

Agenda item:	4
Report title:	Outcome of the assurance assessments pilot
Report by:	Anna Rowland , Assistant Director, Policy, Business Transformation and Safeguarding, anna.rowland@gmc-uk.org , 020 7189 5077
Action:	To note

Executive summary

This provides an update on the evaluation of the assurance assessments pilot. The pilot started in January 2015, as a result of concerns being raised about doctors returning to unrestricted practice without having fully remediated. The purpose of an assurance assessment is to obtain an objective assessment of a doctor's remediation before removing restrictions on their practice in cases involving clinical failings or deficient performance.

This paper is linked with an Executive Report (at Annex A) which provides additional detail about the outcomes of the pilot. The Executive Report further provides a series of recommendations to improve the effectiveness of the current pilot process and identifies requirements for transferring the process into business as usual.

Recommendations

Executive Board is asked to:

- a** Note the outcome of the assurance assessments pilot.
- b** Approve the recommendations contained in the Executive Report (at Annex A).

Outcome of the assurance assessments pilot

Background

- 1** The assurance assessment process was introduced following concerns raised in 2014 about doctors returning to unrestricted practice before they had fully remediated. An assurance assessment is designed to be a targeted assessment that specifically tests areas of a doctor's practice that were previously found to be deficient. The outcome of an assurance assessment can then be used to inform decision making around the lifting of restrictions.
- 2** We envisaged that assurance assessments would typically be used for doctors with undertakings, who have been engaging with the GMC, providing evidence of their remediation. During the pilot we also reviewed cases going to tribunal for review where the doctor had conditions or was suspended for clinical issues to see if the assurance assessment process would work within the tribunal framework. However, the timescales for these cases do not support the assurance assessments model. Given the success of the pilot we propose we should review the tribunal framework to consider if the assurance assessment process might be incorporated.
- 3** We agreed a phased approach to delivering the pilot following concerns raised by the medical defence organisations in 2015. Phase 1 was restricted to performance cases and Phase 2 extended the criteria to include clinical misconduct. (More detail about the Phase 1 and 2 criteria can be found at Annex B.) This approach has provided greater confidence in the process for the medical defence bodies but has extended the length of the pilot. We have only just completed the first Phase 2 assurance assessment and await the Case Examiner decision on whether restrictions can be lifted. We have another Phase 2 assurance assessment scheduled for July 2019. However, we now have a good volume of experience of completed assurance assessments from Phase 1 to inform this evaluation.

Pilot volumes and outcomes

- 4** Since the pilot started, 58 Phase 1 cases have been referred to the assurance assessment review group (AARG) to confirm the suitability of cases for inclusion in the pilot. Of these, 28 assurance assessments have been completed to date. In 12 of these cases the outcome of the assessment has resulted in us being unable to lift the restrictions. And in two of them, the outcome was so serious that we referred the doctor to an interim orders tribunal. This demonstrates the value of assurance assessments as part of our framework to protect patients.

- 5** Six doctors have been able to provide objective evidence of their remediation and learning from the pilot; as to what constitutes objective evidence will be added to the guidance document to ensure consistency in our approach. A further four doctors were referred directly to the Case Examiners (see Annex A) and provided similar objective evidence. We will look to introduce longitudinal tracking of doctors in our FTP processes where we have accepted alternative sources of evidence in place of an assurance assessment to determine whether that evidence is providing robust assurance about a doctor's remediation.
- 6** We have identified five Phase 2 cases. Of those, one assurance assessment has been completed and we await a decision on whether restrictions can be lifted. Another assurance assessment is scheduled for July 2019.
- 7** Two doctors in Phase 2 of the pilot have provided objective evidence that has allowed us to lift their restrictions without an assurance assessment. Again, this will be updated in the guidance. As a result of an error by the pilot team one doctor's restrictions were lifted without requiring the doctor to undertake an assurance assessment.
- 8** See Annex A for further details of pilot volumes, outcomes and the progress of current cases.

Timeliness

- 9** An assurance assessment can take several months to set up and complete, due to the complexities of the process. However some ways we can speed up the process have been identified. The Executive Report (at Annex A) details areas where greater oversight of the pilot could improve timeliness.

Quality

- 10** The assurance assessment model seems to work very well. It is more focussed and targeted than a full performance assessment and therefore more proportionate for all involved but at the same time it appears to be very effective at identifying that some doctors have not remediated failings previously identified, despite our receiving positive workplace reports. This confirms that workplace reports are a very important indicator that a doctor may be ready for restrictions to be removed but assurance assessments are a more rigorous tool for ensuring that remediation has been fully effective. We will look to introduce a feedback loop through the Employment Liaison Adviser to the Responsible Officer in cases where an assurance assessment has identified continuing failings that had not been flagged to us in workplace reports. We will also explore if we could ask more appropriate questions of those in the workplace about the extent of a doctor's remediation.

- 11** The evaluation did identify areas where the management of the assurance assessment process could be improved such as better use of the pilot tracker to improve reporting, and more awareness raising, and safeguards to ensure staff identify cases that require an assurance assessment.
- 12** During the pilot, we have received queries from doctors invited to undertake an assurance assessment. These queries have been dealt with by Assurance Assessment Review Group during the pilot but we will revise our guidance and operational manuals to help staff deal with these queries in a business as usual model. We have recently updated the Assurance Assessment Factsheet to clarify that we require objective evidence before restrictions can be lifted. We will review all other supporting documentation similarly. During the pilot we have developed clearer definitions around what constitutes objective evidence that would exempt a doctor from completing an assurance assessment.
- 13** Some doctors change specialty or grade during the time in which we monitor their undertakings. We will develop the guidance to include this scenario. Since the pilot started we have introduced prohibitive undertakings, for example to prohibit a doctor practising a procedure or specialty and we now consider their use in these cases as a way to manage any outstanding risks.

Next steps

- 14** The Executive Report at Annex A provides additional detail on the performance of the pilot, together with a series of recommendations to improve the effectiveness of the process. Furthermore, some requirements for taking the pilot forward into business as usual are identified within that report. We will monitor the implementation of the recommendations to ensure changes are embedded before moving the assurance assessment process into business as usual.

General
Medical
Council

4 - Annex A - Outcome of the Assurance Assessments Pilot

Executive Report – May 2019

Working with doctors Working for patients

Contents

- Executive summary
- Success of pilot
- High level pilot process
- Recommendations

General Medical Council

Working with doctors Working for patients

Glossary

AA – Assurance Assessment

AARG – Assurance Assessment Review Group

AoI – Allegation of Impairment

BAU – Business As Usual

CE – Case Examiner

CERF – Case Examiner Referral Form

FTP – Fitness to Practise

GMC – General Medical Council

NCAS – National Clinical Assessment Service

Executive Summary

Following concerns about doctors returning to unrestricted practice before they had fully remediated, we decided to seek objective assessment of a doctor's remediation before removing restrictions on practice in cases involving clinical failings or deficient performance.

In January 2015 we started a pilot of assurance assessments (AAs). These are targeted assessments that specifically test the areas of a doctor's practice that were previously found to be deficient. AAs provide objective evidence for decision makers when they are reaching a decision on whether to lift restrictions.

The Case Review Team (CRT) actively monitors doctors with restrictions. We envisaged that AAs would typically be used for doctors with undertakings, who have been engaging with the GMC on a regular basis, providing evidence of remediation. During the pilot we also reviewed cases going to tribunal for review where the doctor had conditions or was suspended for clinical issues to see if the AA process would work within the tribunal framework however the timescales for these cases do not support the AA model. Given the success of the pilot (see next slide) we propose we should review the tribunal framework to consider if the AA process might be incorporated.

Originally the pilot was planned to last 18-24 months. However, following feedback from the medical defence organisations, we re-worked our original plans to deliver the pilot in a phased model. Phase 1 was restricted to performance cases and Phase 2 extended the pilot to clinical misconduct cases. Phase 2 went live in May 2017. Detailed criteria for the two phases of the pilot can be found in Annex B.

Success of Pilot

PILOT VOLUMES

- The assurance assessment review group (AARG) has considered 58 cases Phase 1 – 52 were suitable:
- The rationale for rejecting the six cases were:
 - 3 cases where the case did not meet Phase 1 criteria and Phase 2 had not started.
 - 1 case where the doctor's maternity leave presented exceptional circumstances which allowed the Case Examiners (CEs) to revoke undertakings without an AA.
 - 1 case where it was too early to consider revocation of undertakings.
 - 1 case where there was insufficient evidence to support consideration of revocation.
- AARG has considered and accepted five cases for Phase 2.

OUTCOMES

Phase 1 - completed cases

- In Phase 1, 28 AAs have been completed to date. Of these,
 - 15 doctors (54%) were found to be fit to practise generally.
 - 1 doctor (3%) was fit to practise at a level lower than their qualifications.
 - 12 doctors (43%) were not fit to practise without restrictions on their practice. Of these, for 2 doctors, the risks were so serious they were referred to IOT.

This demonstrates the success of the assurance assessment model in identifying where doctors have not fully remediated previously identified failings despite positive workplace reports. Prohibitive undertakings, eg. prohibiting particular procedures, have been used for extra assurance.

Phase 2 - completed cases

- One Phase 2 AA has been completed and we await CE decision on whether the doctor's restrictions can be lifted.

Phase 1 – doctor provided objective evidence

- Six doctors in Phase 1 of the pilot have been able to provide us with objective evidence of their fitness to practise which has negated the need for an AA. This evidence has included:
 - 2 workplace assessments
 - 1 FY2 rotation evidence
 - 1 formal re-training programme
 - 1 evidence of a completed NCAS action plan (now known as a practitioner performance advice)
 - 1 local investigation
- Four further doctors were referred directly to the CEs and provided similar objective evidence which enabled revocation of their undertakings:
 - 2 workplace assessments
 - 1 FY2 rotation
 - 1 formal re-training programme

Phase 2 – doctor provided objective evidence

- Two cases identified as suitable for Phase 2 of the pilot had undertakings revoked without an AA. The doctors were able to provide evidence from workplace assessments.

Success of Pilot

Phase 1 - cancellations

- Two Phase 1 AAs have been cancelled.
 - 1 following receipt of additional information as a result of which the GMC rescinded the offer of an AA at this time.
 - 1 when the doctor applied for and was granted voluntary erasure from the register.

Phase 1 – revocation without AA

- The pilot process involves investigation staff identifying cases where the information we hold suggests revocation of undertakings may be appropriate. On evaluation we found 8 cases where staff had not identified relevant cases. In order to address this going forward, we are doing further awareness with staff supported by amended operational guidance. We have already amended the Case Examiner Referral Form (CERF) to ensure that in future CEs identify any cases missed by investigation staff and return them to AARG for review. We will also introduce a process to support the identification of cases that require an AA.
- We revoked undertakings for 4 doctors who had changed specialty while their practice was restricted. We were unable to assess them in their new specialty as their practice had not been found to be deficient in this area. These doctors had also been unable to fully remediate the failings which led to their undertakings because of the specialty change. Since the introduction of prohibitive undertakings these are considered in these cases and could be used where we think extra assurance is needed.

Phase 2 – revocation without AA

- On evaluation we found 1 error by the pilot team involving failure to implement an AARG decision. We have now introduced weekly monitoring to avoid this in future.

Current pilot cases

- In Phase 1 of the pilot, the current cases are:
 - 5 AAs have been scheduled
 - 2 doctors have accepted an invitation to undertake an AA and the AA is to be set up
 - 2 doctors have been invited to undertake an AA and we waiting for their response
 - 1 AA has been paused as the doctor is unwell
 - 4 cases have been considered by AARG and we await further information from the doctor
 - 1 case is scheduled for AARG meeting scheduled for with AARG meeting on 24/05/2019
 - 1 doctor has failed to complete an AA and undertakings remain effective
- One Phase 2 AA is scheduled for July 2019.

Success of Pilot

Timeliness

- It is accepted that an AA can take several months to set up and take place, given the nature of this activity. However we have identified areas where timeliness can be improved:
 - The email model for the AARG has now been replaced by a weekly meeting to speed us decisions. We need to consider how this oversight will be replicated in a BAU process.
 - We are proposing the introduction of SLAs for assessor report writing and submission to reduce the time it takes – on occasion this has taken up to 2 months.

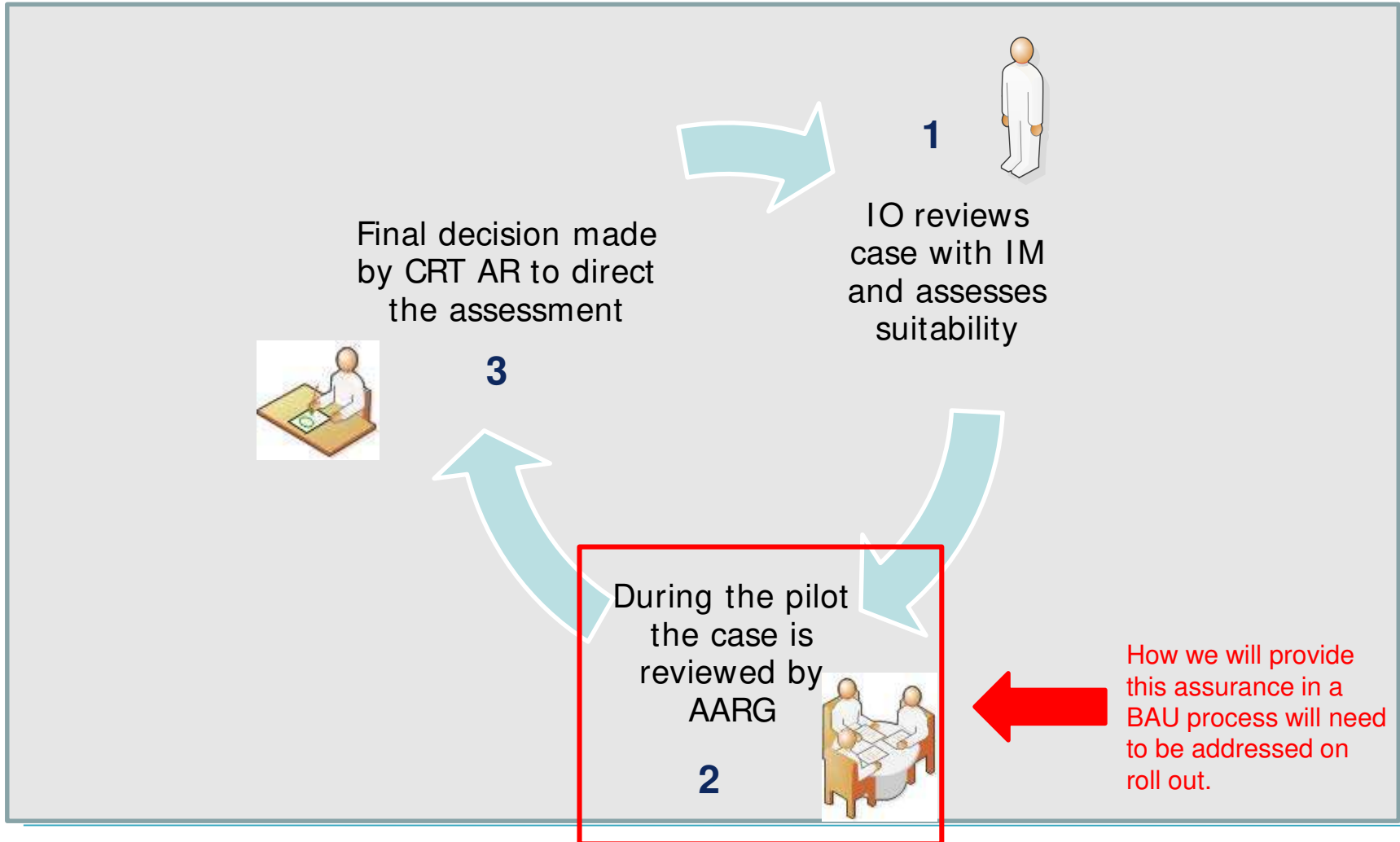
Quality

The pilot has demonstrated that the AA model works well. It is more focussed and targeted than a full performance assessment and therefore more proportionate for all involved. At the same time it has proved effective at identifying doctors who, despite positive workplace reports, have not remediated. In 46% of pilot cases the AA identified continuing failings that had not been flagged to us in workplace reports. We will introduce a feedback loop through the Employment Liaison Adviser (ELA) to the RO in these cases and explore if we could ask more appropriate questions of those in the workplace about the extent of a doctor's remediation.

- We will look to introduce longitudinal tracking of doctors in our FTP processes where we have accepted alternative sources of evidence in place of an assurance assessment to determine whether that evidence is providing robust assurance about a doctor's remediation.

- The evaluation did identify areas where management of the AA process could be improved – see below.
 - It is proposed to provide further guidance to the team on recording AAs in Siebel to reduce variation and make case identification easier.
 - Additional oversight of the completion of the pilot tracker has been introduced to ensure consistent recording to support accurate reporting.
 - 8 cases were referred to the CEs for decision on the revocation of undertakings without referral to the AARG and without an assurance assessment being implemented. We will introduce exception reporting to avoid this in future.
 - We have received queries from some doctors who have been invited to undertake an AA. These queries have been dealt with by AARG during the pilot but we will develop our guidance and operational manual to support staff deal with these queries in a business as usual model. The AA Factsheet has recently been updated to make it clearer that our policy is that objective evidence of remediation is required. We will review all other supporting documentation similarly. During the pilot we have developed clearer definitions around what constitutes objective evidence that would exempt a doctor from completing an AA.
 - Some doctors change specialty / grade during the time in which we monitor their undertakings. When they come to request revocation due to the change in specialty an AA is not always appropriate. Since the introduction of prohibitive undertakings, we can use them to manage any outstanding risks in these cases.

High level pilot process



Recommendations

1. Approve the use of AAs as part of the GMC's approach to obtaining assurance before returning doctors to unrestricted practice, with monitoring of implementation of these recommendations to provide assurance that changes have been embedded.
 2. Review the tribunal framework to consider if the AA process might be incorporated into conditions and suspension cases.
 3. Consider whether service level agreements for the various steps in the AA process or the process as a whole would identify/minimise any delays.
 4. Introduce a feedback loop through the ELA to the RO in cases where an AA has identified continuing failings that had not been flagged to us in workplace reports and explore if we could ask more appropriate questions of those in the workplace about the extent of a doctor's remediation.
 5. Introduce longitudinal tracking of doctors in our FTP processes where we have accepted alternative sources of evidence in place of an assurance assessment to determine whether that evidence is providing robust assurance about a doctor's remediation.
 6. The Pilot Manager to share responsibility for the pilot tracker with CRT to ensure accurate reporting.
 7. Review all documents to reflect recent changes to AA Factsheet.
 8. Review and update operational guidance – particularly in relation to how AAs should be recorded in Siebel.
 9. Update the CERF and 'Case Review CE – Decision form' to prompt consideration of an AA and AARG review.
 11. Review the progress of all ongoing cases during the weekly AARG meeting.
 12. Revise guidance and operational manuals to include:
 - i. How to respond to queries from doctors who have been asked to undertake an AA.
 - ii. Our approach to an AA when a doctor changes specialty/grade while we are monitoring undertakings.
 - iii. Additional examples of objective evidence the doctor could provide instead of completing an AA.
 13. Update training materials to reflect changes to process and consider whether training is required for operational teams.
 14. Investigate exception reporting to identify cases not going through the AA process to ensure they are picked up before a decision on revocation of restrictions is made.
 15. Develop business as usual (BAU) process for AAs that includes:
 - i. Steps to ensure the identification of all cases that require an AA.
 - ii. Efficiency in our process steps to avoid any unnecessary delays.
 - iii. Quality assurance of activities to ensure consistency and adherence to guidance and policy.
 - iv. Escalation route for cases where additional support is required.
 - v. Feedback loop on the decision making process to facilitate learning and improve consistency.
 - vi. Monitors progress of all ongoing cases.
 16. Agree and develop future reporting requirements for the pilot and BAU process.
 17. Develop communications for FTP staff about the pilot and the issues encountered to increase awareness and improve consistency.
-

4– Outcomes of the Assurance Assessment pilot

4 – Annex B

Assurance Assessments – pilot summary

Pilot – Phase 1

Cases involving **clinical failings** which meet at least one of the following criteria:

- a** The doctor has been found impaired on the grounds of **performance** (at a fitness to practise panel), which has resulted in undertakings being agreed or conditions/a suspension being imposed.
- b** The doctor previously had a performance assessment (either during the investigation stages, or during monitoring by the Case Review Team).
- c** The doctor has a condition or undertaking in place to have an assessment of their performance.

Phase 1 of the pilot launched in January 2015. The first assurance assessment was completed in 2015.

Pilot – Phase 2

- a** Cases involving **clinical failings** where the doctor has been found impaired on the grounds of misconduct as a result of clinical failings (at a fitness to practise panel), which has resulted in a period of suspension, conditions or undertakings. Misconduct cases that relate exclusively to a probity matter (e.g. fraud) will therefore be excluded from the pilot.
- b** The doctor has undertakings related to clinical failings, agreed with a case examiner.

Phase 2 of the pilot started in May 2017.

Next steps

The pilot considered the use of assurance assessments in conditions and suspension cases but they are not compatible with the tribunal framework timetable. On completion of the pilot, we will review the tribunal framework to explore the viability of introducing assurance assessments for conditions and suspension cases.