For decision

Implementing the Doctor Support Service

Issue
1 The future provision of the Doctor Support Service following evaluation of the pilot.

Options
2 The following options have been considered:
   a Option A: To cease providing the Doctor Support Service.
   b Option B: To continue to offer a Doctor Support Service to all doctors with an open investigation with the current scope of service.
   c Option C: To continue to offer a Doctor Support Service to all doctors with an open investigation with an enhanced level of service.

Recommendation
3 The Strategy and Policy Board is asked to approve Option C above, at an estimated cost of £5,000 from 1 January to 1 May 2015, and an estimated cost of £27,080 from 1 May to 31 December 2015.
Implementing the Doctor Support Service

Issue

Findings of the independent evaluation

4 The Doctor Support Service provides confidential peer emotional support for doctors whose fitness to practise is being investigated. The pilot has now concluded and the independent evaluation of the service is now complete, the report of which is at Annex A. A summary of the background to the pilot is at Annex B.

5 We have extended our contract with the British Medical Association (BMA) to the end of 2014 to continue to run the service while its future is decided.

6 From the feedback it is clear that doctors who have used the service have derived real benefit from it. Those doctors who accessed the service generally agreed that the service was easy to access and use, that the allocated support time was sufficient and that they valued the fact that the supporters themselves were doctors and that there was continuity of access to one supporter throughout the process.

7 Some prominent quotes from the feedback received identify the importance of the service to doctors in the investigation process including the importance of confidentiality:

- ‘It helped more than I could ever have imagined.’
- Another referred to the service as ‘a supportive ear’.
- ‘Someone I could trust to maintain confidentiality.’
- ‘The careful listening and guidance and open communication were for me important.’

8 Doctor supporters themselves described it as ‘providing some support when it is most needed’ and that it was a privilege to ‘help those in real difficulty in some small way’.

9 Respondents also raised a number of suggested improvements which could be made to the current service provision. We recommend that as part of any contract, post pilot, we aim to incorporate these improvements into the service provision. This will ensure the service continues to respond to the needs of its users in the future:

a Extending availability of the service beyond six hours on a case by case basis as many other doctors do not require the full six hours.

b Consideration of other mediums of technology to facilitate the provision of support, e.g. Skype.
c Exploring ways to provide greater choice for doctors in relation to the time and date of the initial contact.

d The introduction of an on-going system of feedback from the service users to ensure ongoing development and response to the services users’ needs.

e Ensuring a system of appraisal for the supporters to ensure consistency in approach and support provided.

f Providing a mechanism for supporters to share experiences and share best practice.

Options

10 Following analysis of the feedback, three options were considered.

**Option A: To cease providing the Doctor Support Service**

11 Ceasing the service would save £15,000 per year (at the current contract rate). However, from the feedback we have received it is clear that doctors using the service have derived real benefit from peer support during an investigation. The GMC recognises that this can be a very difficult time for the doctor and their immediate family. It was in recognition of this that the pilot was established, and for this reason we do not recommend this option.

**Option B: To continue to offer a Doctor Support Service to all doctors with an open investigation with the current scope of service**

12 It is clear from the evaluation that the pilot model has been successful. However the evaluation also highlighted several areas where improvement could be made. Having studied that feedback carefully we consider that the service can be enhanced. We therefore do not recommend this option.

**Option C: To continue to offer a Doctor Support Service to all doctors with an open investigation with an enhanced level of service**

13 Given the overall positive feedback about the service and the conclusions of the evaluation, we suggest that this provides a strong rationale to continue to provide an independent emotional support service for doctors who have an open investigation.

14 We recommend that the pilot continues to operate in its current form while we offer invitations to quote for the service with a number of enhancements. We recommend that the following provision is detailed in the invitation to quote:
a Emotional support is to be provided by doctors, who will be adequately trained in the GMC process of investigation so that they can provide independent emotional support throughout the process.

b The current provision of six hours telephone support throughout the investigation is to remain but we suggest the introduction of an element of flexibility to be able to extend this on a case by case basis.

c Continue to offer two days of face to face support at a hearing.

d Embed the provision of face to face support at a doctor meeting at the end of the investigation to coincide with rollout plans for meetings with doctors.

e Require a future service to provide a safety net of support for doctors who require emotional support outside of core operational hours

f The new service provision will be flexible regarding the medium of support requested by the service user e.g. Skype, email.

15 To ensure that the service continues to respond to the needs of its users in the future it also considered that a peer discussion group and a system of ongoing feedback and appraisal should be incorporated. These enhancements are likely to have some cost implications as follows:

a If the introduction of a measure of flexibility in telephone support were to result in a 10% increase in usage this would cost £1,500 per year.

b If enhanced publication of the availability of doctor supporters to accompany unrepresented doctors to meetings with the GMC resulted in a doctor supporter attending one meeting a month the additional cost would be £2,000 per year.

c Two half-day peer support sessions a year would cost £5,000 per year. Ongoing support and appraisal estimated at an hour a month for each supporter would cost £7,500 per year.

d Only two doctors took up the offer of support at a hearing during the pilot. As doctors currently receiving telephone support are called to hearings this is likely to increase. A 50% increase in requests for support at hearings in the first year of roll out would cost an additional £2,120 per year.

Current contract considerations

16 The current contract for the service ends on 31 December 2014. We will need to extend the current contract for a short period to allow for the invitation to quote exercise to be completed for the provision of the future service. It is recommended that the invitation to quote exercise begins in early December 2014 and runs until
mid-January 2015. The current contract would need to be extended to May 2015 to allow sufficient time for the invitation to quote exercise to conclude, for clarification meetings to be held and for the service to be set up by the chosen provider. By extending the current contract this will ensure service provision remains throughout any transitional period. The cost of extending the service from 1 January to 1 May 2015 is £5,000.

Cost of rollout

17 Take up of the service increased by 50% in year two when compared with year one. A further 50% uplift in use of the service would cost £7,500 per year.

18 Taking account of the proposed enhancements and the estimated increase in take up, we estimate that the cost of delivering an enhanced service going forward would be £40,620 per year. For the period 1 May to 31 December 2015 this would be £27,080. If the Board approves the rollout of the enhanced service in principle, an implementation plan including the estimated costs of rollout will be taken to the Performance and Resources Board and will be taken into account when we seek invitations to quote for future service provision.

Implementation

19 The implementation date will depend on the outcome of the invitation to quote and whether there is a change in service provider. As noted above, extending the current contract until the start of the new contract will ensure that service provision will remain during the transitional period.

Risks

20 Doctors self-refer to the service. Any significant increase in usage of the service in future would increase the cost of the service. We have built in an estimated 50% increase in usage in the service in the first year of rollout to manage this risk.
Supporting information

How this issue relates to the corporate strategy and business plan

22  Strategic aim 3: Improve the level of engagement and efficiency in the handling of complaints and concerns about patient safety; and Strategic aim 5: Work better together to improve our overall effectiveness, our responsiveness and the delivery of our regulatory functions.

How this issue supports the principles of better regulation

23  The Doctor Support Service, like the Witness Service, is not about delivery of regulation but about fairness to those who are involved in an investigation. We know that doctors find being subject to investigation stressful and can become isolated. This service aims to reduce that stress and isolation by providing peer support.

What engagement approach has been used to inform the work (and what further communication and engagement is needed)

24  During the pilot we delivered a range of activities targeting operational staff throughout the GMC to promote awareness of the pilot service, as well as online information on both the internet and intranet, and linked this to a dedicated page on the BMA’s own website, detailing the service further. Doctors under investigation receive regular reminders about the service in our correspondence with them.

25  Once the enhanced service is in place we plan to run engagement events with the service provider, inviting them into the GMC to engage with our staff in person. We will also update our internet and intranet pages to reflect the new service, and continue to work with our Communications team to engage with key interests including medical defence organisations, patient groups and staff within the four countries.

What equality and diversity considerations relate to this issue

26  The service is inclusive and accessible to everyone, regardless of religion, sexual orientation, age, gender, ethnicity, physical or mental disability or sensory impairment. All supporters have received equality and diversity training. The service provides emotional support but cannot provide medical or legal advice or advice about the doctor’s fitness to practise case. Supporters are able to signpost the doctor to other services if they consider that to be appropriate. If the service is rolled out, the Equality Analysis undertaken for the pilot will be reviewed and updated.

If you have any questions about this paper please contact: Anna Rowland, Assistant Director – Policy and Planning, arowland@gmc-uk.org, 020 7189 5077
Final report of the pilot of the Doctor Support Service
Final Report of the Pilot of The Doctor Support Service

July 2014
1 Introduction

There are currently around 250,000 doctors on the General Medical Council’s (GMC) register, of whom approximately 150,000 are in active practice. Over 200 doctors are referred to a fitness to practise panel each year. The GMC receives complaints from a variety of sources including members of the public, doctors and employers. Many of these complaints relate to a doctor’s own health and concerns that they are not taking enough care of themselves to be able to treat patients safely.

An investigation into a doctor’s fitness to practise may take several months and the GMC recognises that this can be a very difficult time for the doctor and their immediate family. The pressure of being the subject of an investigation, where the doctor’s livelihood is potentially at risk, can sometimes cause emotional distress or anxiety.

It was with this appreciation of the nature of complaints they receive, and the effect investigations can have on doctors that the GMC established a pilot of a new independent service to provide emotional support for doctors.

The pilot service has been run on behalf of the GMC by BMA Doctors for Doctors. The service is staffed by doctors who are experienced in providing peer support. The service provides emotional support but cannot provide medical or legal advice and the supporter is someone that the doctor can talk to, who understands the process, but is not connected to it.

Doctors undergoing fitness to practise investigations are notified of this confidential service when the investigation is opened and at key stages throughout it. This provides the contact details relating to the service directly to the doctor enabling them to make contact. As the service is confidential, the GMC will only know a doctor is receiving support if the doctor notifies the GMC that they are being accompanied to a meeting or hearing by a supporter. Please note that the GMC have been conducting a pilot of meetings with doctors undergoing fitness to practise investigations, which has very recently completed.
2 Executive Summary

This final report provides information on the evaluation of the GMC funded pilot of the Doctors’ Support Service as delivered by the BMA Doctors for Doctors unit.

This report covers the period from 1st January 2013 to 13th May 2014. We have understood from the BMA, that during this evaluation period, 140 doctors accessed the service, and there have been 13 supporters who have provided support to these doctors during this time.

For reasons of maintaining confidentiality, the BMA contacted all doctors who used the service during this period requesting that they complete and return an electronic questionnaire, 15 were returned. We contacted all 13 supporters directly and completed telephone interviews with them.

Key Findings and Recommendations

Our findings and recommendations are based on the feedback we have received from electronic questionnaires completed by doctors and the telephone interviews completed with supporters. The feedback is purely from their perspective and based on their understanding.

- The majority of doctors found it easy to access the service. However we did note that comment was made that it was not possible to make initial contact at the weekend or out of hours (it is an answerphone service, dealt with the next day or immediately following a weekend. The message does offer access to the BMA counselling service out of hours). It may be appropriate to review this in terms of providing greater hours of coverage.

- The majority of doctors were provided with the amount of support time they required, and this appears, for the majority, to be 6 hours or less. There was one doctor who suggested it would be useful to have contact perhaps every two to four weeks throughout the period of the investigation.

- The fact that the supporters are doctors was clearly considered to be of benefit to the doctors seeking support who responded to the questionnaire.

- Some doctors who responded suggested that it was good to have the continuity of one supporter. We suggest that if the doctor requests support at a meeting or a hearing, and their allocated supporter is unable to attend, if a different supporter is offered, consideration needs to be given to a ‘hand over’ process with the aim of ensuring the quality of support is maintained and that the doctor is fully comfortable with the arrangements.

- There was some suggestion from supporters that it would be useful to understand when is a good time to make the initial contact with the doctor, and we suggest this is information requested at the time they contact the BMA and then passed to the allocated supporter.

- Some supporters suggested that there were some issues with the website/database, we would suggest that this is investigated in order to ensure they can deliver the quality of service required.

- There does not appear to be any ongoing assessment of the service and this was observed by some supporters, suggesting that feedback from the doctors would be useful. We agree that this would be highly beneficial in order to ensure the service continues to meet requirements and to evolve and improve. We would add that
there could also be value in establishing an ‘appraisal’ process for supporters, and this would give assurances to them, as individuals, that they are meeting the doctors requirements and to the GMC that the required standard is being maintained

- Currently this service is provided by telephone only. We consider that consideration be given to potential value/disvalue for face to face meetings, including the use of technology such as Skype

- The doctors who responded provided some very informative and illustrative feedback and we would suggest consideration is given to including quotes from doctors who have used the service in any future promotional material as this has the potential to bring the service to life

- The feedback we have received (albeit limited in quantity) tells us that the service in overall terms is successful.
3 Acknowledgements

We would like to take this opportunity to acknowledge the help and support provided to us by Dr M Peters, Head of the Doctors for Doctors Unit at the BMA and Tom Rapanakis, Service Coordinator, the Doctors for Doctors Unit at the BMA. We would also like to thank Lyndsey Dodd our Project Manager at the GMC for her guidance and support. We thank all three of them for giving so generously of their time and expertise. Most importantly we would like to pass on our particular thanks to all the doctors using this service who took time to complete questionnaires, and the supporters who completed telephone interviews with us, without whom we would have been unable to complete this work.
4 Background and Context

This GMC pilot of a new independent service to provide emotional support for doctors undergoing fitness to practise investigations began in April 2012. The pilot service has been funded by the GMC and delivered by the BMA Doctors for Doctors unit. It is important to note that not only is the service free to use but also the doctor does not need to be a member of the BMA to access the service. The GMC does not know that a doctor has used the service unless the doctor requests their supporter to attend a meeting with the GMC or a fitness to practise hearing.

The service gives doctors, involved in a fitness to practise case, access to telephone support from the point at which they learn a complaint has been made about them, until the case is concluded. It also offers orientation visits to the MPTS Manchester hearing centre, and an independent supporter to accompany the doctor on the first day and one other day of the hearing.

This initiative is among a range of recent activities to improve information and support for doctors who are subject to an investigation into their fitness to practise, which includes:

- The recently launched Information for Doctors’ leaflet
- An interactive hearing room which enables doctors to take a virtual tour of GMC premises before they attend a hearing
- A specific section on the GMC website to help doctors with health concerns to understand fitness to practise process
- A pilot of meetings with doctors during an investigation.

The Doctor Support Service is open to any doctor who requires additional emotional support during the investigation or adjudication stage of fitness to practise procedures.

Doctors with particular needs who may self-refer to the service include:

- Unrepresented doctors.
- Doctors with a pre-existing mental health condition, or other disability
- Doctors who are experiencing emotional distress as a result of anxiety about a fitness to practise investigation
- Overseas-qualified doctors who may have particular difficulty understanding the system and culture of the GMC’s legal process.

The service is inclusive and accessible to everyone, regardless of religion, sexual orientation, age, gender, ethnicity, physical or mental disability or sensory impairment.

The service provides emotional support but cannot provide medical or legal advice or advice about the doctor’s fitness to practise case. Supporters are able to signpost the doctor to other services if they consider that to be appropriate.
5 Our Planned Approach

Following discussions with representatives of the GMC and the BMA the planned approach was agreed as follows:

- We developed questionnaires and Personal Data Forms (PDFs) for the doctors accessing the service and these were distributed to all those doctors by the BMA and completed questionnaires were returned to the BMA.
- On receipt of the completed questionnaires and PDFs, the BMA team redacted any identifying detail and then forwarded the documents to us.
- We developed semi structured interview guides, and used these as the basis for telephone interviews with the doctors’ supporters.

Taking this approach gave assurances that all those contributing to the evaluation process would be completely anonymous.

We then completed the evaluation of the service based on the data gathered.

Copies of the questionnaire for doctors and the interview guide for doctor supporters are attached at Appendices 1 and 2 respectively.
6 The Evaluation

The pilot was operational for two years and this evaluation relates to doctors accessing the service during the period from 1st January 2013 to 13th May 2014. Our understanding is that, during this period, 140 doctors used the service. This shows a considerable increase in usage as during the first period of operation, 79 doctors accessed the service. This is an increase of 89%, and although we are unable to provide a definitive reason for this, it is likely that it is due to improvement of awareness of the service.

We also understand that the BMA contacted all the doctors who had used the service, during the aforementioned period, and requested that they complete and return the questionnaire and also a Personal Data Form (PDF). Completion of both was entirely voluntary and the doctors were able to complete the questionnaire and not provide the personal data if they preferred.

There was a response rate of 10.7% (15) in relation to the questionnaires and 14 PDFs were returned. The personal data has been collated and provided separately. This response rate was achieved following three reminders sent by the BMA.

This response rate is a little disappointing; as our expectation going into the project (based on our previous experience) was in the region of 20+ %. That said, it is important to note that when conducting this type of research when participation is voluntary and those participating are undergoing and commenting on potentially stressful circumstances it is very challenging to accurately estimate participation rates. It is therefore not possible to give any definitive reasoning for this response rate and we would certainly not suggest that the BMA should carry out any further ‘chasing’. We can speculate that a higher response rate might have been achieved if the evaluation had been ongoing throughout the year, rather than being left until the end, as then the experience may have been fresher in the minds of the users. However, support is ongoing throughout a doctor’s case and therefore this approach would have meant that responses would potentially have only related to an initial part of the service provided.

There are 13 doctors’ supporters and we telephone interviewed all of them.

**We recommend that** should evaluations of similar services be completed in future, that consideration is given to informing the doctors at the start of their use of the service that there will be an evaluation, which they will be contacted about. This may help to improve response rates. Consideration could also be given to introducing a short phone survey after each call when the doctor would be able to provide quick and immediate feedback. This would no doubt need some expert input as in order to do this and take account of all contact, the system would need to be able (no doubt) to pick up calls made to and from the BMA’s Doctors Support Unit and the supporters themselves on both their landlines and their mobiles.
7 Caveats Relating to Feedback Received

The doctors using the service were invited to provide input to the evaluation by way of electronic questionnaire, which was considered to be the most effective methodology. The use of such questionnaires is an efficient method and was used because it was felt that doctors who had gone through fitness to practise processes, and had accessed this support service, should not be contacted directly by us. This is understandable. However, restricting the methodology in this way does not allow for any in depth questioning in order to seek clarification of particular points, and responses can be open to interpretation. This has been the case with the feedback we have received. Some examples are:

In response to the question -
‘Were there any particular aspects of the service which did not work well for you?’
One doctor replied -
‘Yes I think it put things into perspective.’

In response to the question -
‘If this service is taken forward, do you have any suggestions that could improve it?’
One doctor replied –
‘Continuity by the same doctor and desired package of time for that particular issue e.g. Currency as a lump sum allocated for that particular issue from the start.’

When we have used quotes from the questionnaires completed by the doctors we have made no changes to the quotes in anyway.
8 Feedback Received

8.1 Doctors using the service

We detail below the responses received from the doctors who completed and returned questionnaires. As previously stated there were 15 questionnaires returned, it is only at question one however, where we actually comment on all 15 responses. The reason for this is, that based on the responses from one doctor in relation to questions 2 – 12 (inclusive), and our discussions in relation to this with the Head of the BMA’s Doctors for Doctors Support Unit, we are of the view that this one doctor called the BMA enquiry line for trade union type employment assistance (we suspect in error) and then provided responses based upon that.

It should be noted that the doctors, did not all respond, to all questions within the questionnaire, we therefore show against each question how many responses were received to that specific question.

There were 15 responses to the first question. There was one response which we believe must have been a misunderstanding as it simply said ‘very helpful’, and therefore we have removed it.

Our interpretation of responses therefore is that all 14 responses found out about the service via the GMC, with one of the 14 stating the GMC and BMA. This, if we take account of the fact that there were actually 15 responses (one of which was removed) is 93% of the total, or of course it is 100% of the responses taken account of. The responses further break down as shown in the table below:

<table>
<thead>
<tr>
<th>Question 1: How did you find out about this support service?</th>
<th>Number responded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Literature</td>
<td>9</td>
</tr>
<tr>
<td>Advice</td>
<td>3</td>
</tr>
<tr>
<td>Telephone</td>
<td>1</td>
</tr>
<tr>
<td>Website</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
</tr>
</tbody>
</table>

The second question was:

**Once you became aware of the support service, did you find it easy to access?**

We asked for a response using the Likert Scale where 1 was difficult and 5 was very easy. The Likert Scale is a method of measuring attitudes by asking participants to respond to a statement, or series of statements about a topic, stating to what degree they agree with it/them. This approach is usually used to measure attitudes or opinions.

There were 13 responses. Seven (54%) stated that it was very easy to access (using the rating of 5), five rated it at 4 and one rates it at 3. The pie chart on the next page illustrates this:
Ease of Access

In response to the follow up question of 'Why was that?' the majority who had rated the ease of access as 4 or 5 referred to the fact that a telephone number was provided and they just needed to make a call.

Comments included:

'I rang them and they rang back. Simples'

'I just called the support number and immediately was promised to get some kind of communication / call in the coming 48 hours from a support doctor. And I did.'

The one doctor who rated the ease of access at three on the Likert Scale stated:

'When I first contacted service I left message twice on the answer phone but received no reply; I tried a week or two later and spoke to the coordinator, after that telephone call I received support.'

The third question was: **What made you decide to take up the support service?**

There were 14 responses and the doctors gave a variety of responses including:

'Thought it would help to have someone accept me as I am. Someone who has made a mistake and realised it after the actual event, without being discriminating.'

'Intense stress of the referral. GMC advice, MDU advice and legal advice.'

'Because I felt completely alone and had nowhere else to turn to.'

'Any support when you need it, when you need it. I am grateful to receive in times of
As I lost my … … years ago, having had to deal with an incredible and unbearable amount of chaos and huge hurdles and pain with nearly no support whatsoever, I couldn’t believe that there would be somebody willing to listen and guide me when going through another unexpected, traumatic, spiteful, vindictive totally appalling and undeserved complaint.’

The fourth question was:

**When did you first use the support service?**

We asked for the month and year and all except two gave this detail, one only provided the year, and one the season and the year. We show the information provided below:

<table>
<thead>
<tr>
<th>Date</th>
<th>Numbers of doctors making contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2012*</td>
<td>1</td>
</tr>
<tr>
<td>2013</td>
<td>1</td>
</tr>
<tr>
<td>January 2013</td>
<td>1</td>
</tr>
<tr>
<td>February 2013</td>
<td>1</td>
</tr>
<tr>
<td>April 2013</td>
<td>1</td>
</tr>
<tr>
<td>June 2013</td>
<td>1</td>
</tr>
<tr>
<td>July 2013</td>
<td>1</td>
</tr>
<tr>
<td>September 2013</td>
<td>1</td>
</tr>
<tr>
<td>Summer 2013</td>
<td>1</td>
</tr>
<tr>
<td>February 2014</td>
<td>1</td>
</tr>
<tr>
<td>March 2014</td>
<td>1</td>
</tr>
<tr>
<td>April 2014</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
</tr>
</tbody>
</table>

Question 5 asked:

**Approximately how much telephone support service time have you taken up to date?**

There were 14 responses to this question, however three did not state how much actual time they had taken up, despite the fact we had requested total time in hours and minutes; they simply referred to the number of telephone calls/conversations, with two referring to one call and one referring to three.

The amount of time taken was quite varied, the minimum amount of time stated was 10 minutes (1 doctor) and the maximum was 6 hours (1 doctor stating 6 hours and 1 doctor stating 5-6 hours).

<table>
<thead>
<tr>
<th>Approximate amount of time</th>
<th>Number of doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 1 hour</td>
<td>7</td>
</tr>
<tr>
<td>More than 1 and less than 2 hours</td>
<td>0</td>
</tr>
<tr>
<td>More than 2 and less than 3 hours</td>
<td>0</td>
</tr>
<tr>
<td>More than 3 hours</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>
Question 6 asked:

**Is this the amount of time you actually needed?**

The overwhelming majority, 12 (86%) of the 14 said that it was. Two of the respondents (14%), said that it was not. These two doctors were asked at question 7:

**How much time did you ideally want from the Supporter?** Both responded but only one specified how much time they actually wanted. We include the two responses below:

- ‘I would have liked to use at least four 2 hours sessions for my issue. Talking to work colleague is not and never the same.’

- ‘Follow-up would have been longer.’

There were four responses to this question from doctors who had said the amount of time had been adequate. Three of them simply reiterated this and one said:

- ‘I would have appreciated ongoing support on the regular basis – every two to four weeks throughout the investigation.’

The doctors who had responded they had not received an adequate amount of time when next asked:

**Why did the supporter not provide this amount of time for you?**

said:

- ‘I got a feeling that this was voluntary service and doctors providing this service were voluntiars (sic.).’

- ‘Don’t know.’

- ‘Because once the GMC judgement was complete, I felt things were OK. In retrospect, I could have done with further follow-up support, as other issues arose over the following months.’

Question 8 asked:

**Did you feel that the supporter understood your issues?**

Again we sought responses on a Likert Scale where 5 was fully understood and 1 was no understanding. All 14 answered the question, with 9 saying their issues were fully understood by the doctor supporter, three giving a rating of 4, one giving a rating of 3 and one giving a rating of 2.

Some examples of why the doctors said they felt their issues were fully understood are:

- ‘This was a clinical management dispute issue and I was able to obtain a reasonably balanced guidance. This, when I measure it with senior legal advice at a significant cost, worked out more informative helpful and well targeted to the clinical issue.’

- ‘She was very empathetic and listened very well. She was not directive although she...’
did discuss options such as retirement and doing locums.’

‘She was well-acquainted with GMC procedures and was able to put my situation in context.’

‘He was very supportive & understanding & shared his personal experience of dealing with a GMC complaint.’

The one doctor who rated this at 2 stated they felt this because:

‘He did not understand how I felt at the time leading to the mistake… In hindsight I realise as he said that what I did was a foolish thing to do …’

We consider that the comment made by the doctor who rated the level of understanding as 3, is also worthy of noting:

‘Unless one has been through the ordeal, it is impossible to fully understand.’

Question 9 was:

**Which particular aspects of the service worked well for you?**

We were unsurprised to receive a wide range of responses and there were 14 in total. The vast majority 12 (86%) were positive, with the focus, in the main, being about having support and being able to talk. A selection of the comments received, are shown below:

‘Advised what I was going through was normal.’

‘A supportive ear. Someone I could trust to maintain confidentiality.’

‘The careful listening and guidance and open communication were for me important as you can feel very lonely when you are confronted with a nasty problem you never expected to be confronted with.’

There was one negative comment, simply stating ‘Nil’. This we would usually have interpreted as meaning that there was no aspect of the service which worked well for the doctor, this interpretation however does not make sense when considered with this doctor’s responses to the other questions he/she answered which were positive. We therefore feel this response indicated they had nothing more to say rather than a negative comment about the service, particularly as this doctor did not respond to the follow on question.

Question 9a was a follow on question asking:

**Why was this?**

There were 7 responses to the question one of which was not actually about the service. As the remaining 6 were all different we have included them all below:

‘It is difficult to just talk to colleagues or family.’
‘Friendly and gave me time at the time I needed it.’

‘The first thing lost in a GMC ‘medical’ investigation is the right to privacy. Everything I say to any doctor is passed on almost verbatim to the ‘Tribunal’. I felt I could trust no-one. It was good to be able to verbalise my worries knowing what I said remained confidential.’

‘She had very Good listening skills.’

‘It is easy to go into a flat spin when you are referred and this gave me perspective again.’

‘Professionalism’

Question number 10 asked:

**Were there any particular aspects of the service, which did not work well for you?**

There were 12 responses to this question five of which categorically stated that there were no aspects of the service which did not work well for them, one added ‘great service’.

The other 7 responses were very mixed. Two were quite difficult to understand fully, and it is possible that they had simply misread the question and were actually explaining what they had liked about the service:

‘Yes I think it put things into perspective.’

‘Opportunity to speak to an outsider.’

Because they are so varied we have also included the remaining 5 responses below:

‘Adequate time at the session or not having enough number of sessions.’

‘As above (Friendly and gave me time at the time I needed it.) Please note that the details given to me on your leaflet were out of date. It indicated that the support service was about to come to an end, when this was not the case. That was stressful in itself to think that may be the case, which almost put me off asking for it.’

‘The limitations of the contact being over the phone and not face-to-face.’

‘Not really. I talked to him about my concerns and he was very supportive.’

‘I know that there are limitations in what can be offered as support. Though some basic legal advice and guidance based on the facts would be nice.’

Question 11 was:

**If this service is taken forward, do you have any suggestions that could improve the service?**

There were 12 responses to the question one of which stated there was nothing they could suggest.
The other 11 responses were wide ranging and for that reason we have included all of them:

<table>
<thead>
<tr>
<th>Response</th>
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<tbody>
<tr>
<td>'Maybe follow up conversations. Maybe co-ordinated support with our employers – Occupational Health.'</td>
</tr>
<tr>
<td>'This would be invaluable for others who need more support.'</td>
</tr>
<tr>
<td>'I initially didn’t contact the service when I was first referred to the GMC. At the time I was receiving intensive psychiatric input and had spent a lot of time discussing my problems with nurses and psychiatrists. It was the day before the IOP that I decided to ring as I felt I had nothing to lose and it may help. It helped more than I could have imagined. There isn’t a great deal of information given about the service. Testimonials from doctors who have benefitted from it would have encouraged me to call sooner than I did. More information about the service would have been useful.'</td>
</tr>
<tr>
<td>'Face-to-face contact would be more personal. Contact with someone who has been through ’the system’ and has personal experience of what it entails. Longer-term follow-up to pick up on ’post-traumatic’ issues.'</td>
</tr>
<tr>
<td>'Yes, I would like to have regular contact throughout investigation.'</td>
</tr>
<tr>
<td>'Perhaps having some face to sessions in a nearby locality may be helpful.'</td>
</tr>
<tr>
<td>'Keep up the good work.'</td>
</tr>
<tr>
<td>'I thinks it helps better those doctors who have no legal –MDU or LMC support.'</td>
</tr>
<tr>
<td>'Maintain high standards.'</td>
</tr>
<tr>
<td>'Yes, being able to have some ~30 min of free legal advice would be very helpful. It would put the person involved in a complaint at ease just to have a clear chat.'</td>
</tr>
<tr>
<td>'Continuity (sic.) by the same doctor and desired package of time for that particular issue e.g. Currency as a lump sum allocated for that particular issue from the start.'</td>
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Question 12 was:
If the GMC request that you attend a hearing/have asked you to attend a hearing, do you plan to/did you ask your Doctor Supporter to attend a hearing with you? And there was a follow up question 12a which asked:
What are/were your reasons for taking that decision?
There were 13 responses to question 12, the vast majority (9) answered ‘no’ and 3 answered ‘yes’. One responded:

<table>
<thead>
<tr>
<th>Response</th>
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<tbody>
<tr>
<td>'Yes or no ??:// As I haven’t received a request I can’t answer that question. Also I don’t want to be too demanding. I am not sure where that support doctor lives.'</td>
</tr>
</tbody>
</table>

Of the 9 who answered ‘no’, three said this was because there was no hearing/further action or it was not applicable as yet. There were a variety of other reasons given for not requesting the supporter attend, including:
‘… The solicitor attached to my defence organisation and my defence organisation have been supportive enough to handle this without the BMA in addition. However, I can imagine that it would be needed by others. I may change my mind if I have to go for a hearing.’

‘I attended one hearing with my husband and one with a legal representative through Bar Probono and at these hearings I felt that people on the tribunal panel had already made up their minds about the final outcome, and what I said made no difference. In view of this fact I was not in the financial position to attend the meetings being held in Manchester. The GMC were not willing to hold any of the tribunal meetings in the London building other than the one with my bar probono solicitor, that would have been more convenient for me…’

‘I am well supported by my family and legal team. Were that not the case then I would certainly ask them to attend with me.’

There were also a mixture of reasons why the doctors said they would ask the supporter to attend a hearing and this included:

‘Balanced, independent point of view and experience.’

The final question, number 13 asked:

**Do you have any other comments you would like to make about the service you were provided with and/or the pilot in general?**

Eleven doctors responded to this question, of which five said ‘no/no thank you’. The other 6 responses were all very positive and we detail them below:

‘I could not praise enough the support and understanding to give some rough guidance.
I am sure there are many other issues that this service would help.’

‘Please make it permanent.’

‘Big Thank you to the doctor who supported me,
It felt that she was able to find out what was my main concern and support me in that area with sound advice; it was good for my emotional wellbeing not to feel completely isolated.’

‘Brilliant & very useful.’

‘I would be happy to work for this service should you ever need a consultant occupational physician.’

And perhaps the most poignant:

‘The initial correspondence from the GMC is very hostile and left me with no hope for the future. I was contemplating suicide from the day this all started. The support service should be given more prominence in the correspondence that is sent out. I hope that the counsellors can feed back to the GMC about the way they communicate with vulnerable doctors.’
### 8.2 Feedback received from Doctor Supporters (contracted by BMA)

The telephone interviews with supporters were about gathering qualitative data, and each of the 13 we spoke with was very open and generous with their time for the discussion. We had anticipated that the interviews would take approximately 25 minutes although it is always accepted that with any semi-structured interview approach may take longer. The table below provides detail of the length of the interviews:

<table>
<thead>
<tr>
<th>Length of Interview</th>
<th>Number of Doctor Supporters</th>
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</thead>
<tbody>
<tr>
<td>10 minutes</td>
<td>1</td>
</tr>
<tr>
<td>12 minutes</td>
<td>1</td>
</tr>
<tr>
<td>14 minutes</td>
<td>1</td>
</tr>
<tr>
<td>16 minutes</td>
<td>1</td>
</tr>
<tr>
<td>19 minutes</td>
<td>1</td>
</tr>
<tr>
<td>23 minutes</td>
<td>1</td>
</tr>
<tr>
<td>25 minutes</td>
<td>2</td>
</tr>
<tr>
<td>27 minutes</td>
<td>1</td>
</tr>
<tr>
<td>30 minutes</td>
<td>1</td>
</tr>
<tr>
<td>31 minutes</td>
<td>1</td>
</tr>
<tr>
<td>34 minutes</td>
<td>1</td>
</tr>
<tr>
<td>39 minutes</td>
<td>1</td>
</tr>
<tr>
<td><strong>Totals: 291 minutes (4.85 hours)</strong></td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>

Prior to commencing the interview proper, we asked each supporter to give us an approximate indication of the number of doctors they had worked with during the last year. There was some variation in this, the supporters quoting the lowest was 6 doctors and the highest was 16.

The first question we asked the supporters was:

**What level of support did you provide for the Doctor?**

Two supporters told us that there had been a considerable range, with one stating a minimum of 30 minutes and a maximum of 12 hours, however a rough average appeared to be about 2 hours per doctor; and the second supporter saying a minimum of 20 minutes and a maximum in excess of 6 hours.

Question 2 asked:

**Why did they provide that level of support?**

We received a wide range of responses; however there was a consistency in that 12 of the 13 supporters stated that it was the level of support needed to meet the doctors’ requirements.

Some examples of the comments we received were:

| "It rather depends on how long the GMC investigation takes. It tends to be open ended, depending on what the doctor needs." |
| "This has been entirely linked to the need of the doctor. We are able to provide up to 6 hours support and it is driven by them." |
| "… Mostly they are trying to deal with the shock of the whole situation and in particular receiving the letter from the GMC…" |
Question 3 asked:
Did you feel the amount/level of support you were able to provide met the doctor’s requirements?
Ten of the 13 said ‘yes’ or they thought so. One said ‘never fully’ and explained this by adding ‘…on an emotional thought level, they want the supporter to take the issue away completely…’, one told us it was ‘hard to say’, but yes for some and one told us ‘sometimes’.
Comments included:

‘Sometimes. We are not able to take all the stress away, they still have to ‘face the music’ with the GMC. It helps them get things in perspective; this is part of their life, not their whole life.
Often they are just looking for help although they are not always clear what help they want. I think some feel we might have some enduring insight to the GMC.’

‘Based on the feedback I have received I would say yes, but of course I don’t know if they are just being polite. They understand the boundaries we are working within and that I cannot offer a clinical position. I can help with sign posting and talk as one professional to another.’

The next question asked:
Did you feel you understood the doctors’ issues?
The table below shows the responses received:

<table>
<thead>
<tr>
<th>Response received</th>
<th>Number of Doctor Supporters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>9</td>
</tr>
<tr>
<td>Yes almost always; mostly yes</td>
<td>2</td>
</tr>
<tr>
<td>Usually</td>
<td>1</td>
</tr>
<tr>
<td>I think I have</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>

The follow on question (4a) was:
Why was that?
This elicited a very wide range of responses although a number of the supporters did make reference to their own experience and professional specialism(s), comments included:

‘I do … so am familiar with the issues. Sometimes it takes time to untangle things. Initially they are all angry with the GMC and tend to feel the GMC is against them. So the first conversation is always half an hour to an hour and is about allowing them to ‘off load’ and hearing their story.’

‘As a doctor one has the ability to appreciate what being in that type of situation would mean. All perceive themselves to be in trouble with the GMC, it is almost to the point of terror for the doctor, and it appears to be unlike this in any other discipline. So one can realise how upset they are to find themselves in that situation. For the majority of them everything will be OK. I ask them to ‘tell me the story’ of how they got to that point and I try to see it how they see it.’

‘…There seems to be a disproportionate number of doctors whom we are asked to support who do not have a proper career structure and who are not members of a medical defence organisation.'
Having worked in the health service, you tend to understand and have the greatest understanding of those working in the same specialism.’

‘Because I am a practising hospital consultant. I am … and have experienced a lot during my career. I am a bit older/experienced and still practising in the modern NHS so am familiar with what they talk to me about.’

Question 5 was:
Which particular aspects of the offer did you feel worked well for the doctor?
There was some commonality in the responses with references to the supporters being doctors themselves and that the service provided an independent person who would listen to them. We provide some of the comments below:

‘Overwhelmingly that we (the supporters) are doctors.’

‘Being able to speak to a disinterested fellow professional, someone who works in the profession and is able to give a slightly longer perspective. Some of the doctors do lack insight. This is a very profound situation for them and often quite de-stabilising. I think it is good that we are able to respond very quickly to their request for support.’

‘The service provides someone for them to talk to, who has time to give them. There are not adequate numbers of mentors in the system. These doctors are often jumbled in their thinking and we help them think things through clearly, and more logically.’

Question 6 was:
What did you feel didn't work well for the doctor and why did you think that?
Six of the supporters explained that some of the doctors were expecting advice/legal guidance. We provide a couple of those comments below:

‘Some of them expect more than just support they expect advice and more than just phone calls with us. We do explain to them immediately that we cannot provide advice. Sometimes they seem to want solutions we cannot provide and this may be because of a lack of understanding of the service. They are angry with the GMC and often the MDUs as well…’

‘They often want us to do things outside our remit. We are supporters not advocates although I have offered to read through documents they are going to submit to help them put things more clearly.’

Three of the supporters commented on the fact it is a telephone service including:

The fact that it is all done by telephone, face to face would have advantages

‘It is possibly difficult for some that this is all by telephone, perhaps an element of distrust. Not being face to face means that they cannot see body language. We don’t know the whole story, and often by the time they speak with us, a lot has happened. It is probably difficult for some of them to explain everything which has happened succinctly…’
Two supporters made reference to the timing of calls. One said that because the Supporter has to make the initial call to the doctor; it is taken out of the doctor’s control. The other referenced the fact that it was difficult to judge when is likely to be an ideal/convenient time (for the doctor) for that initial call.

Question 7 asked the supporters what worked well for them with an additional question of why that was. Two of the supporters commented that there was a window of 48 hours in which to make the initial call to the doctor and that this meant there was no pressure/they could do this at a convenient time, and a third commented that the call to the doctor could be made at a convenient time.

Three supporters made specific comment about the support from their colleagues based at the BMA and four talked about being of use/giving something back/considering it a privilege.

We considered that the following comments provide good illustration of the responses to this question:

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I like being able to provide a helpline contact for them and I feel privileged to be able to help those in real difficulty in some small way. Having the database which I can get into quickly and check details. I like acting as a sort of ‘mental’ bridge for them. I am comfortable in the role. I value the support of both … and … Without good effective coordination of a service dependent on individuals working in isolation I doubt whether I would have stuck with the pilot. This has been brought home to me with a doctor in difficulty I spoke to last weekend but applies to various instances throughout the last year. They are brilliant with me ….’

I feel I owe this to my profession. I have had a long and, in the main, happy career. I have been offered support during the challenging times and I now feel in a position to pass this on. I feel I have the right skills to do this work and it makes me feel good.’

‘Having seen developments over a number of years, it profoundly upset me that there is such a lack of support for young doctors compared to what has been available in the past (just 12 years ago). This service is providing some support when it is most needed.’

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Question 8 asked supporters: Were there any particular aspects of the service which did not work well for you? and 8a: What were they?

There were two supporters who provided specific comment about the website/database:
‘…On the website I try to record something briefly and it has to be kept anonymised, this can mean when I refer back to them later they are not always that clear even to me.’

‘Now numbers are going up the database does not appear to fully meet need. It is very light on detail, the drop down boxes are not particularly relevant and the search facility could be improved.’

N.B. The website was also mentioned in response to question 9 see below.

Two supporters commented on wanting to provide more support:

‘Always tend to feel you should provide more support and time, but that is difficult. When the doctor has no defence support, they do look for a lot of support from us. Perhaps the GMC should consider if the doctors without defence need something in addition.’

‘Sometimes I feel somewhat inadequate, particularly for those doctors who do not have any medical defence. I think there should be a rule that they should have medical indemnity. Those doctors who do not have this need more than we can give.’

We reported previously that comment had been received about the lack of feedback and this was again raised, albeit by only one supporter.

The penultimate question (number 9) was:

If this service is taken forward, do you have any suggestions that could improve the offer?

Each supporter provided useful comment and because each is different we consider it inappropriate not to include them all:

‘Greater promotion/advertising of the service, we need to remember that not all doctors are members of the BMA. Information needs to be available within the doctors’ unions, Trusts etc. More training and introduction of new techniques for us supporters, although… I recognise cost implications. All supporters should be aware of the GMC processes and ideally experience them in some way, as this allows greater empathy. Going forward I think we perhaps do need to consider a 24/7 reach. At this time if a doctor first makes contact at a weekend nothing can be done until the Monday.’

N.B. A doctor using the service commented on the fact that it was not possible to make initial contact at the weekend, other than to leave a message, the BMA do however offer a 24 hour counselling service for doctors requiring that.

‘Perhaps there is a need for more advertising. I have the sense that there are parts of the GMC who do not know we are there. There is not really very much I would change, I think it works as it is. Just being available is the important thing, giving distressed doctors the space to ‘unload’. I like doing it.’

‘I think the initial contact process is not always ideal and that is not really anyone’s fault. The BMA do not always know our availability, and so they contact us on a rota basis and then if we say we are not available, they move on to the next supporter. We do inform BMA if we are taking holiday. To date I have not been asked to attend a hearing and I have no regrets about this. I
feel rather diffident about attending hearings, mainly because I think one is likely to be rather a ‘spare part’. We are supporting the doctor not their case.’

‘I think it is important that we continue to ensure we maintain a supporter role and simply direct doctors towards professional help if that is needed.’

‘I should pay more attention to the things I am not good at such as recording details on timesheets. There is a problem with the website in that I must keep putting Ethnicity in each time, it does not “remember” it. It would be useful if GMC could provide greater detail on the timescales and keep the doctors informed of what is happening. When they are waiting for letters it is very challenging for them. Communication is key and the GMC is not very good at that. The doctors don’t seem to know what is happening and neither do the defence organisations.’

‘If we are unable to provide support for a doctor at a hearing, when they have requested that, perhaps our colleagues should be asked if they can cover this. I know some of our group have been able to do this. It does seem that often doctors contact us when it is very near the date of their hearing. I think they should be notified of this service when they are first contacted by the GMC’

‘I have only attended one meeting at the GMC with a doctor and our expectations were completely wrong. The doctor had travelled a considerable distance and this had been costly, the only outcome, it seemed, was to be told to include another piece of paper with the response. This seemed like a lost opportunity, it could have been done by video conference or similar. I use the GMC website to look back on history of a case; this helps me in regard to how to support the doctor. It is good that the GMC extended this for a further year, but these cases run for a long time sometimes 3-5 years. I think it needs that length of time therefore to complete a full evaluation. Closer contact with GMC/MPTS to provide feedback and training would be beneficial to me as the procedures and the way in which they are interpreted are developing all the time. We are into our third year of the Pilot and I am not sure whether the Supporter Service has ticked the GMC and MPTS boxes and how far it has met, failed or exceeded their expectations…’

‘I would like to consider using SKYPE as this would provide face to face contact, although I am not sure everyone would want to do that. Because it is my field of expertise I am more comfortable working with hospital doctors. I wonder therefore if there would be value in matching our expertise to that of the doctor, but I appreciate this would be very challenging.’

‘Need to use multi-media approach; e-mail, text, phone, to understand when is best time for the initial conversation.’

‘Perhaps it would be useful to have more supporters with greater geographical coverage, this would be necessary if we move towards face to face meetings with doctors. It would need to be carefully thought through if we did this as it would not be appropriate to provide support to a doctor in the same city.’

‘It would be useful if there was someone who took responsibility to check with the doctors to see if they still need the service and require anything more from us.’
Currently we expect the doctor to call us if they need us, but maybe they don’t want to do this. Sometimes I offer them another interview but at the time they may think they do not need it. We don’t really know what stage the case is at and they will have different needs at different stages, the problem is they often don’t know what stage the case is at either. So it would be useful if the GMC indicated the stage of the process or if our coordinator had the details.

“There is a need to try and get as much feedback as possible from doctors using the service, to understand what they think would improve it. The opportunity for them to talk about it is helpful.’

‘The doctors themselves are often just not clear about the process and they are not comfortable about calling the GMC to obtain an understanding of what is happening next. The GMC case advisers should be doing a better job about explaining their role and purpose so that the doctors are clear, that in regard to anything about process they can contact that person.’

Our final question (number 10) asked:
Do you have any other comments you would like to make about the service or the pilot in general?
(These views are those of the individual Doctor Supporters and are not to our knowledge influenced by the BMA.)

Eight of the supporters commented that it was a good/useful/valuable service and one supporter considered they had covered everything when answering the other questions. Again because there is such variation in the responses and we felt all were worthy of consideration, we have included them all, even though some points such as not claiming payment has already been mentioned:

‘I believe this is a crucial service and no-one else provides it. Doctors have told me they do not get support even from the MDU. It is essential that GMC do not stop this. There are a significant number of doctors who need this service and without it may come to harm. It has to be freely accessible.’

‘I think we deliver this service well and I would not like us to lose it. It is a worthwhile service for doctors in an unpleasant situation. I am proud of what we do and consider that we are the right people to do it. I hope it continues.’

‘This service I feel is good, it has clear focus and I get the feeling my support has been helpful. The most important thing is, that we are doctors supporting doctors...’

‘I consider it to be a very valuable service. Doctors in these situations do need support; it is a very big burden for them. The group of doctors providing this support service all have an understanding of the GMC processes which is also important.’

‘This service is of great value and I always feel I have done something useful when I have worked with a doctor in this way. These doctors are so frightened of the GMC, their perceptions must be improved and this service can help do that.’

‘I think this is very useful service and I am very grateful to have been given the...’
opportunity to be part of it. It would be nice to know what the GMC think about it… It would be nice to know what colleagues think and it would be useful to see copy of the evaluation report.’

‘For me it works well, but I do not see the full picture. It would be nice to get some feedback about the doctors we work with, this would probably add to the job satisfaction. Some of the doctors do call and let me know, but I don’t hear from all of them.’

‘Some of these doctors are in really desperate straits and it is good we can provide some support for them. I am surprised at how many doctors do not have any sort of indemnity, this leaves them isolated and with no legal support. In the 20 years I have been a GP I believe these numbers have increased. The insurance companies have become increasingly commercial in approach and stick rigidly to whatever is stated in the small print. Some doctors believe they have cover, but they have not checked the small print thoroughly.’

‘… and … [the pilot administrators] do a really good job!’

‘Overall this seems to be a useful service for the doctor. I hope that the GMC will provide it on a permanent basis. It would be very good to obtain feedback from the doctors using the service as well.’

‘I do think it was very sensible to allow the pilot to continue for another year. I think that perhaps some consideration needs to be given to the level of shock these doctors experience when they receive a letter from the GMC, it is a ‘bolt from the blue’. Perhaps thought needs to be given to how they are first informed, although a phone call or e-mail would probably have the same effect.’

‘The doctors who have spoken to me seem to be in two categories:
1. Those requiring longer amounts of time do genuinely need help and support
2. Those who have been dealt with by one conversation, could have had their queries resolved by a good case adviser at the GMC, they have not really required this service.'
8.3 Personal data

We have collated all of the personal data we received directly in response to the Personal Data Forms (PDFs) provided and this information has been provided separately.

Of the 15 doctors who returned questionnaires, 14 completed and returned PDFs. As this is a fairly small percentage of the total number of doctors who used the service and there is not any particularly identifiable theme we do not consider it appropriate to place any interpretation upon it.
9 Our Findings and Recommendations

We do recognise fully that the number of doctors providing input to this evaluation is limited. Of the 140 doctors who had used the service 15 completed questionnaires (14 have been reported on); this is a small number to use as the basis for decisions. However it can be argued that the fact that we received feedback from 100% of the supporters does provide a balance, but it might be considered that the supporters have an interest in the service continuing. We stress that in making this statement we are not giving an opinion, but merely highlighting a point an independent reader might observe.

The majority of doctors responding found it easy to access the service and this view was echoed by the supporters. However, one doctor mentioned the fact that the service was not accessible (initially) at the weekend and ‘after hours’, which was the time when he/she had adequate time and ‘gathered the thoughts for the purpose’. One of the supporters said:

‘…Going forward I think we perhaps do need to consider 24/7 reach. At this time if a doctor first makes contact at a weekend nothing can be done until Monday.’

In response to our question asking why they had contacted the service, they referred to stress/anxiety/worry and needing to talk to someone about the issue they faced. The doctors’ supporters confirmed this in response to our question what they thought worked well for the doctors.

By the end of year 1 of this pilot, a third of the doctors had received more than three hours of support, by the end of year 2 only one fifth of the doctors responding had received more than three hours support. We considered this worthy of note although we cannot conclude anything specific from this particular finding.

86% (12) of the doctors responding told us that the amount of time their supporter had provided was adequate. 14% (2) said it had not been adequate, however of those two, one said that more time had not been provided because ‘… I thought things were OK. In retrospect, I could have done with further follow up support…’ So arguably only one of the doctors responding was indicating that the support they received was not adequate and that was a ‘failing’ of the service itself.

The majority of the doctors (60%) said that the supporters fully understood their issues and the supporters all told us that they did/usually did.

One doctor did make the following statement in response to what did not work so well:

‘Please note that the details given to me on your leaflet were out of date. It indicated that the support service was about to come to an end, when this was not the case. That was stressful in itself to think that may be the case, which almost put me off asking for it.’

Although this was only said by one doctor, and perhaps on the surface appears a minor issue, as this doctor stated it may put doctors off accessing the service. Having considered all of the feedback we have gathered, we are of the opinion that for the vast majority of those doctors who have responded the support service was helpful and met the majority of their needs. This was also the opinion of the supporters. We have previously reported that, the challenge is that we do not know the opinions of those doctors who did not respond and unfortunately the supporters could not provide any real clarity on this, as they do not receive any formal feedback.
If the service is taken forward, we suggest the following recommendations for consideration:

- The supporters for the doctors should continue to be doctors, as this was recognised as being an advantage and is we suspect why the supporters felt they understood the doctors’ issues and why the doctors (in the main) supported that view.

- The doctor seeking support is asked when they initially make contact, what is the best method of contacting them and, particularly if they request to be telephoned, what is the preferred time.

- A system is established to allow for assessment of the service, which includes ‘appraisal’ of the supporters by the organisation employing them, and also seeks feedback from the doctors accessing the service. We suggest that it is important, ideally, to obtain this feedback at the point when the doctor decides not to ‘use’ any further support, although we recognise this would be challenging, agreement to this should be sought from the doctors when they first make contact, and should be outlined in explanatory/promotional materials. The reasons for doing this should be explained clearly and we suggest this is to ensure that the supporters are maintaining a consistent and appropriate standard and also to inform any changes/improvements to the service.

- If the doctor requests support at a meeting or a hearing, and their allocated supporter is unable to attend, if a different supporter is offered, consideration needs to be given to a ‘hand over’ process with the aim of ensuring the quality of support is maintained and that the doctor is fully comfortable with the arrangements.

- A number of the supporters identified issues with the website/database they are required to use and this should be investigated further with a view to considering amendments and/or additional training in the use of these tools.

- The supporters have regular meetings and this forms part of their contractual arrangements. These meetings should be used, in part, as a standardisation meeting i.e. to give input, share experiences and ensure all supporters are operating to the same standard; to provide updates and also to provide feedback.

- A review of the need and value of extending the ability to access the service (at the initial stage) at weekends.

- Consider the potential/value/dis-value for face to face meetings including the use of technology such as Skype.

- Regularly review promotional materials to ensure their currency and accuracy.

- Use some direct quotes from the doctors who have used the service in information/promotional material about the service.
Questionnaire for Doctors
Regarding Doctors for Doctors Service

1. How did you find out about this support service?

2. Once you became aware of the support service, did you find it easy to access?

   1  2  3  4  5

   On a scale of 1-5 where 1 is difficult and 5 is very easy.

   2a. Why was that?

3. What made you decide to take up the support service?

4. When did you first use the support service?

   Month:  Year:

5. Approximately how much telephone support service time have you received?

   Please state total time in hours and minutes
6. Was this amount of time adequate?

   Yes

   No

   If you answered ‘no’ please go to question 7
   If you answered ‘yes’ please go to question 8

7. How much time did you ideally want from the Doctor Supporter?

7a. Why did the Doctor Supporter not provide this amount of time for you?

8. Did you feel that the Doctor Supporter understood your issues?

   1 2 3 4 5

   On a scale of 1-5 where 1 is no understanding and 5 is fully understood

8a. Why did you feel this?

9. Which particular aspects of the service worked well for you?

9a. Why was this?
10. Were there any particular aspects of the service which did not work well for you?
*Please specify below:*

11. If this service is taken forward, do you have any suggestions that could improve it?
*Please specify below:*

12. If the GMC request that you attend a hearing/have asked you to attend a hearing, do you plan to/did you ask your Doctor’s supporter to attend with you?

Yes

No

12a. What are/were your reasons for taking that decision?

13. Do you have any other comments you would like to make about the service you were provided with and/or the pilot in general?

Thank you for assisting with this evaluation.
Appendix 2

This is designed for a semi-structured interview – therefore the questions are a framework and the interviewee should be encouraged to give as much comment as possible within the agreed time allowed.

N.B. Table below should be completed by interviewer not asked of interviewee and not passed to GMC.

<table>
<thead>
<tr>
<th>Name of interviewee</th>
<th>Date of interview</th>
<th>Start time</th>
<th>Finish time</th>
</tr>
</thead>
</table>

As mentioned when we arranged this meeting with you, it should take approximately 25 minutes to complete and I will initially explain the background to this work. I will then move on to the specific questions relating to the evaluation exercise.

A personal data form was forwarded to you,

I can confirm that I have received this back – thank you.

or

I have not received this back, may I ask when you will be forwarding this?

As you know we have been contracted by the General Medical Council (GMC) to complete an independent evaluation of the pilot project which you are participating in.

We are randomly selecting a number of participants to participate in the evaluation and as you know, participation is on a voluntary basis.

Responses will be treated confidentially and no respondent will be named within our report. However, should you specifically request that we name you to the GMC project managers and highlight any of your comments to them we will of course do this.

You will be aware that this project has been piloting a confidential, independent emotional support for doctors in the fitness to practise process, and that the service has been run on behalf of the GMC by BMA Doctors for Doctors.

1. What level of support did you provide for the Doctor?
   
   Obtain an understanding of the number of hours provided and over what period of time

2. Why was that?
If interviewee does not appear to grasp what the question refers to ask if it was for example: what the doctor asked for; that was the only time he/she (the supporter) had available; this was the amount of time the supporter was told to give; it was constrained by finances etc.

3. Did you feel the amount/level of support you were able to provide met the doctor’s requirements?

3a. Why was that?

4. Did you feel that you understood the doctor’s issues?

4a. Why was that?

5. Which particular aspects of this offer did you feel worked well for the doctor?

5a. Why was that?

6. What did you feel didn’t work well for the doctor?

6a. Why was that?

7. Considering the service from your perspective as a doctor supporter, which particular aspects worked well for you?

7a. Why was this?

8. Were there any particular aspects of the service which did not work well for you?

8a. What were they?

9. If this service is taken forward, do you have any suggestions that could improve the offer?

10. Do you have any other comments you would like to make about the service or the pilot in general?

Close:
That completes all of our questions – thank you.

On behalf of the GMC, BMA and Hewell Taylor Freed & Associates, I would like to thank you very much for your useful input today.
Background to the Doctor Support Service pilot

1 The Doctor Support Service pilot, providing emotional support for doctors undergoing fitness to practise investigations began in April 2012. The pilot service has been funded by the GMC and delivered by the BMA Doctors for Doctors unit.

2 The Doctor Support Service is open to any doctor who requires emotional support during the investigation or adjudication stage of the fitness to practise procedures. It is important to note that not only is the service free to use but also the doctor does not need to be a member of the BMA to access the service. The GMC does not know that a doctor has used the service unless the doctor requests their supporter to attend a meeting with the GMC or a fitness to practise hearing.

3 The service gives doctors involved in a fitness to practise case access to telephone support from the point at which they learn a complaint has been made about them, until the case is concluded. It also offers orientation visits to the MPTS Manchester hearing centre, an independent supporter to accompany the doctor to a meeting with the GMC (within the meetings with doctors pilot) or on the first day and one other day of an MPTS IOP or fitness to practise hearing (subject to availability of a supporter).

4 This initiative is among a range of recent activities to improve information and support for doctors who are subject to an investigation into their fitness to practise, which includes:

a The recently launched Information for Doctors’ leaflet.

b An interactive hearing room which enables doctors to take a virtual tour of GMC premises before they attend a hearing.

c A specific section on the GMC website to help doctors with health concerns to understand the fitness to practise process.

d A pilot of meetings with doctors during an investigation.
Current Service Provision

5 Any doctor who is subject to a GMC fitness to practise investigation is able to contact the service for support.

6 The current level of support consists of: Up to six hours of telephone support; Subject to supporter availability, face to face support for up to two days of an IOP or fitness to practise hearing (the first day and 1 other); The doctor can also have a supporter attend a meeting with the GMC within the doctor meetings pilot.

7 It is important to note that the service does not provide medical or legal advice to doctors. The service is staffed by doctors who have received training on GMC processes to provide emotional support for doctors subject to an investigation on a confidential basis.