Understanding employer’s referrals of doctors to the General Medical Council

Research Report for GMC

January 2017
All interpretation and opinion in this report is that of the authors alone and do not necessarily reflect those of the General Medical Council.

The authors would like to thank all participating staff at case study sites for their frank and honest contributions to this research.
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1. **Executive Summary**

1.1 **Background, Objectives and Methodology**

Employers of doctors are key partners in the GMC’s work to ensure that doctors remain fit to practise. An aspect of this is that employers signal concerns relating to fitness to practise to the GMC. The GMC is keen to better understand the local processes and cultures that ultimately lead to doctors being referred to them via this route. In particular, they would like to identify any promising approaches within local processes that Trusts feel have been beneficial in how they handle and deal with concerns about doctors and ensure the right concerns and complaints are escalated.

More specifically, the objectives were:

- To better understand the local processes that ultimately lead to an employer referring a doctor to the GMC.
- To understand whether different approaches might lead to differences in the way different groups of doctors – in terms of their roles, seniority or demographics – are engaged with, or affected by complaints or raising of concerns.
- To identify, within this, any promising approaches that Trusts are using that might be transferable to other situations. The aim being to share information and ideas rather than promote a specific way of working. (Note that the promising approaches and ideas identified within the report are the views of the individuals who took part in the research and not the views of the GMC).

The research comprised of 11 site visits to a selection of NHS Acute Trusts in England, alongside a review of their documented processes. A range of interviews with a number of differing job titles and roles were interviewed at each site. These included some or all of the following:

- Responsible Officer (RO).
- Chief Doctor (we refer to those in this role as Medical Director or MD, although this was not always their job title).
- Senior Doctor.
- Human Resources (HR) Lead / Director.
- HR Non-Lead.
- Case Managers.
- Case Investigators.
- Appraisal Leads.
- Administrator / Other.

In total, 11 site visits were undertaken comprising a total of 49 interviews, involving 52 individuals. Further details on the Trusts involved are provided in Appendix 1.

This case study approach involving 11 Acute Trusts in England was designed to give depth of understanding of local processes at a selection of comparable sites. It does not seek to or claim to be representative of the many and varied types of organisations that employ doctors or the hundreds of appointed ROs.
1.2 Key findings

Local processes and the desire for local resolution
Concerns at all sites came to light in a number of ways, for example, via performance data, serious incident reviews, patient complaints and colleagues raising concerns. In relation to all sources of concern, larger organisations naturally adopted more complex systems of management and the RO or the combined MD/RO of these large organisations was far less likely to hear about issues directly (as was often the case at the smaller Trusts that were visited).

Regardless of size of organisation, interviewees across all Trusts who took part in this research favoured local resolution of issues whenever possible. Only the most serious of concerns were said to be escalated to the GMC, without first attempting to deal with them via internal processes. Even where Trusts chose to make an immediate referral they would run their internal processes in parallel. Responsible Officers were confident that they had made appropriate referrals to the GMC, and the Employer Liaison Service was cited as giving invaluable advice regarding whether or not a concern met the GMC thresholds for referral.

Local processes for dealing with concerns revealed most variation at the initial stages of dealing with a concern, when individuals were trying to establish the nature and seriousness of the concern. For example, most Trusts had a core decision making group through which concerns about doctors could be raised, debated and monitored; however, the make-up of the group and frequency with which it met, varied. For example, the group did not always involve the RO (in instances where the RO role was separated from the role of MD). Most of these meetings were face to face but at one Trust the group conversed over email. Another variation at the early stage of dealing with a concern is the level of HR support, some Trusts always had a HR representative present at early conversations with the doctor at the heart of the concern; other Trusts sometimes chose a one to one approach.

Problematic aspects of dealing with concerns
Even at these early stages there were a number of difficulties identified by interviewees, not least unpicking complex and borderline cases; balancing the need for confidentiality with the desire to foster an open and transparent culture; the subjectivity and isolation of decision makers.

Once a concern had been identified as serious, Trusts would trigger the Department of Health’s Maintaining High Professional Standards in the Modern NHS (MHPS) process and few had made significant local adaptations to this process. However, a high proportion of interviewees identified difficulties associated with the MHPS process:

- The litigiousness of the process.
- The tight timetables involved.
- Maintaining a pool of trained Case Investigators.
- Accessing credible expert witnesses.
- Variability of National Clinical Assessment Service (NCAS) advice and assistance.
- Unwilling witnesses and the inability to collate sufficient evidence.
- The generation of counter complaints.

**Difference by type of doctor**

There was some suggestion amongst a number of interviewees that the likelihood of issues coming to light was not the same for all groups of doctors. For example, some felt that concerns were more likely to be raised against locums, doctors who qualified overseas, doctors approaching retirement and doctors that worked in specialisms that are easy to benchmark. Conversely, some interviewees felt that concerns were less likely to be raised (or more carefully considered before they were raised) against trainee doctors, popular doctors and doctors from non-white backgrounds.

Once concerns had been raised there were some differences in the processes for dealing with concerns. For example:
- Educational supervisors handle issues relating to trainee doctors, escalating them to the relevant deanery if necessary.
- For doctors demonstrating a lack of insight the Trust may decide to pursue the MHPS route more quickly.

**Promising approaches and ideas for the future**

At each case study site individuals were asked if they could think of any promising approaches that enabled their Trust to identify or deal with concerns raised more effectively. Many of those interviewed found it difficult to answer whether the current practice in their Trust could be described as promising, since few had knowledge of what other employers are doing. However, in a number of cases interviewees identified aspects of their approach that they believed worked particularly well. These are highlighted throughout the report as 'promising approaches'.

There has been no formal evaluation of these approaches and so it should be noted that they are promising only from the perspective of the interviewee(s) who outlined them as such. The research team has not selected promising approaches according to any particular criteria (other than the interviewee believing they were promising). The fact that they are included within this report does not mean that they have been evaluated or endorsed by the GMC.

Promising approaches include:
- An organisation collaboratively setting and widely promoting clear organisational values.
- Targeted appraisals (to ‘nip issues in the bud’).
- Establishing a wide pool of case investigators.
- Formalised learning via review of previous cases.
• Appointing two (rather than one) case investigators.
• Unconscious bias training for senior leaders.

In addition to these promising approaches interviewees also identified a number of ideas for the future. These are simply individuals’ thoughts on how to make the process of dealing with concerns about doctors more effective. Again, they have not been evaluated or endorsed by the GMC.

Ideas for the future include:
• An integrated Professional Support Unit to provide a more holistic approach to remediation.
• A forum for Case Investigators.
• Sharing legal and HR expertise (across smaller Trusts).
• A ‘faculty’ of Case Managers.
• Sharing Case Investigators at a Regional level.
• Establishing an expert witness database.
• Terms of reference for expert witnesses.
• Reverting to a single employer for trainees.

2. **Background, objectives and methodology**

2.1 **Background**

Employers of doctors are key partners in the GMC’s work to ensure that doctors remain fit to practise. An aspect of this is that employers – and other doctors in the work place acting individually – signal concerns relating to fitness to practise to the GMC. The GMC also receives concerns or complaints from a range of other sources – from others acting in a public capacity such as the police – or from patients.

Whilst the GMC has done a good deal of previous research and data analysis to understand the patterns of complaints, concerns and referrals it receives and what happens once they have been received; it has not previously conducted any research to understand the processes that precede an employer deciding whether or not to refer a doctor.

Evidence suggests that employers which might (based on their size and type) be expected to refer similar numbers and types of cases to the GMC do not necessarily do so. There appears, in fact, to be variation in the levels and kinds of referrals from ostensibly similar employers. The GMC, therefore, wishes to understand, as far as possible, the reasons why such differences might exist.

The GMC is also keen to better understand the local processes and cultures that ultimately lead to doctors being referred to them. In particular, they would like to identify any promising approaches in local complaints processes, escalation criteria
and concern-raising cultures that help Trusts deal with concerns locally and ensure the right concerns and complaints are escalated.

The GMC already knew from feedback that one important aspect of their relationship with employers is the interaction of the Employer Liaison Service with Responsible Officers and this study, therefore, has purposefully not focussed on that service. Instead, the focus is on understanding how the wider culture and processes within employing organisations help or hinder the referral of concerns to the GMC.

2.2 Research objectives
The objectives of the project were as follows:
- To better understand the local processes that ultimately lead to an employer referring a doctor to the GMC.
- To understand whether different approaches might lead to differences in the way different groups of doctors – in terms of their roles, seniority or demographics – are engaged with, or affected by complaints or raising of concerns.
- To identify, within this, any promising approaches that Trusts are using that might be transferable to other situations. The aim being to share information and ideas rather than promote a specific way of working. (Note that the promising approaches and ideas referred to within the report are promising in the views of the individuals who took part in the research and not necessarily in the view of the GMC or the research team).

2.3 Methodology

Case study approach
The chosen approach for this research was to select a small number of contrasting employers, undertaking a small number of in-depth interviews with doctors in different positions within the Trust. In addition, a paper exercise to review documented processes was undertaken for these same recruited sites.

The study sample was restricted to acute secondary NHS Trusts in England in order to be able to compare and contrast approaches operating in the same overall system. Typically within this system the relationship between a doctor and their RO is through an employment link. There is a range of other frameworks within which doctors practise that are outside the scope of this research.

The exact organisations included in the sample will remain confidential since recruitment to participate in the research was undertaken on this understanding. This was felt to be important in order that employers and their staff would feel fully able to be honest about what does happen on the ground, in addition to what should happen, in theory.
**Sampling and recruitment process**

The sampling and recruitment process was designed to include random sampling but also to get an even spread of trusts. All Acute Trusts in England were grouped into strata based on:

- A mix of different sized Trusts.
- A mix of foundation Trusts and non-foundation Trusts.
- A mix of rural and urban Trusts.
- Some teaching hospitals.
- Some Trusts from ethnically diverse areas of England.
- Trusts from different regions of England.
- A mix in terms of the number of case referrals to the GMC over recent years.

The GMC then selected a random sample from each stratum, to obtain a total of 40 suitable Acute Trusts in England, which were then identified to Community Research, along with contact details of each organisation’s Responsible Officer (RO).

Using the same criteria set out above, Community Research randomly selected a good spread of Acute Trusts in the final sample.

A small number of Trusts were excluded from the final sample because of specific known factors that would make it difficult for them to respond— for example, where it was known that the RO was very new in post (n=3), or where the Trust was currently in Special Measures (n=4).

All ROs were told about the research project in an edition of the regular RO newsletter. The nature and aims of the research were explained so that ROs, when approached, would have some prior understanding of the project.

An email was then sent to a mixed sample of 23 English Acute Trusts from the list of 40 provided (chosen by Community Research and unknown to the GMC) and this was followed up with emails and / or telephone calls to ask whether the RO would be willing for their Trust to participate. Where agreement was given the Community Research researcher then liaised with the RO or a nominated individual within the Trust to agree and arrange the necessary interviews to be undertaken on an agreed date or dates on site at the Trust.

In total, 11 site visits were undertaken comprising a total of 49 interviews, involving 52 individuals. Further details on the Trusts involved are provided in Appendix 1.

**Fieldwork process**

As agreed with the Trust a researcher from Community Research undertook interviews on site with a range of staff. Staff with a number of differing job titles and roles were interviewed at each site. These included some or all of the following:

- RO.
• Chief Doctor (we refer to those in this role as Medical Director or MD, although this was not always their job title).
• Senior Doctor.
• Human Resources (HR) Lead / Director.
• HR Non-Lead.
• Case Managers.
• Case Investigators.
• Appraisal Leads.
• Administrator / Other.

Interviews followed a semi-structured discussion guide which can be found at Appendix 2. Hypothetical scenarios were used during some interviews to help stimulate discussion. Interviews were recorded and transcribed for analysis. On occasion where on-site interviews could not be undertaken with key staff members, follow up interviews were undertaken by telephone. On occasion staff requested that they be interviewed as a pair rather than individually and where this request was made it was accommodated.

Where possible, documented processes were downloaded from employer’s websites in order that researchers could compare the processes described to the processes documented. Where such documents were not published, researchers asked for these to be sent by email following the site visits and in most cases the documents were subsequently received.

**Analysis process**

By its nature, qualitative research generates a large volume of data. In this case, all of the interviews were audio-recorded (with the participant's permission) and then transcribed in full. An important part of the research process is, therefore, to try to organise the material in a way that allows themes and patterns in the data to be drawn out. For this project Community Research adopted an iterative process:

• Prior to reporting the full team of four researchers met for a whole day to develop the themes and structure for reporting.
• With key report headings in place each researcher read back through their own transcripts in full and recorded emerging findings under the agreed headings of the report.
• Each researcher then took responsibility for finalising a particular section, ensuring that it reflected all the points raised.
• The finalised sections were then further reviewed by the entire team of researchers to ensure that they were representative of all Trusts that participated in the research (and key points from the analysis had not become lost in the drafting process).

The entire report was then edited by a lead member of the project team to ensure consistency of style and adherence to objectives.
2.4 Notes on reading the report

There are a number of caveats that should be borne in mind when considering the research findings.

The sample size and methodology for this research does not lend itself to making generalisations or numerical conclusions about all employers of doctors. It is worth noting that the ROs within Trusts that participated in this research ‘opted in’ to the process and actively responded to communication about the research saying that they were willing to participate. It could be that those who opted into the process are different in some way (in terms of their processes or approach) than the wider sample of employers eligible to participate.

Additionally, ROs suggested the most appropriate people for the researchers to speak to within Trusts, albeit with the suggestions of the kind of roles that would be relevant made by the researchers. It is therefore also possible that staff not chosen to participate by ROs would have given a different perspective.

Promising approaches and ideas for the future

Many of those interviewed found it difficult to answer whether the current practice in their Trust could be described as promising, since few had knowledge of what other employers are doing. However, in a number of cases interviewees identified aspects of their approach that they believed worked particularly well. These are highlighted throughout the report as 'promising approaches'. There has been no formal evaluation of these approaches and so it should be noted that they are promising only from the perspective of the interviewee(s) who outlined them as such.

In addition, a number of ideas and suggestions were made that were not part of current practices but which interviewees suggested might be helpful additions to make the process of dealing with concerns about doctors more effective. These ideas for the future are also presented in the report but, again it should be noted, that no attempt has been made to assess the feasibility or impact of such approaches.
3. **Local processes explored**

**Section summary:**
- Local processes are generally influenced by two inter-related factors: culture and size of organisation.
  - Strength and experience of the leadership team and HR function also interplay with these key factors.
- The processes for dealing with concerns show most variation at the initial stages of dealing with a concern: when Trusts are trying to establish the nature and seriousness of the concern.
  - In particular, the use and make-up of a decision making group across different sized Trusts.
- Wherever possible, local processes will favour local resolution and only the most serious of concerns are immediately escalated (to NCAS/GMC) without first going through an internal process.
- Staff at several Trusts spoke of one to one chats and mediation as early attempts at resolution.
  - The nature of these ‘chats’ was likely to be dependent on the concern but trusts did reveal slightly different approaches; not all were attended by an HR representative, not all were documented.
- If the concern is deemed ‘serious’ it will be dealt with under MHPS and standard procedures, albeit with some local adaptations, are strictly adhered to.
  - The litigiousness of the process means that local adaptions tend to be small.
- The Employer Liaison Service played a key role in guiding ROs as to if, and when, they should consider raising a formal concern with the GMC.

3.1 **General context**

A number of consistent factors were apparent across all case study sites with regard to the context within which Trusts are dealing with concerns about doctors.

These are summarised in Figure 1:
3.1.1 Risks

Staff at all Trusts expressed a desire to deal with concerns about doctors fairly and effectively. They explained the considerable risks involved in getting the process wrong in terms of:

- Potential impact on the health and career of a doctor.
- Litigation and financial cost to the organisation.
- Reputational risk.

However, they recognised that ‘getting it right’ was challenging as concerns are often based on complex issues that needed to be carefully unpicked. Adhering to structured and set procedures can be challenging when the concerns are so variable in nature.

3.1.2 Greater openness and transparency within the NHS

There was widespread recognition of a move towards greater openness within the NHS (partly as a result of the Francis report) in terms of encouraging the raising of concerns.

Staff at approximately half of case study sites also highlighted that there was a move towards greater transparency in the process for dealing with concerns specifically within their own organisation. Several HR staff interviewed stressed that they had worked hard to develop a more open culture and to communicate their organisation’s robust processes for dealing with concerns.

Increasingly robust, sophisticated systems used across all case study sites for flagging and reporting on serious incidents are also seen to be contributing to a more open approach and a greater likelihood that concerns will come to light.
3.1.3 Introduction of revalidation and regular appraisals

The introduction of revalidation has created a new category of concern relating to doctors not engaging with the revalidation and appraisal process. Whilst a number of interviewees said it is not usual for concerns to come to light through the appraisal process, doctors’ appraisals are a new potential source of information during any investigations into any concerns.

Within some Trusts the appraisal system was regarded as an opportunity to get doctors to reflect on their conduct – therefore it was having more of an impact as a method of preventing concerns occurring that might eventually lead to external referral.

One interviewee highlighted that it would be interesting to see if there is any correlation between doctors with issues with revalidation and wider concerns being raised.

3.1.4 Employer Liaison Service (ELS)

The ELS has undoubtedly enabled Trusts to work more closely with the GMC in raising the right types of concerns. All ROs, and many others interviewed, spoke favourably about the advice ROs receive from their local Employer Liaison Advisor (ELA) about Fitness to Practise thresholds. Decisions about whether cases meet the GMC’s thresholds for investigation have been made far easier by the fact that such issues can easily be discussed between the RO and the local ELA.

3.1.5 Difficulties recruiting doctors.

Staff based in Trusts in rural areas (and more generally those outside of the South East) referred to the increasing difficulty they faced in recruiting and retaining ‘good’ doctors. This was seen as directly impacting on the number of concerns raised within their organisations.

“You know right now lots of Trusts ourselves included, you’re not spoilt for choice. So you might be making borderline decisions more often than you would. To be honest with you, they’ll probably be people we appointed into specialities in the last few years that if there was a strong field, as there was say five, ten years ago, they probably wouldn’t have got a look in.”

(Case Study 11)

The perception was also expressed that, out of necessity, Trusts facing these difficulties with doctors’ recruitment were more likely to work hard on remediation of doctors – making the best of the staff they can attract.
3.2 Key factors influencing how concerns about doctors are raised and dealt with

There appear to be two key factors, closely linked, that impact significantly both on the number of concerns that come to light and the processes in place for dealing with such concerns about medical staff – the size and culture of the organisation. Another three factors identified – sub-cultures, strength of leadership and strength of the HR function also inter-relate with the two main factors. Figure 2 summarises the picture.

![Figure 2 – Key factors of influence](image)

### 3.2.1 Culture

Most interviewees recognised that organisational culture, whilst hard to define in specific terms, was a key influence both on raising concerns and on the process of dealing with concerns that are raised.

One interviewee described how staff use their organisational values to help inform their decision-making processes as an example of a well-functioning culture:

"What we say to our staff is 'if you’ve got a decision that you have to make, use the values to come to that decision and, ultimately, if you can’t decide use the vision [quotes vision wording] as your 'tiebreaker', and that’s the way we’ve put it across to the people that work with us and it seems to have stuck.” (Case Study 3)"
An example of a less well-functioning culture is provided below:

"It was standard practice in xxx was for everybody to keep a black book so that if your colleague did something that you thought was a bit wrong you wrote it down.... So you kept it in your pocket and when you were challenged or wanted to sort that individual out you used your black book and you rapidly refer to the GMC. The individual being referred to the GMC usually knew that this was about to happen so they tried to get in first and refer the referrer to the GMC using their black book. Now, hopefully that's changing and it never occurred in this institution but it was rife in xxx and I suspect that it wasn't just xxx. I don't have national experience, but I suspect in poorly performing and poorly managed hospitals that has become a route” (Case Study 9)

Several of those interviewed talked not only of organisational level culture but of the presence of sub-cultures within their organisations. Surgery, paediatrics and A&E received several mentions as areas that can tend to develop a distinct sub-culture within a Trust. For example, there was a perceived difference in the personality types of doctors attracted to paediatrics versus surgery that impacted on the level of reflection.

"Paediatricians are excellent at reflecting....and managing themselves, taking incidents very seriously. Whereas one or two other specialists, particularly some of the surgical specialities, are not so introspective. That may reflect, once again, surgeons versus physicians, on the whole surgeons tend to be optimistic, sort of confident, non-self-doubting in their personality types” (Case Study 10)

A&E’s culture was singled out as being a place where issues and concerns are perhaps more easily missed because of the ‘maelstrom’ nature of the working environment.

At a number of case study sites interviewees pointed to attempts to influence the culture by developing and promoting a clear set of organisational values for staff to adhere to. Failure to meet these values and expected behaviours would then trigger disciplinary procedures for staff of any profession or level. One example of such a programme is highlighted as a promising approach in Box A.
### BOX A – Promising Approach from Case Study 6  
(Large Trust in the North of England)

#### 3.2.2 Size of Trust

The research has uncovered some clear differences that arise from the overall size of Trusts. At the most simple level the more doctors a Trust employs the higher the number of concerns about doctors they are likely to deal with. However, Trust size and organisational culture are closely interlinked with perceived benefits and disadvantages on both sides in terms of how concerns about doctors come to light and are dealt with.

Differences arise from the fact that larger trusts have more doctors; therefore they deal with more concerns and cases; but they also have greater resources to draw on. These differences are summarised in Figure 3.
Figure 3 – Key differences between small and large Trusts

### 3.2.3 Strength and experience of leadership team

Several interviewees highlighted the importance of high quality leadership. They explained that good leadership influences the culture of raising of concerns, ensures that anyone raising a concern is protected and also deals with concerns appropriately; not escalating them without good cause and dealing with all staff in the same manner, regardless of their status.

Whilst none of those interviewed pointed to having poor leadership in their own current organisation (of course many of those interviewed were in senior leadership roles) they had recognised it within other Trusts.

"I have to say, I think this organisation, and I talk to colleagues in other organisations, is particularly good at not ducking the difficult issues, and almost no matter how big your name, the organisation will investigate you and will investigate you fairly and appropriately and will take suitable action.” (Case Study 3)

The level of experience and confidence of individual senior managers – particularly the RO/MD - was seen to be a vital factor in determining how concerns get dealt with.
Those with less experience and confidence may turn to external referral at an earlier stage:

"Now, some of it is absolutely clear-cut, if you punch a patient, if you are found to have been taking heroin, well that’s easy, isn’t it? But I think there are real difficulties and I think you’ll find that organisations that are less self-confident will probably refer a lot of people up because they think ‘well, they’ll let us know if they don’t really feel it’s important’. "(Case Study 3)

The individual personalities of the people in these pivotally important roles, was also felt to be a highly relevant factor. There was a strong feeling that in cases that are on the borderline the subjective viewpoint of the RO and /or the MD (in instances where the role is not combined) will come into play. As is the case in any other walk of life the individuals filling these roles will differ in terms of their attitudes and their personal approach:

"I suspect that the personality of the Medical Director probably plays a role as well.... If you’re the kind of 'hang, draw and quarter them' Medical Director who says 'goodness me, based on what you’ve told me that’s terrible’, - straight on the phone to the GMC.”(Case Study 7)

3.2.4 Strength of Human Resources (HR) function

Several of those interviewed recognised the role that a strong and experienced HR team also plays in the process of dealing with concerns about doctors. In particular, having experience and understanding of the MHPS process and not being daunted by it.

The role of HR professionals was extremely important at all case study sites. At some larger sites a number of HR professionals specialised in MHPS, studying and advising on the latest case law implications and always providing hand-holding support on due process to case investigators. In some Trusts the emergence of this type of “Medical HR” resource is seen as crucial.

"Our HR department is being reconstructed and we’re beefing up our medical personnel function, so I hope that they will be able to retain some of the skills in support of our Investigators.”(Case Study 8)

The quality of support and the strength of the relationship between the HR and senior medical staff was also seen as a vitally important factor in determining how effectively and confidently Trusts deal with concerns about medical professionals.
Overview of RO role
The overarching role of the RO is to protect patients by ensuring that the GMC’s standards are met by licensed doctors.

More specifically, in relation to the referral of doctors to the GMC, Responsible Officer Guidance sets out that ‘ROs will be accountable for the oversight of all associated processes. The RO is expected to co-operate with the GMC in establishing the appropriateness of the referral and will oversee the collation of the relevant information. The RO will also be expected to liaise with the appropriate Medical Royal College or Faculty, where appropriate, through the College Regional Advisors for independent advice on the relevant specialist practice and also, in cases of concern, for advice on the performance of the doctor’.¹

Out of the 11 case study sites 4 had separated the RO role from the role of the MD. In two further Trusts this role separation was planned or being considered for the future.

Reasons for splitting
The reasons for separation differed between Trusts. In some cases this had initially come about during a transition – a change of Medical Director meant an interim RO had to be appointed and the incoming MD suggested that the interim arrangement should continue. In other cases a firm decision to separate the roles had occurred – where this was the case this had usually been because the workload of undertaking the dual role was considered too much of a burden for one individual.

The nature of the split
Where separation had occurred the exact split of the responsibilities between MD and RO was not always the same. At two sites the RO focussed mostly on revalidation and appraisal and was less directly involved in management of conduct cases (albeit that the RO was kept informed of any such issues).

Whilst written terms of reference for the role split may exist (this was not always made clear) the reality tended to be more fluid and the degree to which the arrangement worked well was very reliant on good communication between the two post-holders.

Even where the MD and RO role were not officially split the revalidation aspect of the RO role was often delegated.

¹ Taken from Role of the Responsible Officer: Responsible Officer Guidance – Closing the gap in Medical Regulation, Draft version 4
Pros and cons of splitting the roles of MD and RO

The pros and cons of splitting the role of RO from the MD role are set out in the table below:

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
</tr>
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<tbody>
<tr>
<td>More manageable workloads.</td>
<td>Possibility of elements of responsibility falling between the two individuals.</td>
</tr>
<tr>
<td>Less individual subjectivity on difficult cases and decision making – more discussion.</td>
<td>&quot;We do have a gap though, and we know about the gap and we’re working through the best way to address it, which is around senior medical leadership of the quality agenda.” (Case Study 6)</td>
</tr>
<tr>
<td>Reduced conflicts of interest.</td>
<td>Is absolutely reliant on good relationship and communication between RO and MD.</td>
</tr>
<tr>
<td>between RO role and Board role to:</td>
<td>&quot;If we do go to that model you have to have a very close relationship between the RO and the Medical Director or you’re going to end up working potentially on the same thing in different ways or missing things that we ought to know about.” (Case Study 5)</td>
</tr>
<tr>
<td>▪ Preserve the reputation of the trust.</td>
<td>Allows MDs to back away from responsibilities that some feel should be theirs.</td>
</tr>
<tr>
<td>▪ Manage resources efficiently.</td>
<td>&quot;I just think, if you see your role as the Medical Director as setting standards and raising standards and making sure people work to and live by those standards, then delegating the Responsible Officers just seems like an odd thing to do to me.” (Case Study 2)</td>
</tr>
<tr>
<td>&quot;I think in some respects it’s helpful because there may be employment issues but you still recognise that that doctor probably is fit to practise, or hasn’t reached that kind of threshold.” (Case Study 6)</td>
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<td>One RO described the split as being useful to preserve the unique and separate interest of the two roles:</td>
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<td>&quot;The RO is an idealist, in pursuit of excellence. The MD is a pragmatist getting people to work harder for less money!” (Case Study 7)</td>
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<tr>
<td>Allows MD to take a step back at early stages and is therefore less conflicted as a Case Manager should MHPS investigation take place:</td>
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<td>&quot;If it goes further and you get into disciplinaries and appeals and conduct and so on and so forth, MHPS type procedures, that your Medical Director is not necessarily conflicted by earlier involvement.” (Case Study 7)</td>
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Whilst most of those interviewed in Trusts with a split role felt it was working well, one RO was not as supportive of the approach. This was based on a perception that communication was not working as well as it needs to. However the split role was a relatively new arrangement and this RO’s MD counterpart did express a feeling that it would take time to get it right.

3.3 How does the process differ between case study sites?

At all sites the process of dealing with a concern was naturally dependent on the exact nature of the concern. Interviewees found it difficult to generalise about the process. The more formal processes described at all sites adhere very closely to the
documented process set out in MHPS and by NCAS. The process differs for health, conduct and performance cases. Rather than describe these standard processes, this report will focus on areas where differences of approach have been found.

3.3.1 How concerns come to light

Concerns at all sites come to light in a number of ways – for example from performance data, serious incident reviews, patient complaints and from colleagues raising concerns. Whilst the sources of concerns coming to light were essentially the same; a key difference, influenced strongly by size, was the degree to which the RO and / or MD would hear about issues (particularly those raised by staff) directly or indirectly in the first instance.

In smaller Trusts where the MD and / or RO is likely to know or be known known by all medical staff individually, there is clearly a greater chance that they will be made aware at an early stage and more directly. In larger Trusts staff raising concerns are more likely to go to their immediate Department or Clinical Director. Likewise reviews of complaints and serious incidents are managed through a complex structure and will only be escalated to the MD and /or RO at a later stage. In relation to all sources of concern, larger organisations naturally have much more complex systems of management. One interviewee described the complexity in play:

"So we're a massive organisation so we've got complicated ways of managing things by different people at different levels and in different settings. So complaints, not serious incidents, serious incidents and never- events are handled in different ways by different people. Serious incidents and the never events probably by the same people but what I might call ordinary incidents are handled at a kind of management level and are only fed up if there's a review of some sort required. And then complaints is managed by another part of the forest as well. So that's how the formal recorded stuff happens and those would tend to be along the lines of capability, as defined by MHPS. But there's obviously all the conduct stuff that starts somewhere and is managed one day by someone in one way but eventually, for some small proportion, gets right up to the MD. So that all works in a completely different way and, of course, health is another kettle of fish altogether. So we've got different people managing different bits in different ways." (Case Study 6)

In contrast, the description of how things can work in a small Trust is stark:

"The numbers we get are small, it's an advantage being in a small hospital because I know pretty much every Consultant in the corridor that I pass, even though I may not work with all of them on a regular basis. I would know them to stop them and say hello to and just have a
chat, and we would usually have something to pick up on. So that’s a real advantage for me.” (Case Study 7)

TARGETED APPRAISALS
At case study sites 5 and 7, both of which employed fewer than 500 doctors, the concept of targeted appraisal was in use, as a way of preventing doctors in potential difficulty becoming embroiled in more serious issues. In these locations, rather than randomly assigning appraisers they specifically assigned appraisers either with full NCAS investigation training (site 5); or who were known to be particularly fastidious and careful appraisers (site 7), to doctors about whom there were concerns. This was said to mean a more stringent and meaningful appraisal and revalidation process; specifically designed to nip issues in the bud rather than allow them to pass and ultimately lead to concerns or complaints further down the line.

“The three, four, five heart-sink individuals [the RO] knows are in the system and, even though your appraiser is supposedly to be randomly assigned, he didn’t randomly assign; he deliberately took the half a dozen of the individuals, or had the ability to take half a dozen individuals who are potentially running into trouble and assign them to a senior appraiser as part of a revalidation, who had remediation skills. So I personally was involved in seven or eight individuals with my appraiser hat and I’ve actually turned them around.” (Case Study 5)

This particular suggestion was tested at later case study sites as a possible ‘promising approach’. The response was mixed with a number of interviewees stating strongly that the appraisal process is not a place for managing concerns and that this approach could mean issues that should be raised with the RO are not.

Some others who felt this was a good idea would want to work towards this approach but felt it could be difficult when currently the individual is allowed to choose his or her own appraiser as an aspect of an open process. An interim measure one Trust was hoping to put in place was to restrict the number of times an individual could choose the same appraiser over subsequent years.

BOX B – Promising Approach from Case Studies 5 and 7
(Small Trusts in the North and South of England)

3.3.2 The Triage Process

Initial fact finding and sense checking
Once an issue has come to the notice of the MD and / or RO there is an initial process needed to establish the facts of the case. At all sites it was clear that the nature of this early stage process is very dependent on the exact details of the case. Early consideration will be given as to whether patient safety could be at risk and, therefore, whether there is an urgent need to restrict the doctor’s duties or exclude them from work. Senior doctors also explained that they would try to establish, at the
earliest possible opportunity, if a practitioner’s health was at the root of a concern to ensure that health issues were dealt with by the appropriate mechanisms - occupational health.

"I think you must be absolutely crystal clear that this is not a health issue because that should be managed in a different way. So I think most medical directors will agree with that.” (Case Study 9)

In most cases the MD and / or the RO would discuss the case with an HR Director or another senior colleague at this early stage, prior to a formal process, simply to take soundings on how things should proceed and how the facts should be established. At all sites these very early stages were very variable in nature, and interviewees struggled to describe a generic process:

"So once something is raised, what I do initially is... well, I hear very clearly what the issue is and, pending on how I assess the severity, I will often have a discussion with the Director of HR, because he’s got a lot of experience from other Trusts, just to sense check my view. I often have a discussion in confidence with the Trust Secretary who is a Solicitor, because I find he’s a very good barometer of public view... So I sense check it with those.” (Case Study 5)

Initially, if the concern was raised by a colleague and it was not black or white, a member of the senior team may have a brief look around for any evidence to support or quash a concern that has been raised - looking to see if it is a genuine issue or a clash of personalities.

This 'look around' may include a quick review of previous appraisals, CLIPS data (Complaints, Litigation, Incidents, PALS, Safeguarding) or off the record conversations with colleagues working with the individual in question. This initial stage was common between sites but highly variable in nature. Rather than uncovering variation between case study sites in terms of this early stage there is, in fact, considerable variation in the process applied at all sites case by case, depending on the nature of the issue.

**The core decision making group**

Following, or sometimes concurrently with, this initial fact finding investigation, at almost all sites the MD and / or RO would broaden the discussion and consult a wider group of senior colleagues. It is in consultation with this group that a decision is made as to proceed with a formal process or to attempt informal resolution. It is also this wider group that discusses whether or not a referral to the GMC will be appropriate at this early stage. In most cases this group would meet face to face to discuss cases, often as part of a regular management meeting. At one site (Case Study 5) the process was email based – with the same core group emailed by the RO (also the MD
on this site) with an outline of the issues and with each individual responding with their views, copying in other group members.

"I have a decision making group...I will actually email them with the bones of the issues, I will say 'so and so, the allegation is X'...they themselves recognise that they did this, or do not.' Our options are a) given the fact that this person does recognise and is, I believe, aware of the issue, we could elect to apply a form of sanction, formal written warning, whatever it is, we might list them [the options available]. Or we could go to a panel hearing, and a full investigation panel hearing, and that’s depending on the individual accepting those. The DMG comes back and each individual comes back individually with their view of what should happen." (Case Study 5)

This decision making group was generally limited to a small number of senior clinicians and HR representatives and was particular to each Trust. For example:

- Case Study 2 - HR (2 members)) and 2 Medical Directors. The RO was not included (see 3.3.3)
- Case Study 5 – RO/MD (combined role), non-Executive Director, Deputy Medical Director, HR Director, Chief Nurse.
- Case Study 6 – MD, HR Director, RO, Deputy MD, a senior HR Manager
- Case Study 9 – MD/RO (combined role), CEO, HR Director

In some cases a group was not convened in the first instance. At Case Study 1 the early discussion was always between the MD and the HR Director alone; sometimes a wider discussion was held with three further senior doctors, but the RO (separate role) was not routinely involved at these early stages. A regular weekly meeting, of senior doctors at this site was held and did review ongoing cases but wider involvement at the initial stages was not always undertaken. This was not felt by the MD and HR Director to be problematic, as the RO would be involved should the case warrant consideration of referral to the GMC. However, the RO in this case did feel that communications were not working as well as they should:

"I think it’s a slightly fractured thing that needs a lot holding together..I've been around a long time, then I'm probably managing to get it to work properly but I think, if you kind of reinvented it, this wouldn't be how I would invent it." (Case Study 1)

At another Trust (Case Study 2), they have relatively recently introduced a weekly meeting which has helped ensure that cases progress more quickly and streamlined the process. They described the meeting as 'sacrosanct' in their diaries. Involving different personalities and a mix of HR and clinical staff at the meeting built an element of challenge into the process.
"It also allows really... the strength of the group and the knowledge within the group and the fact that that will be challenged within the group and the person who is less experienced kind of improves their learning as well. So it’s a right thing that the group works better than just having the one person, because whereas you can get consistency with one person, you can say there’s a serious lack of consistency with one person, with a group you're more or less guaranteed consistency of the decision making." (Case Study 2)

In one instance the precise make-up of the decision making group was dependent upon the concern being looked at. This small Trust further believed that a set decision making group was impracticable because it could contain an individual who was connected to the doctor in question.

Whilst none of these groups had a formal constitution or came under the scrutiny of any external quality assurance process, most interviewees held the view that this was not necessary. They explained that the legitimacy of the group came from the seniority and status of those within it, their trust in one another and their experience of the work involved. A number of individuals within Trusts spoke about the need to ensure that this group contained a mix of personalities and potential viewpoints; highlighting the danger of the MD only seeking the opinion of like-minded individuals.

"I think the main assurance is that it’s a group and it’s learning all the time about how it responds to some things. I think it would be fair to say that there are hawks and doves in that group and the doves are brave enough to say when they think the hawks are being too brutal, and the hawks are very happy to say 'come on, we need to work this in a certain way'. I think it’s really hard to do formal reviews and ensure consistency because all the cases are so different." (Case Study 6)

Other methods adopted to provide some assurance around the decision making group were not universal but included:

- Case Study 6 – where the members of this group had received unconscious bias training (see Box F).
- Case Study 11 – where all conversations within the decision making group are documented and kept on record in case they are ever challenged.

3.3.3 Case management and review

In larger Trusts this decision making group was likely to meet on a regular basis, often weekly. In smaller Trusts it was often, but not always, more ad hoc. Interviewees from the larger Trusts explained that the regularity of the meeting ensured that issues were progressed and ongoing cases did not lose momentum. Each
week a full review of all ongoing cases and issues would be undertaken and actions would be set and delegated for the following week.

Some of the larger Trusts deliberately kept the MD out of this meeting and not responsible for direct case management so that they would be more objective in the case of appeal or secondary decision making:

"The reason it was set up was just that, it was a number of reasons. One, it was to have a robust process that didn't rely on one person making a decision. But it was also a process to allow the Medical Director as Executive to one, be advised, but also be not directly involved in the operational management of the process, so that they can be slightly separate from that process because a lot of the secondary decision making will have to go to the MD." (Case Study 2)

"It has the advantage of keeping xx out of it as far as possible because, if he was to case manage the consultants, then it would be very difficult for him if there was an appeal against anything then to get involved. So it's something that we started to do a number of years ago, where the very senior Divisional Directors and the Deputy Medical Directors would take on those cases so that there would be a second line that people could appeal to so it made the process easier to manage internally." (Case Study 3)

Whilst not at the weekly meetings, the MD (also the RO in both cases) at these sites (Case Studies 2 and 3) was still very involved in overseeing decisions and had regular meetings with the ELA to discuss escalation of more serious cases.

**3.3.4 Further investigations**

Where a concern is deemed to warrant further investigation, a more structured process is undertaken. The purpose of this investigation is to establish whether it is a serious concern that needs to be dealt with via the more formal MHPS route or, indeed, whether this is an issue that could be dealt with under other Trust policies, via local resolution and / or via Occupational Health.

This stage could feed directly into the more formal investigation stage should the case go forward under MHPS. It, therefore, needs to follow MHPS principles and be well documented, as ultimately it could be used to inform a more formal process.

"We want to do it as a mini MHPS standard is what I'm saying because what you don't want to do is start something which is half-baked, find out there's something which you should have done properly, i.e. you should have looked at terms and conditions or you should have actually interviewed or set it up as a proper interview process or somebody's said something or put some
paperwork out. It should be done in the same kind of standard, so therefore it’s very clear. So, yes, in my mind it’s what I call a mini MHPS.” (Case Study 11)

There was to some extent a blurred line, therefore, between this pre-MHPS stage – to decide whether the case should be dealt with under MHPS - and the MHPS process itself. For most Trusts, where informal became formal was the point at which the senior team/decision making group took the view that there was a “serious” issue to escalate and that not working under MHPS would be considered a risk.

3.3.5 Local resolution

Interviewees from all Trusts explained that, unless the concern raised related to patient safety, criminality, repeated patterns of bad behaviour, lack of insight or was likely to necessitate exclusion i.e. was deemed ‘serious’ then it was both desirable and appropriate to seek local resolution in the first instance, using line management or within departments or directorates. However, it was recognised that local resolution was not always possible if the concern related to a manager of a department. In these instances all Trusts encouraged the concern to be escalated to the next level.

Most senior staff explained that concerns raised directly with the Medical Director, but which were not deemed to be of a serious enough nature were subsequently de-escalated. Clearly, in larger trusts the levels through which concerns might be escalated and de-escalated were much more extensive.

In these larger organisations there are, by definition, a larger number of managers who might have to deal with these low level issues. If such issues are repeated they may need to be escalated (again). The MD and / or RO cannot have a full picture of what is happening for all these minor concerns and the extent to which they are visible depends to some extent on the confidence and attitude of the local manager.

"Some of them will know this because they’ve been Clinical Directors a long time, some of them are a bit greener so we’d be more direct at saying ‘well done, you’ve done the right thing, thank you for letting me know, now see them again, tell them you’ve had to escalate it to me, tell them that I’m concerned about it and if anything else happens we will have to consider formal action as a possibility’. Record all of that, put it on their file and monitor it, so follow it up specifically. Hopefully, that happens most of the time, I’d have no way of knowing, we don’t track it.” (Case Study 6, RO)

In addition to local management by departmental or clinical directors a number of other approaches were described as part of the mix of possible approaches to achieving local resolution, including:
• The MD or RO having a fairly informal ‘chat’ with the doctor in question. Interviewees reported that lower level concerns were often dealt with by directly speaking with the individual involved. The precise nature of these chats varied according to the concern and the attitude of the doctor. A number of senior staff advised that any meeting, even this informal chat, should be attended by a member of the HR team and a note that the meeting took place left on file. However, there were also a few sites where this strict adherence to recording and witnessing of such chats is not universally applied. The decision about whether or not to involve the HR team to document the conversation was dependent on the profile of HR amongst the senior medical team and/or the capacity of the HR team to be involved.

"I will either discuss it with the individual on their own, but more commonly I will actually orchestrate a meeting with the individual and a member of HR present and that is so that it’s witnessed.” (Case Study 5)

• Interviews in around half of the Trusts involved in this research referred to mediation as a means of dealing with behavioural issues:

"We may offer facilities where we mediate; that’s something that we do and again we can do that as a one to one if there are just two people involved and it’s just a clash of personalities. Or we can do a bigger mediation if it was a group of consultants or junior doctors that had an issue.” (Case Study 11)

• Staff from one Trust reported that, on occasion, the decision making group decides not to pursue the concern but instead conducts a ‘protected conversation’ with the doctor in question. The idea of “protected conversations” is to allow employers to enter into off-the-record conversations with a view to agreeing the exit of an employee. No other case studies applied this approach and the Trust in question explained that it was only appropriate in certain situations and with very clear provisos.

"I would think it’s very rare other Trusts use it, very rare. I don’t know why, I have no idea why. I think people are a bit frightened of it, you have to have some nerves to do it and the thing is, it isn’t right in all situations. So I would never have a protected conversation if there was any patient safety that was at risk, never, ever, ever. So they have to be more on the personal behaviour type things.” (Case Study 9)

• One large Foundation Trust had their own fast track disciplinary process which they used for less serious cases where the doctor in question has shown insight.
"We have our own fast-track policy here, which covers all staff, and we do use it quite a lot with our medical staff whereby, if somebody accepts that they’ve done something wrong then we don’t go through a whole process, we’ve got a fast-track where they can go straight to an outcome, which can range from... it doesn’t cover no case because, if they put their hand up and said yes, I’ve done something wrong, but we can then go immediately to a sanction short of dismissal, short of dismissal and final written warning. So if a Consultant comes in, puts their hand up and said my behaviour in theatre was unacceptable, I’m quite happy to go through retraining and to do whatever you want to do, then we don’t take them through the full MHPS. So we may well give them a written warning at that time which is agreed with them and with their rep, it saves the emotional baggage that you get with a process, it saves a huge amount of time, it saves a huge amount of cost..." (Case Study 3)

**IDEA FOR THE FUTURE:**
One senior doctor suggested the idea of developing an integrated ‘professional support unit’ at their Trust. They envisaged this unit providing a more holistic approach to remediation for doctors in difficulty since in many cases issues arose because of a complex combination of health and related performance issues which are not easily separated and should be resolved in an integrated way.

“...So in that professional support it would be the classic things like Occupational health, mentoring schemes and then you’d tailor fit them to the individual needs. And I think catching somebody early on, providing professional support does make a happy workforce and add to their longevity... Sometimes we feel that Occupational health is, not too isolated, but it’s not integrated with any other services that would help a doctor to get back on track.” (Case Study 6)

### Case Study 6
**(Large Trust in the North of England)**

#### 3.3.6 MHPS Process
All Trusts had their own policy based on MHPS. Once the senior team has established that they will be dealing with a concern under MHPS there was little significant deviation from the standard process, albeit that the various Trust’s policies add further detail to the basic framework supplied by NHS England. Medical Directors and other senior doctors frequently referred to the idea that if MHPS was not followed to the letter then the Trust would be opening itself up to litigation and the outcome of the
process could be undermined. Several believed that MHPS was written to protect doctors and that dealing with a doctor under MHPS was a time consuming and costly process for the Trust to undertake.

"I think it seems like all the cards are with the individual and not many with the Trust really. You have to work quite hard to follow it, it's very difficult not to go off track at all." (Case Study 11

However, some felt that MHPS can be useful as it allowed them to cite (and blame) the process when making difficult decisions and communicating them to staff.

"Because it gives you a structure to do it, it depersonalises it. I can say 'look, this isn’t me’, but it is, ‘but I’m doing this within MHPS, this is what we have to do and this is how we do it’." (Case Study 2)

Some Trusts had adapted or adjusted the standard MHPS process to better reflect the needs of their organisation. However, where changes had been made interviewees tended to express some nervousness that any such changes could be challenged by a doctor’s legal team and used as a way to undermine and challenge the process. Because of this nervousness changes tended, for the most part to be described as being relatively small. They included:

- Not adhering to the requirement to have a designated Non-Executive Director (NED) to oversee a case.
- Including an additional appeal process. However, the current HR team at this site are in the process of taking this out as it has proved unworkable, doesn't add any value and delays the process even further.
- Departing from the prescribed roles set out within MHPS, for example:
  - Not always assigning the MD as the Case Manager. This was usually because the MD’s workload and the number of investigations would make adherence to this requirement untenable. The MD would only act as Case Manager in cases where the doctor being investigated was very senior or where the case was particularly difficult or contentious. Furthermore it was explained that not having the MD as Case Manager ensures the MD's independence if the case goes to appeal.
  - Not requiring the Case Manager to present to panel hearings, instead asking that the Case Investigator undertakes this role since they are closer to and have a better detailed knowledge of the evidence.

The HR Lead at one Trust explained that they had chosen to make a more significant change to the MHPS process and had removed the mandatory requirement to consult NCAS.
3.3.7 Involving NCAS

The role of NCAS is set out clearly within MHPS. Taking the decision on whether to involve NCAS or not is therefore closely tied to the process of deciding whether the case warrants invoking the MHPS process. This decision is mostly taken by the core decision making group (see 3.3.2) and the majority of sites appreciated an independent view of a situation. NCAS support was particularly welcomed in instances where a senior team feels a concern may necessitate a suspension.

"Suspending someone from the Trust is meant to be this neutral act, we know it’s a neutral act, but it has immense consequences and I think to be very clear that that - and that isn't something that as a medical director, you can't kind of phone a friend in the Trust and ask them whether or not you feel that this is serious enough to warrant a suspension. So, that, again should go through an external benchmarking to say actually what I’m hearing here is potentially serious enough or that it would interfere with the investigation.” (Case Study 11)

At most Trusts the relationship with NCAS was perceived positively and both ROs and MDs talked of valuing the ability to speak to NCAS staff and gain advice over difficult decisions. NCAS was also seen as invaluable in helping Trusts to design packages of support which, are more likely to be seen as fair and robust given NCAS’ external status.

3.3.8 Referral to the GMC

Ultimately the decision to escalate a concern to the GMC lies with the Responsible Officer. However this is usually something that would be discussed with the core decision making group (all but one case study site referred to such group) during the early triage and investigation process. Whilst the RO was not always involved directly in this decision making group, should the group think referral to the GMC is necessary the involvement of the RO would then be necessary.

In many cases this decision on whether or not to refer is clear-cut – for example, immediate referral would occur in cases of severe and/or immediate compromise of patient safety, criminal activity and/or completely unacceptable behaviour i.e. sexual impropriety, self-prescribing, drinking at work. Where the decision is not clear cut further investigations will be undertaken (see 4.3.4).

The timing of such a referral varies. It may need to occur immediately – in cases of immediate compromise of patient safety; it may only occur after a full investigation and of course in some cases (i.e. police matters) the GMC may be informed by another party.

"I think to go to the GMC you’re looking for two groups of people, those who have just done something horrendous, be it behavioural or clinical,
abusing patients when they examine them and that sort of thing. Nobody would have a doubt about that. And then there’s the doctors who at the end of a very detailed and thorough internal investigation just say ‘well, I’m glad that’s over, that was a load of nonsense, let’s just get on with life’ and, if they show no evidence of reflection and what you were dealing with had the potential to harm patients, then I think that goes to the GMC because there’s no evidence that they’re changing their behaviour.” (Case Study 3)

For concerns that warranted internal investigation but not immediate referral to the GMC, ROs explained that their close relationship and regular meetings with their ELA were helpful in deciding if, and at what point, the concern needed to be escalated to the GMC. The RO often had discussions with the ELA about an ongoing case prior to officially reporting it.

Perhaps, unsurprisingly, no interviewees felt that their own Trust would ever refer a doctor to the GMC that would not be likely to meet the thresholds for investigation. Trusts reported that, if possible, they preferred to resolve concerns via internal processes. Interviewees felt that involving the GMC unnecessarily:

- Prolonged the matter.
- Was very distressing for the doctor involved.
- Was a waste of GMC resources.

"As long as they’re safe, referral is a last resort, you’ve got to try everything else first. After all, the GMC is an expensive resource, it’s a limited resource and it needs to be used appropriately, and it needs to concentrate on those people that really need it. We have a duty to filter out those people, not over burden the GMC.” (Case Study 4)

ROs were confident that they had a good feel for the GMC’s thresholds. They did not feel the need for further guidance and, in fact, felt that since all cases are so different and individual, truly comprehensive guidance would be impossibly long. The ability to discuss borderline cases with their ELA provides all the additional guidance that most ROs felt they might need.

A number of interviewees believed there was a clear distinction between the GMC process and internal disciplinary procedures. They acknowledged that the GMC is concerned with fitness to practice across the UK whereas a Trust is also concerned with a doctor’s ability to perform a particular role to the necessary standard within the Trust.

"I’ve got standards of conduct in xx based on our organisational values, based on what I expect of teams when they’re working together, which are different [to the GMC]” (Case Study 8)
4. Problematic aspects of dealing with concerns about doctors

Section summary:
- Interviewees highlighted several recurring difficulties when dealing with concerns about doctors:
  - Subjectivity and isolation for decision makers.
  - Balancing the need for confidentiality with the desire to foster an open and transparent culture.
  - Desire to see greater parity between how concerns are dealt with for medical and non-medical staff.
  - Unpicking complex and borderline cases.
- Once concerns were deemed ‘serious’ there was also a great deal of difficulty in managing the MHPS process:
  - The litigiousness of the process.
  - The tight timelines involved.
  - Maintaining a pool of trained Case Investigators.
  - Accessing credible expert witnesses.
  - The sometimes variable quality of NCAS advice and assistance.
  - Unwilling witnesses and the inability to collate sufficient evidence.
  - The generation of counter complaints.
- These problematic aspects gave rise to several ideas and promising approaches that are highlighted in text boxes throughout the report. They include:
  - Formalised learning via review of previous cases.
  - A forum for Case Investigators.
  - Sharing Case Investigators at a regional level.
  - Sharing legal and HR expertise.

4.1 General difficulties of dealing with concerns

Interviewees were asked to outline the aspect of the processes for dealing with concerns about doctors that cause the most problems or issues. The findings were fairly consistent across all 11 Trusts, albeit with some variation based on the size and resources of the organisation. The nature of the difficulties described is presented in Figure 5.
4.1.1 Subjectivity and isolation for decision makers

A number of interviewees, particularly those working in smaller organisations with relatively occasional exposure to investigating and managing concerns, expressed doubts and fears about their own skills to deal effectively with cases and always to make the right decisions. Despite the sharing of these responsibilities with colleagues and the ability to discuss dilemmas with the ELA and/or NCAS, there remained a sense of a heavy responsibility and nervousness that their own subjective viewpoint and approach could be wrong.

"I think it does strike me that often it is down to my interpretation at the beginning, the action I take right at the beginning dictates what happens and sometimes I wonder how right that is. As I said, I could be wrong but then, as I say, I do calibrate... when I’m calibrating or when I’m listening to other ROs talk, there are times when people handle things a little differently, it’s not uniform.” (Case Study 5)

Similar concerns were expressed by some of those involved in case investigation work – a feeling that their experience and skills in undertaking such investigations, could be improved if they were able to share and discuss their concerns with others doing similar work.

"I do feel a little bit that the role of the Case Investigator can be quite a lonely one and, as I say, that we’re not using it enough. Within this organisation I would absolutely say that we need to have a better way of learning and sharing appropriately.” (Case Study 1)
Feelings of isolation were exacerbated by the need to keep details of cases strictly confidential, often a case investigator could not talk to another senior colleague about the issues of a case because that colleague may be acting as the Case Manager and would need to maintain distance from the investigation.

4.1.2 Confidentiality vs. transparency

This desire to learn from previous cases was hampered by the need to keep cases confidential, as required by MHPS and for the protection of the doctor at the centre of any concern.

Sharing learning amongst those managing concerns was not the only conflict in this regard, there was also a frustration, frequently expressed, that senior staff within Trusts could not communicate to their wider staff that they do deal with doctors’ poor behaviour and performance. Such communication is vital to build confidence in the system and to encourage staff to raise concerns. Often, however, from the point of view of the wider staff, a poor doctor may just disappear from view and it will never be known that the Trust has taken the necessary action to deal with a concern. This may leave staff feeling that poor doctors get away with things, when in fact this is not the case.

"Because it’s done in a way that is appropriate, proportionate and confidential, I think the wider medical body don’t necessarily realise that it’s happened as much as it perhaps has. So unless they have direct contact with the doctors that were causing the biggest problems that have now been more managed, I don’t think they necessarily perceive that we’re dealing with the problems.”(Case Study 5)
**IDEA FOR THE FUTURE:**
A forum for Case Investigators

It was suggested that a mechanism or system for learning from cases across all trusts, perhaps facilitated by the GMC or at regional level, would be helpful.

This would not just be learning for ROs but would be cascaded and shared across all of those who are involved in processes of this nature – including HR staff and case investigators.

There could also be wider learning points for sharing with all doctors, in terms of pitfalls to avoid in their practice.

“So it might be a useful thing that would come from your report if the GMC can, in collaboration with the Trust, come up with some sort of a mechanism... of communication of those lessons learnt to everybody in the Trust, or beyond that. Because what happens in one Trust is a lesson for another Trust. It could happen to anybody so, if there was an investigation about sexual harassment from which we learnt some big lessons we didn’t know about before. This should be feeding everybody, not just the Trust where it happened but across the board. So the GMC and the Trust can come to some sort of agreement for this to be presented, in a generic way of course, not identified.” (Case Study 10)

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**Case Study 10**
(Large Trust in the South)

**WIDE POOL OF CASE INVESTIGATORS**
One Trust makes a point of having a wide group of individuals who are trained as case investigators – at consultant level and not just management – so that the process is viewed as being fair as it is conducted by peers of the doctors in difficulty.

“So we do have a wider group here that are involved and I think we benefit from that, and that’s just the way we approach it. And having 30 of our 60 are consultants, so 30 consultants who are active in MIPPS cases. So it’s not seen as something which is done by management. It’s very difficult for a group of Consultants to say this is unfair when it’s a peer that they admire who undertakes the process, and it gives them assurance that the process is a fair process as well.” (Case Study 3)

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**BOX C – Promising Approach from Case Study 3**
(Large Trust in the Midlands)
### 4.1.3 Desire for greater parity between medical and non-medical staff

A number of senior staff across a range of case study sites expressed a frustration that doctors could not be dealt with as any other employee would be. The existence of specific national guidance for these staff alone, necessitates a different approach which, for some, is seen as unjustified.

"So, therefore, nurses are going to be far less protected than doctors. I happen to believe that the accountability should be the same, they’re both professions and they’re both dealing with patients and I find it very difficult to justify why doctors are treated differently to a nurse” (Case Study 4)

This lack of parity is also seen as harmful to the overall culture of an organisation. Where fairness, values and expected standards of behaviour are being communicated to all staff, from doctors to nurses to porters, some interviewees felt that to have a different and separate system for dealing with issues that arise amongst a particular sub-set of staff sends an unhelpful message.

### 4.1.4 Dealing with complex or borderline cases

Many of those involved in investigating and managing concerns emphasised that it is difficult to generalise about how easy or difficult the process is. Some cases prove particularly difficult either because there is a complex interplay of factors involved; or because there are different points of view of the same issue; or because there are grey areas – cases where the issues are simply not clear-cut.

In many cases what begins as a performance issue may turn out to be a health issue and / or may also lead on to issues of misconduct, this kind of complexity makes cases particularly hard to manage.

Cases can be particularly difficult as well where a sub-culture within a Trust has gone badly wrong and relationships have become dysfunctional. It is then very difficult for a Case Investigator to get to the truth of the issues arising from any concerns raised.

"Where there is a long history of intradepartmental bickering, I get heart sink with those. Particularly where it’s unclear whether we’re looking at an overall individual major contribution to the bickering, or is it just the dysfunction of the department. Those are the ones that I get heart sink over most, because I know it’s going to be really difficult to find facts.” (Case Study 6)

A number of interviewees stated that the more extreme cases of poor behaviour or performance are, in fact, easier to deal with than low level repeated issues that are individually less serious. Low level repeated issues can be harder to define, harder to investigate and harder to manage.
4.2 Difficulties of managing the process

4.2.1 Litigiousness of the process

Several interviewees – particularly those in HR roles - were very critical of the MHPS framework. The perceived inadequacies of the documented process were seen as having led to an increase in legal intervention on both sides, with the grey areas and gaps within MHPS being tested in court.

Given the litigious nature of the MHPS process several Trusts mentioned seeking the advice of their legal advisors in the initial stages of an investigation.

"If you make a slip in process, a small slip in process, the value of the entire investigation is called into question and you could lose the entire value of the investigation on a date, an email, an incorrectly carried out conversation, da de da, and that’s just the reality." (Case Study 5)
IDEA FOR THE FUTURE:
Sharing legal and HR expertise
One large Trust in the Midlands has invested in its own specialist employment lawyer and Medical Resource Officer which has saved it money and helped build expertise within the Trust. They suggested that smaller Trusts could group together to pool resources to replicate this.

“We relatively early brought in our own in-house employment lawyer, which I think is something that’s made a massive difference in the speed of which we manage our MHPS cases. ... I think if you’re looking for what’s the good practice we have here, we pay less now in legal fees which cover her salary. ... if I was at a small Trust and I was talking about employing an employment lawyer at £80k a year, then it would be a very difficult sell. Whereas ... we’ve got enough work and we were spending enough with legal teams anyway to justify it. But there’d be no reason why two or three Trusts couldn’t come together and employ their own.” (Case Study 3)

Case Study 3
(Large Trust in the Midlands)
One HR Director was particularly vociferous in their criticism of MHPS and outlined the damage being done by the current situation – both in terms of achieving fair outcomes and in the damaged relationships that lengthy legal battles can cause.

"So its 10 years old, its riddled with holes, it’s full of case law, its nationally negotiated, it doesn’t seem to be working for anybody. We end up with people floundering around on the edges of them unless they’re cast iron and it’s just become a complete mess in terms of doing it, and is damaging the relationship and the confidence that people have got and, in 90% of the ones that you deal with, you end up with a debate on who was following the right process, not on whether you tried to resolve the basis of the original complaint, and it’s terrible, it damages relationships.” (Case Study 6)

4.2.2 Timelines
The fact that key MHPS roles have to be taken by staff with ongoing clinical duties causes considerable difficulties, especially given that resources are already stretched.

Several MDs and HR leads felt that the MD (or equivalent) often did not have the capacity to take on the case manager role that is required by MHPS. Furthermore, finding a senior doctor with the training and availability to conduct a thorough investigation and write a report within the 5 week time limit set out in MHPS was
hugely problematic. Case investigators themselves went on to explain that coordinating interviews with witnesses who often worked shift patterns added to the time pressure. Several interviewees felt that time pressures were likely to become even more apparent as a result of the Carter Review.

"It’s very, very, very difficult to get a clinically driven or clinically led investigations now because performance, this work from Carter on job planning. Doctor productivity is going to make it much more difficult to get clinicians to be involved in a lot of those processes because it’s all about how many direct clinical activities you deliver and how many patients you see within those. Absolutely the right thing to do but we have to absolutely make sure, and I think the GMC need to think about how they influence the Carter review and the model hospital and the units that they use called the WAU.” (Case Study 4)

**IDEA FOR THE FUTURE:** Creating a 'Faculty' of Case Managers
One large Trust deliberately trained all its Divisional Directors to be case managers partly to tackle the issue of those currently undertaking the role being overwhelmed with work and also to try to ensure that more middle management take some responsibility for the process. One interviewee at the Trust would like to take this one step further and develop a faculty of Case Managers like they have done with Appraisers get them comprehensively trained and quality assure their work.

**Case Study 2**
*(Large Trust in the Midlands)*

**4.2.3 Maintaining a pool of trained case investigators**
A key difficulty expressed many times within interviews, across the majority of sites, was the need to balance the number of trained case investigators with the number of cases, given that it is impossible to predict the number of cases a Trust would be required to investigate under MHPS. In small hospitals this can prove particularly difficult since a decision may be made to train someone as a Case Investigator but they then lose their skills and knowledge through lack of exposure to actual cases.
IDEA FOR THE FUTURE: 
Sharing Case Investigators at Regional Level

Given the problems of achieving the right numbers of Case Investigators (particularly in smaller Trusts) the idea was suggested, by a number of interviewees, of sharing the resource of those who are trained across a region. In some regions this was actively being discussed. This also has advantages from the point of view of avoiding inevitable conflicts of interest in very small organisations.

"[External case investigators] could sit outside all organisations and be supportive to all organisations, or could be sitting in one organisation and supportive to all organisations. In both of those the Trust that’s the employer would have to make the decisions, but the investigation could be run independently by that particular resource."
(Case Study 4)

"I think I’m increasingly taking the view that we need to get external people to do the investigation... I’ve already had to think about who has a vested interest in this, who’s doing whose private practice, who knows whom, whose wife knows whose wife, all that kind of business..."
(Case Study 8)

Case Studies 4 and 8 (Small Trust in the North of England and Large Trust in the South of England)

In some cases, concern was expressed that people were being asked to undertake the role of Case Investigator without adequate training:

"I have a slight concern that not everybody who is involved in the process has really had the training, I think there’s a lot of it is kind of training on the hoof. So if you look above your head there, that is my Case Investigator training manual, there’s a Case investigator and I think there are only two people in the Trust who have actually had that."
(Case Study 1)

Access to training for investigators was reported to be a problem by some, whilst others gave positive feedback about the NCAS course and did not suggest that access had been a problem. Larger organisations, with a need for a wider pool of investigators were able to organise in-house courses, often led by someone who had previously been NCAS trained, also bringing in external experts such as lawyers.
DUAL INVESTIGATORS WITH ADDITIONAL TRAINING

A decision was taken to appoint both a doctor and a manager to investigate cases since each provides different perspectives and skills.

In addition specific training in the PACE framework is being given to investigators. This is aimed at ensuring that investigations are more thorough and more nuanced.

“We always have a consultant and a manager on the investigating team, who will work directly to the Case Manager, and that tends to work quite well. I know some places where they’ll either have a consultant or they’ll have a manager, whatever they’re using, and you don’t tend to get that dual opinion of what’s going on. It helps us to get to the crux of what’s happening. I think, far more quickly. If you have doctors doing it, they’ll be great on the clinical side and they’ll tend to ignore some of the softer aspects, if you have a manager doing it then they tend to be very strong on the softer aspects and not necessarily picking up on some of the nuances and the clinical issues. So that works for us, and having people properly trained works.” (Case Study 3)

“I think we can learn more from other people that use the PACE framework, which we’ve been talking to xxxx, our employment lawyer, about could we learn a bit more about how do we get more of a sense of enquiry into our investigations and a bit less of what happened, just getting a very straight statement. We don’t always push to find out what’s really happening underneath and you do then get to the point of disciplinary where actually nuances are coming out that really should have been picked up at the investigation side, or an area wasn’t looked at, or mitigation wasn’t looked at, or motivation wasn’t looked at.” (Case Study 3)

BOX E – Promising Approach from Case Study 3 (Large Trust in the Midlands)

4.2.4 Accessing independent experts

Many interviewees reported having difficulties in gaining independent expertise on clinical matters, both internally and externally. For example:

- Internally
  - Small Trusts have a very small pool of clinicians to turn to with some specialisms only employing one or two consultants.
  - Larger Trusts may carry out pioneering surgery which few internally are qualified to give an opinion on.

- Externally
  - NCAS can be slow and give equivocal advice (see 4.2.5.)
  - Experts are costly and can be inconsistent.
There is a limited pool of ‘external experts.’

Whilst Royal Colleges can be helpful in providing external clinical expertise (albeit that this is an expensive option) it can be difficult to find someone regionally who is prepared to provide an opinion about a peer and there might also be a conflict of interest if they have mutual connections.

"We had a Pathologist competence case and when we started to look at it we could see that there was a history from other organisations that just hadn’t been dealt with, and what we found then.... is that a lot of doors closed on us, nobody would help us. So we went to the Royal College of Pathologists. Everybody wanted to wash their hands of it because it was difficult, because it was competence and no one would really say, in terms of thresholds etc. No one would pin their colour to the mast and say ‘that the doctor doesn’t meet the threshold on however many samples they were putting through’. So in the end we ended up getting NCAS, the Royal College Rep and the GMC at the table, because we said ‘we’ve had enough of it and you need to help us work on the situation’.“(Case Study 1)
IDEA FOR THE FUTURE:
Expert witness database.
Active use of networks to create a list of expert witnesses not in region to support any investigation at lower/no cost versus using the Royal Colleges. This also avoids local conflict of interest.

Given the “small world” difficulties that can be created, especially in niche specialisms, a senior doctor in one Trust uses informal Action Learning Set\(^2\) contacts to reach out to specialists in other parts of the country. They are used as an informal sounding board and also as a formal expert witness if necessary.

Case Study 8
(Large Trust in the South)

“...my former MD introduced me to a medical director’s action learning set. The point is that’s introduced me to a bunch of medical directors as far away as Yorkshire and Essex and Kent, so now I have a group of people I can turn to if I need advice and support about things.” (Case Study 8)

\(^2\) An Action Learning Set (ALS) is a group of people, in this instance Medical Directors, who meet with the specific intention of solving workplace problems. The main aim of an ALS is to come away with a set of realistic actions that will help to solve or understand the issues at hand.
IDEA FOR THE FUTURE:
Terms of reference for expert witnesses – to improve the selection of expert witnesses based on relevant criteria. This will ensure that witnesses:

- Have the necessary expertise.
- Have true independence/no conflicts of interest.
- Are available for an appropriate amount of time.
- Are recompensed accordingly.

“So I have proposed to... number one, they have real expertise in the areas, secondly, they are truly independent from the process, there is no conflict of interest, because this is crucial. That infrequency that you discover, for example, that the independent Assessor knew a couple of people in the process. So they’re not independent and, finally, they have the time and they are being rewarded accordingly to do the review thoroughly. Because if you give them a bunch of papers that big and a couple of days to see, or a week to see, they produce a final report, as you can imagine it won’t be a thorough report. And they would offer you a further report for £50 or £100, so the resources have to be there for that.”
(Case Study 10)

Case Study 10
(Large Trust in the South)

4.2.5 NCAS

In many cases NCAS advice and support was welcomed and seen as helpful. However a number of issues were raised about NCAS and its role within the MHPS process. These issues included:

- NCAS involvement increasing the time taken to complete the MHPS process.
- NCAS being perceived as giving equivocal advice.
- The quality of advice being perceived as variable, depending on the individual NCAS advisor.
- NCAS providing limited support with practicalities – for example they advise a placement for the practitioner in question, but leave it to the individual Trust to secure the placement.

Two case study sites report that NCAS had incorrectly documented the issues involved in a case. In one instance:

"I said 'no, the facts are wrong......he had to go back and get them to rewrite.... then what happened, they had made the mistake, you have the hearing then you’ve got these two letters, one that’s been corrected by NCAS, but the employee says 'oh, something sinister has gone on here, you phoned NCAS to try and get the letter changed', 'yes, that’s right because it was factually incorrect.’”
(Case Study 9)
4.2.6 Unwilling witnesses/gathering firm evidence

Some interviewees explained that it can be extremely difficult to get witnesses to come forward and speak against a colleague. Clearly, without this substantiation a case cannot be pursued.

"When you explain to people ‘if that’s what you’re saying, you can’t say that to me and then walk away from it because I can’t then talk to somebody’. A lot of people want it to be done anonymously.” (Case Study 6)

Giving potential witnesses the confidence to come forward and also giving Case Investigators the skills they need to get the best out of witnesses were described as major challenges within the process.

4.2.7 Counter complaints

One interviewee highlighted that Trusts can sometimes get mired in claims and counter claims – one reaction to being challenged over a concern is for the doctor in question to claim they are being victimised and to make a counter complaint.

"What they do if someone raises a complaint is that they then say they’re a whistleblower. Then they claim they are being bullied and then they don’t show up to the meetings. That’s what the BMA tells them to do I think. It’s a regular thing.” (Case Study 8)
5. **Difference by type of doctor**

**Section summary:**
- There was suggestion that the likelihood of issues coming to light was not the same for all groups of doctors. It was felt amongst some interviewees that concerns were more likely to be raised against locums, doctors who qualified overseas, doctors nearing retirement and doctors working in specific specialisms (that were easier to benchmark).
- Conversely, some interviewees felt that concerns were less likely to be raised (or greatly considered before they were raised) against trainee doctors, popular doctors and doctors from non-white backgrounds.
- Once concerns had been raised there were some differences in the processes for dealing with these concerns:
  - For a doctor clearly demonstrating lack of insight a Trust may pursue a formal MHPS route more quickly.
  - Trainees would ultimately be dealt with via the relevant deanery.

This section of the report highlights some differences in the way in which different types of doctors might be subject to different processes or be more or less likely to surface for scrutiny. It should be noted that, in general, those interviewed were sometimes reluctant to suggest that different kinds of doctors are likely to be affected differently. Since those interviewed were in roles where they are invested in the process of managing concerns many were reluctant to admit there might be bias in that process. However, when prompted or invited to offer specific examples, some issues emerge which they did acknowledge.

5.1 **Differences in the likelihood of issues coming to light**

Some types of doctor are said to be more likely to be picked up and have concerns or issues raised about them and others less likely. The reasons for these differences varied for each type of doctor and are explained below.

5.1.1 **Locums**

Locums are often perceived by their peers and managers not to be genuinely part of “the team” and so they tend to be an easier category for staff to challenge or expose. Coupled with some (not always conscious) question marks raised by other doctors about the integrity and/or capability of those who choose to work as locums. However, it is a paradox that locums can also be in a category of those less likely to be dealt with (in process terms) than permanent staff, because it is easier to let them go than to include them in the employer’s formal appraisal and performance management processes (see section 5.2)

"We’ve all had rubbish locums, and we just think, ‘Oh, thank God they’re gone.' And you can be poorly performing, and unless you do something that is wrong-wrong and causes harm to patients, if you’re just lazy or
ineffective, then you will slip through the net, yes. And if you're a lazy, ineffective doctor you probably are going to be a locum rather than in a substantive position. So yes, they are a huge risk.” (Case Study 11)

There was also some acknowledgement that locums, through no fault of their own, could be placed in situations that made them particularly vulnerable.

"But I do think locums get a harder time.... and perhaps because more issues occur because they’re not familiar with the processes that happen on a daily basis. We have locum induction packs but you cannot convey to a locum, in a short period of time before they’re there to do a list that needs to be done, all the nuances of how a place works.” (Case Study 7)

When issues do arise with regard to a locum there is said to be a greater likelihood of the issue being raised with the GMC specifically because it is harder for a Trust to track what is happening.

"If it’s your own employee who you’ve got confidence and you’ve got systems in place that they’re not going to work anywhere else, they’re a permanent member of staff so Occupational Health can keep an eye on them better, I’d be more relaxed about not informing the GMC. If it’s a locum who turns up for a couple of odd shifts, we never see again, I’d be going 'actually I’ve got no assurance, I can’t control this, it’s got the potential to be an ongoing problem and, when it is an ongoing problem, at some point in the future when they do cause harm to a patient we'll look back and go who knew what when?’” (Case Study 6)

The RO at one site indicated that they had reported a locum for not turning up for duty. He did not believe this met the GMC threshold but he felt that the locum needed to understand the gravity of the situation. Other interviewees felt that Trusts might be more likely to escalate concerns about locums (potentially below the threshold) to the GMC because it was one of the few, if not the only, organisation that had oversight of a locum’s behaviour.

**5.1.2 Doctors who qualified overseas**

Those who qualified overseas were also perceived as more likely to have concerns raised about them. This was said to be because their training may not include an understanding of the requirements of appraisal and reflective practice. They may also be used to a much more hierarchical work culture where the doctor is not challenged or questioned by other staff (particularly junior staff or nurses).

"Well I think there is an issue, and I think you've got several different issues. Firstly entry to medical school is different; secondly I think the culture to medicine is very different. And thirdly actually they don't,
they’re not used to an appraisal process. So that’s a challenge.” (Case Study 11)

In addition, it was admitted, by some interviewees, that medical staff probably do take a different attitude to those who have trained overseas:

"I think NHS trained male consultants, in general, very generally, probably do treat NHS trainees differently to the way they do treat overseas trainees in a very general sense.” (Case Study 7)

5.1.3 Those with protected characteristics
Clearly there is a link and a cross over between those who qualify overseas and those who are from non-white3 backgrounds. Whilst it was highlighted that those who qualify outside the UK may be more likely to come under scrutiny; some interviewees in fact report that they might be encouraged to give extra consideration to reporting a colleague from a non-white background. This is because of perceptions that there may be counter accusations of racism. This possibility might make them less likely to report or even to draw back from doing so at all.

"Sometimes I feel that might be used as an excuse, without sounding too outrageous. Sometimes I might think a behaviour is not acceptable, and the response will be, ‘You need to be really careful. That could be perceived as racist.’ So the behaviour is unacceptable, but because the doctor in question is non-white, non-British, then I need to be very careful before I would take that further.” (Case Study 11)

A similar point was made by the same interviewee with regard to possible accusations of sexism.

"The same can probably be said for women who are less than full-time. You need to be really careful before you criticise a woman who’s less than full-time because you’re comparing her with somebody doing a full-time job”(Case Study 11)

Those who are older and nearing retirement are also highlighted as being more likely to have concerns raised about them. For these doctors the habit of reflection is not as well embedded as for those who have trained and qualified in the revalidation era. Their attitude to patients and other staff is also said to be more likely to result in a higher level of complaints that need investigation.

"I think your junior doctors and people that are coming through have more awareness and understanding of certain things. So, yes, the hope is... I think one of the difficulties you have whilst you’ve got some of the

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3 We use non-white background here to denote skin colour (based on the thoughts of interviewees), rather than nationality or race.
older cohort is that they’re still here, so they’re still an influence. So you still see some of those barriers of the juniors against the established medical staff and the clashes that can bring.” (Case Study 4)

There was a sense amongst interviewees that younger doctors were more likely to raise concerns than older generations because training around the professional duty to raise concerns has changed significantly and ‘old boys’ networks were not as prevalent. In fact some interviewees pointed to an increasing number of cases raised by younger consultants and doctors against older consultants on the basis that standards of practice have changed and younger doctors perceive some of the older doctors’ practise as inherently outdated and unsafe.

"I think potentially you probably are at risk at the end of your career, and sometimes you’re perhaps at risk from some of the naivety of young people coming in who don’t quite understand how much in their lifetime as a consultant that actually there will be changes and it’s our duty to keep up to date, but you have to work out which bits of practice needs to change and which bits may not be what people are now doing. It’s about keeping up to date with best practice and guidelines and stuff like that, and demonstrating that you are.” (Case Study 1)

UNCONSCIOUS BIAS TRAINING FOR SENIOR LEADERS

In direct recognition of the fact that doctors with protected characteristics tend to be over-represented amongst concerns raised, and that the senior decision makers involved in case investigation and management tend not to be representative, all senior managers had undergone unconscious bias training.

BOX F – Promising Approach from Case Study 6

(Large Trust in the North of England)
5.1.4 Likeability
To some extent linked to the issues with locums and doctors from different cultural and training backgrounds there was a more general admission that concerns are more likely to be raised about doctors who just ‘don’t fit in’ with the team and culture around them:

"Undoubtedly, background, familiarity, language, your degree of comfort in the surroundings that you’re in. If you just fit in and everyone accepts you as one of the team, it’s a hell of a lot easier than if you’re a bit different." (Case Study 6)

Interviewees also recognise that human nature makes it more likely that “nice” doctors can be tolerated or excused by their immediate colleagues even if their capability might be in question at the margins, so that they might be less likely to surface with issues.

Conversely, at the extremes, those who are difficult characters to the point that they instil fear in colleagues may be able to get away with more. Some interviewees highlighted that senior consultants displaying “alpha male” type behaviour and instilling fear in subordinate team members would fall into this category and surgeons are mentioned by interviewees at more than one Trust as a likely example of this ‘type’. Other staff members can be reluctant or fearful of escalating their concerns. In addition, such concerns can also be persistent and low level rather than meeting a threshold which then makes them difficult to deal with, especially if the doctor in question is medically competent.

5.1.5 Doctors working in specific specialisms
Those working in specialisms where outcome measures are more easily benchmarked against colleagues and performance “outliers” are more easily identified. This makes objective evidence gathering easier.

"So I can measure stuff and I’d say the people who I can measure the outcomes on, it’s easy to look at how they’re doing. People who I haven’t got good outcome measures for, it’s more difficult.” (Case Study 6)

Potentially less likely to be picked up, is the individual working in a specialism with shortages within a Trust (despite the fact that this could be a locum). One interviewee mentioned that the impact on a team’s workload might discourage staff from raising an issue or lead to senior medical staff putting pressure on nursing staff not to do so.
5.1.6 Trainees
One interviewee suggested that concerns about trainees may be less likely to come to
light because of a tendency for senior colleagues to protect them from any scrutiny
that could impact on their long term career:

“So there’s a Datix system, when you’re reporting you need to declare
whether a trainee’s been involved with any incident or not.... Now,
some Consultants would have openly told us in the past they were not
quite sure about putting a trainee’s name down in the Datix because
they’re not quite sure where that would end for the trainee.” (Case
Study 6)

Another interviewee felt that their culture was one where no blame was the default
position in cases of “Never Events” and that their open culture relied upon staff
feeling that one-off mistakes were accepted as a part of training. As a consequence
he felt that he did not always inform the Deanery RO of such events, not in any
deliberate way - but inadvertently, given the Trust’s desire to work positively with
trainees making excusable errors.

5.2 Process differences when issues do come to light
As well as describing different types of doctor who may be more or less likely to be
affected by concerns, those interviewed also highlighted that, in practice, their
processes might differ for different types of doctors in terms of both professional and
personal characteristics.

5.2.1 The role of insight
Every Trust’s own internal appraisal process will place weight on a doctor’s ability to
remediate by showing insight and evidence of reflection. This is a no blame process
that offers the doctor every chance to agree to support or behavioural agreements as
appropriate to avoid escalation. However if the doctor is clearly demonstrating a lack
of insight then the Trust is more likely to pursue a formal MHPS route more quickly.

“As long as they show insight, they recognise something, there’s
something that can be done, they perhaps can be supported in a certain
way, then it doesn’t really involve, need to involve NCAS.” (Case Study
11)

Lack of insight will tend to make the process more protracted, litigious and
uncomfortable. It was an occasional catalyst to an RO remarking that a
straightforward capability issue is much easier to deal with than an issue of conduct,
especially where a doctor has no insight. In these cases Trusts expect to have to put
formal measures in place under MHPS with the support of NCAS, which can be a set
of frustratingly slow steps until lack of insight can be finally and conclusively
demonstrated.
5.2.2 Locums (especially short term locums)

The problems of dealing with locums were very commonly raised by interviewees and widely acknowledged to be one of the most challenging categories of doctor to effectively apply Trust processes to and/or pursue MHPS with. Short term locums, in particular, were not easily inculcated into a Trust’s culture or values or included in the formal process of appraisal, which makes it difficult to include them in the Trust’s own regular performance monitoring processes.

As locums have an external RO it can be difficult for Trust staff to get evidence of previous appraisals in support of any investigations. It also means that any concerns need to be raised with the locum’s RO rather than using the Trust’s own processes. Trusts were more likely to mention locums to the GMC informally (via the ELA relationship) or report them formally if they had concerns and the locum was leaving and/or applying for a substantive post elsewhere.

"It’s very difficult to pick up information from their previous RO about what they’ve been doing, often they move from one agency to another and nobody’s really got a good track of them. We struggle to get regular appraisals so you just have so little information about their practice". (Case Study 4)

5.2.3 Trainees

Concerns raised about trainees follow a process that involves raising the concern with the educational supervisor in the first instance and then escalating to the Post Graduate Medical Education director, and ultimately, the relevant deanery. Serious concerns regarding trainees may be reported straight to the Medical Director.

"So it isn’t a joined up system, it’s a problem where nobody is the lead employer. So the Deanery has responsibility for their overall education and, in fact, the Dean is the RO, but for time to get to the real employer, because it changes with every step of the rotation, is actually difficult to tie together. So you could have a low level trainee just being a problem all the way through and not being dealt with correctly by the end of it.” (Case Study 6)

Whilst many interviewees recognised that trainees need to be treated differently, some were critical that Deaneries did not always respond appropriately and share information. They also feared that concerns could become lost and/or were not recorded properly so that patterns of behaviours were not picked up over a period of time.

"The difficulty we often have is that sometimes, because trainees rotate, sometimes the history doesn’t rotate with them, that’s the problem. That’s a significant problem so what tends to happen, or what can
happen, is that the Deanery will be aware of a problem with a trainee but wouldn't necessarily want to share that information with us. So that is a serious issue.” (Case Study 6)

Several interviewees felt that their experiences (diverse though they were), suggested that better sharing of information about trainees might equip Trusts to better support trainees that had been subject of concern. One HR Director also felt that the requirements for dealing with trainees under MHPS are less than clear:

“The handling of doctors in training, as far as MHPS is concerned, I think is a little bit woolly.” (Case Study 7)

**IDEA FOR THE FUTURE:**

One possible suggestion for more effective management of trainees is to revert to a single employer for trainees throughout their rotations.

This would mean that trainees who were in the middle of an investigation, for example for misconduct, would not be able to move away from the process.

**Case Study 6**

*(Large Trust in the North of England)*

**5.2.4 Impact of protected characteristics**

In the case of an employee with protected characteristics, the Trust might state that it pays particular attention to documenting each step of an informal or formal process accurately and in writing or that it may take the formal approach more quickly because of a heightened sensitivity to possible counter accusations of racism or sexism. There is a fear that the doctor concerned can easily extend the process by invoking his or her protected status at a later stage. Trusts are aware of the elevated risk of a counter claim.

"We're conscious of gender, I think we're conscious of ethnicity, and qualified in Britain or not, shall we say, and saying are we being
consistent in the way in which we handle this individual. I’m always aware of it....there are things that make you more sensitive.” (Case Study 6)
6. Conclusions and recommendations

The size and culture of a Trust influences local disciplinary processes.

Local processes were strongly influenced by two inter-related factors: culture and size of organisation. The strength and experience of the leadership team and HR function also interplayed with these key factors.

Large Trusts were more likely to have access to specialist HR support and internal legal advice than was the case in smaller Trusts. Large organisations also had a wider pool of trained case investigators.

Smaller Trusts struggled more with resourcing the disciplinary process but, conversely the smaller size of the organisation was perceived as advantageous (compared with large Trusts) when communicating expected behaviours and in fostering an open, positive culture. Smaller Trusts were also felt to have some advantages in terms of ease of early detection of concerns.

There is a strong desire for local resolution and a wide appreciation of the Employer Liaison Service.

Local resolution of issues was favoured whenever possible. Only the most serious of concerns were said to be escalated to the GMC, without first attempting to deal with them via internal processes. Responsible Officers were generally very confident that they had made appropriate referrals to the GMC, and the Employer Liaison Service was cited as giving invaluable advice regarding whether or not a concern would meet the GMC’s thresholds for referral.

A core decision making group often plays an important role at the initial stages of dealing with a concern.

Local processes for dealing with concerns revealed most variation at the initial stages, when individuals are trying to establish the nature and seriousness of the issue. Most Trusts had a core decision making group through which concerns about doctors could be raised, debated and monitored; however, the make-up of the group and frequency with which it met, varied.

Interviewees highlighted several problematic aspects within the handling of concerns about doctors.

There were a number of difficulties identified by interviewees in the handling of concerns about doctors, in particular:

- Having to unpick complex and borderline cases.
- Balancing the need for confidentiality, with the desire to foster an open and transparent culture where staff are confident that concerns are dealt with properly.
- The subjectivity and isolation of decision makers.

There was also a desire expressed by some for greater parity of process between medical and non-medical staff.
**Interviewees highlight some difficulties with MHPS.**

Once a concern had been identified as serious, Trusts would trigger the Department of Health’s Maintaining High Professional Standards in the Modern NHS (MHPS) process and few had made significant local adaptations to this process. However interviewees identified difficulties associated with the MHPS process including:

- The litigiousness of the process.
- The tight timetables involved.
- Maintaining a pool of trained Case Investigators.
- Accessing credible expert witnesses.
- Variability of National Clinical Assessment Service (NCAS) advice and assistance.
- Unwilling witnesses and the inability to collate sufficient evidence.
- Counter complaints.

Several HR directors were keen to share their thoughts on the MHPS process and conducting a workshop with this specific audience could provide Trusts the opportunity to share their experiences and work towards generating solutions.

**Differences are highlighted in the likelihood of issues coming to light and (to a lesser extent) the process followed, by type of doctor.**

There was some suggestion that the likelihood of issues coming to light was not the same for all groups of doctors. Some felt that concerns were more likely to be raised against locums, doctors who qualified overseas, doctors approaching retirement and doctors that work in specialisms that are easy to benchmark. Conversely, some interviewees felt that concerns were less likely to be raised (or more carefully considered before they were raised) against trainee doctors, popular doctors and doctors from non-white backgrounds.

Once concerns are raised there were also some differences in the processes for dealing with concerns. For example:

- For doctors with protected characteristics, Trusts may take particular care to carefully document a process or may take a formal approach more quickly due to heightened sensitivity to possible counter allegations of racism or sexism.
- For doctors demonstrating a lack of insight the Trust may decide to pursue the MHPS route more quickly.
- Educational supervisors handle issues relating to trainee doctors, escalating them to the relevant deanery if necessary.
- Short-term locums will be referred to the locum’s RO rather than undergoing the Trust’s own processes. There is also a sense that Trust ROs may be more likely to report such doctors to the GMC to ensure that the issue is recorded.
Interviewees find it hard to identify promising approaches locally and Trusts are unsure as to what happens elsewhere.⁴

Many of those interviewed found it difficult to answer whether the current practice in their Trust could be described as ‘promising’, since few had knowledge of what other employers are doing. However, in a number of cases interviewees identified aspects of their approach that they believed worked particularly well. Examples included:

- An organisation collaboratively setting and widely promoting clear organisational values.
- Targeted appraisals (to ‘nip issues in the bud’).
- Formalised learning via review of previous cases.
- Appointing two (rather than one) case investigators.
- Unconscious bias training for senior leaders.

There may be more scope to encourage sharing of good practice relating to both less formal local processes and the formal process for MHPS by facilitating regional workshops.

Interviewees suggested several ideas for the future that may be worth exploring further.

In addition to these promising approaches interviewees also identified a number of ideas for the future. Ideas for the future included:

- An integrated Professional Support Unit to provide a more holistic approach to remediation.
- A forum for Case Investigators to share points of learning and potential pitfalls to avoid.
- Sharing legal and HR expertise (across smaller Trusts).
- A ‘faculty’ of Case Managers to ensure they are comprehensively trained and to quality assure their work.
- Sharing Case Investigators at a Regional level.
- Establishing an expert witness database.
- Establishing terms of reference for expert witnesses.
- Reverting to a single employer for trainees.

It may be useful to invite feedback on promising approaches and potential ideas from a wider pool of senior NHS staff via a further phase of qualitative and/or quantitative research.

⁴ Promising approaches and potential ideas have not been evaluated or endorsed by the GMC. They are promising only from the perspective of the interviewee(s) who outlined them as such.
Appendix 1 - List of case study characteristics

There are 40 NHS Acute Trusts in England, 11 of which took part in this research. The following data provides the maximum detail about each case study site without making it possible to identify the exact Trusts that took part.

<table>
<thead>
<tr>
<th>Case study number</th>
<th>Location in England</th>
<th>Employs more or fewer than 500 doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>South(^5)</td>
<td>Fewer</td>
</tr>
<tr>
<td>2</td>
<td>Midlands(^6)</td>
<td>More</td>
</tr>
<tr>
<td>3</td>
<td>Midlands</td>
<td>More</td>
</tr>
<tr>
<td>4</td>
<td>North(^7)</td>
<td>Fewer</td>
</tr>
<tr>
<td>5</td>
<td>South</td>
<td>Fewer</td>
</tr>
<tr>
<td>6</td>
<td>North</td>
<td>More</td>
</tr>
<tr>
<td>7</td>
<td>North</td>
<td>Fewer</td>
</tr>
<tr>
<td>8</td>
<td>South</td>
<td>More</td>
</tr>
<tr>
<td>9</td>
<td>South</td>
<td>More</td>
</tr>
<tr>
<td>10</td>
<td>South</td>
<td>More</td>
</tr>
<tr>
<td>11</td>
<td>Midlands</td>
<td>Fewer</td>
</tr>
</tbody>
</table>

- 5 of the 11 sites were teaching hospitals or associate teaching sites.
- 2 were in rural locations.
- 6 of the 11 sites were Foundation Trusts.

\(^5\) Includes South-West, South East and Greater London
\(^6\) Includes East Midlands, West Midlands and East Anglia
\(^7\) Includes North East, North West and Yorkshire & Humber
Appendix 2 - Research instruments

FINAL discussion guide  Case study scenarios