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The Pennine Acute Hospitals NHS
NHS Trust

Doctors in Difficulty – HR Perspective

Recognise
Respond
Refer
Reflect

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Associate Director Lead Employer Team

Objectives

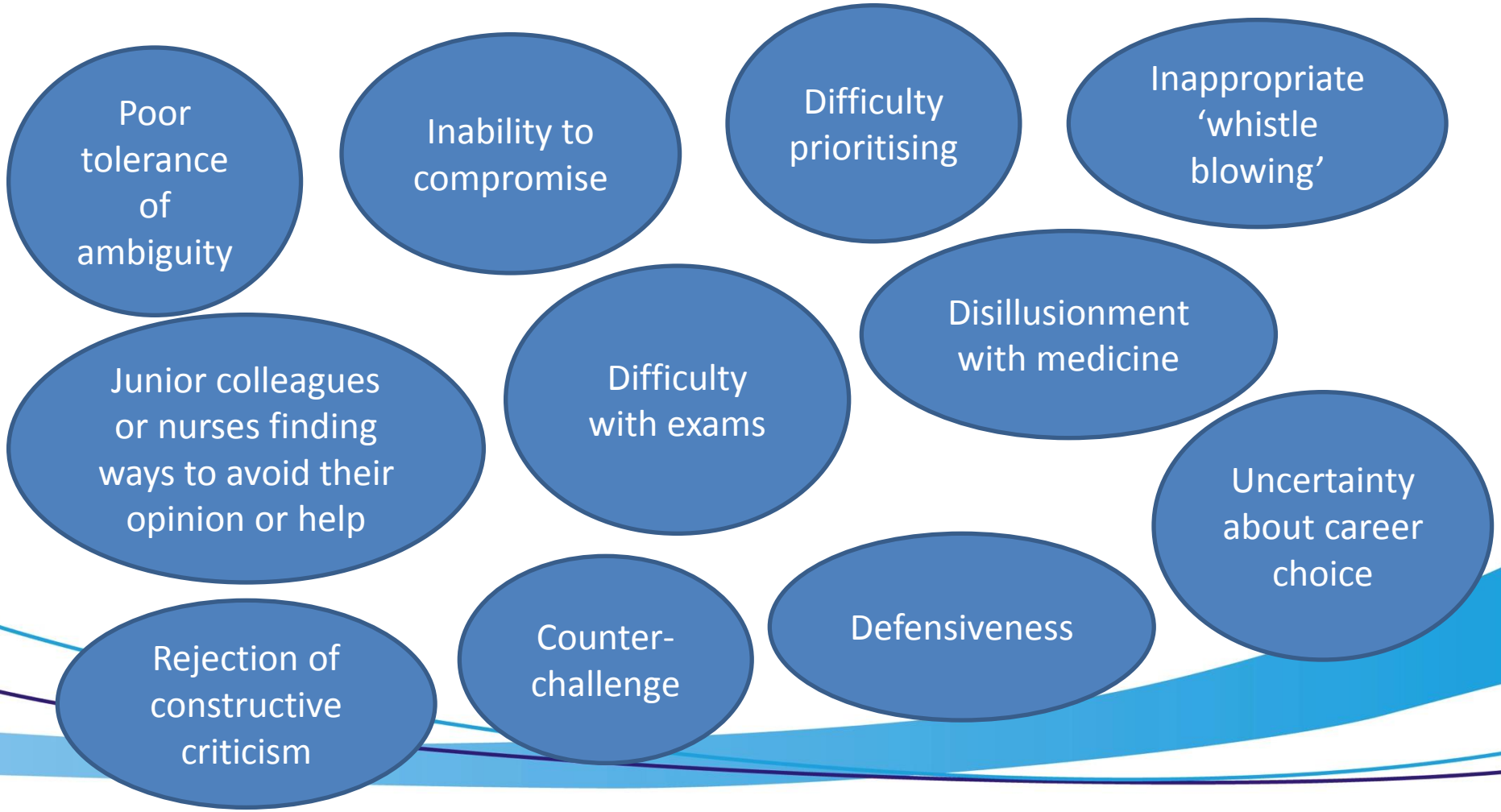
- To understand how to recognise the early signs when a doctor may be in difficulty
- To understand the importance of the need to respond
- Who to refer to for advice
- To understand how Level 2 and 3 concerns need to be managed within the HR policy framework
- To understand the risks of not following policy
- To understand the benefits of reflection

Recognising Concerns – Early Intervention

- Prevention, early recognition and early intervention are the preferred approach
- Level 1, 2 and 3 concerns
- HEENW Doctors in Difficulty Policy
- HR Policies

Recognising the Early Signs

Recognising the Early Signs (2)



How do you respond

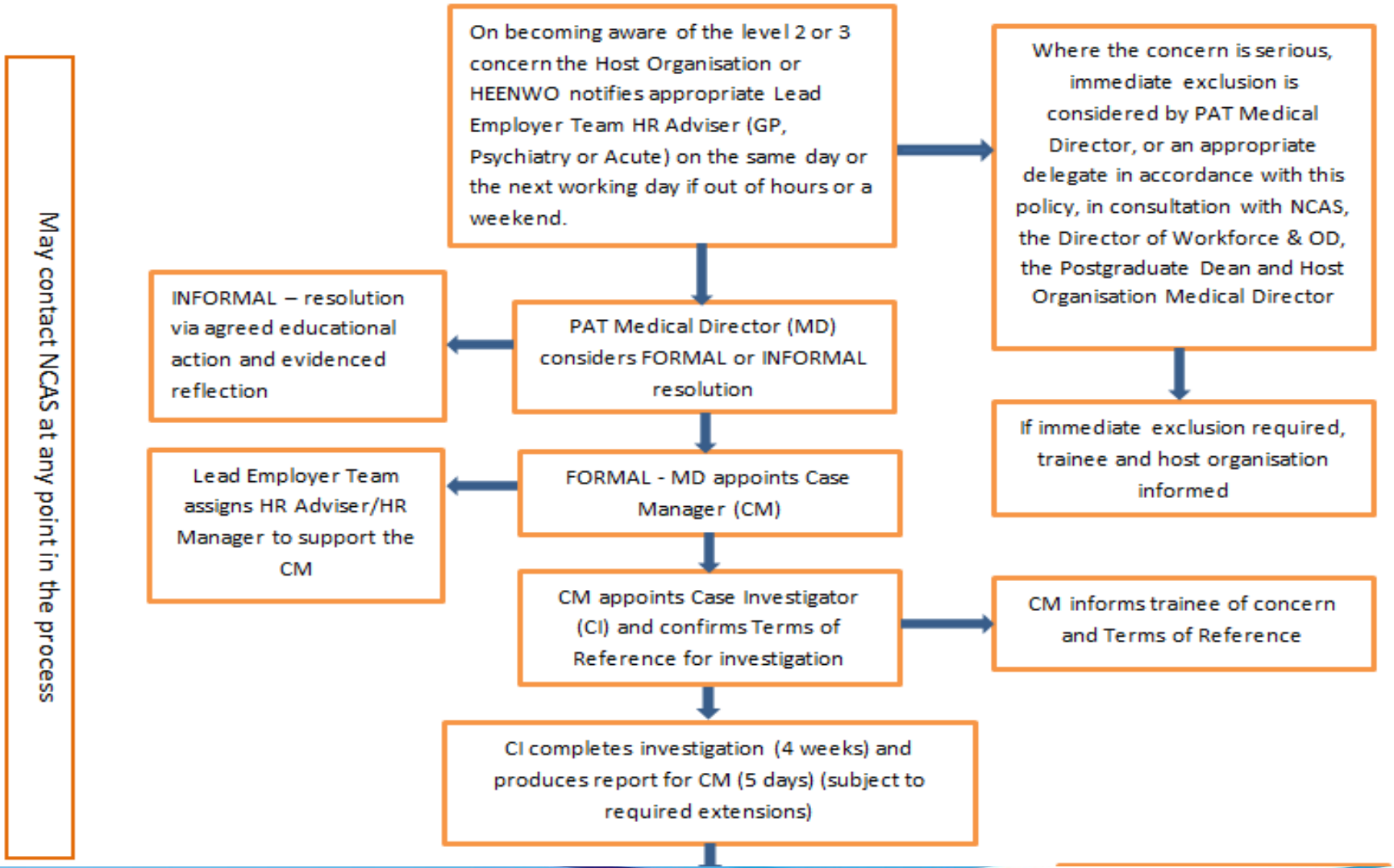
- Preliminary assessment of concern
- Speak to the trainee
- Further investigation / seek advice
- Agree action plan and review date
- Refer

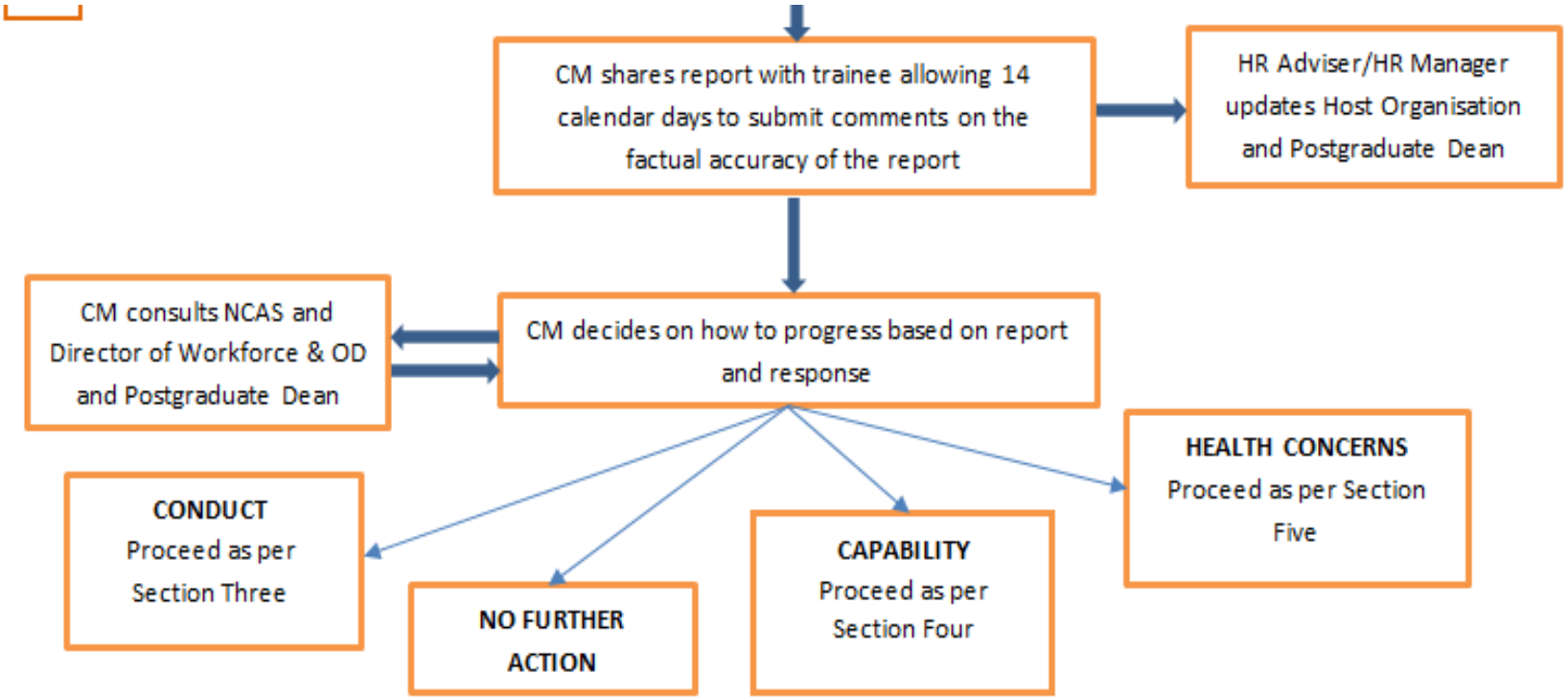
Referral Process

- **Level 2:** TPD or Head of School refer to Speciality Associate Dean using form S1
- **Level 3:** Direct referral to the Postgraduate Dean via the Specialty Associate Dean or in emergency direct to the PG Dean (Responsible Officer)
- Inform Lead Employer Team

Process Flow for Handling Issues of Concern

The Health Education North West guidance document entitled "Doctors in Difficulty" defines the levels of concern. The process flow below advocates the pathway for handling level 2 and 3 concerns as defined in that document.





NOTES: restrictions or exclusion can be implemented, revised or removed during any stage of the above process and will be determined by the Case Manager. Referral to a relevant regulator (eg GMC/GDC) can also take place at any stage during the process. Capability issues shall be identified and addressed initially through ARCP processes in accordance with the Gold Guide except in serious cases which the Postgraduate Dean has indicated cannot be managed through an ARCP process

Refer – HR Policies / Procedures

- Handling Concerns Policy (MHPS)
- Management of Attendance Policy & Procedure
- Bullying & Harassment
- Grievance & Disputes Procedure

Conduct / Capability Concerns

- MHPS Framework
  - Standards of behaviour and conduct
  - Capability (severe issues that cannot be dealt with via the ARCP process)
  - Responsible Officer informed of all concerns
  - Restriction of Practice and Exclusion from work

Conduct / Capability Concerns

- Case Manager / Case Investigator appointed
- Formal investigation
- Findings considered by Case Manager
- Decision as to whether informal / formal resolution
- Police / GMC Investigations

Management of Attendance

- Short term sickness absence
- Short term persistent sickness absence
- Long term sickness absence
- Triggers:
  - » 10 days absence within 12 months
  - » 4 weeks' continuous sickness absence
  - » 3 separate episodes within a 6 month period
  - » Patterns occur e.g. regular Monday or Friday absences

Management of Attendance

- Stage 1 – First Review (supported by local HR)
- Stage 2 – Second Review (supported by LET HR)
- Stage 3 – Third Review (LET HR lead this)
- Stage 4 – Final Stage Dismissal (LET HR lead this)
- Attendance Management Toolkit

Bullying & Harassment / Grievances

- Complex cases as relate to personal/professional relationships
- Change of supervisor / location may be required
- Support for all parties – complainant / respondent
- Informal resolution
- Mediation

Risks of not following due process

- Injunctions
- Judicial review
- Conduct/capability hearing decisions overturned at Appeal
- Employment Tribunal claims upheld

Referrals to External Agencies

- GMC – any fitness to practice concerns
- DBS – Safeguarding Vulnerable Groups Act 2006 places legal duty on employer to refer post investigation

Reflection

- Case reviews (during or once resolved)
- Sharing best practice
- Personal development
- DDRG

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Doctors in Difficulty
Key Messages from OH

Dr Sue Richardson MB ChB MFOM
Consultant Occupational Physician
February 2017

Objectives

- To understand the role of OH
- To understand what happens during an OH consultation
- To understand why doctors can behave differently when they are ill – signpost to further information
- To understand some of the Dos and Don’ts, so we can work together and avoid pitfalls.

OH Consultation

- Ground Rules
  - Not the Headmistress
  - Confidential – with caveats
  - Can't treat or refer (psychological services)
  - Impartial
  - Report – consent
- OH Records
  - Separate to p file, clinical records
  - Who has access to what?

OH Consultation (2)

- GMC guidance on consent (2009)
  - Absence of an OH report rarely benefits the employee/doctor
  - DNAs
- Refusal to attend OH
  - Obeying a reasonable management instruction

OH Consultation (3)

- Fitness to attend investigations/meetings with managers/HR etc
  - Criteria
- OH are not managing the employee, the manager is

Doctors who are ill

- We all get ill but we behave differently to other health care users
- Use informal pathways for advice and treatment, we may self diagnose and self treat
- Worry about
  - Lack of confidentiality
  - Negative effect on careers
  - Stigma
  - Denial

Doctors who are ill (2)

- Obstacles
  - Perfectionist culture
  - Timely access to GP/hospital appointments
- We may present much later

Background reading and resources

- Mental health and ill health in doctors (2008) Department of Health
- Handling concerns about practitioners' health – A guide for managers (2010) NCAS
- Invisible patients (2010) Department of Health
- Doctors who commit suicide while under GMC fitness to practise investigation – internal review (2014) GMC
- Return to Practice Guidance – Academy of Medical Royal Colleges (2012)

The perfect referral and process

- The doctor has seen the referral before the OH consultation, and it has been discussed with them, so no surprises, no hidden agenda or factual inaccuracies – don't forget, the employee will see it during the consultation
- The referral makes clear whether it is because of concerns about health, or whether it is for support during a difficult process e.g. GMC
- It is factual and objective with clear questions

The perfect referral and process(2)

- The referral contains enough relevant information especially if there are issues surrounding behaviour, conduct, probity etc.
- There is no drip feeding and additions to the referral from other sources.
- The whole process must involve timely investigation. If they are not ill at the beginning, they will be by the end of the process.

The perfect referral and process(3)

- Stay in touch with doctor. More people complain that the trust do not keep in touch, and they do not know what is happening, than complain about being hassled.
- Phone for advice about writing a referral
  - No behind the scenes phone calls
- NCAS – Resource B is helpful – “Handling concerns about practitioners’ health”

Pitfalls

- OH does not have ESP
- Stick to one referrer – copious emails from people “adding bits”
- Referring too late

Pitfalls (2)

- Not implementing adjustments suggested by previous reports (simple stuff – new chair)
- Do not expect OH to advise on managerial/HR issues
- If you are unclear or not happy with the OH report – RING US!
  - No cc'ing the world and his dog into emails

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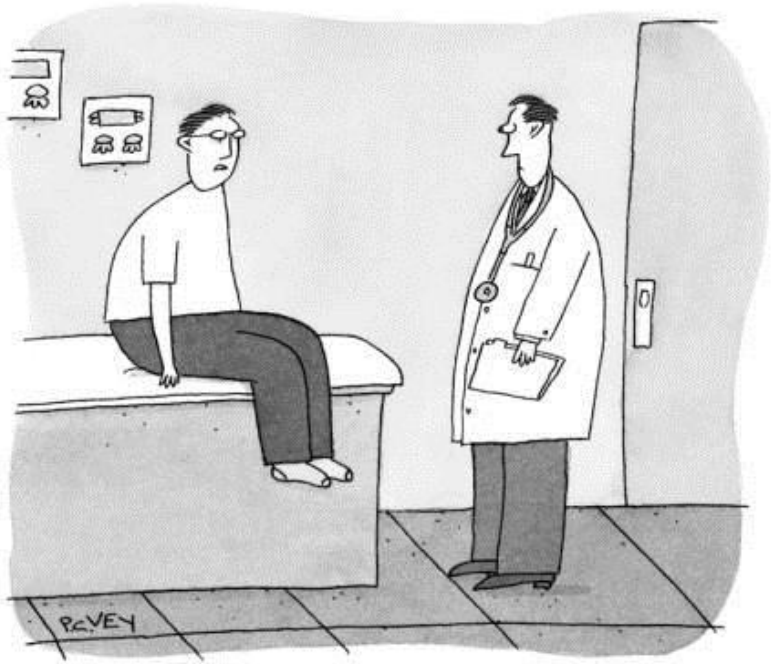
Policies / Procedures / Guidance

- Lead Employer Website

  www.pat.nhs.uk/education-and-research/policies.htm

  - Management of Attendance Policy
  - Handling Concerns Policy
  - Grievance & Disputes Procedure
  - Bullying & Harassment
  - OH Referral Template
  - Managers guide to completing the management referral

Thank you



"Give it to me straight, Doc. How long do I have to ignore your advice?"

Case Study 1

- Following an Outcome 3 at their recent ARCP your trainee has raised a case of Bullying & Harassment against you (as their ES).
- You have a copy of the timeline of events the trainee has raised.
- Please identify areas where early interventions may have provided a more positive outcome.

Case Study 1 – Timeline of Events

March 2015 – A colleague informs you of an incident that happened at a handover meeting last week, in which it is alleged that the trainee upset a junior registrar.

May 2015 - Manager called trainee to transfer a patient. Trainee reports department was short staffed, should have been 6 or 7 but only 4 on duty. Trainee states they did transfer patient but not straight away. Incident was reported to you. It was also alleged a junior registrar on the bleep was distressed regarding the manner it was handled in.

June 2015 – Trainee absent with stress for 3 weeks.

July 2015 – Nurse complained to you that the trainee was rude to him on the ward.

August 2015– Trainee reports feeling shocked at reading your report which made reference to the incidents above.

August 2015 – Trainee receives Outcome 3 at ARCP.

September 2015 – Trainee lodges formal Bullying & Harassment claim with LET against you.

Model Answer

- Early intervention – speak to the trainee about each incident as soon as possible afterwards.
- Explore if there are any underlying issues.
- Document your discussions and any agreed actions.
- OH referral made as soon as reported stress. (Referral form is below)
- Consideration given to any recommendations made within OH report.
- ES discusses report with trainee ahead of ARCP review so no surprises.

Model Answer – OH Referral Request

- Have you discussed the reasons for referral with the trainee: YES / NO
- Please provide as much information as possible regarding this OH referral request.
- Please include as much sickness absence history as you can.
- If you are worried about the trainee's physical or mental well-being, please describe your concerns below. These should include: physical or mental disabilities, inability to undertake certain duties or activities, any injury sustained at work or at home, changes in behaviour, conflict with colleagues or manager.

Model Answer – OH Referral Request (2)

- Please provide details of any action that has already been taken to support the trainee. Include details of any risk assessments, adjustments, alterations to hours or duties, etc.
- Questions which you wish Occupational Health to address. (Please consider what you need to know in order to support and manage the trainee. Tick only those questions that are relevant.)
  - Does the trainee have an underlying medical condition
  - Advice on return to work: likely date? Phased return?
  - Is there likely to be a residual disability which will prevent the trainee from carrying out normal duties?
  - What adjustments in the workplace would help support this trainee?
  - Would this trainee be covered by the Equality Act 2010?
  - Any other questions, please state in the box below

Case Study 2

- You have been advised that a female patient has made a complaint to PALS about your trainee following a consultation that included an intimate examination and the patient then receiving a friend request from the trainee on Facebook.

Case Study 2

- What should you do?
- Who is responsible for managing this case?
- What policy/policies apply?

Model Answer

- Preliminary fact find
- Get a copy of patient complaint
- Make notes of any conversations
- Seek advice (AD/HOS/Medical Director/LET HR)
- Refer to AD / HOS / LET HR
- MHPS policy applies – conduct issue – managed by LET
- GMC maintaining professional boundaries
- GMC guidance on doctors use of social media

Case Study 3

- ‘High flyer’ in general surgery, FY2
- Recognised depression/anxiety, referred to GP
- Went to Clinical Supervisor in confidence to discuss, told not to tell anyone as it would mess up their career
- Subsequently withdrew, others observed the problem, resulted in significant time off and late OH intervention
- Recovered but took longer
- Lost specialty training offer