



REMEDICATION FOR GENERAL PRACTITIONERS

A RCGP POLICY DOCUMENT WITH INPUT FROM REPRESENTATIVES FROM

The General Practitioner's Committee of the British Medical Association, The Postgraduate Deaneries, NES Scotland, The National Clinical Assessment Service, The Revalidation Support Team, The Independent Doctor's Forum and The Patient Partnership Group of the RCGP

Executive summary

This document is intended to inform the current discussions on remediation for general practitioners. It is based on the findings in the Department of Health's *Tackling Concerns Locally* report (2009) and experience in Wales and the London Deanery. It tries to draw together good practice to address three key challenges:

- Clarity on the responsibilities of all the key stakeholders in remediation
- Consensus on the processes for tackling concerns and remediation, and the application of those processes consistently throughout the UK
- Sufficient resources to deliver a system of remediation that is value for money and effective in maintaining services while ensuring patient safety

We propose a four stage process as set out in *Tackling Concerns Locally* and implemented in Wales:

1. Identifying issues
2. Investigation
3. Deciding on actions
4. Remediation, re-skilling and rehabilitation

For each of these stages we propose a simple but effective model which reflects the best practice already evident in some sites throughout the UK.

Lastly we propose a funding model with the main financial burden for remediation being shared by the primary care organisation and the deanery. We argue for the need for additional resources to guarantee the success of the project.

Introduction

With over 55,000 doctors on the General Practice Register it is inevitable that some general practitioners will be poor performers¹. When they do perform poorly, they place patients at risk. There are already mature systems for offering remediation in some parts of the country. However the provision is inconsistent and geographically patchy. As local processes – such as clinical governance and annual appraisals – are enhanced in preparation for revalidation there may well be an increased identified need for remediation, and more demands for a consistent approach.

At a meeting held at the Royal College of General Practitioners on 28th October 2009 the organisations contributing to this document met to discuss the way forward. It was agreed that:

- Where remediation has been systematised and adequately resourced it works reasonably well
- Investment in remediation, especially in the early stages of deteriorating performance, can save money
- There is a need for a structured approach to facilitating GPs out of the profession when remediation has failed or where remediation is not appropriate.
- There must be support for those involved with remediation to manage the risks involved, ranging from protecting patient safety to indemnity of those commissioning and providing the remediation.

The group then identified three challenges:

- The initial challenge is to be clear on the responsibilities of all the key stakeholders
- The second challenge is to achieve agreement on the processes and to apply those processes consistently throughout the UK
- The third challenge is to achieve sufficient resources to deliver a system of remediation that is robust, value for money and effective in maintaining services while ensuring patient safety

This paper has been written to inform discussions to address these three key challenges. It takes as its foundation the Department of Health's report *Tackling Concerns Locally* (2009). It has been further deeply informed by the Standard Operational Policy for the Primary care Advisory Team in Public Health Wales provided by Professor Malcolm Lewis; and by evidence provided by Dr Alex Jamieson and Dr Julia Whiteman of the London Deanery.

This paper has been authored by a group including: Niall Cameron, Antony Chuter, Colin Hunter, Alex Jamieson, Terry John, David Johnson, Has Joshi, Keith Judkins, Ken Lawton, Malcolm Lewis, Beth McCarron-Nash, Claire McLaughlan, Mike Pringle, Nigel Sparrow, and Lucy Warner. The Department of Health (England) has also provided comments.

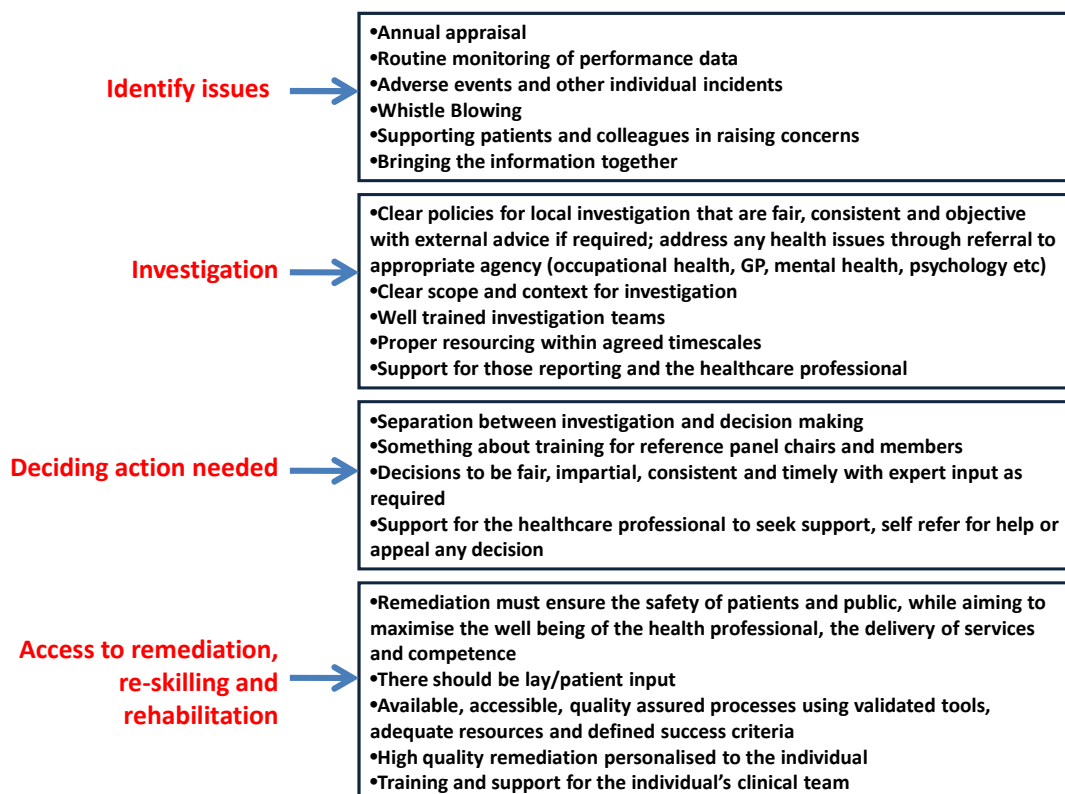
¹ NCAS estimates that it will receive 270 GP referrals in 2009; The London Deanery GP Performance Unit received 25 requests for advice and 30 referrals in 2008 against a rising annual trend. It has 44 currently active cases.

Remediation: The Principles

Based on *Tackling Concerns Locally*, the group started from the following four premises:

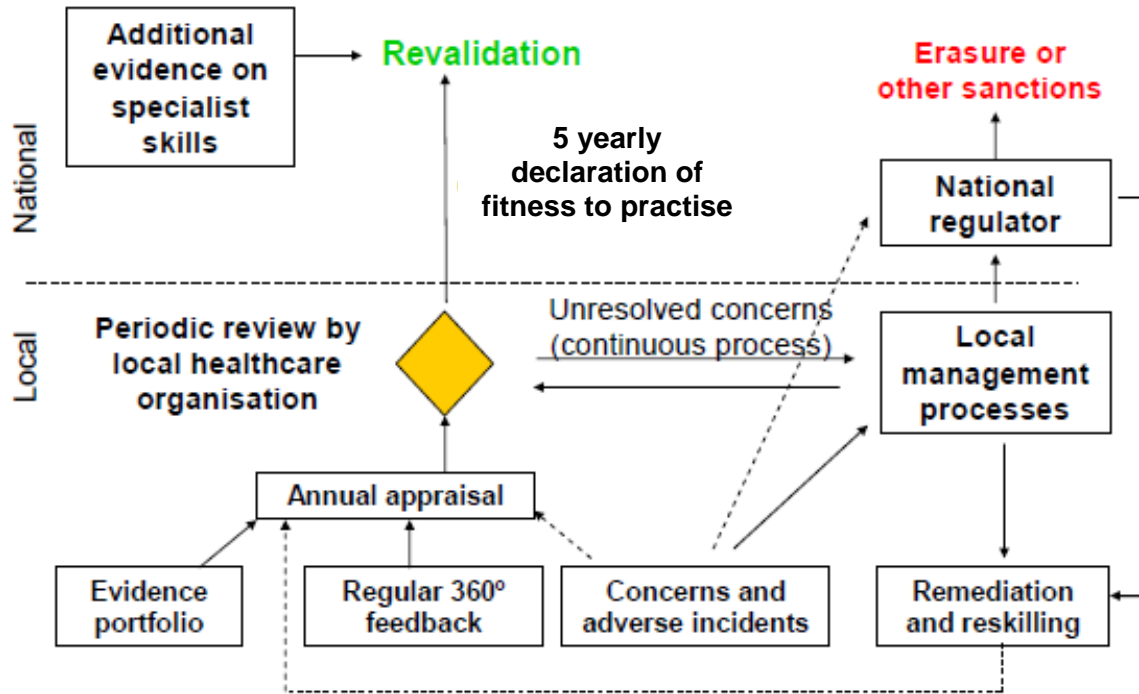
- I. Annual appraisals and clinical governance monitoring systems need to be sensitive enough to pick up the early signs of deteriorating performance, conduct and health at the earliest possible stage. Similarly staff with concerns over a colleague should be encouraged to come forward as early as possible to share their concerns or strong suspicions;
- II. Annual appraisals need to maintain their formative element so a GP undergoing remediation or about whom there are concerns can have a robust reflective appraisal to give the opportunity to consider and review with a colleague the internal shifts they need to make to remedy the deficiencies in their practice;
- III. Where concerns are substantiated, healthcare organisations should act as quickly as possible, with the aim of protecting patients by addressing systematic issues and offering additional training or remediation, re-skilling and rehabilitation wherever this would be effective;
- IV. Nevertheless, healthcare organisations should not shirk their responsibility to refer healthcare professionals to the national regulator where local interventions have failed to address the problems or where a serious issue of fitness to practise emerges.

Tackling Concerns Locally went on to identify four stages: identifying issues, investigation, deciding on what action is needed, and access to remediation, re-skilling and rehabilitation. Within those four stages, the report identified a number of principles:



The Tackling Concerns Locally report offered a model for how the whole of remediation might fit together:

How it all fits together



A Model for Remediation in General Practice

We propose a model with the same four stages as proposed in *Tackling Concerns Locally*, each of which needs defined processes. We are aware that there is wide variation and that total consistency is unrealistic. This model will need to be adapted to local circumstances.

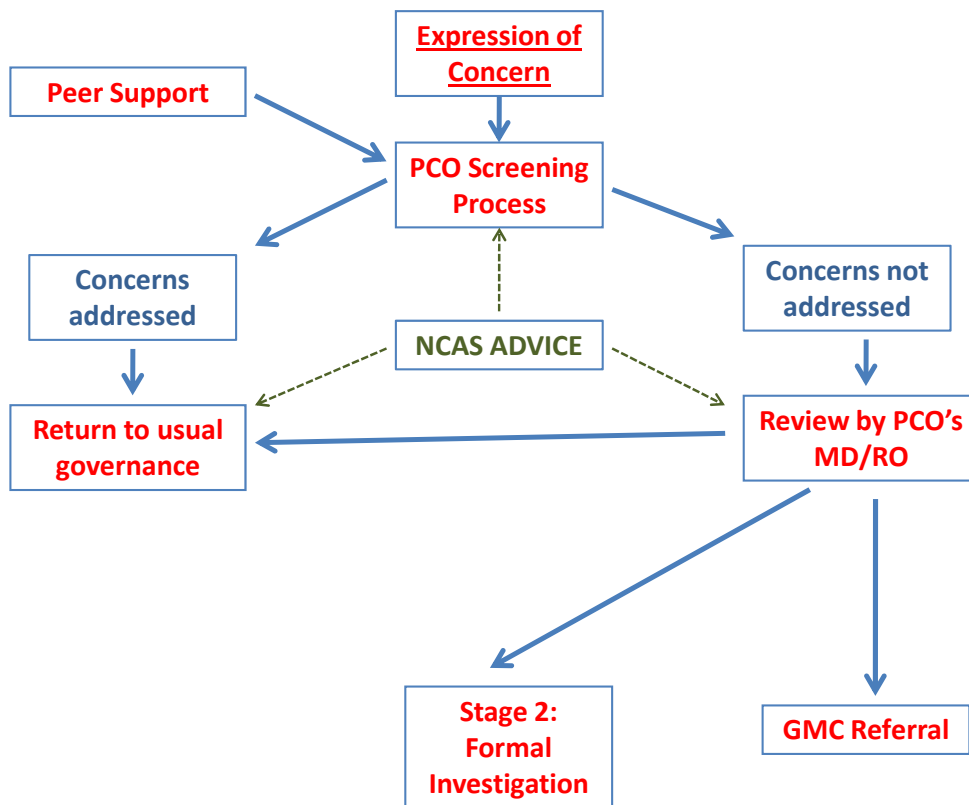
STAGE 1: Identifying issues

Stage 1 – the screening process – starts either with a cause of concern being raised about a GP and then referred to the primary care organisation's screening process, or the GP themselves becoming aware that their performance is unsafe in some way and seeking advice from a local tutor or their Deanery. Appraisers may, from time to time, be the first to identify concerns and this may increase when appraisers are trained to work within the framework of the new strengthened appraisal module. The GP should be notified that a concern has been raised and is being considered by the screening process. Their response at the identification phase is important as an indicator of insight into the issues of concern and likely engagement with appropriate professional development.

Each primary care organisation (PCO) needs to have a screening process. At minimum it should involve a non-executive board member, a PCO executive, the PCO's medical director of primary care and an LMC nominee. They may wish to engage confidentially with a peer support group outside their organisation in situations where judgement is fine or difficult (this may develop as an outcome from the GMC Affiliates pilot, or from arrangements set up at regional level).

Many concerns will be judged to be unfounded, or sufficiently minor or straightforward to be handled within the normal clinical governance processes in place locally. Even when this is the case the GP may benefit from voluntary mentoring or educational supervision which may be commissioned or provided, for example, by the local Deanery.

A small number of cases will provoke such serious concerns that an immediate referral to the GMC is required. Otherwise, the GP should proceed to stage 2.



STAGE 2: Investigation

Where problems are thought to be complex or cannot be addressed through normal clinical governance processes, an investigation is required. For this the Medical Director of the PCO should convene an Investigating Team. This team is charged with responsibility to ascertain the facts; determine the past and present risks to patients, the public, colleagues and the doctor themselves; decide on and recommend appropriate actions; and to draft a report. An Investigating Team needs to be comprised of suitably skilled and trained staff either at the PCO or more usually as a resource shared between PCOs and based at one PCO or at SHA level.

Throughout the investigation, the team must be alert to risks for public or patient safety, either through acts of omission or commission. If these are strongly suspected, NCAS should be involved at an early stage. It would be normal practice to consider an occupational health or psychometric assessment at this stage.

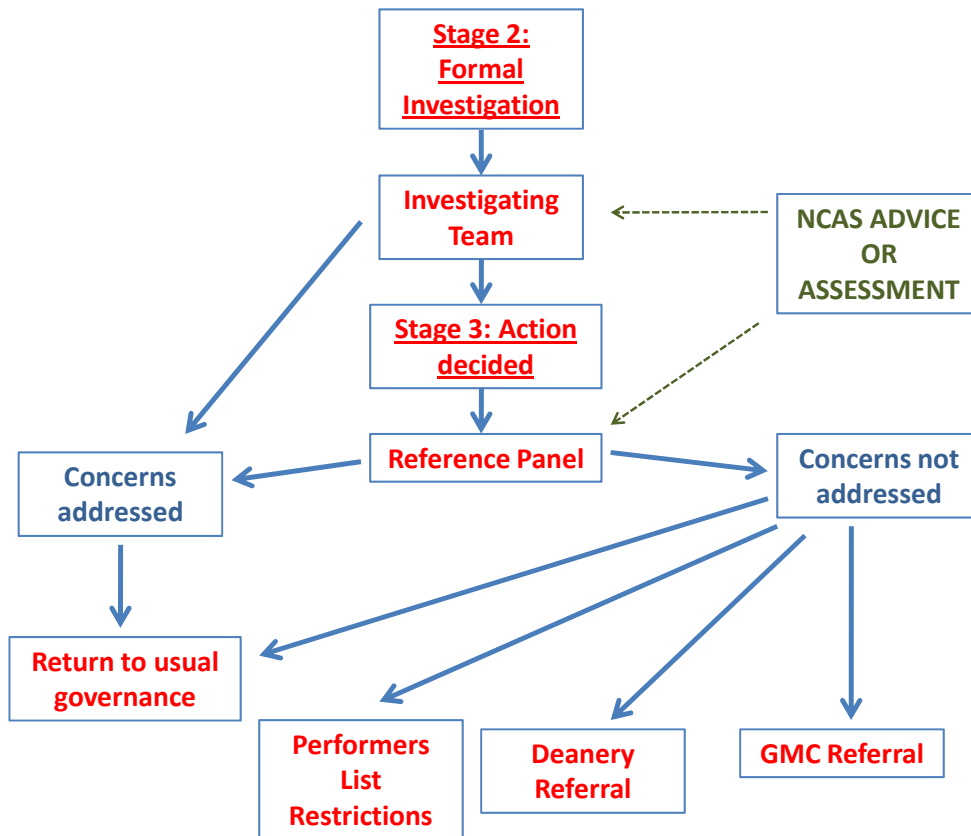
In undertaking this investigation, the investigating team will only recommend appropriate actions if it is sure that the presenting issue has been sufficiently explored to reveal any underlying or associated issues. If not totally satisfied that this is the case, the investigating team may ask the Medical Director to refer to NCAS for an assessment which will use a systematic and standard approach to inform a view about a practitioner's performance and will identify factors that may have led to a performance difficulty. At a minimum NCAS advice should be sought about the local investigation processes to ensure consistency and equity. In conducting the investigation it is important to consider whether health issues may be

contributing to poor performance and, if appropriate, to involve occupational health services at an early stage.

STAGE 3: Deciding on action

The Investigating Team's report should be considered by the Medical Director who, if appropriate, convenes a Reference Panel to consider the report's findings, seeking advice as appropriate from the Deanery, NCAS or the GMC. The Reference Panel must act within the GMS contract and professional regulations. It can decide that no action, in addition to normal clinical governance processes, is required; refer the GP to the Deanery for a remediation programme; refer the GP to NCAS (if not already done); refer the GP to occupational health or other locally available resources available to address practitioner health (e.g. in London the PHP service); refer the GP to the GMC; or impose restrictions on the GP through the Performers List regulations (suspension, conditions [which can only be applied if there is evidence for removal but there is mitigation], or removal). Performers List action should only be taken after a NCAS assessment. The level of insight as demonstrated by the GP's willingness to accept investigation findings and work to construct a meaningful action plan is a key factor in deciding on action.

The Reference Panel should, at minimum, be chaired by a PCO Trust Executive, and attended by a PCO Non-executive director, a Medical Director from another PCO and an LMC Nominee. The GP, the PCO's Medical Director (or deputy) and another GP to act as a friend to the GP would normally attend the Panel.



STAGE 4: Remediation, re-skilling and rehabilitation

The advice of NCAS, an SHA remediation support group (if one is founded) or the Deanery may be sought at any stage in the process, but they should be involved in any referral for remediation, re-skilling and rehabilitation. If the problem concerns the GP's health then the occupational health service or other specialist services should be used. In London there is very positive experience with a pilot health diagnostic and intervention service.

The main Deanery interventions include:

- Making an assessment on educational grounds of the commitment of the referred practitioner to engage in remediation.
- Satisfying themselves that any remediation package they construct does not compromise patient safety nor those involved in delivering the remediation i.e. the workplace and educational supervisors, their practice teams and any other learners in the workplace.
- Support in the workplace through mentorship and educational supervision (currently limited availability).
- Retraining by the practitioner in a practice with a trainer who is appropriately trained to supervise practice and learning (currently limited availability).
- Supporting the referred GP in compiling and delivering a PDP related to their learning needs, providing reports on progress as necessary.
- Support outside of direct intervention in service provision for practitioners who have had their GMC registration suspended.

- Providing career counselling including facilitating reflection on alternative career pathways and career options.

When the PCO is satisfied with progress with remediation or re-skilling – based on reports from the Deanery and the GP concerned to the PCO Reference Panel – a plan for return to work and continuing support will be required.

Collaborative working

Although this process seems PCO-centric it is essential that all the stakeholders collaborate to ensure the right decisions are made to protect patient safety and achieve effective remediation. In addition to the PCO, the key partners are NCAS, the GMC, the Deanery, the LMCs, the local Investigating Team, other PCOs, SHAs, and organisations that provide support for sick doctors.

Resources for Remediation in General Practice

The current position varies significantly between parts of the UK. The three key parties are the GP requiring remediation, the primary care organisation (PCO) and the Deanery. We believe that this should continue to be the case but that all areas of the UK should adopt the best practice.

We propose that the PCO should be responsible for all the costs in Stages 1 to 3 – from concerns being expressed through to remediation being prescribed by the Reference Panel. NCAS should continue to offer its services to PCOs at no extra cost.

We propose that the PCO should meet half the cost of the agreed remediation. We also propose that the Deanery provides the other half of the cost of the agreed remediation. In many Deaneries the funds to achieve this have already been allocated. In others, remediation will need prioritisation within the budget. However, we recognise that remediation may, in the next few years place a special extra burden on PCOs and Deaneries. We therefore call on the Departments of Health to allocate specific additional funds to ensure there are sufficient resources in the system to ensure effective remediation.

The funding of remediation for GPs who are partly or wholly engaged in private practice needs to be discussed and resolved. There will be other non-standard groups that need consideration.

If funds are insufficient, remediation will not be effective, and the profession will not agree to revalidation going ahead.

November 2009