General Medical Council

Agenda item:	**4**
Report title:	**Health PE pilot – Readiness to transfer to business as usual**
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Action:	**To consider**

Executive summary

The piloting of Health Provisional Enquiries (Health PE) was part of the Supporting Vulnerable Doctors programme. The pilot started in September 2017 and this paper provides an update on the evaluation of the pilot.

The Executive Report (at Annex A) provides additional detail on the findings of the evaluation of the pilot. Based on that evaluation, we recommend the pilot transfers to business as usual (BAU) from 1 January 2020.

Recommendations

The Executive Board is asked to:

a Note the findings of evaluation of the Health PE pilot.

b Approve the recommendations contained in the Executive Report:

- **i** Publication of the self-referral resource for doctors following review by the Practitioner Health Programme and the medical defence organisations.
- **ii** Introduction of improvements identified during the pilot and corresponding updates to guidance for decision makers.
- **iii** The transfer of the Health PE process to BAU from 1 January 2020.

Update on the PE Health pilot

Background

1 In 2015 we appointed Professor Louis Appleby, a psychiatrist from the University of Manchester, as an independent expert to advise us on where improvements could be made to our fitness to practise processes. He worked with us to examine each stage of the investigation process to identify ways in which we could reduce the impact of our investigations, particularly for doctors who may be vulnerable.

2 This review resulted in a set of proposals for improvement. One of these proposals was “avoid full investigations whenever possible in cases that are (solely or primarily) about a doctor’s health”. In response to this recommendation, in September 2017, we expanded the use of provisional enquiries to cases involving health concerns.

3 We use provisional enquiries in health cases where it appears from the information we have that a doctor’s health may be affecting their ability to practise safely and there is a lack of detailed information about the health concerns. In these circumstances, we may make some provisional enquiries, to help us decide whether we need to assess the doctor’s fitness to practise. This will help make sure that we only open an investigation where it is absolutely necessary to protect the public, which should lead to fewer doctors undergoing a full investigation when the only concern is about their health.

4 There is usually no need for us to be involved where a doctor’s health condition is being treated and any risks to patient care are being managed. Where there are continuing risks, and we need to put arrangements in place to protect the public, we aim to do this by mutual agreement to reduce the impact on the doctor.

5 The Health PE process sits with the Communications Investigation Team (CIT), a team with a focus on sensitive handling of cases involving concerns about a doctor’s health. Additionally a pilot review group meets up to three times a week dependent on whether there are new or returning cases to discuss. The review group discussions provide advice (including medical expertise) to the team and this advice has supported the development of guidance.

Pilot volumes and outcomes

6 Since the pilot started, 71 enquiries have been referred to the review group for discussion.

7 Of these, 46 enquiries were found to be suitable for the pilot:

a 35 were concluded following provisional enquiries as we were assured that the doctor's health condition was being managed locally and there was no risk to patient safety.

b 9 were promoted for a full investigation following provisional enquiries as we were unable to obtain the assurances we required about the doctor's health and any impact on patient safety from our initial enquiries. A full investigation in cases relating solely to a doctor's health comprises a health assessment, where two independent medical experts carry out an assessment of the doctor's health and provide a report about the impact of their health on their fitness to practise.

- We have completed a full investigation in six of these cases
  - four of these cases have concluded with undertakings.
  - one case has concluded with no action, following a health assessment.
  - one case has been referred to hearing, as there are allegations relating to dishonesty as well as concerns about the doctor's health.
- The other three cases are still in the investigation stage.

c 2 provisional enquiries are ongoing.

8 27 enquiries referred to the group were not suitable for the pilot. Of these, 10 were referred to a full investigation; 15 were closed at triage; one was referred to the general (non-health) PE process; and one was closed and disclosed to the doctor and their RO in the Notify RO process. We have taken learning from these cases and have suggested updates to the Triage Manual for Health Enquiries.

Success of the pilot

9 The pilot is working well to reduce the impact on doctors where the concerns relate solely to their health by ensuring we only carry out a full investigation where necessary. Of those cases identified as suitable for the pilot, provisional enquiries have assured us that the doctor's health is being managed locally and there is no risk to patient safety in 76% of enquiries. There are two further provisional enquiries ongoing so this percentage could increase. This closure rate is in line with other provisional enquiries streams.

Timeliness

10 The purpose of provisional enquiries is to carry out swift enquiries in order to ensure we only carry out a full investigation where necessary and speed up the process for all involved. In the early stages of the pilot, the PE Health enquiries were taking longer than the general PE SLAs of concluding 75% of cases in 63 days and 90% in 84 days. This has impacted on the achievement of SLAs for those cases that were then promoted for full investigation following provisional enquiries. The process was audited in August and October 2018 and it was identified at this time that average duration of Health PEs up to audit was 112 days. As a result of these audits, CIT introduced a number of improvements based on audit recommendations. These include:

- scheduling three pilot review group meetings each week to minimise delays in accessing advice on the enquiry.
- identifying dedicated staff to handle all the provisional enquiries.
- access to medical expertise for decision makers in the pilot review group avoiding the delay introduced if separate medical CE advice is sought.

11 These changes were introduced from 1 November 2018. Since that time, the average duration of the Health PE process has reduced to 61 days. There is additional analysis of time savings made to key stages in the Health PE process in Annex A. It is however clear that the changes introduced have had positive and significant impact on timeliness of the process.

Quality

12 Audits completed in August and October 2018 were very positive about the quality of the process in terms of decision making and decision reasoning. The interim evaluation was also positive about the performance of the pilot.

13 Audit and interim evaluation recommendations have been implemented. All recommendations were about improving the Health PE process, rather than introducing fundamental changes.

14 Although we have taken learning from discussions in the pilot review groups, the principles that were identified at the outset of the process have not needed revisiting and this has supported consistency throughout the pilot.

15 Anecdotally, the PE Health pilot has been positively received by doctors. Staff have also received positive feedback on the use of the communications plan and their general approach.

Business as usual process

16 We have developed a business as usual process which closely mirrors the pilot process. This is to mitigate risk to the quality or timeliness of the process following transfer to BAU. For example, we have:

- Retained the scheduling of review groups three times a week to provide CIT staff with early access to medical advice.
- Decided that CIT staff should continue to manage the process to maintain the single point of contact for health cases.
- Provided the CIT Manager with access to a Siebel dashboard to monitor progress of cases. The dashboard also flags cases that are approaching SLA, which prompts an additional review of progress to determine whether we should wait for outstanding information or promote the case for full investigation.
- Completed a document review exercise to reflect the BAU process.
- Secured additional medical expertise to support the review groups to support timely decision making.
- Developed a resource for doctors who self refer concerns about their health to the GMC to guide them through what types of information are useful to help us quickly decide whether it is necessary to open an investigation.
- Retained the Assistant Director of the Case Examiner Team as a member of the BAU review group which will provide ongoing oversight and assurance of the process.

Next steps

17 The Executive Report at Annex A provides additional detail on the performance of the pilot. Through outcomes from the audits and the interim evaluation, significant improvements have been implemented and embedded within the Health PE process. Based on this, we recommend the Health PE process transfers to business as usual from 1 January 2020.

General Medical Council

Item 4, Annex A – Health provisional enquiries – Readiness to transfer to business as usual

Executive Board
December 2019

Final evaluation - November 2019

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Glossary

BAU – Business as usual

CARF – Case advice referral form

CE – Case Examiner

CIT – Communications investigation team

PE – Provisional enquiries

S1 – Stream 1 investigation

SLA – Service level agreement

SR – Service request

Executive summary

The Health provisional enquiries (Health PE) pilot arose from the Supporting Vulnerable Doctors programme of work and started in September 2017.

Health provisional enquiries aim to improve the information available when deciding if a full investigation is needed. It involves getting early specialist medical input on matters relating to a doctors' health and this was a separate recommendation of the Supporting Vulnerable Doctors programme, for example by accessing specialist handling advice.

We use provisional enquiries in health cases where it appears from the information we have that a doctor's health may be affecting their ability to practise safely and there is a lack of detailed information about the health concerns. In these circumstances, we may make some provisional enquiries, to help us decide whether we need to formally assess the doctor's fitness to practise. This will help make sure that we only open a full investigation where it is necessary to protect the public, which should lead to fewer doctors undergoing a full investigation when the only concern is about their health.

There is usually no need for us to be involved where a doctor's health condition is being treated and any risks to patient care are being managed. Where there are continuing risks, and we need to put arrangements in place to protect the public, we aim to do this by mutual agreement to reduce the impact on the doctor.

The guidance provides criteria as to when a PE may be considered suitable (or not) when a health concern has been raised.

Our approach

The Health PE process sits with the Communications Investigation Team (CIT). This team was specifically set up and trained to work sensitively with doctors where we need to assess any risk to patients solely due to their health. The team works with the doctor adapting their approach depending on the doctor's vulnerability and circumstances.

In the pilot, a pilot review group (of senior GMC decision makers) assesses the suitability of the case for a provisional enquiry and considers evidence gathered through provisional enquiries. This group includes a medical Case Examiner to support decision making given these cases are about a doctor's health – which was a further proposal agreed as part of the Supporting Vulnerable Doctors programme. This group ensures there is guidance available for decision makers handling cases in this pilot and has ensured consistency in our approach.

We can request specific medical input to help us understand the circumstances of a case and how to handle communications. For example, the case examiner may feel we would benefit from a second opinion from one of our associate health examiners or medical supervisors. This may be because they would like input from a specific specialty, or because the request is particularly complex. To date, as part of the Health PE process we have only obtained expert opinion from the doctor's own treating doctors but this process remains available.

The pilot was audited in August and October 2018 and has received positive audit outcomes. An interim evaluation of the pilot was completed in March 2019. We have since implemented audit recommendations and interim evaluation recommendations We provide in this evaluation an update on our current position.

Next steps

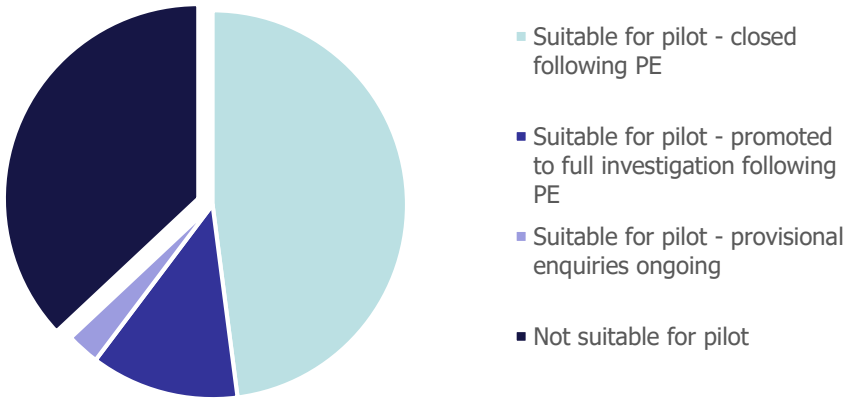
Based on the content of this evaluation, we recommend that the Health PE process transfers to business as usual from 1 January 2020.

Pilot outcomes

Pilot volumes

- The pilot review group has considered 71 enquiries (at 15 November 2019) – 46 were suitable for inclusion in the pilot.*

Outcome of enquiries referred to Health PE pilot review group



- **Closure rate**

Of the 46 enquiries found suitable for the pilot:

- 35 were closed following provisional enquiries as we were assured the doctor's health condition was being managed locally and there was no risk to patient safety.
- 9 were promoted for a S1 full investigation following provisional enquiries as we were unable to obtain the assurances we needed about the doctor's health and its impact on patient safety from our initial enquiries.
- 2 provisional enquiries are ongoing.

The 35 cases that closed following provisional enquiries represents a 76% closure rate which demonstrates that this process is working well to ensure we only undertake a full investigation where necessary in relation to health concerns. This closure rate is similar to that for other provisional enquiry streams.

* Of the 27 enquiries not suitable for the pilot, 10 were referred to a S1 full investigation; 16 were closed at triage (one of which was disclosed to the doctor and RO in the Notify RO process); 1 was referred to the general (non-health) PE.

Pilot outcomes

Timeliness

At the outset of the pilot, we were unsure how long the particular types of enquiries needed in a health case were likely to take, particularly given the vulnerability of the doctor. We therefore decided to use the standard PE SLAs initially while we gained more experience through the pilot of how long these enquiries were likely to take. These SLAs are 75% of enquiries to be completed in 63 days and 90% to be completed in 84 days. In the initial stages of the pilot our enquiries were taking longer than general PEs.

As these cases were taking longer than the general PE process, two audits completed in August and October 2018 focused on timeliness and provided a breakdown of time taken for each key task. However, it wasn't possible to identify any specific tasks within the process that caused delays. Where delays had occurred they had happened at different points in the process for different cases. It was noted that some delays were unavoidable such as the time taken to obtain information from external third parties and that in some cases staff had had to prioritise other types of cases within their mixed case load.

At the time of the audit, the average time to conclude Health PE cases was 112 days. This exceeds the general PE SLAs and therefore impacts on the achievement of S1 SLAs for cases that are promoted to S1 following provisional enquiries.

The CIT team reviewed their approach based on the audit outcomes and introduced three major changes.

- Three pilot review group meetings are scheduled each week to minimise delays in the AR accessing advice on the enquiry.
- A dedicated member of staff has been allocated to dealing with all Health PE cases to avoid delays due to prioritisation of other cases.
- Medical expertise is now accessed at the review group rather than requesting separate medical CE advice before the meeting.

Following the audits in August and October 2018, the time taken to complete our enquiries has significantly reduced. Please see the next slide for examples of how these changes have impacted on timeliness of the process.

Pilot outcomes

- **Timeliness continued**

Pre-audit	Post-audit
Average length of Health PE process 112 days.	Average length of Health PE process 61 days.
Average time taken from enquiry received to first meeting of review group was 35 days.	Average time taken from enquiry received to first meeting of review group is 7 days.
16 provisional enquiries completed • 2 achieved 63 day SLA **(13%)** • 6 more (total 8) achieved 84 day SLA **(50%)**	19 provisional enquiries completed • 15 achieved 63 day SLA **(79%)** • 1 more (total 16) achieved 84 day SLA **(84%)**
5 cases promoted to full investigation following provisional enquiries. • Promoted after average of 117 days.	4 cases promoted to full investigation following provisional enquiries. • Promoted after average of 41 days.
Final PE decision took an average of 10 days.	Final PE decision takes an average of one day.
	CIT manager introduced a new SLA for triage decisions to be made within 2 days of receiving the group's advice. • The average time taken is one day.

We had considered at the time of the interim evaluation whether CIT staff uniquely handling a mixed caseload was contributing to delays. For this team, the doctors undergoing a full investigation are some of the most vulnerable doctors in our FTP processes.

However, allocating the Health PE cases to a dedicated group of staff has brought some significant time savings in the process.

We further considered whether it would be appropriate to move the Health PE process to the wider PE team so that focus remained on making swift enquiries. However, this has been weighed against the risks to single point of contact for health cases and we have taken the decision to leave the Health PE process with the CIT team, especially given that volumes are relatively low and are being well managed by the team.

Pilot outcomes

Timeliness

- We have noted that 72% of cases that were suitable for the pilot involved the doctor self-referring to us. Often we receive little detail around the doctor's condition, treatment and the support they have in place and we need go back to them for further information. Where relevant information is provided with the self-referral, we have been able to conclude provisional enquiries in as few as 11 days. We have taken the opportunity to develop a resource to support doctors who are self referring to us about a health condition. This guides them through what types of information are useful to help us quickly decide whether it is necessary to open an investigation. We will be sharing this new resource with the Practitioner Health Programme and the medical defence organisations for their comments before we start using it. This should yield further time efficiencies once introduced.

Quality

- The pilot was audited in August and October 2018 where it was found "the results are extremely positive with all decisions being made considered correct and well reasoned". The audit also provided a number of recommendations which CIT has implemented.

- The Health PE referral form works well to record the advice provided by the review group. However, the team has since worked with the Investigation Enhancement Team to launch new sections for the Case Advice Referral Form (CARF) (the form that collates all the key information for decision makers) to include PE cases, as this will ensure consistency with other work streams and reduce duplication of work should a PE case be promoted to S1. The CARF has been introduced into the process and is working effectively to record information collected in the Health PE process and the review group advice.

- A service request (SR) was introduced following the audit which provides a location to store the PE group advice in Siebel. This SR has been used in all cases since. We also retrospectively saved the SR to all earlier cases considered as part of the pilot to ensure there was a full dataset for Health PE cases. This SR allowed the development of a Siebel dashboard to provide management information on all cases considered by the review group.

- CIT staff have received positive feedback on the pilot process and the approach taken by staff on the team to support doctors.

- There is clear guidance for decision makers to support the pilot process. It requires some amendment based on learning from the pilot (see next slide). It should be noted however that there is minimal change to the principles agreed before the pilot started which will support consistency.

Learning from pilot review group meetings

The guidance should be updated to reflect or clarify the following:

- Health allegations should not be closed in the Health PE process if there are connected misconduct or performance allegations that require referral to S1 investigation. Health concerns can provide mitigation where they are linked to conduct of performance concerns so it is better to consider these in the round.

- The health PE process, like all our PE procedures, is designed to clarify if a full investigation is necessary and therefore is only appropriate where concerns about a doctor's health pose a risk to patients. PE is therefore unlikely to be necessary where the doctor does not have a licence to practise (an alert should be placed on their record so that any risk can be assessed if they apply for a licence).

- If we receive sufficient information as part of the referral / self-referral to provide us with assurance that there is no risk to patients, we can close the enquiry without opening a Health PE or investigation.

Business as usual process

- To maintain the quality and timeliness of the Health PE process when it transfers to business as usual, we have very closely mirrored the pilot process. For example, we will continue to have review groups scheduled three times a week to provide CIT staff with early access to medical advice. The Assistant Director, Case Examiner Team will continue to provide oversight and assurance of the process. The process will remain with the CIT team who are experienced in dealing with these types of cases.
- We have taken learning from decision making throughout the pilot (see previous slide) and have updated decision maker guidance. These documents are in the document review and approval process currently and will be published before the pilot transfers to BAU.
- We have provided the CIT Manager with access to a Siebel dashboard to monitor progress of cases. The dashboard also flags cases that are approaching SLA, which prompts whether any additional steps need to be taken.
- We have updated the documents that support Health PE to reflect the proposed BAU process, incorporate changes that have been introduced since the pilot started and include learning we have taken from the pilot. We are currently working through the document review and approval process.
- We have secured additional medical expertise to support the BAU process and support a timely process.
- We have developed a resource for doctors who self refer to us to help us to make decisions for these doctors more quickly – we will share this with the Practitioner Health Programme and medical defence organisations before we roll this out.
- Based on the current performance of the process and subject to these improvements, we recommend that this process transfers to BAU from 1 January 2020.

Recommendations

The Executive Board is asked to approve:

1. Publication of the self-referral resource for doctors following review by the Practitioner Health Programme and the medical defence organisations.
2. Introduction of improvements identified during the pilot and corresponding updates to guidance for decision makers.
3. The transfer of the Health PE process to BAU from 1 January 2020.