GP Trainees in Difficulty Peninsinsula GP Policy

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Trainees in Difficulty

1. Introduction

This overview of the management of GP `Trainees in Difficulty' is aimed at any clinicians with educational responsibilities such as Educational Supervisors (ES) and / or Clinical Supervisors (CS) both in hospital and GP Trainers in practices. These guidelines are also relevant to GP Programme Directors and Associate Directors who will also be expected to be involved in managing trainees in difficulty.

The diagnostic framework and the principles of best practice attempt to provide guidance on the identification, support and management of trainees in difficulty and to provide clinicians with a systematic approach to dealing with these challenging and often complex issues. Maintaining patient safety should be paramount when managing trainees in difficulty.

The spectrum of performance problems is wide and can range from minor, momentary aberrations of behaviour, to major misdemeanours or persistent unprofessional behaviours or even acts of gross criminality. Performance issues that appear simple and straightforward at the outset are often very complex on further investigation whilst those problems presenting as complex messy issues tend to be the ones that are more easily sorted out. Periods of transition (changing jobs, moving regions, personal life events etc) can be associated with stress and a deterioration of clinical performance, which may require additional vigilance and support. A trainees’ health may affect performance. Fortunately, serious performance issues amongst trainees are rare. This infrequency, together with the supervisors’ perceived lack of expertise and the complexity of situations as detailed above, along with the increasing requirement for robust evidence, heightens anxiety and concerns amongst those who may have to deal with such matters.

There is a growing emphasis on professionalism and demographic changes to the trainee population – e.g. increasing numbers of mature trainees and trainees from different cultural backgrounds give other challenges. The monitoring and responding to trainee performance overall and recognising a trainee who is in difficulty is making increasing demands on the educational
network. Hence we need to ensure clarity and equality in the processes and responsibilities with supporting a trainee in difficulty. This document sets out the GP Department’s position.

2. Roles & Responsibilities

A trainee, as an employee, has a contractual relationship with their employer and is subject to local and national terms and conditions of employment. This will include clinical accountability and governance frameworks in addition to recognised disciplinary procedures. Trainees have a responsibility to fully engage with the educational process.

The employer must ensure that employment laws are upheld and employer responsibilities implemented. They are directly responsible for the management of performance and disciplinary matters. The employer must ensure that issues identified are addressed in a proportionate, timely and objective way. The acute trust or the practice is the employer depending on the post.

The clinical or educational supervising Consultants or Trainers will be involved in the identification, support and management of a trainee in difficulty.

GP Speciality Programme Directors (PDs) give local support to the clinical or educational supervisors and the trainees. They will instigate meetings for the initial investigation of issues of concern that arise in secondary care posts. In primary care the trainer/ES normally arranges meetings, but after initial investigation the PD may subsequently become involved depending on the issues.

The GP department of the deanery has responsibility for all doctors in GP speciality training and is responsible for problems that arise which prevent normal progression through the training process, for whatever reason. Trainers and PDs should advise Patch Associate Directors (ADs) of any issues giving concern about trainees. The Patch AD becomes the case manager for any GP trainee giving cause for concern. The Patch AD may also inform the Educational Executive who will be able to give further advice and support. Further resources can be accessed for trainees through the support structure being developed.
ARCP All trainees have an annual review of competence progression. All evidence accumulated on a trainee in difficulty, by the CS, ES, PD and AD needs to be submitted to the panel. The panel also requires an opinion and an action plan from the Patch AD in order to reach a decision on outcome. It is essential that all evidence is received by the assessment team well in advance of the trainee’s ARCP date. If evidence is not available to the panel, no decision will be made and this will delay an outcome being reached which could have detrimental consequences for the trainee. Most information should be within the eportfolio. A trainee may have already been receiving focused training, and the panel will decide whether a doctor requires further focused training or an extension of training.

In GP Specialty Training a maximum of six months remedial training may be granted irrespective of whether failure to progress (ARCP outcome 3) is in primary or secondary care posts. This means that the estimated completion date will be extended by six months (f/t) only. Any further periods of remedial training following an ARCP outcome 4, will only be granted in exceptional circumstances where the trainee can demonstrate mitigating circumstances and can show the appeal panel that additional training will lead to successful completion of training (ARCP outcome 1)

Patient safety:

There must be clear procedures to address immediately any concerns about patient safety arising from the training of doctors. This is the responsibility of the “Training providers” that is hospitals and other institutions including practices where training takes place. Local Education Providers (LEPs) should have a culture of clinical incident reporting and processes whereby there is reflection and learning form reported incidents with feedback on the outcome of incident investigation.

3. Diagnosis of the difficulty

There are three potential areas of difficulty for trainees:

A. Probity: Personal conduct or Professional conduct

B. Health and sickness issues

C. Competence and performance issues

There are frequent overlaps between these areas, and very often supervisors are dealing with
complex issues. Early recognition and appropriate intervention, coupled with effective feedback and appropriate support for trainee and trainer are essential if trainees in difficulty are to be managed effectively and successfully.

**A. Probity**

**i) Personal conduct issues**

Examples include theft, fraud, assault on another member of staff, vandalism, rudeness, bullying, racial and sexual harassment, downloading pornography from a computer in the library, or attitude problems in relation to colleagues, other staff and patients. The Trust or GP Trainer (as the employer) will take the lead under its approved disciplinary procedures. The GP Trainer or Trust should inform the PD and Patch AD in writing that disciplinary procedures are taking place with a doctor in training.

It should be remembered that attitude problems may be a symptom of underlying performance problems and this may need to be investigated at the same time as disciplinary procedures take their course.

**ii) Professional conduct issues**

Examples include research misconduct, failure to take consent properly, prescribing issues eg self-prescribing, improper relationships with patients, improper certification issues (such as the signing of cremation forms, sickness certification, passport forms in situations where it is illegal to do so), and breach of confidentiality. Again the Trust or the GP Trainer (as the employer) will take the lead under its disciplinary procedures and will inform the Deanery in writing at the earliest stage. The Deanery will provide an input into such a disciplinary process, via the PD or Patch AD.

Any decision to involve the General Medical Council is a very serious one for the doctor involved and this will be a joint decision between the Trust or GP Trainer and the Deanery. The General
Medical Council recommends that approved procedures be followed first at the local level, Referral to the GMC of a GP specialist trainee is normally made by the GP Dean or Head of School after a consideration of the evidence given by the educators involved.

**B. Health & Sickness Issues**

Doctors become ill like all other individuals. Consider physical, mental health and behavioural issues (high functioning Asperger’s Syndrome is a not uncommon finding in trainees in difficulty) as well as substance misuse such as drugs or alcohol. All trainees should be registered with a GP (not their GP Trainer). Checks should be made that all trainees in difficulty have registered with a GP and have consulted with them as appropriate.

Trainees in difficulty should have access to an Occupational Health Assessment if their health is in question. "Good Medical Practice" requires doctors to seek and follow advice from a Consultant Occupational Physician if their judgement or performance might be affected by illness. Those trainees employed by an Acute Trust have access to OH through the HR department. GP trainees have access to OH through the PCT, but where this is not available the Patch AD and GP department can advise where OH advice can be sought.

The Disability Discrimination Act (1995) covers both physical and mental impairments that affect a person’s ability to carry out day-to-day tasks and requires employers to make reasonable adjustments to work pattern, content, and environment.

Ensure adequate support is available eg. Deanery mentor scheme, Staff Counselling services through Trust OH, MedNet or PHP (refer to Deanery website). Consider national services such as 'Doctor Support Network' or 'Doctors for Doctors' run by the British Medical Association.

**C. Competence and Performance Issues**

It is important to remember that there may be precipitating factors in the trainee’s home / social life that are affecting their performance. It is worthwhile having a wide index of suspicion as helping the trainee address these challenges can be a simple and very beneficial intervention.
4. Guidance for Trainers, PDs, CS and ES

4.1. Patient safety is the yardstick for dealing with all concerns about performance. This includes a consideration of possible risks to the trainee’s future patients as well as their current ones.

4.2. Poor performance is a symptom, not a diagnosis. Poor performance in a trainee may reflect other problems, both personal and in relation to the educational environment. Consider the competencies of the trainee, as well as systems issues, health and personal circumstances. Look for patterns e.g. previous complaints or similar difficulties. Apparently simple problems can turn out to be very complicated - and vice versa. Trainers will need to critically evaluate their own performance including a trainer reflecting on the trainer-trainee relationship.

4.3. Meetings with the trainee. Early on when concerns arise, the CS or ES should explore and discuss the issues with the trainee collating information. The supervisors need to listen to content from trainees, making no pre-judgements. Performance related issues are often a symptom of an underlying problem, which if relevant need to be brought to the fore so that trainees can be helped appropriately. It is important to clarify what induction processes were in place when the trainee started the placement where the performance issue was recognised. Was there an induction? Did the trainee engage? i.e. were there systematic processes in place to ensure that a trainee should know what to do. This can provide clarity on the important distinction between probity / conduct and performance – “could but wouldn’t” or “couldn’t so didn’t”.

A helpful question is; “Describe a time when everything was going well.” ie both communication and performance. This can make the interview seem less persecutory and also cast light on the trainee’s overall perspective and experience. This very simple meeting might resolve the problem.

PDs need to be involved early. Such sensitive discussions need protected time and space. PDs are in a challenging position. They have to balance the needs of patient safety, educational management, and the pastoral care of the trainee concerned. During this information gathering phase, PDs will have responsibilities for discussions with the trainee and trainer/CS/ES.

After the initial exploratory meeting, any follow up meetings must be properly prepared, following good HR practice. The trainee needs to be informed of the reasons and agenda for the meeting and who will be attending. During a meeting, clarification needs to be given that information about the trainees’ health will remain confidential, but any performance issues that might affect patient safety will be discussed with others on a need to know basis. Meetings held might be with the educational and clinical supervisors or with the PDs alone. Many problems can be resolved at local level, by using the principles of finding out the facts rather than opinions, giving honest but constructive feedback and setting targets for improvement. Following these through will usually work well. If local resolution fails then seek help early consulting with the Patch AD.

4.4. All documentation should be full and shared with all parties. Record everything fully and at the time, including all face-to-face discussions and phone conversations. Preferably place all
documentation on ePortfolio using Educator notes if necessary. Ensure that all documentation is copied to the trainee’s file at the Deanery.

4.5. Seek support and supervision early. If you are a trainer, programme director or educational supervisor - contact your patch AD.

4.6. Case management should be undertaken by an AD i.e. not the trainer, supervisor or programme director. When simple measures have failed to resolve the problem, ADs should take appropriate action while being careful not to rush into making precipitate judgements or decisions. Much of the information gathering may well have been done by the CE, ES and PDs.

If you are an AD - consult your director as appropriate. ADs need to be alert to the limits of their competence in relation to issues that are increasingly likely to lead to formal hearings of one kind or another. Remain aware that other resources may need to be engaged in order to help with a problem e.g. assessment tools, human resources etc. The Associate Director leading on performance for trainees in difficulty will be able to give advice.

4.7. All discussions with trainer and trainee should be reflective and non-judgemental. The objective is always to try and establish (or re-establish) a safe and effective learning environment.

4.8. Consider how to provide support for both the educator and the trainee. Both may be distressed and need support of various kinds from peers or seniors.

4.9. Learning Plan. Each of the learning needs must be clearly identified and a personal development plan written and agreed between all parties. There must be specific learning objectives, achievements which can be measured and done within a specified time. The trainee needs to be engaged taking the lead with compiling the learning plan to demonstrate insight into what needs to be achieved and placing the PDP on the ePortfolio.

4.10. Assessment should be objective, fair and valid. Assessment should be wide-ranging and carried out as soon as concerns are raised. It should also involve self-assessment by the trainee concerned. Use standard assessment tools where possible such as the workplace-based assessments of nMRCGP. See below section on assessment. If in doubt seek advice about the appropriate tools to use.

4.11. Any concerns and possible sanctions should be precise and explicit. If significant action has to be taken, such as removal from a practice or a programme, this should always occur after a transparent process with advance warning, except in the most extreme cases.
4.12. Be clear at all times about everyone’s roles i.e. who is supporting whom, who is assessing whom, and where the buck stops.

4.13 The patch AD is responsible for coordinating assessments by other experienced trainers to identify / clarify the performance issues

Remember

• Act early but surely.
• Poor performance is a symptom, not a diagnosis.
• If it isn’t written down, it hasn’t happened.
• No surprises.

5. ES report “Failure to progress”

Any ‘unsatisfactory’ outcome on an ES report will result in an ARCP panel interview ie an extra panel at 6 months, 18 months or 30 months.

6. Extension of Training

6.1 Extension of training: this may be given for a number of reasons; ill health, maternity leave or poor performance.

6.2 Remedial trainee: a trainee who an ARCP has given Outcome 3 “inadequate progress by the trainee – additional training time required”. This is called remedial training.

6.3 Length of time of extension: Each trainee is given a up to 6 month (FTE) extension to the 3 year training programme due to performance concerns. This period of remedial training may occur at any stage during the three-year training programme. (Note the relevant Gold Guide for each trainee is the one in force at the time of starting their GP Specialty training). Those who have had an Inter Deanery transfer are only allowed one 6 month extension for performance concerns in their total programme.

6.4 Failure after Extension of Training: If after 6 months the trainee has still not passed elements of nMRCGP ie AKT, CSA or WPBA and there is “failure to progress”, the ARCP decision will result in an ARCP outcome 4 and removal from training.

6.5 Review: The trainee may request a review of the ARCP decision Outcome 4 provided he /she can provide additional evidence.
6.6 Appeal: Trainees have an automatic right of appeal against Outcome 4 “removal from training”. The appeal panel may uphold the trainee’s appeal and grant a further 6 months exceptional extra training.

7. Patch AD responsibilities for a Trainee on Remedial Extension

7.1 Case Management: Once an ARCP has decided that a trainee requires a remedial extension of training due to performance concerns, the Patch AD is responsible for the continuing case management using all the principles of best practice outlined above.

7.2. Learning environment. Ensure that the protected learning environment either in hospital or practice is compatible with the opportunity to express the competencies required at the level of training and address the trainee’s learning needs. Remedial trainees require extra time from the supervisors, and frequently need to be in a supernumerary position. Consider the personality types of trainee and learning styles and make sure these are compatible with the CS / trainer.

7.3 Funding of remedial training or supranumary post must be clarified by AD

7.4. Meetings between Patch AD, ES/CS and Trainee

Patch AD is expected to have initial, 3 month and 5 month meetings with the remedial trainee and educational/clinical supervisor. This is to facilitate the educational contract and a focused learning plan for the 6 months extension. These meetings must be documented and placed on the ‘Educator Notes’ within ePortfolio.

7.5. Support for the trainee and trainer:

There needs to be clarification about which educators are supporting the trainee and which the trainer, as this is a very stressful time for both. An identified person PD or AD must be available to support the trainee and Trainer.

Resources such as Trainer group / peer support / Mentoring / Coaching – managed by Lesley Seward / Psychotherapy should all be considered

7.6. An Educational Contract needs to be established with the trainee that includes;

• A statement of clear aims, objectives, assessment requirements and a statement of what signifies successful remediation. This is detailed within the Learning Plan.

• Workload / Service Provision adjustments
• Educational provision

• agreement from the trainee to release information to key people.

7.7. Learning Plan. An assessment of learning needs is followed by a specific learning plan for the 6 months, reviewed during this period. The plan should include:

• individual learning objectives

• specific teaching methods for each objective

• quantify trainees reflections if appropriate eg no of entries on log diary

• assessments to be used

• time plan including expected learning outcomes at different points of remedial training if appropriate

• Agreement on how educators will monitor and support in a time frame

7.8. Trainee’s reflections. The quality and quantity of trainee’s reflections need to be assessed and expectations included in the Learning Plan.

• Self Appraisal

• Learning Log; At least one reflective entry made by trainee within the learning log each week (assessments ie COTs, CBDs etc are separate from this requirement)
APPENDIX 1: Examples of Risk Assessment Criteria for Doctors Requiring Professional Support

1. Health Issues

Low Risk
• Insight into difficulties.
• Takes appropriate time off sick.
• Insight into limitations caused by health issue.
• Seeks help and advice appropriately (from own GP or occupational health or appropriate colleagues) and follows this advice.
• Responds to concern raised by colleagues and modifies behaviour appropriately.
• Complies fully with all treatment and reasonable adjustments to workplace roles/conditions.

Medium Risk
• Limited insight into difficulties.
• Continues to work whilst moderately unwell.
• Limited awareness into limitations caused by health issue.
• Seeks advice appropriately but appears reluctant to follow this.
• Some appropriate response to concerns raised by colleagues.
• Complies on the whole with remediation package.

High Risk
• No insight into health problem.
• Continues to attend work even when obviously unwell.
• No insight into clinical limitations caused by health issue; may jeopardise patient care.
• Does not seek help or advice for health issue.
• Unwilling or unable to respond appropriately to concerns raised by colleagues.
• Does not comply with treatment or reasonable adjustments.

2. Capability
Low Risk
- Insight into capability issues.
- Performance difficulties are not serious or repetitive.
- Does not attempt to perform tasks when not capable.
- Takes responsibility for the task, and ensures that it is completed under supervision or completed by an appropriate colleague.
- Seeks advice and supervision appropriately.
- Demonstrates expected improvement in areas of weakness.
- Demonstrates the ability to learn from experience.

Medium Risk
- Limited insight into capability difficulties.
- May attempt to perform low risk or simple tasks when not capable, but then seeks advice and supervision.
- Demonstrates some improvement in areas of weakness.
- Demonstrates some ability to reflect and learn from experience, but there are still concerns in this area.
- Repeated sick leave often of short duration and possibly associated with on-call.
- Repeated avoidance of acute situations.

High Risk
- No insight into lack of capability.
- Performance difficulties are serious or repetitive.
- Attempts to perform high risk task(s) when not capable.
- Inability to communicate effectively.
- Repeated inappropriate delegation of clinical responsibility.
- Repeated inadequate supervision of delegated clinical tasks.
- Ineffective ingrained clinical team working skills.
- Does not seek appropriate advice or supervision, therefore putting patients at risk.
- If unable to complete the task, does not ensure that it is completed by a colleague.
• Seems unable or unwilling to improve in areas of weakness.
• Does not demonstrate the ability to reflect and learn from experience.
• May make formal complaints about colleagues who express concern about capability.

3. Conduct

Low Risk
• One episode of minor misconduct only (N.B. need to check that there have not been any episodes in previous posts).
• Individual agrees when challenged that conduct was inappropriate.
• Demonstrates remorse for misconduct.
• Demonstrates the ability to reflect and learn from experience and there is no evidence of further misconduct.
• Seeks advice appropriately on conduct and associated issues.
• External factor present (family/financial/work related/evidence of stress).
• Detailed work history available and no concerns.

Medium Risk
• Two or three episodes of minor misconduct (check back to other posts).
• Individual agrees when challenged that conduct was inappropriate.
• Demonstrates appropriate remorse for misconduct.
• Demonstrates the ability to reflect and learn from experience, but some very minor concerns about conduct may remain.
• Sometimes seeks advice on conduct and associated issues.

High Risk
• Repeated episodes of minor misconduct, or one or more episodes of serious misconduct.
• Individual does not agree that conduct was inappropriate, or denies misconduct.
• No expression of remorse.
• Unable to demonstrate the ability to reflect and learn from experience.
• Unable or unwilling to accept advice on conduct-related issues.
• No external contributory factors.
• Work history difficult to verify/previous concerns.

APPENDIX 2 – Flow Chart for Managing Trainees in difficulty

IDENTIFICATION OF UNDERPERFORMANCE BY TRAINER

• ES Unsatisfactory progress
• Poor CSA/AKT fails
• WPBA CONCERNS
AD Coordinated assessments.

- Advanced Trainer assessments – WPBA / Video consultations
- Attachment to other trainers
- Interview with TPD / AD
- Occupational Health
- Epo Review

ARCP

Supporting Trainer

- TPD / AD
- Mentoring with advanced trainer
- Sharing workload
- Financial support
- Trainer group

REVIEW MEETING

- Evaluate assessments / Summarise findings
- Sharing of learning by trainers / AD / TPD’s
- ES report summary

Supporting Trainee

- Assigned TPD
- Coaching / Mentoring
- Peer support
- Occ Health recommendations.
- Part time working
- Specialist skills eg CSA