

Agenda item:	8
Report title:	Managing communications with vulnerable doctors
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Action:	For decision

Executive summary

This paper provides an update on the interface between current work in train to implement a standardised and coordinated approach across the organisation for managing our communications with particularly vulnerable doctors, including a decision-making process for stopping automated communications (the current vulnerable doctors project) and work arising from the suicide review (the Appleby proposals).

Recommendations

The Strategy and Policy Board is asked to:

- a** Consider the overlap between the work arising from the current vulnerable doctors project and the Appleby proposals.
- b** Agree the preferred Option 1: to pause the current vulnerable doctors project work and expand the scope of the work to implement the Appleby proposals to include correspondence with all doctors who are particularly vulnerable as well as those who are subject to investigation by the GMC.

Background

- 1 Following concerns by the Fitness to Practise directorate Performance Assessment team that a particular doctor was vulnerable, but who had received several automated communications from various parts of the organisation, a review of how we manage communications with doctors considered so vulnerable that we may consider stopping our usual automated communications was carried out (the current vulnerable doctors project).
- 2 Colleagues across the organisation were consulted to understand current processes for managing communication with vulnerable doctors, deciding their vulnerability requires a stop of automated communications and sharing information with other teams/directorates.

Overview of work currently underway

- 3 The review identified that there is currently no standard approach for:
 - a Deciding to stop automated communications to a particularly vulnerable doctor.
 - b Managing all other communications with a doctor who falls into this category of vulnerability.
 - c Sharing information across the organisation in order that all colleagues who may interact with the doctor are aware that they are currently considered vulnerable.
- 4 This work seeks to implement a holistic and pro-active approach to achieve consistency and ensure that all communications take account of the doctor's vulnerability.

Progress so far

- 5 The approach arising from the current vulnerable doctors project will apply to doctors who are particularly vulnerable, using definitions developed in guidance carried out as part of the Appleby project in order to support staff who are dealing with vulnerable doctors. For the purposes of this project this approach will apply to all doctors falling into Category One of the definition of vulnerability contained in the staff guidance. Category One also includes doctors who are considered 'high risk' as set out in the lines to take guidance document (the full definition of 'high risk' is at Annex A).
- 6 Given the definition, it is anticipated that doctors falling into Category One would also meet the threshold for fitness to practise to undertake an assessment of their health unless there were exceptional circumstances.

- 7** The decision as to whether a doctor falls within the category of vulnerability which triggers this process will be made by a medical case examiner (preferably with an interest in mental health). The case examiner will also provide advice in relation to methods and style of communication, and will indicate the date on which they wish to review the matter (with a longstop date of three months).
- 8** When the case examiner decides that a doctor falls into this category, the Fitness to Practise directorate Complaints and Correspondence team will act as the central point of coordination for referring matters to the case examiner, implementing the case examiner's decision and ensuring regular review of each doctor falling into this category. Implementing the case examiner's decision will include liaising with colleagues across the GMC and Medical Practitioners Tribunal Service (MPTS) to advise what action they need to take with their ongoing communications to the doctor.
- 9** Siebel has been developed to enable better control of automated communications, and make clear to all colleagues that a doctor is considered vulnerable and that automated communications have been stopped. A new 'vulnerable doctor' alert type will have the effect of stopping a small number of automated communications sent as part of the Registration operational processes. Other automated communications, such as those related to revalidation and fees and billing, will be stopped using existing functionality and processes. The new alert will also provide visibility to colleagues across the organisation that a particular doctor is considered vulnerable and that automated communications with them have been stopped.
- 10** Workshops with teams across the organisation who interact directly with doctors have been held. During these workshops, the proposed operational process (at Annex B) was examined and it was agreed how this process would work for each team. Methods of interaction with all relevant teams have now been agreed.
- 11** The implementation plan for this work is at Annex C and implementation is planned for December 2016. From mid-October training and communications will be developed, to be delivered in November 2016.

What safeguards are currently in place?

- 12** At present, we identify doctors who may be particularly vulnerable (if they are detained under the Mental Health Act or we hold information that suggests they may have suicidal ideation). For such doctors we place a stop on automated communication about revalidation as such communications, being automated, are not subject to any staff oversight and, as they relate to the doctor's licence to practice, could be a significant stressor for a doctor who is particularly vulnerable.

Overlap of the current vulnerable doctors project with the Appleby Proposals

- 13** The current vulnerable doctors project was in progress when, following the suicide review, we commenced a review of how to reduce the impact of our fitness to practise procedures on vulnerable doctors. This work was overseen by Professor Louis Appleby, a leading mental health expert and we have published a set of [proposals](#) (the Appleby proposals).
- 14** One of the proposals arising from that work is that, for any doctor under fitness to practise investigation, the investigation officer will co-ordinate all correspondence from across the organisation, to avoid our inadvertently overwhelming a doctor with correspondence when they are in an anxious state that is particularly exacerbated by GMC correspondence.
- 15** There are overlaps but the current vulnerable doctors project only applies to a small number of doctors under investigation in fitness to practise, that is those fall within the Category One definition of vulnerable (they are receiving palliative care, we hold information about suicidal ideation or they are detained under the Mental Health Act).
- 16** The Appleby proposals, propose a new system to stop automated communication for all doctors under investigation and divert correspondence across the GMC via the investigation officer. If that approach were implemented, the system arising from the current vulnerable doctors project would apply only to those doctors who are not currently under investigation but are classed as falling within the Category One definition of vulnerable, for example, because information about their vulnerability has arisen in relation to another of our functions such as their registration or revalidation. Once identified as falling within the Category One vulnerability definition, an assessment of whether this impacts on their fitness to practise is likely to be subsequently carried out.

Options for managing the interface between the current vulnerable doctors project and the Appleby proposals

- 17** There are two options for managing the overlap between these two projects:

Option 1

- 18** To pause the current vulnerable doctors project work and expand the scope of the work to implement the Appleby proposals to include correspondence with all doctors who are particularly vulnerable as well as those who are subject to investigation by the GMC. The benefits of this approach are that it would enable us to explore a single, streamlined system and therefore be more proportionate enabling a comprehensive approach to communication. It would have less impact on staff,

involve a single set of Siebel changes, be less complex, and reduce the risks of confusion.

- 19** The disadvantage is that the relevant aspect of the Appleby proposals has a delivery date of the end of 2017. There is still much work to do to assess the proposal and examine the best way to deliver the required improvement. Therefore aligning these projects will delay the implementation of the current vulnerable doctors' project. There is a risk that during that time our approach to communicating with vulnerable doctors may give rise to criticism. This is mitigated, but only partially, by current arrangements to stop automated revalidation communication being sent to vulnerable doctors.

Option 2

- 20** To implement the current vulnerable doctors project work and, when work commences on developing the Appleby proposals, to consider to what extent the system introduced by the current vulnerable doctors project continues to be needed. It may be that, even with the Appleby proposals in place, there would continue to be a need for that system to remain in place but it is also possible that the Appleby proposals may remove the need for it going forward.
- 21** The advantage of pushing ahead to implement the current vulnerable doctors project is that it will avoid any delay in improving our communication with vulnerable doctors and much of the developmental work has already been carried out.
- 22** The disadvantages are that stopping automated communications with doctors and introducing a manual process to manage that correspondence is a very complex and resource intensive process. The implementation phase will involve significant changes to existing operational systems as well as Siebel. This will introduce significant additional operational requirements. There is a question about whether it is proportionate to make these changes as we are about to commence work to develop the Appleby proposals, particularly when it is unclear whether those changes will continue to be required in addition to the Appleby proposals. There is also a risk of causing confusion among staff by introducing these two approaches within 12 months of each other.

Recommendation

- 23** On balance we recommend Option 1, to delay the current vulnerable doctors project and integrating it with the work to develop the Appleby proposals (Option 1). The Board is asked to approve that approach.

8 – Managing communications with vulnerable doctors

8 – Annex A

Modifying our approach for vulnerable individuals

Introduction

- 1 Our processes can be stressful for all individuals involved, particularly doctors. It is important to recognise when an individual may be vulnerable so that, where appropriate, we can modify our approach to communication and reduce the impact and stress on the individual.

Definition of 'vulnerable'

- 2 We define being vulnerable as:

An individual in need of additional support, for example specialist communication, because of certain characteristics or circumstances, including:

- a presence of mental health issues
- b being a child or young person aged under 18 years
- c being an older person or being frail
- d having a disability
- e bereavement
- f history of abuse or neglect.

Levels of vulnerability

- 3** The GMC has identified three main categories of vulnerability that occur in our procedures. The table below sets out some guidance for staff to help in determining when it might be necessary to modify our approach to communicating with these individuals.
- 4** The table is not prescriptive – staff should use it as a starting point, and should take care to consider all the information they have available. There will be some issues which might not fall neatly in to the following categories, but which may still mean an individual is vulnerable. For example, because they have (or have had) education, language or economic difficulties.

	Category one – consider under the stop comms process	Category two – additional support and modified communication	Category three – modified communication
Presence of mental health issues	Mental health issues – either as defined under the ‘high risk’ category in our <i>Lines to take</i> guidance, or the individual has been sectioned under the Mental Health Act.	Mental health issues as defined under the ‘medium risk’ category in our <i>Lines to take</i> guidance.	Mental health issues as defined by the ‘low risk’ category in our <i>Lines to take</i> guidance
Being a young child or person aged under 18 years	Where a legal guardian has requested that we cease communication	Where other factors (as outlined in paragraph 2) are also present	In all other cases
Being an older person or	Being an older person	Being an older person	Being an older person

<p>being frail</p>	<p>Where the individual lacks capacity and/or the person who can make decisions on their behalf, as recognised under the Mental Capacity Act*, has requested that we cease communication</p> <p>Physical frailty: Physical health issues that require us to stop communication - for example, an individual receiving palliative care.</p>	<p>Where the individual has limited capacity.</p> <p>Physical frailty: Serious physical health issues - for example, an individual receiving treatment for cancer.</p>	<p>Where the individual has struggled to navigate our processes or communication and/or other factors (as outlined in paragraph 2) are also present</p> <p>Physical frailty: Any physical health issue which requires us to adjust our approach to communication</p>
<p>Having a disability[†]</p>	<p>Health issues relating to a disability which require us to stop communication.</p>	<p>Significant issues relating to a disability which requires reasonable adjustments</p>	<p>Issues relating to a disability which requires reasonable adjustments</p>

* <http://www.legislation.gov.uk/ukpga/2005/9/contents>

[†] The Equality Act 2010 states that:

(6)(1) A person (P) has a disability if—

(a) P has a physical or mental impairment, and

(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

Bereavement	The category will be determined by the impact the bereavement has had on the individual – these instances should be considered on a case-by-case basis.
History of abuse or neglect	The category will be determined by the seriousness and proximity of the abuse or neglect, the age of the person and the impact on the individual – these instances should be considered on a case-by-case basis.

High risk situations

- 5 The below is an excerpt from the document entitled 'Lines to take – handling interactions with doctors, complainants and witnesses where there is a risk of suicide':

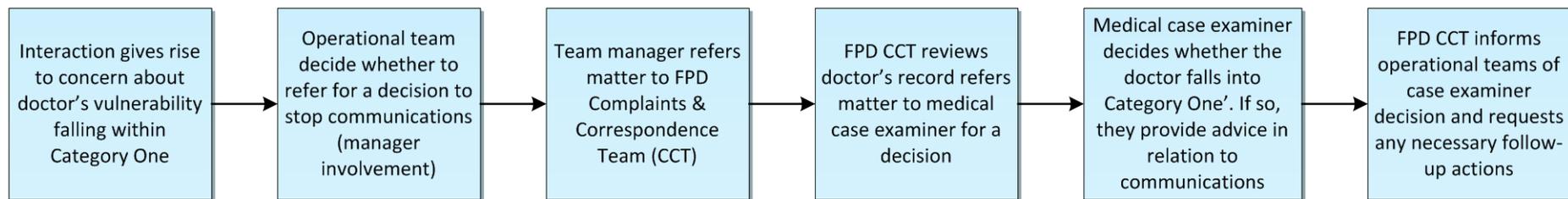
*'A situation is **high risk** when a caller or individual is:*

- *In the process of harming themselves*
- *has a plan to harm themselves or take their own life (the more detailed the plan, the higher the risk)*
- *has something in the room they could use to harm themselves with and talks about using it*
- *someone we already know is at a risk of suicide or has tried to commit suicide in the past and is currently expressing suicidal feelings.'*

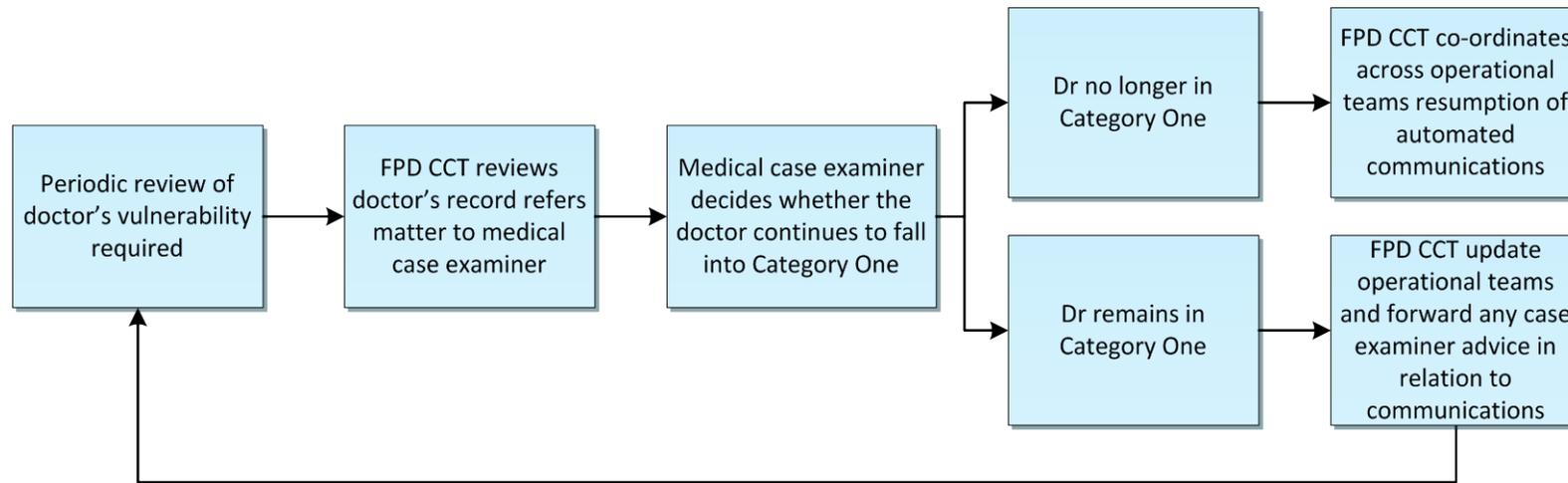
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8 – Annex B

Process for deciding to stop automated communications



Process for resuming automated communications



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8 – Annex C

Implementation plan

