK Revalidation Delivery Board. The Board has been charged with developing four workstreams namely: appraisal, IT provision required for revalidation, Responsible Officer and Remediation and Rehabilitation. The latter workstream is led by Dr Sally Davies, SubDean (Performance) at the Wales Deanery. This workstream was established in October 2009 and received funding from the Wales Assembly government for the appointment of an executive officer.

The first phase involved stakeholder interviews across Wales, undertaking a literature survey of causes of performance issues in doctors and existing evidence for remediation, a survey of support available across the Health Boards and Trusts in Wales, and identification of best practice and gaps in provision. The work is regularly reported back to the Delivery Board. The next phase will be to undertake a pilot in Wales to complement those pilots already underway in England.

Northern Ireland

The Department of Health, Social Services and Public Safety (DHSSPS) is currently reviewing its guidance in relation to remediation and rehabilitation to reflect the revalidation process, the role of Responsible Officers and recommendations from the final reports of the Department of Health Tackling Concerns working group.

A key principle in the revision of this guidance and its implementation is that remediation and rehabilitation must ensure the safety of patients and the public while ensuring the wellbeing of the healthcare professional. In progressing this work, DHSSPS are committed to engaging with key stakeholders including doctors, Responsible Officers, the General Medical Council, and healthcare providers to ensure that changes in guidance will be successfully implemented and will be effective.