Complaints
&
Professional Standards:

Supporting You to Support our Patients

7th July 2021

Dr Gopal K Sharma - Associate Medical Director

Miss Michelle Lake – Head of Professional Standards & Revalidation

Mrs Cathie Cunnington - Head of Complaints Team

Mrs Liz Hart – Programme Manager, Professional Standards Team

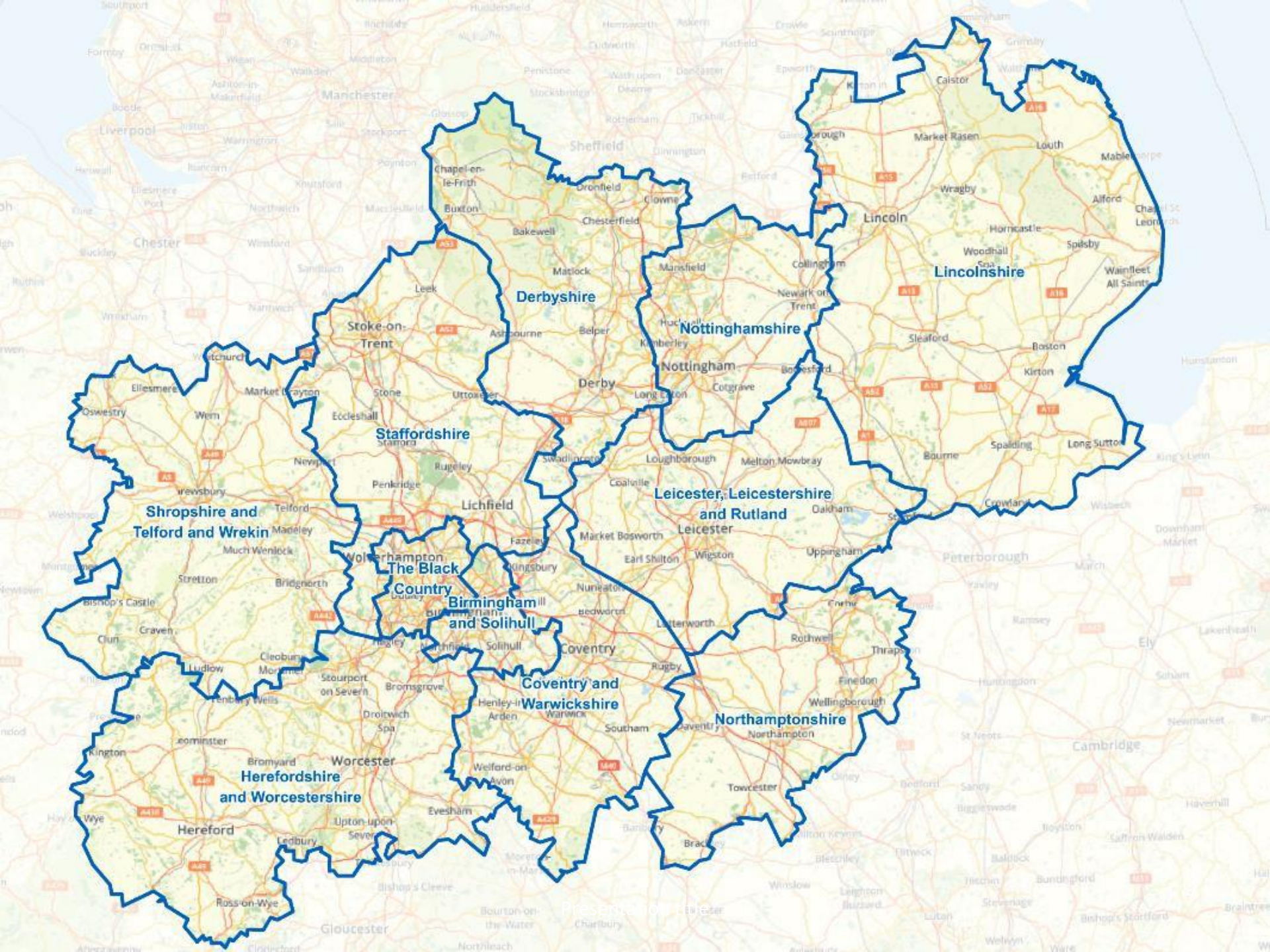
NHS England and NHS Improvement

Agenda

	Item	Time
1.	**Welcome & Scene Setting** Gopal Sharma	1.00pm - 1.20pm
2.	**GP Appraisal & Revalidation** Michelle Lake	1.20pm - 1.40pm
3.	**Responding to Complaints** Cathie Cunnington	1.40pm – 2.00pm
5.	**Professional Standards Process** Liz Hart	2.00pm – 2.20pm
6.	**Summary & Case Study** Gopal Sharma	2.20pm – 2.40pm
7.	**Q & A**	2.40pm – 3.00pm
8.	**Thank you**	

NHSE/I – The Midlands Region

- **North Midlands** - Shropshire, Staffordshire, Derbyshire & Nottinghamshire (Dave Briggs)
- **West Midlands** – Hereford, Worcestershire, Birmingham, Solihull, Black Country, Coventry & Warwickshire (Jessica Sokolov)
- **Central Midlands** - Northamptonshire, Leicestershire & Lincolnshire (Aly Rashid)


Derbyshire
Nottinghamshire
Lincolnshire
Staffordshire
Shropshire and Telford and Wrekin
Leicester, Leicestershire and Rutland
The Black Country
Birmingham and Solihull
Coventry and Warwickshire
Northamptonshire
Herefordshire and Worcestershire
Stoke-on-Trent
Derby
Nottingham
Leicester
Lincoln
Worcester
Hereford
Coventry

MDs & ROs……

Nigel Sturrock

- Aly Rashid — Leicestershire, Lincolnshire & Rutland
- Dave Briggs — Derbyshire & Nottinghamshire
- Jessica Sokolov — Birmingham, Solihull & Black Country
- Anne-Marie Holder — Staffordshire, Shropshire, Herefordshire & Worcestershire
- Saqib Anwar — Northants, Coventry & Warwick

Strategic Challenges

"Primary care is in a phase of rapid transition, there is widespread consensus that the traditional model of general practice is no longer fit for purpose and, in response to a range of pressures, new approaches to care delivery and organisational design are emerging."

The Nuffield Trust

The Proverbial Mismatch!

DEMAND

SUPPLY

GP Shortages – The Hard Facts!

The Research:

- Falling numbers since 1960s, accelerated recently
- 2,500 more GPs needed since 2015 to keep stable
- 28% fewer doctors/capita than Europe
- Only 62 WTE GPs/100,000 - lowest for 15yrs!

GPs Save Lives:

- 10 extra GPs/100,000 increases life expectancy by 51.5 days
- Specialists only add 19.2 days

More than HALF of GPs fear patients are being put in danger because ten-minute appointments are too short, survey reveals

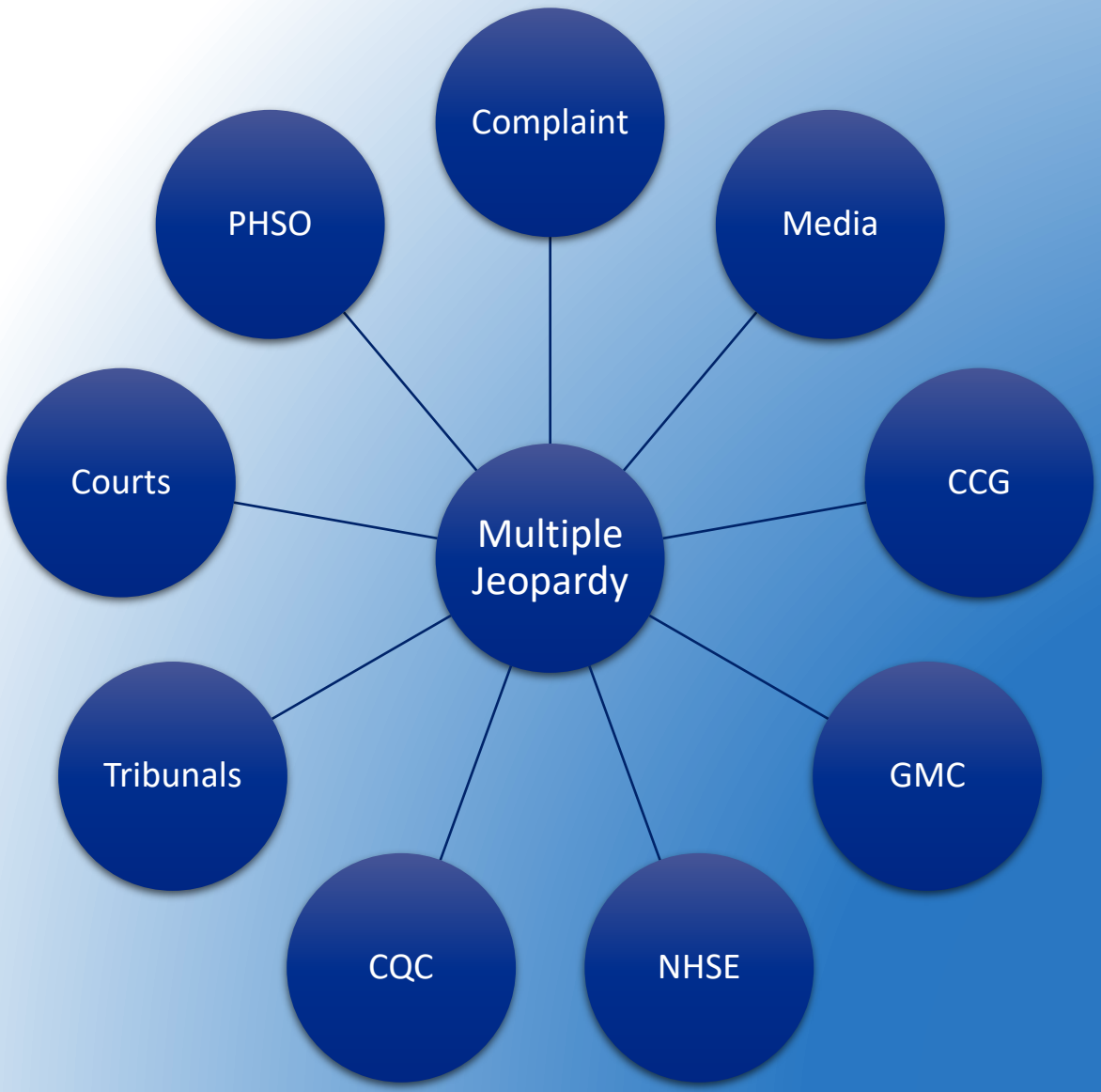
- 53% said patient safety is compromised because consultations are too short
- Family doctors are campaigning for standard appointments to be 15 minutes
- Head of the Royal College of GPs warned the entire profession could 'crumble'

By ELEANOR HAYWARD HEALTH REPORTER FOR THE DAILY MAIL

Reasons for Workforce Crisis?

- More P/T workers
- Rejection of Partnership Model
- Portfolio Working
- Earlier Retirement
- Emigration
- Demoralised work-force -
  - Workload Burden
  - Regulatory Burden:
    - CQC
    - GMC
    - NHSE

The Strain of Professional Scrutiny



Possible Reactions to Concerns - Supporting Our Practitioners

- **Regulatory Processes are Intrusive & Protracted:**
  - Sense of Injustice
  - Mistrust
  - Compulsion to recount in detail
  - Blame, Anger or Guilt
  - Overly keen to Rectify v Poor Insight/Reflection v Disengaged

- **Complaints & Investigations are Stressful:**
  - Loss of Autonomy/Control
  - Shame & Humiliation
  - Loss of Daily Purpose, Identity & Self-Respect
  - Threat to Livelihood & Career
  - Risk of Family Breakdown
  - Mental Illness – Depression, Anxiety, Suicide

It's Like Grief!

My First Medical Lecture – 1981!

- ***"Remember, always be careful out there because that next patient walking through the door could be the end of your career!"***

- **Our Challenge - Maintaining Professional Standards whilst reducing Regulatory Fear & Burden?**

GP Recruitment Schemes

- **Increased National Training**
  - Lincs Med School
- **International Recruitment Schemes**
  - Midlands Pilot – circa 100 new GPs in last 3yrs

GP Retention Strategies

Reduce Workload Burden:

- Primary Care Networks (PCN's)
- Integrated Care Systems (ICSs)
- NHS Digital – AI, remote monitoring
- Allied Health Professionals – ANPs
- Limited Scope of Practice for GPs - GPwSIs
- GP Retainer Scheme (HEE)

Lobby for Pensions Reforms

Manage Regulatory Fear …..

GP Retainer Scheme

Operated by HEE

Offers Funding & Educational Support

For GPs thinking of leaving NHS Practice

1- 4 sessions/wk

For up to 5yrs

Practice receives £4,000/session/yr

Retainer GP gets £1,000/session/yr

Reducing Regulatory Burden….

Practitioner Performance

to

Professional Standards Teams

Flexible approach to A&R

and

Performers List

Separate Regulation

of

Allied Health Professionals

GP Appraisals & Revalidation

Michelle Lake
Head of Professional Standards & Revalidation

The Changing Face of Appraisal

- Purpose & Background

- Supporting Doctors during the Pandemic
  - Appraisal 2020 Model
  - Supporting Appraisers to support you
  - Evaluation

- Looking forwards – the future of appraisal

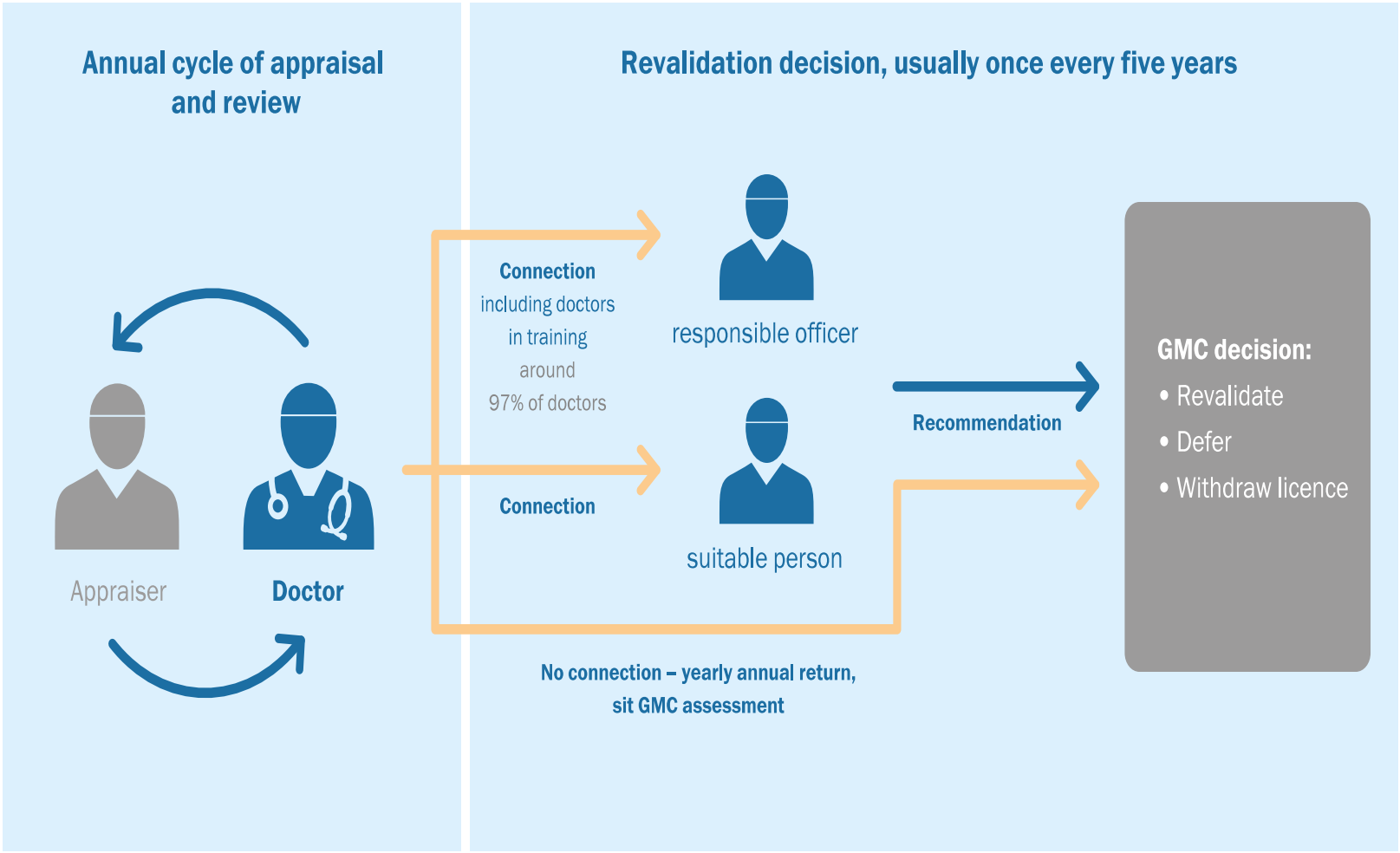
What Appraisees Say

- ‘The preparation was relevant and less time consuming. I enjoyed this appraisal and feel I benefitted so much more than my previous ones’

- ‘It felt more focused on me as a doctor and my wellbeing – and therefore the standard of care I can give rather than the emphasis being on me proving I’m not Harold Shipman which so much of the previous format felt like’

- ‘By making it simpler, cutting out all the ‘tick boxes’ made it much less of a chore and I engaged much better in the discussions’

Revalidation – what is it?



Supporting Doctors to Revalidate

- GMC requirements - Guidance on supporting information for appraisal and revalidation - GMC (gmc-uk.org)

- Our Role
  - How we process a recommendation
  - The different types of recommendation
    - Approve/defer/refer

- GMC approach to revalidation during Covid: Changes made to revalidation in response to the coronavirus COVID-19 pandemic - GMC (gmc-uk.org)

  - Top Tips!

Responding to Complaints

Cathie Cunnington
Head of Complaints

The NHSE Complaints Process

- Statutory Obligation to Respond
- Provider or Commissioner
- Agreement and Consent
- Provider response
- Clinical Advice
- Contractual Advice
- Other Specialist Advice
- NHSE Response

A Good Complaint Response

- Written in plain English, on provider headed paper and is addressed to the complainant with any medical or technical terms explained.
- Summarises the complaint and addresses all of the points identified, if not, explains why.
- Explains the steps taken to investigate the complaint and what evidence has been taken into account.
- Provide a thorough explanation of findings and what the provider thinks happened, if necessary, explain what should have happened.
- State the conclusions made, based on the evidence. Ensure the decision is clear.
- Provides an apology if something has gone wrong, an apology is not an admission of liability. In many cases a carefully worded apology and a thorough explanation can resolve a complaint.
- Informs the complainant of any lessons learnt or actions taken as a result of their complaint and offers the option of a meeting.
- For clinical complaints, the response is signed by a GP Partner or Senior GP with responsibility for complaints

Sample Opening Paragraphs

Dear XXXX

I am writing on behalf of the practice in my capacity as a GP Partner. First and foremost, I would like to express sincere condolences on the sudden passing of your brother. Secondly, I wish to thank you for taking the time to summarise your concerns, which NHS England have forwarded to us for our attention.

Having not been involved in this case, I have strived to review your brother's records as an independent medical practitioner and have spoken with the clinicians involved in your brother's care, before collating a response to your complaint.

Dear XXXX

On behalf of the Doctors and Staff, I would like to express my sincere condolences and say how sorry we are for your loss. We very much appreciate you taking the time to write to us, this has given us the opportunity to review and reflect on the care we provided to your mother and I hope this response addresses your concerns.

As the Senior Partner within the partnership who has overall responsibility for the handling of complaints, I have been appointed to investigate and respond to your complaint, having not been involved in your mother's care during this period. I have discussed your complaint with all of the clinicians involved in your mother's care, before responding to you.

I thought it would be helpful to provide a chronology of the contact your mother had with the practice and then I will answer your specific concerns.

The Clinical Review

- Adds Independence and Value to the Complaint Response
- Informs Conclusions
- Highlights Learning
- Prompts Reflection
- Recommends Referrals

Professional Standards

Michelle Lake – Head of Professional Standards
&
Liz Hart
Professional Standards Manager

Introduction to Professional Regulations Team

- Part of the Professional Standards Team, in Medical Directorate

- Trained Case Managers and Clinicians that support MD/RO in working to clear and publicly available processes

- The principles of the Professional Regulation team are:
  - Protection of patients and the public, minimising risk and improving care standards
  - To compassionately discharge its statutory duties and have a care for the wellbeing of the practitioner
  - To provide consistent and equitable treatment of practitioners it supports

Where do Concerns come from?

- **Self-Referrals** from Practitioners
- Whistleblowing, Colleagues Concerns, Clinical Incidents, Audits, Safeguarding Teams, SI Reviews, Occupational Health
- **CCGs** – Where Performance Indicators or contractual mechanisms might indicate a concern about/for an individual
- **Regulators** or External Agencies – GMC, CQC, PHSO
- **Justice System** - Police, Courts & Coroner
- **Internal NHSE** – Complaints Team, significant concerns about engagement with appraisal/revalidation requirements, Primary Care

Why Practitioners get into Difficulty

- Deficiency in Clinical Knowledge & Skills
- Behavioural or Conduct Issues
- Health Concerns
- Work Context
- Poor Systems/Processes
- Lack of Support
- BUT often a Combination

Supporting Early Resolution

Avoiding premature escalation of concerns

Having a fair and balanced initial triage of information – based on **risk** assessment

Being open about what information we receive and how we have assessed it

Making Formal Decisions

- Performance Advisory Group – PAG
- Performers List Decision Panel – PLDP
- For those concerns which do indicate a moderate to high risk to patient, service or the practitioner themselves
- Fact-finding and engaging with performer in a pro-active and supportive way
- Interventions which safely investigate and remediate concerns
- Only in most serious cases do we look at conditions, suspension or removal from the Performers List

Fair Outcomes

- Using risk assessment to inform PAG/PLDP outcomes
- Outcomes:
    - Should address the concerns
    - Should be achievable within a reasonable timescale and within the working environment
    - Should be the standard of “the reasonable doctor”

    - ***Not*** intended to be punitive
    - ***Not*** the “aspirational gold standard”
    - ***Not*** the “what I do in my practice is…” standard
    - ***Not*** a “fishing exercise” and “I wonder what else..”

The Practitioner Voice

"I felt the case was managed fairly at all times"

"I felt supported from yourselves as well as multiple other sources. Was nice to be able to check in with my case manager at regular intervals"

"I felt the process was very fair and gave me time to reflect on the incident"

"I think it unfair that more than one process has to be gone through for a single complaint. Despite being found with no case to answer by the GMC I still have to wait for another body to assess whether they agree without any input or transparency in that process"

"I was informed and kept updated with the progress in a professional manner"

"I was offered occupational health services and I was pleased to be given this opportunity as it was a stressful time"

"I have discussed this with my appraiser despite already discussing the original incident last year"

Summary & Case Study

Dr Gopal Sharma

Definition of Insight?

"A readiness to explore both intellectually and emotionally how & why I and those I interact with behave, think and feel as we do and for me to adapt my behaviour accordingly"

Brown, Joffe & McAvoy 2013

3 components:

- **Acceptance** of the incident
- **Critical Analysis** of why it might have happened
- **Genuine Motivation** to modify future behaviour/systems to reduce risk of recurrence

Good Prognostic Indicators

- **Personal Factors:**
  - Conscientious
  - Reflective
  - Insightful
  - Motivated to change
  - Capacity for change
  - Personal Resilience
- **Environmental Factors:**
  - Facilitating work environment & culture
  - Support systems (personal & organisational)

Fitness to Practice v Fitness for Purpose

Criterion	FtP	FfP
Definition:	Minimum Standard for a doctor	Required Standard to be a GP (typically higher)
Determined by:	Regulator - GMC	Employer - CCG & NHSE
Legal Guidance:	GMC GMP RO Regs 2010	PL Regs 2013 (Amended 2015)
Sample Differences	• 40 GP sessions/yr • Validated 5yrly Surveys	• Only 1 session/yr • Mandatory Training locally specified, e.g. BLS & Safeguarding
Monitored by:	Responsible Officer (RO)	Medical Director (MD)

Conflicting Judgements!

- **FtP v FfP**
  - Perception of double jeopardy
  - Differences in outcomes between GMC & NHSE panels
- **Burden of Proof:** Balance of Probabilities (civil)
- **PHSO Standards:** Gold Standard from Guidelines
- **NHSE:** Average GP (Bolam) Test but use Guidelines to promote Reflective Improvement & Shared Learning

Fair & Proportionate Outcomes

- **Trained Teams** of Investigators & Panelists
- **Separated Functions** - Investigative & Judicial
- **Confidential** - IG & GDPR Compliant (need-to-know basis)
- **Open Processes**:
  - Practitioner Fully Informed - right to know what's said with a right of reply & representation
  - Subject to FOI & SARs
- **Independent:**
  - COIs checked at each stage
  - Differently Constituted Panels when escalated
  - LMC Representation at PAGs (provides local context)
  - Lay Chairs for **all** PLDPs (powers to take PL actions)

Fair & Proportionate Outcomes

- **Investigations are Focused:**
  - Avoid “fishing exercises”
  - Agreed ToR
- **Consistency** is achieved via:
  - Templates
  - Bank of Standard Conditions
  - QA Feedback
  - Annual Peer Review Process
- **Standards of Proof:**
  - Civil Burden of Proof
  - The Reasonable Practitioner Test – not “gold standard”

Fair & Proportionate Outcomes

- **Conditions are SMART** - achievable in the real working environment & not a “Back-Door” Suspension
- **Decisions are based on Fact** with written reasons
- **Outcomes are Proportionate** and not Punative
- **Aim** is to:
  - Safeguard Patient Care
  - Maintain Service Efficiency & Public Confidence
  - Support Practitioner Rehabilitation through focused Reflective Learning
- **Right of Appeal** to PHL, FTT

Case Study: The Complaint

"I'm unhappy about the delayed diagnosis of my late husband's bowel cancer. He went to his GP many times. They should have realised something was seriously wrong":

- 12/08/2011: Epigastric Pains – Given PPI
- 24/11/2011: Diarrhoea – Reassured, Physical = N, Check FBC, Try OTC Lomotil
- 03/02/2012: Lomotil helped but now more Diarrhoea. Reassured, try another course.
- 23/02/2012: Still Diarrhoea but prev BT = N. Reassured ? drug side-effect. Switched PPI to H2RA.
- 28/01/2013: Rectal Bleeding, stool still variable but currently normal
- 28/07/2014: 2WW Referral for Bloody Diarrhoea
- 3/09/2014: Stage 4 Colorectal Cancer Diagnosed
- 03/01/2015: Died from Metastatic Bowel Cancer

Case Study: GP Response

- In late 2011 & early 2012 he had no symptoms suggestive of bowel cancer and hence he was not referred.

- There were also no other Red Flags when he consulted with rectal bleeding on 28/01/2013.

- However, with hindsight the GP acknowledges that he “may have missed clues from the change in bowel habit and has learnt to be more vigilant in future”.

Case Study: Clinical Review

- This case concerns a 72yr old man who:
  - First presented in August 2011 with some upper GI symptoms (felt to be acid-related & responded to PPI), but;
  - Followed by a persistent change in bowel habit from Nov 2011 onwards, and;
  - Also fresh rectal bleeding in January 2013.
- Symptoms waxed & waned over the index period:
  - Partly due to the natural history of such conditions, but;
  - Also, possibly because of symptomatic relief afforded by Lomotil;
  - A long-term PPI, later switched to a H2RA under the mistaken assumption that the PPI might have been the cause of his diarrhoea.
- *If NICE Guidelines had been followed, this patient should certainly have been offered a 2WW referral at both attendances in Feb 2012*
- *I could even argue even that he should have been referred when first presenting with diarrhoea in Nov 011, although others may accept mitigation because at least the GP made some other relevant suggestions at that time.*

Case Study: Clinical Review

- In Jan 2013 there was no adequate explanation for the painless rectal bleeding (negative DRE) and yet, the GP fails to put himself in a position to fully explore other potential Red Flags such as change in weight, appetite, etc.

- According to NICE Guidelines, unexplained rectal bleeding in over 50s is in itself a reason for a 2WW referral.

- Risk Rated: **15**
    - Likelihood of Recurrence: **Possible – 3** because of inadequate GP Reflections
    - Severity: **Catastrophic – 5** because earlier referral, diagnosis & treatment could have meant a better prognosis

Case Study: Complaints Outcome

- Referral to PST
- Rationale:
  - NICE Guidelines not followed
  - Several Missed Opportunities for a 2WW Referral
  - Despite his age, alternative, less likely explanations were considered first, e.g. prolonged viral GE, late-onset IBS, a PPI side-effect and bizarrely, even a painless anal fissure was mentioned, etc
  - Lack of Professional Curiosity - False reassurance was derived from the initial normal physical exam & blood tests
  - False Reassurances were also given to patient on more than one occasion
  - In adequate safety-netting advice with no firm follow-up arrangements

Case Study: Complaints Outcome

- Rationale Continued:
  - Failure to properly review at subsequent presentations with repeat detailed history, clinical examination & further blood tests;
  - Inappropriate symptomatic prescribing of Lomotil, which would have further masked/confused the symptoms and thus delayed the diagnosis;
  - Poor knowledge of the local 2WW Colo-rectal Referral Protocol, which required a fresh FBC & U&Es within the preceding 3mths;
  - Inadequate Reflection in the GP Response, still failing to accept the earlier Red Flags to a cancer diagnosis.

Case Study: PST Outcome

- **ITS:**
  - Details of the Complaint, GP Response & Clinical Review Findings were assessed
  - Risk score confirmed at 15
  - Signposted onto PAG
- **PAG:** Suggested Opportunity to:
  - Meet with a Clinical Lead – Check on GPs welfare & facilitate learning – agreed to Audit all new Ca diagnoses to identify any avoidable delays in referral as per NICE Guidance
  - Provide a further Written Response, including Reflection, Learning & Impact (changes to current practice)
  - Discuss at Appraisal
  - Seek further support – LMC, MDO, etc.

Over to you……