

REMEDICATION WORKING GROUP

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EXECUTIVE SUMMARY

- Patient safety should be the paramount consideration in any remediation programme
- The report is a response to the Department of Health's 2011 Remediation Report which recommended¹ that the 'medical Royal Colleges should produce guidance and also provide assessment and specialist input into remediation programmes'
- The principles in the Academy's 2009 remediation report² remain accurate and this report builds on that work
- Problems identified with existing remediation provision include failure to address concerns at an early stage, procedural errors and lack of clarity regarding availability of help from specialist organisations
- Eight Colleges have undertaken invited reviews which have involved a review of the work of a doctor in response to concerns or a review of a clinical service which identified a problem with the work of a doctor
- The Faculty of Public Health, the Faculty of Occupational Medicine and the Faculty of Pharmaceutical Medicine are Designated Bodies for the purposes of revalidation which presents a potential conflict of interests for their future involvement in remediation
- The Royal College of General Practitioners has until recently rarely been involved in the investigation of concerns about GPs or general practices, but is currently considering its future role in setting standards for the investigation of such concerns.

Key Recommendations

- Direct involvement of a College in remediation should be commissioned by a Designated Body and underpinned by an agreement covering indemnity and funding
- Colleges which provide invited reviews should agree a set of principles for the conduct and quality assurance of these
- Colleges should consider how they might provide more structured support for doctors following appointment to their first career grade post and to doctors who are appointed to a career grade post not having worked in the UK before
- Colleges should review their guidance and educational resources so that Designated Bodies can access them to support the remediation of early or low level concerns
- Colleges should consider how they might encourage and develop the role of senior doctors who provide supervision for peers undergoing remediation
- There is scope for using existing assessment tools in a formative sense to support programmes of remediation but there is not currently sufficient evidence to support their use in a summative sense to predict a doctor's future performance
- It will not always be possible for doctors to return to their original scope of practice, and Colleges should consider how they might support and advise doctors in this situation
- The report endorses the Revalidation Support Team's recommendation³ for Designated Bodies to pool expertise and resources, through regional Professional Support Units (PSUs), in order to facilitate remediation
- Future involvement of Colleges in remediation is likely to take place in partnership with other organisations such as the National Clinical Assessment Service (NCAS) via PSUs, particularly where complex interventions such as external placements are required
- Further work is required to define mechanisms and funding arrangements for remediation of doctors such as locums, doctors whose prescribed connection is to an independent healthcare provider and doctors with no identified prescribed connection.

1. BACKGROUND

The Academy of Medical Royal Colleges' first report on the remediation of doctors² was published in 2009. It considered how, in the context of revalidation, a need for remediation of a doctor's practice might arise, how this need might be met and who might be involved in the delivery of remediation. The principles for successful remediation set out in the report remain accurate and form the basis for this report. However, plans for the introduction of revalidation are now much further advanced than they were in 2009 and the Academy has been asked to consider in greater detail how the Medical Royal Colleges and Faculties might provide specialist input into remediation.

Sir Liam Donaldson's report on the revalidation of doctors, *Good Doctors, Safer Patients* (2006) recommended that a '*clear and unambiguous set of standards should be set for each area of specialist medical practice. This work should be undertaken by the medical Royal Colleges and specialist associations, with the input of patient representatives, led by the Academy of Medical Royal Colleges. This will enable the specification of good practice to be extended from the generic into each specialist field of practice (including general practice) and provide the basis for a regular objective assessment of standards*'.⁴

This recommendation was endorsed by the government white paper *Trust, Assurance and Safety* (2007), which also recognised that it '*is important that regulatory processes not only protect patients, but also have built-in mechanisms to help health professionals retain or regain their fitness to practise, when that is an appropriate and proportionate course of action*'.⁵

The National Clinical Assessment Authority (later designated the National Clinical Assessment Service - NCAS) was set up as a Special Health Authority in 2001 to advise organisations on the handling of doctors whose health, capability or behaviour in a professional context had given rise to concern and to provide a mechanism for the assessment of those doctors. *Good Doctors, Safer Patients* and *Trust, Assurance and Safety* both recommended that NCAS should maintain a prominent role in the rehabilitation of doctors where a concern had been identified. During its existence, NCAS has built up a large body of experience and expertise in the assessment of doctors whose performance has given cause for concern and it has published guidance on the principles of rehabilitation and remediation in its publication *Back on Track*⁶. The Department of Health's disciplinary framework for doctors and dentists in secondary care, *Maintaining high professional standards in the modern NHS*⁷ and Performers' List regulations place an onus on health care organisations in England to consult NCAS where concerns about the performance of doctors arise, especially where exclusion from work, suspension or restriction of professional practice is being considered.

A working party was set up by the Department of Health to take forward the recommendations of *Good doctors, safer patients* under the chairmanship of Professor Jenny Simpson. Its report, *Tackling concerns locally*⁸ endorsed the continuing role of NCAS in the assessment and remediation of doctors. The report also recommended that the Royal Colleges should have a role in the development of clinical indicators of the performance of doctors, and in the sharing of learning about the detection and management of performance, conduct and health issues in health professionals.

In 2010, the Department of Health for England (DH) commissioned a report on the remediation of doctors from a steering group chaired by Professor Hugo Mascie-Taylor. The group's remit was to examine the ways in which issues of clinical competence or capability are currently handled in England and to make recommendations on future models and structures for remediation. A key recommendation of this report was that *'the medical Royal Colleges should produce guidance and also provide assessment and specialist input into remediation programmes'*.¹

This report is therefore written against the background of an expectation that the medical royal colleges and faculties should be "part of the solution" for the remediation of doctors whose performance has given rise to concern.

2. REMIT AND OBJECTIVES

The Academy reconvened a working group in 2012 to consider the implications for the medical Royal Colleges and Faculties (referred to in this report as “Colleges”) of accepting the recommendation in the report of the Department of Health’s steering group on the remediation of doctors that ‘the medical Royal Colleges should produce guidance and also provide assessment and specialist input into remediation programmes’.¹

2.1 Terminology

Tackling concerns locally and the report of the DH Remediation Steering Group define the terms remediation, re-skilling and rehabilitation. This report uses the term *remediation* throughout, without making any assumptions of culpability on the part of the doctor whose practice is believed to require remediation.

2.2 Assumptions and exclusions from scope

- This report considers only the remediation of doctors who are not in specialty or GP training programmes. Doctors in specialty or GP training programmes are formally assessed against curricula which have been approved by the GMC. The Annual Review of Competence Progression (ARCP) process makes provision for additional targeted training where a trainee has not achieved all the required competencies for the stage of training under review. There is already specialty input to the ARCP process and Postgraduate Deaneries also have a variety of mechanisms for providing support for doctors in training who are in difficulty
- The Colleges are charitable bodies incorporated by Royal Charter, with responsibilities for setting and maintaining standards of professional practice in their respective specialty areas. It is not envisaged that the Colleges will become regulators of health care in the future
- The role of the Responsible Officer for a doctor whose practice is believed to require remediation is defined in the Medical Profession (Responsible Officers) Regulations (2010). Although a Responsible Officer may delegate certain roles and functions to other individuals or bodies, he / she retains overall responsibility for the process. This report therefore assumes that, where Colleges assist with aspects of the process of remediation for an individual doctor, they will enter into a contract with the doctor’s Designated Body which will include an agreement about indemnity and funding
- As noted in the Academy’s 2009 report on remediation, the safety of patients should be the paramount consideration in any plan for remediation.

3. PROBLEMS HIGHLIGHTED WITH EXISTING PROVISION FOR REMEDIATION

The report of the Remediation Steering Group commissioned by the Department of Health notes that many of the problems highlighted in 1999 by Sir Liam Donaldson in *Supporting doctors, protecting patients*⁹ still exist despite the availability of the services of NCAS and the existence of a considerable volume of written guidance on the detection and management of performance, capability, health and conduct issues in doctors. In particular:

- Low-level concerns sometimes remain unaddressed for long periods until they escalate into more serious problems, by which time the underlying causes have become chronic and difficult to remedy
- The process of investigating concerns may be marred by procedural errors, poor communication and delays which can result in the process becoming unnecessarily adversarial rather than supportive
- There is little clarity about the range of specialist help available from organisations such as the Colleges, and how such help can be obtained.

The report also highlights the need for adequate training capacity to permit the placement of doctors whose practice requires remediation. A consequence of this recommendation is that there is also a need to ensure that there is no detrimental effect on trainees and other staff in the unit where remediation of a doctor is taking place. If there is insufficient training capacity, there is a risk for instance that quality of supervision or opportunities for training in interventional procedures for existing trainees will be diminished as a result of a senior trainer having to devote attention to a doctor requiring remediation.

4. STATUS AND EXPERTISE OF THE COLLEGES

The Colleges occupy a singular position in the oversight of the work of the medical profession. They are professional associations, constituted by Royal Charter and charged with the responsibility of advancing the science and practice of their specialties for the benefit of the public. As repositories of specialist knowledge and expertise, they define and promote high standards of professional practice by a variety of means, such as examinations, published guidelines and scientific research. The Colleges are frequently called on to provide authoritative advice on specialty matters by the general public, health care commissioners and providers, regulatory bodies and the departments of health.

The Colleges cannot act as trades unions and they have not sought or been granted status as professional regulatory bodies through legislation. However, in some circumstances, health care regulators may delegate authority to Colleges to review the work of individual doctors, health care premises or training programmes. For instance, responsibility for setting training curricula and making recommendations on admission to the specialist or GP registers is undertaken by Colleges for the General Medical Council (GMC). Finally, the Colleges are charitable bodies, financed largely by subscriptions of members and as such, they have a legal obligation to manage their funds in a manner compatible with their charitable status, which includes a responsibility to minimise the risk of litigation.

It is against this background that any proposals for the Colleges to have a role in remediation need to be considered. This does not imply that Colleges should adopt an excessively risk-averse approach to involvement in remediation, but the extent of their involvement will be guided by the terms of their Royal Charters and their areas of expertise.

5. CURRENT PROVISION OF ADVICE BY COLLEGES TO DESIGNATED BODIES IN RESPONSE TO CONCERNS ABOUT THE PERFORMANCE OF CLINICAL SERVICES OR INDIVIDUAL PRACTITIONERS

The Colleges (with the exception of the Royal College of Surgeons in Ireland, the Royal College of Physicians of Ireland and the Faculty of Dental Surgery) were asked by the Academy in March 2012 to provide information about the number and type of requests they had received from health care organisations to review the work of clinical services or individual doctors in response to concerns. They were asked to indicate the benefits and challenges of reviews they had undertaken. They were also asked to indicate whether they had been involved in facilitating the remediation of individual doctors.

It was clear from the responses that the services provided by each College have been shaped by the number and nature of requests for advice that they received and the environment in which their members typically work. The Faculty of Public Health, the Faculty of Pharmaceutical Medicine and the Faculty of Occupational Medicine do not have mechanisms for reviewing the work of services or individual doctors. Many of their members are not employed directly by the NHS and tend to work individually or in very small teams. Where concerns have arisen about members of these faculties, they have usually resulted in referrals to NCAS.

Historically, most Postgraduate Deaneries have carried responsibility for the continuing education of general practitioners, although the structures and funding arrangements vary. Where concerns have arisen about a general practice or individual general practitioners that have not required referral to the GMC, it has usually been the case that the relevant Primary Care Trust (PCT) or Health Board has sought the help of the Postgraduate Deanery or its supporting structures, the Local Medical Committee, or a Professional Support Unit (in areas of the country where these have been formed as a collaborative venture between PCTs). As a result, it was unusual until recently for the Royal College of General Practitioners to become directly involved in the investigation of concerns about general practices or general practitioners. In response to an increased number of direct enquiries, the RCGP is currently considering setting benchmarks and standards for the investigation and management of concerns about performance.

The remaining Colleges (most of whose members are employed by the NHS in secondary care settings) receive variable numbers of requests for help from health care providers and have, in response to such requests developed mechanisms for invited reviews of clinical services using senior peers from outside the organisation. The scope of an invited review is agreed between the organisation and the College in advance, normally underpinned by an indemnity agreement.

Eight Colleges indicated that they have undertaken invited reviews which have involved a review of the work of an individual doctor in response to concerns, or had undertaken a review of a clinical service where it became apparent that there was a problem with the work of an individual doctor. Of these, six Colleges reported experience of facilitating a programme of remediation for a doctor, with very small numbers of cases in total. Where this has occurred, it has almost always been in conjunction with NCAS. One College reported that it had facilitated a programme of remediation for a doctor, who was referred to the GMC following an assessment at the end of the period of remediation. The doctor was subsequently allowed to return to work by the GMC and the College was taken to an employment tribunal by the doctor concerned.

Colleges report that the benefits that have arisen from invited reviews included:

- The ability to clarify issues and recommend solutions where internal investigations have failed to do so
- The ability to address wider system or clinical governance issues in situations where the initial concern had centred around an individual doctor
- The ability to identify potential threats to the safety of patients
- The ability to provide timely support and prevent a situation from deteriorating to the point where intervention of the regulator might otherwise have been necessary
- The ability to stimulate the development of a coherent vision for a clinical service
- A stimulus to improve team-working
- A clearer understanding of justifiable variation in practice
- Positive feedback from organisations and individuals involved in the review.

Although major problems (such as legal action against a College) appear to be rare, Colleges also reported a number of difficulties they had encountered with conducting invited reviews and facilitating remediation:

- The expectations of employers and doctors can be unrealistic, particularly in terms of the time required to put necessary changes into action
- It can be difficult to secure a commitment to a constructive solution when relations between doctors and employers are poor
- Conducting a review and producing a written report within a tight time frame is very demanding for reviewers who usually have heavy clinical commitments of their own
- Arranging clinical placements and supervision for doctors requiring remediation can be difficult and can place a heavy burden on a “receiving” department or practice, which may already have substantial existing training commitments
- Some organisations provide little feedback or fail to act on recommendations.

6. FUTURE INVOLVEMENT OF THE COLLEGES IN THE REMEDIATION OF DOCTORS

6.1 The NHS Revalidation Support Team's view

The NHS Revalidation Support Team has recently conducted a survey of Responsible Officers which includes questions about the number and types of performance issues they are currently seeing amongst doctors with whom they have a prescribed connection. At the time of discussion, the data from the survey had yet to be analysed fully, but early indications suggested that there are three main areas where Responsible Officers would particularly welcome input from the Colleges.

1. When a concern has been raised (for instance from clinical outcome data, a clinical incident or a complaint), it is very helpful for the Responsible Officer to be able to obtain an early opinion about whether the data is “within the range of normal for the specialty”, of possible concern or likely to be of serious concern, so that the initial response and investigation is proportionate to the level of risk to patient safety
2. Guidance on support to doctors where early concerns have been identified, and where there is no imminent likelihood of a referral to the GMC
3. Help with arranging external placements for retraining for a small minority of situations where it is impractical for support to be provided within the doctor's own workplace.

Where this is requested by Responsible Officers, College input on these issues is supported.

6.2 The Colleges' views

The Colleges were also asked by the Academy to give their opinions on ways in which they might play a part in the remediation of doctors in the future. The range of responses broadly reflected the previous experience of the Colleges in providing advice to health care providers outlined in the previous section.

All Colleges define and promote high standards of professional practice through education and training, published guidance and scientific research, and these standards will continue to be general benchmarks against which the need for remediation and the success of remedial interventions can be determined.

It seems likely that Colleges will continue to receive requests for invited reviews of clinical services following the start of revalidation, and those Colleges which already have mechanisms for invited reviews indicated that they plan to continue to provide this service. The Academy and its member Colleges are also in the process of training senior doctors to respond to requests for advice on specialty matters relating to revalidation and have defined standards for the provision of such advice. The experience of the Colleges is that only a small proportion of invited reviews identify a need for remediation of the practice of an individual doctor and even where this is the case, it is usually one facet of a wider analysis of a clinical service. Where the organisation commissioning the review agrees that there is a need for remediation, further work will be required to determine what type of support is required and how this might be achieved. Only six Colleges indicated that they have experience of facilitating programmes of remediation to date, with small numbers of cases, and in almost all cases, their involvement has been in partnership with NCAS.

Building on the experience from invited reviews of clinical services, Colleges identified a number of areas where they may be able to contribute to the process of remediation:

1. The point at which a doctor moves from a training post into their first career-grade post is a particularly important transition. A combination of new responsibilities, high expectations, and the absence of immediate supervision can combine to make it a lonely and stressful experience, however good the training which preceded the appointment. The transition can also pose dilemmas for the doctor's immediate colleagues if a problem arises. A laissez-faire approach may risk allowing the doctor to get into more difficulty, perhaps even putting the safety of patients at risk. On the other hand, over-reaction to an isolated error can hinder a doctor in developing the mature decision-making skills which are necessary to be a successful independent practitioner. This can be a difficult call, but even good doctors can get into serious difficulty at this point in their career and it is therefore vital that good peer support and mentoring mechanisms are in place.

Doctors who hold specialist qualifications from other European Union member states can be appointed to non-training posts in the UK having never worked in the UK before. They may face all the difficulties mentioned above, with the additional challenges of having to communicate in English as a second language and adjusting to significant differences in the way clinical situations are commonly managed from one country to another.

Employers have an important role to play in these situations by ensuring that induction processes are adequate and making provision for mentoring or coaching. The Colleges can also play an important part in providing educational resources targeted at this stage of a doctor's career. Mentoring is a generic skill for which training is widely available and a mentor does not necessarily need to belong to the same specialty as the doctor being mentored. However, coaching for the newly appointed career grade doctor implies that the coach will be available to advise on specialty-related skills. Colleges may wish to consider whether "training the trainers" programmes could be adapted or extended to include peer-coaching skills.

It is important to make the most of opportunities to prevent future performance problems.

2. For early or low-level concerns about performance, a need for remediation may be addressed by means of an intensified or targeted programme of CPD, which would normally be instituted, supervised and evaluated by the doctor's own organisation, principally through the appraisal process. Colleges can help by signposting access to existing educational resources such as seminars, e-learning resources, skills workshops, or published guidance.
3. Where a programme of remediation identifies a need for a doctor to work under clinical supervision to achieve or regain particular competencies or objectives, it is very likely that the clinical supervisor will be a peer in the

same field with acknowledged clinical and training expertise. Although the task of retraining a doctor who is no longer in a training post is generally regarded as more challenging than the task of providing clinical supervision to doctors in training, it is likely that many of the same attributes and competencies will be required for both situations. The Colleges already play a substantial role in the training of clinical and educational supervisors of doctors in training and Colleges may wish to consider whether “training the trainers” programmes and other educational resources could be adapted to include situations where a trainer may be providing supervision to a peer who requires clinical supervision.

4. It is vitally important that the goals of a programme of remediation are realistic. It is important to recognise that there may be occasions when it has to be acknowledged that remediation is not going to succeed and that continuation in current practise is not appropriate. Where an investigation or a programme of remediation has identified that it is unlikely that the doctor will return to their former scope of practice, there is likely to be a need for guidance on career development which may require a greater level of specialist knowledge than can be provided in a general mentoring process. Colleges could provide input at this point. Where a programme of remediation appears to be falling short of its objectives, it is necessary to review the reasons for this. Possible courses of action might be to terminate the programme (e.g. because of lack of engagement of the doctor), put in additional training resources, allow additional time or to accept that the original goals are unattainable and settle for more modest goals (e.g. a more limited clinical role). Colleges may be able to advise on setting and reviewing specialty-related training goals, though a summative judgement about whether the doctor can return to their original clinical role, or whether some form of on-going restriction of practice is required has to be made by the Responsible Officer (RO). The RO is also responsible for on-going monitoring of the doctor’s practice following remediation.

6.3 Assessment

The recommendation in the report on the remediation of doctors commissioned by the Department of Health that “the medical Royal Colleges should... provide assessment... [in] remediation programmes”¹ requires further comment. There are at least four senses in which the word “assessment” may apply to the process of remediation:

1. Following notification of a possible concern involving a doctor (where this is not serious enough to require immediate referral to the GMC), the Responsible Officer, as part of the initial investigation, may decide to commission an external assessment of the clinical service to which the doctor contributes. In this situation, an invited review by the relevant College may be helpful to establish whether there is genuine cause for concern and to provide a picture of the general health of the clinical service in which the doctor works. As noted above, the Colleges whose members are based mainly in secondary care environments already have experience of conducting this type of assessment.

2. Where a Responsible Officer has concerns about the performance of a doctor, it is necessary to make an assessment of the relative contribution of conduct, health and capability issues to the concern. Any or all of these elements may be present and it may be necessary to address them in parallel for the doctor to be able to continue safe and effective practice. NCAS has extensive experience of conducting this type of assessment in situations where the Responsible Officer requires external advice to assist with this task. The Colleges do not possess the relevant expertise for this type of assessment.
3. Where a deficit in knowledge or capability requiring remediation has been identified, it is necessary to assess the learning and professional development needs of the doctor concerned in order to plan a programme of remediation tailored to those needs which has a realistic prospect of achieving its objectives. These needs may be generic (such as team-working or leadership skills) or specialty-specific (such as a need to refresh aspects of specialty knowledge or a need to acquire or refresh a technical skill). It is also important to establish whether there is a realistic chance of bridging the gap between the doctor's current capabilities and what is required for their current scope of practice with a programme of remediation.

A variety of specialty-specific assessment tools have been used in a formative sense in these circumstances, such as e-learning self-assessment resources, workplace-based assessments and simulators. The Colleges can contribute to this process in a number of ways, for instance by signposting existing educational resources, developing new learning and self-assessment resources aimed at established practitioners, and continuing to develop and validate tools for formative assessment. NCAS also has extensive experience of the use of formative assessment methods to assist with the design of programmes of remediation.

4. At the end of an agreed programme of remediation, it will be necessary to make a summative judgement about whether the shortfall in knowledge or skills identified earlier has been addressed and whether the doctor is ready to resume their normal scope of practice (or a modified scope of practice where this was agreed as an objective of the programme of remediation). The Responsible Officer regulations make clear that this judgement must be made by the Responsible Officer (who has the option to refer the matter to the GMC if he / she remains unsure that the doctor is up to date and fit to practise). Assessment tools such as Objective Structured Clinical Examinations (OSCE) are used to make summative judgements about a doctor's capability, for instance as a component of specialty training programmes.

Their validity and reliability must be tested rigorously before they can be used for qualifying examinations and reviewed periodically thereafter. It cannot be assumed, however, that an assessment tool which has been validated for use in a specialty training programme would be valid or reliable as a means of predicting a doctor's performance following a programme of remediation. Although the GMC has validated a number of summative

assessment tools which are sometimes used in fitness to practise investigations, the Remediation working group does not believe that there is currently adequate evidence to support the use of summative assessment tools by Colleges to predict whether a doctor is likely to be ready to resume their normal practice following a programme of remediation.

7. OTHER INDIVIDUALS OR ORGANISATIONS WITH IMPORTANT ROLES IN THE REMEDIATION OF DOCTORS

7.1 The Responsible Officer (RO)

The Medical Profession (Responsible Officer) Regulations 2010 place a number of duties on ROs and Designated Bodies in relation to responding to concerns about doctors. These include commissioning an investigation and initiating measures to address the concern, which may include mentoring, coaching and remediation. The RO may, if necessary, place restrictions on a doctor's practice pending further investigation or completion of a programme of remediation. The RO is responsible for deciding whether concerns are of sufficient gravity to require referral to the GMC. Following completion of a programme of remediation, the RO must decide whether the doctor is "up to date and fit to practise" and whether any on-going monitoring is required. The RO may seek advice as necessary and delegate aspects of the process to competent individuals or organisations, but remains accountable for ensuring that all doctors with whom the Designated Body has a prescribed connection are "up to date and fit to practise".

7.2 The General Medical Council (GMC)

The GMC has overall responsibility for the regulation of the medical profession in the UK. Through the process of revalidation, doctors who practise in the UK must demonstrate to the GMC periodically that they are up to date and fit to practise through the process of revalidation. The GMC is empowered to remove a doctor from the medical register or impose conditions on practice if his / her fitness to practise is found to be impaired. The GMC could require a doctor to undergo a programme of remediation following a fitness to practise investigation, in which case it would specify the goals that must be achieved and would conduct or commission an evaluation of the outcome of the programme of remediation in order to determine whether the doctor should be allowed to resume practice without further conditions. The GMC has appointed Employer Liaison Advisers who can advise ROs on whether concerns about the practice of a doctor reach a threshold where referral to the GMC should occur or not.

7.3 National Clinical Assessment Service (NCAS)

Since 2001, NCAS has built up an unparalleled body of experience in the provision of advice to health care organisations and the assessment of doctors in regard to concerns about conduct, health and capability. It works with health care providers to find alternatives to exclusion from work where this can be achieved without putting patients at risk and has developed training programmes to give practitioners an opportunity to address aspects of their practice which have given rise to concern. NCAS reviews and synthesise data collected through its work, in order to identify trends and support the development of targeted interventions with evidence of their success. NCAS is working with a number of the Colleges to provide training for reviewers who take part in invited reviews of clinical services. NHS Scotland does not have a contract with NCAS and in Scotland, medical directors of Health Boards are responsible for the assessment of doctors in response to concerns about performance and for initiating programmes of remediation where these are found to be necessary.

7.4 Professional Support Units (PSUs)

The NHS Revalidation Support Team's paper *Supporting Doctors to Provide Safer Healthcare* makes a recommendation that Designated Bodies in England should cooperate at a regional level to develop Professional Support Units which would allow ROs to share learning in responding to concerns, and facilitate the pooling of resources and skills³. It is envisaged that PSUs could have a role in the planning and delivery of remediation, bringing in expertise from Colleges, NCAS, Human Resources experts and GMC Employer Liaison Advisers. In the minority of remediation programmes where an external placement is required, PSUs might be able to coordinate placements within the region so that the doctor does not have an excessive distance to travel. Although the NHS Revalidation Support Team's report is intended for England, this recommendation may also have potential benefits for Scotland, Wales and Northern Ireland, where there is a greater degree of integration between the provision of primary care, secondary care and postgraduate education than in England.

Professional Support Units are not an entirely novel concept. In a few areas of the country, Primary Care Trusts have cooperated to form PSUs, with a particular role in investigating concerns about general practices or general practitioners. If PSUs can be established across the country encompassing all specialties, there will be an opportunity to ensure consistent quality assurance of remediation processes. It will take time to establish these units and build up the required skills within them. This is likely to require the help of other organisations, such as NCAS, Postgraduate Deaneries and the Colleges.

7.5 Health services for doctors

In a proportion of situations where remediation is judged to be necessary, the doctor's health may be a contributing factor to the capability issue, or the circumstances which have led to the investigation may have affected the doctor's health secondarily. Where the health problem requires expertise that the local occupational health department or the doctor's general practitioner cannot provide, it will be necessary to seek specialist help. A number of organisations already provide help for doctors with health problems, notably the Practitioner Health Programme which is commissioned by the London Specialised Commissioning Group on behalf of the London Primary Care Trusts, but which accepts referrals from other parts of the country.¹⁰

7.6 Postgraduate Deaneries and NHS Education for Scotland

Postgraduate Deaneries have a primary responsibility for the postgraduate training of doctors and dentists, but for historical reasons have some responsibility for the continuing education of general practitioners. As noted above, Postgraduate Deaneries and their supporting structures, along with Local Medical Committees and Professional Support Units (where these exist), play an important role in the investigation and remediation of concerns about general practices or general practitioners.

7.7 Lay assessors or advisers

The safety of patients is of paramount importance when investigating or attempting to remediate concerns about doctors. It is important that the processes of investigation and remediation are both proportionate to the level of risk to the safety of patients and fair to the doctor concerned. The involvement of trained lay assessors or advisers in invited review mechanisms and in the planning and quality assurance of remediation interventions can help to maintain this balance, particularly where more complex programmes of remediation are being considered.

7.8 The doctor whose practice requires remediation

The individual who has the greatest influence on the probability of success of a programme of remediation is the doctor for whom the programme is designed. A doctor who has insight into the need for a change in their practice and who takes responsibility for their own learning is far more likely resume and maintain safe and productive practice than a doctor who does not accept that there is a need to change and engages reluctantly with a programme of remediation.

8. CONCLUSIONS

This report is intended to be read in conjunction with the Academy of Medical Royal Colleges' 2009 report on the remediation of doctors, which provides a detailed account of the processes of remediation.

A need for remediation of aspects of a doctor's practice may come to light in a variety of ways, including concerns raised by colleagues, dysfunction of a team or clinical service, complaints by patients, clinical incidents or near misses, or clinical audit and outcomes data. Occasionally, the request for help may come from the doctor themselves.

In situations where aspects of a doctor's practice require remediation, the role of the Responsible Officer is pivotal. The RO is accountable for key decisions concerning the verification of a need for remediation, commissioning of a programme of remediation, verification that the goals of remediation have been achieved and subsequent monitoring to ensure that improvements are sustained, though he / she may delegate aspects of the process to competent individuals or organisations. Where Colleges assist with aspects of the process of remediation, this will be at the request of the RO or a Professional Support Unit, and will be part of a contractual agreement with the Designated Body or Professional Support Unit which covers indemnity and funding arrangements.

Not all situations requiring remediation are predictable or preventable but good induction, support and mentoring, particularly at key career transitions (e.g. from a training post to a first career grade post, or from a post abroad to a career grade post in the UK) may be an important means of reducing the likelihood of subsequent concerns about performance.

Although it is reasonable to take into account the career aspirations of a doctor whose performance has been called into question, it is important to avoid embarking on a programme of remediation that has little realistic chance of success. To do so may put the safety of patients at risk, may incur unjustifiable expense and may be damaging to the morale and reputation of the doctor concerned. Remediation must be developmental rather than punitive, but its goals must be achievable, not merely aspirational. The best achievable outcome of a programme of remediation is not necessarily a return to the doctor's original scope of practice. Colleges and other organisations involved in the investigation of a concern about a doctor's practice should be willing to support the RO in saying "no" to an unrealistic proposal for remediation.

Where there are early, or low-level concerns about a doctor's performance, remediation may be achieved within the doctor's own organisation through appraisal, using an enhanced or targeted programme of CPD combined with mentoring or peer coaching. Colleges may be able to assist by signposting, or advising on suitable educational resources.

Where an investigation of concerns about a doctor's performance suggest that clinical supervision is a necessary component of remediation, it is important to choose a suitably experienced and skilled clinician to undertake this task. It is likely that individuals with these skills will already be recognised as excellent trainers, but further work is required to develop and value the role of trainers as peer-coaches and peer supervisors.

The use of external placements for remediation should be reserved for a minority of situations where it is impractical to provide the necessary facilities within the doctor's own work place or where there has been a serious breakdown in working relationships in the doctor's clinical team. External placements are costly and require very careful planning if they are to achieve their objectives. They must also be structured so as not to impact adversely on the receiving unit's existing training commitments. It is very important that the RO who commissions the external placement maintains close involvement in the process of remediation throughout, as he / she will have to make a summative judgement about whether the doctor is ready to return to their former scope of practice. On return from an external placement, it is likely that the doctor will need continuing support in their own workplace.

The working group strongly endorses the recommendation of the RST's document: *Supporting doctors to provide safer healthcare* that 'Responsible officers should consider pooling resources, for example within a regional professional support unit, to provide adequate numbers of trained investigators and providers of remediation'³. It may be difficult for a Designated Body to conduct the day to day management of a programme of remediation because of competing pressures on the RO, appraisers and the Human Resources department. The proposal to establish geographically-based units seems to offer a practical and logical solution for the day to day management of programmes of remediation. It is often difficult to separate behavioural, health and capability issues when addressing a concern about a doctor's practice, and therefore it may be necessary to coordinate the input of more than one provider of specialist expertise such as NCAS, Colleges and the Practitioner Health Programme. It is important that any programme of remediation is tailored to the needs of the doctor concerned in order to maximise the probability of it achieving its objectives. Where remediation is required and it is not possible to achieve this within the doctor's own organisation, the existence of a regional professional support unit offers the possibility of bringing together the necessary expertise and resources for a programme of remediation without the doctor having to travel an excessive distance from home.

The working group acknowledges the substantial body of experience and expertise built up by NCAS over the last decade. Although it is not within the remit of this group to make recommendations about future contractual relationships between designated bodies and NCAS, the group believes that it is vital that, in the parts of the UK which currently use the services of NCAS, its expertise in the assessment of doctors and the coordination of measures restoration to safe practice continues to be available to Designated Bodies, particularly those which are newly constituted and currently have little experience of responding to concerns about doctors. The working group suggests that NCAS should also play an important role in supporting Professional Support Units as they become established.

The invited review mechanisms already provided by many Colleges can play a valuable role in the early stages of the investigation of a concern about a doctor or a clinical service. At this stage, it is important to establish whether a cause for concern exists and the level of risk it poses to the safety of patients. This can then feed into a subsequent investigation of an individual doctor should this be

required. An invited review also provides a wider perspective which can help to identify structural and system issues underlying a concern about the work of an individual doctor. Addressing such issues effectively may allow the doctor to remain in their normal post but even if an external placement is required, it may facilitate the subsequent reintegration of the doctor into the unit.

The Colleges already provide a number of resources that may make an important contribution to remediation. Published standards, guidelines and national audits provide evidence-based benchmarks against which a need for remediation can be determined. A variety of assessments may be used in a formative sense to help to clarify the doctor's learning needs and assist with the design of a programme of remediation. Where a need for remediation is confirmed, a wide variety of educational resources such as e-learning packages, seminars, courses and skills workshops run by Colleges are available to help to address identified shortfalls in knowledge or skills. Where peer coaching or clinical supervision is required as part of a programme of remediation, the individuals with the necessary skills to undertake these tasks are likely to be senior members of the same specialty College as the doctor.

9. RECOMMENDATIONS

Any direct involvement of a College in a process of remediation of an individual doctor should be commissioned by the doctor's Responsible Officer and should be underpinned by an agreement between the College and the doctor's Designated Body which covers indemnity and funding arrangements. The costs of remediation and options for funding it were explored in detail in the report of the Department of Health's steering group on remediation and the working group agrees with these conclusions. The only additional point to make is that the costs of prevention and early intervention will be small in comparison to the cost of a programme of remediation involving external placement.

Colleges which provide invited reviews of clinical services should agree a set of principles for the conduct and quality assurance of invited reviews. This should be linked to the principles for the provision of specialist advice by Colleges for enquiries relating to revalidation previously agreed by the Academy¹¹. The Colleges should share good practice and experience, including the wider use of trained lay reviewers, and mechanisms for gaining access to these services should be similar for each specialty. The working group also propose that Colleges identify and compile a list of members willing to support and participate in remediation activity.

For historical reasons, concerns about general practices or general practitioners have usually been investigated by Postgraduate Deaneries and their supporting structures, Local Medical Committees or Professional Support Units (in areas where these exist) and were until recently rarely referred to the Royal College of General Practitioners. The existing structures seem to fit well with the NHS Revalidation Support Team's recommendation that Designated Bodies should collaborate to form Professional Support Units at regional level but there may also be a requirement for more direct involvement of the RCGP in setting standards for the investigation of concerns about GPs or general practices at present. Appropriate approaches are currently under consideration by the RCGP with other stakeholders.

The Faculty of Public Health, the Faculty of Occupational Medicine and the Faculty of Pharmaceutical Medicine are Designated Bodies for the purposes of revalidation. If they were to have a direct role in the remediation of doctors in these specialties, this could give rise to conflicts of interest with their roles as Designated Bodies. Historically, when a concern has arisen about a doctor in these specialties which cannot be managed by the employer, a referral has usually been made to NCAS rather than to the relevant Faculty. Although it might be possible to manage a conflict of interests between a role as a Designated Body and a role in remediation, the Working Group suggest that the three Faculties should give priority to developing their roles as Designated Bodies in the first instance, and not attempt to become simultaneously involved in the remediation of doctors in these specialties. However, if it becomes apparent that this course of action is likely to place doctors in these specialties at a disadvantage, this recommendation should be reconsidered.

Colleges should consider how they might provide more structured support for doctors following appointment to their first career grade post and doctors who are appointed to a career grade post, not having worked in the UK before, as a means of reducing the likelihood of future performance concerns.

Colleges should review the guidance and educational resources they currently provide to ensure that they are easily accessible to Designated Bodies as resources to support the remediation of early or low-level concerns.

Colleges should consider ways in which they might develop and value the skills of senior trainers who can provide coaching and clinical supervision to peers. Trainers should themselves have access to a peer network to support what can be a challenging and demanding role.

A variety of assessment tools can be used in a formative sense to identify learning needs and to plan individually tailored programmes of remediation and Professional Support Units are likely to make use of them as their functions develop. Colleges could contribute to the development and validation of assessment tools in partnership with Professional Support Units. However, the Working group does not believe that there is sufficient evidence to support the use by Colleges of assessment tools in a summative sense to predict a doctor's performance following a programme of remediation.

It will not always be possible for a doctor to return to their original scope of practice following a programme of remediation, and the best achievable outcome may be a restricted scope of practice or a change of career. Colleges should consider how they might provide advice to doctors in this situation.

Where Colleges have provided support for programmes of remediation to date, it has almost always been in partnership with NCAS, suggesting that programmes of remediation often require a range of expertise which may not be available in a single organisation. The working group envisage that future input from the Colleges to the planning, implementation and evaluation of programmes of will continue to follow this pattern, rather than Colleges becoming direct providers of programmes of remediation. The working group supports the proposal to establish Professional Support Units at a regional level to manage and coordinate programmes of remediation, drawing on the expertise of other organisations as and when required.

The process of setting up, implementing and evaluating an external clinical placement is always going to be challenging because of the direct costs, the high level of training input required, and the indemnity and clinical governance issues involved. The Working Group suggests that the proposed regional Professional Support Units are likely to provide the most cost-effective mechanism for coordinating the contractual framework for the minority of programmes of remediation which require this approach.

There are a number of groups of doctors whose needs for remediation have not been considered in detail in this report, for instance, locum doctors and doctors who have a prescribed connection for revalidation to an independent healthcare provider. Where a concern about performance arises, factors such as peripatetic practice and relatively isolated practice may make the investigation of the concern and remediation difficult. Further work will be required to define mechanisms and funding arrangements for remediation for these groups of doctors and this work is likely to involve Responsible Officers, Colleges, Deaneries, NCAS and Professional Support Units. There is also a group of doctors who do not currently have a prescribed connection to a designated body and whose arrangements for revalidation have yet to be determined by the GMC. Once plans for revalidation of these doctors have been developed, arrangements for remediation will also need to be considered.

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APPENDIX 1:

EQUALITY IMPACT ASSESSMENT

The main objectives of an Equality Impact Assessment (EIA) are to establish whether implementing the recommendations of the report of the Remediation Working Group is likely:

- a) To result in inequality of access to remediation between groups which are the subject of equality legislation
- b) To impact negatively on one or more groups which are the subject of equality legislation.

NCAS has undertaken an extensive analysis of referrals since its establishment in 2001¹² and has identified that there is a consistently higher probability of referral to NCAS and suspension or exclusion from work in the following groups:

- Male doctors
- Doctors aged 60 and over
- Doctors whose primary medical qualification was obtained outside the UK.

It has been widely reported that these same groups of doctors are statistically over-represented in referrals to the GMC and in all stages of its fitness to practise processes. The reasons for these findings are not fully understood and are the subject of ongoing research.

It is possible therefore that similar trends may be evident in future requests for advice by Designated Bodies to Colleges in situations where remediation of a doctor's practice may be required.

Equality of access

It is necessary to consider whether the recommendations of this report may have different impacts on different groups of doctors in terms of their ability to gain access to help with remediation of aspects of their practice.

The Working Group does not believe that implementation of the recommendations of this report will have any direct negative impact on access to remediation on the basis of gender, race, sexual orientation or religious belief.

However, one of the main determinants of access to remediation is its cost. Although future funding arrangements for remediation are outside the scope of the report, it is likely that some groups of doctors (for instance doctors working in the NHS but not directly employed by it) will experience more difficulty in gaining access to remediation than others until this issue is addressed and this could in theory have a disproportionate impact on groups which are the subject of equality legislation. Colleges are not in a position to subsidise the costs of remediation, but the recommendations of this report on prevention and early intervention when concerns arise may mitigate any such inequality of access by keeping the costs of remediation down.

The report notes that situations will arise where there is no realistic prospect of a doctor returning to their former scope of practice, in which case, a programme of remediation may have more limited goals, or may not be recommended. These situations are more likely to arise in doctors nearing the end of their careers. A decision not to embark on a programme of remediation may be justifiable on a case-by-case basis from research evidence or the use of formative assessment tools, but blanket restrictions on remediation on the grounds of age alone would probably contravene equality legislation.

Doctors with a health problem or disability that forms part of a need for remediation require an assessment by a service with the relevant expertise which may include recommendations on any reasonable adjustments that need to be made to their work or working environment. The Working Group does not consider that the recommendations of this report are likely to restrict access to remediation unfairly on the grounds of health or disability.

Impact

The Working Group does not believe that the implementation of the recommendations of this report will have any negative impact on the probability of a successful outcome of a programme of remediation on the basis of gender, race, sexual orientation, or religious belief.

As noted above, the age of a doctor at the time of referral may influence the probability of success of a programme of remediation. The Working Group considers that the recommendations of the report take into account the needs and aspirations of the doctor, the safety of patients and the cost of remediation fairly.

A programme of remediation for a doctor with a health problem or disability requires specialist input into its design and monitoring that is beyond the scope of this report, but the Working Group do not anticipate that the recommendations of this report will have any negative impact on the likelihood of a successful outcome of remediation in this situation.

The report's emphasis on targeted support for career-grade doctors from outside the UK who are commencing their first post in the UK may reduce the likelihood of concerns arising about their practice subsequently. The emphasis on early remedial interventions may also help to reduce the likelihood of more serious problems arising later.

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