

“PREVENTION - BETTER THAN CURE”

DOCTORS AND DENTISTS IN TRAINING

**Report of the Short-Life Working Group on Poor Performance amongst
Doctors and Dentists in Training**

**Scottish Executive
July 2001**



SCOTTISH EXECUTIVE

Making it work together

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FOREWORD

The Scottish Health Plan, “Our National Health: A Plan for Action, A Plan for Change”, commits the NHS to improving health and the quality of health services in Scotland.

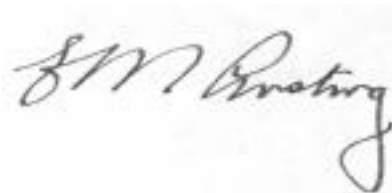
One of the prime concerns of NHS Scotland is that patients should receive the best possible treatment and advice. In achieving this, it is essential that doctors and dentists in training should not put them at risk by inadequate performance or wilful failure. In Scotland, we are fortunate that patient care is usually of a very high standard but, inevitably, lapses sometimes occur. In 1999, the then Scottish Office published a report entitled “*Suspensions – A New Perspective*” which laid down principles for dealing with the rare occurrence of a poorly performing consultant.

This report, together with the parallel report on general practitioners, builds on this experience. It makes a series of recommendations to ensure that the occasional under-performing doctor or dentist in training is identified as early as possible, and to “prevent” rather than “cure” problems. It will also ensure that the mechanisms dealing with under-performing doctors and dentists in training are consistent across Scotland.

We are grateful to the Working Group members for their time and effort, and thank them for their work in producing this report, which we commend. We expect the recommendations to be implemented across Scotland. This will make a significant contribution and help to reduce to an absolute minimum any harm to patients because of under-performance by doctors and dentists in training.



MR T JONES
Chief Executive



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Chief Medical Officer



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Chief Dental Officer

“PREVENTION – BETTER THAN CURE”

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SUMMARY

The recommendations throughout this report should be adopted to ensure consistency of approach across Scottish Trust and Health Boards (as well as across private sector employers). This will minimise confusion, and is of particular importance to training grade doctors and dentists who may move frequently between employers.

The principles outlined in “*Suspensions – A New Perspective*”, published by the then Scottish Office in 1999 should also be adopted for doctors and dentists in training. Details of the principles in that document can be summarised to include:

- ensuring patient safety;
- fairness and openness with the doctor or dentist in question;
- objectivity on the part of the employer; and
- assessment of whether the problem is confined to the individual, is part of a problem within a clinical team, or is caused or exacerbated by other, external, factors.

The processes and guidelines in this current report are intended to:

- aim for early identification of problems within a supportive environment;
- put in, where possible, appropriate and supportive corrective measures; and
- for doctors and dentists in training whose performance or conduct gives cause for concern, create a clear, robust process that is fair to all parties involved.

RECOMMENDATIONS

The following are some specific recommendations from the report. Other, more general guidance, is given in the different sections of the text.

1. All medical and dental staff in training in the hospital sector, from PRHO to SpR should have a continuous career profile, which is retained by the trainee. A copy file should be held in the relevant Deanery (paragraph 3.2).
2. Any instance of individual poor performance should lead to a critical examination of:
 - the doctor or dentist's working hours and patterns of work, to determine whether or not these are part of the underlying cause;
 - any health issues affecting the trainee; and
 - the training supervision of the trainee – whether there are personality clashes, and whether the trainer is operating effectively (paragraph 3.3).
3. Issues of health should be considered very early on in any process dealing with poor performance, to allow any underlying problems to be tackled (paragraph 3.13).
4. Junior doctors and dentists should be registered with a local GP. GP registrars should not register in their training practice, but with an independent GP (paragraph 3.13).
5. The use of smart cards for occupational health records should be piloted, with the doctor or dentist's consent, as a possible way of addressing Occupational Health information transfer (paragraph 3.15).
6. Each hospital site should have at least one designated senior clinician who will act as a trainee's mentor, but who will not be part of the Trust management structure (paragraph 3.16).
7. In circumstances where a potential criminal offence has been committed, the Procurator Fiscal should be consulted in order to establish whether any proceedings proposed by the Health Board or Trust would be prejudicial to a fair trial (paragraph 3.19).
8. To minimise potential problems with locum doctors and dentists, and with trainees on short-term contracts,
 - a reference should be obtained from the last post in which the doctor had been employed, leaving no gaps;

- the reasons for any gaps in employment are clearly understood;
 - employers take their responsibility for this process seriously;
 - moves are made towards a culture where references are open and structured round the person specification for the post; and
 - references given are honest and objective (paragraph 3.22).
9. Trusts should encourage an atmosphere of openness and support, and a culture of “no blame”, ensuring that systems are in place to allow staff to speak freely about any concerns they may have about their own performance or that of others (paragraphs 4.6 and 4.7).
 10. The practical suggestions on organised targeted training should be followed (paragraph 5.15).
 11. SCPMDE should revisit the issue of induction courses for health professionals from outwith the UK (paragraph 6.2).
 12. Someone from a similar cultural background should be involved in addressing any performance or conduct issue that arises with a doctor or dentist from outwith the UK (paragraph 6.2).
 13. Dental vocational training should be reviewed, and the following taken forward urgently:
 - alteration to the dental vocational training regulations and inclusion of the need to complete dental vocational training satisfactorily;
 - implementation of a robust system of assessment for the trainee year; and
 - early discussion with the profession on the proposed changes to regulations (paragraph 7.8).

1. INTRODUCTION

1.1 Some doctors and dentists in training will have problems with their health, their conduct or their competence. While the General Medical Council (GMC) has published useful booklets to help individuals, there are no clear guidelines in Scotland about how NHS Managers, Postgraduate Deans, Directors of Postgraduate General Practice Education, and Educational Supervisors might deal with these problems. This report seeks to fill that gap. Often, particularly with SHOs, the short-term nature of the contract means that it is easier for an employer to allow the contract to lapse rather than taking decisive action, and let the next employer make a renewed judgement of the individual. A short-term contract also means that it is very difficult, if not impossible to take action within the timescale allowed.

1.2 There is a lack of clarity about where accountability and responsibility lie for taking decisions about doctors and dentists in training. This report seeks to clarify these issues and recommends that, except in serious cases of misconduct or poor performance, meaningful local action should be taken to resolve the matter before there is any referral of the individual to the GMC or General Dental Council (GDC). In April 1999 the report of the Short-Life Working Group on Suspensions of Medical and Dental Staff entitled "*Suspensions: A New Perspective*" was published. This set out a number of principles that should guide employers when considering allegations and problems with individual career grade hospital doctors and dentists. Paragraph 4.17 of that report suggested that the way problems were tackled for consultants could also be followed for training grade doctors and dentists provided the Postgraduate Dean was involved. The report did not, however, go into details about how this might be organised on the ground.

1.3 In parallel with work in Scotland, consultation documents on poor performance of doctors were issued in late 1999 and early 2000 by the Department of Health in England, the Welsh Assembly, and the Northern Ireland Office. While the principles identified in these documents were very similar, the suggested ways of tackling the issues differed in some respects from the Scottish model. The Department of Health in England has now set up a National Clinical Assessment Authority (NCAA) to supervise problems of poor performance in England. There are no plans to set up a similar body in Scotland.

1.4 A subsequent review of the position in Scotland by the then Chief Medical Officer, Sir David Carter, in conjunction with leaders of the profession, showed that two particular areas had not been covered in depth, namely difficulties with doctors and dentists in training, and with general medical practitioners. Accordingly, two Short-Life Working Groups were set up in Autumn 2000 to consider problems arising within these groups.

1.5 Responsibility for, and involvement in, helping trainee doctors and dentists with problems rest with a number of individuals and organisations. These include the individuals themselves, consultants and general practitioners for whom the

individual works, NHS Management (and in particular the Trust Medical Director), the local Postgraduate Dean, the local Occupational Health Service, Medical Royal Colleges, the British Medical Association (BMA)/British Dental Association (BDA), Medical and Dental Defence Unions, and the GMC/GDC.

1.6 The remit of the Working Group was agreed as being “to consider and identify best practice in dealing with discipline, poor performance and health amongst doctors and dentists in training in Scotland; and to clarify the roles and responsibilities of the different parties involved. To consider organisational aspects of targeted training for all hospital doctors and dentists.” The report is set out to cover the following areas:

- defining the areas of difficulty and how they might be investigated;
- dissecting out the different roles and responsibilities of individuals and organisations in developing solutions for different problems that might arise;
- documenting lines of accountability and who takes what decision;
- determining the legal issues around the whole area of poorly performing trainees; and
- developing “good practice” and practical guidelines, which will help those with the responsibility in this area to act appropriately.

Method of Working

1.7 In order to draw on the considerable breadth and depth of experience represented by the Working Group, it was decided that members of the Group should produce papers on specific topics within their expertise. Members of the Group also drew on experience from outside the Group in the production of these papers. These papers, along with the discussions that took place at the meetings of the Group form the substance of this report. The Working Group membership is given in Annex A.

1.8 It was recognised from the outset that the production of such a report with its recommendations would be a significant step forward in addressing the problems of poor and inappropriate performance amongst medical and dental staff in training. Consistency of approach across Scottish Trusts and Health Boards (as well as across private sector employers) would minimise confusion and is particularly important for training grade doctors and dentists who may move frequently between employers.

1.9 It was emphasised that the principles outlined in the report “*Suspensions - A New Perspective*” published in 1999 should be applied for doctors and dentists in

training too. Detail of the principles can be found at paragraph 4.3, 4.5 and 4.6 of that document, but in summary they include: -

- ensuring patient safety;
- fairness and openness with the trainee in question;
- objectivity on the part of the employer; and
- assessment of whether the problem is confined to the individual, is part of a problem within a clinical team, or is caused or exacerbated by other, external factors;

2. DEFINING THE AREAS OF DIFFICULTY

Identification

2.1 A poorly performing doctor in training¹ could be defined as one who has not reached the standards expected of trainees in that discipline at that particular stage of training. Standards not only encompass knowledge and technical skills, but also include demonstration of acceptable professional and personal standards of behaviour and attitude.

2.2 Defining the root cause of poor performance is not an easy task. Appropriate identification of such matters requires robust systems and well-trained individuals. The systems should also be aimed at recognising early warning signs and providing supportive intervention, rather than crisis management. In practical terms there are a number of individuals who have a role in the identification process. These include medical and non-medical colleagues, educational supervisors, NHS Managers, Postgraduate Deans and Dental Director, Directors of Postgraduate GP Education, Regional General Practice Vocational Training Advisers (Dental) and the trainees themselves. The BMA and BDA may also assist in clarifying problems.

Defining the problem

2.3 Once a possible problem has been identified, it is essential to analyse what kind of poor performance is in question.

2.4 NHS Circular 1990 (PCS) 8 gives definitions of personal and professional conduct and professional competence as follows:

- **personal conduct:** performance or behaviour of practitioners not associated with the exercise of medical or dental skills;
- **professional conduct:** performance or behaviour of practitioners arising from the exercise of medical or dental skills;
- **professional competence:** adequacy of performance of practitioners related to the exercise of their medical or dental skills and professional judgement.

The Working Group expanded these definitions as follows, essentially adding specific examples and covering situations where problems arise:

Personal Conduct - covers deficient or unacceptable performance or behaviour due to factors other than those associated with the exercise of medical or dental skills and may include: -

¹ References to doctors in training in this document should be taken to include dentists in training. For discussion of issues specific to dentistry, see Section 7 of this report.

- sexual or racial harassment;
- bullying;
- lack of probity;
- lack of reliability and poor timekeeping;
- acting on duty under the influence of drugs or alcohol;
- inappropriate or criminal behaviour;
- inappropriate use of NHS facilities; and
- failure to follow organisational policies and procedures.

Professional Conduct - covers deficient/poor/unacceptable performance or behaviour arising from the exercise of medical or dental skills and may include –

- neglect or disregard of professional responsibilities to patients;
- any abuse by the doctor of his or her position of trust, including a breach of professional confidence, or any form of indecency towards a patient;
- inappropriate or unacceptable attitudes and behaviour towards patients and their relatives, and colleagues; and
- unprofessional and inappropriate attitudes and approach to work.

Professional Competence - performance that is deficient over a period of time is usually considered as “poor performance” On the other hand it might be the committing of an isolated specific serious incident. Poor performance may encompass: -

- failure to keep professional skills and knowledge up-to-date: or in the case of training grade doctors failure to develop professional skills and knowledge appropriately
- failure to work effectively with colleagues;
- failure to recognise the limits of professional competence;
- failure to consult senior colleagues as appropriate;
- attempting to undertake techniques in which the practitioner has not been appropriately trained; and

- failure to communicate effectively with patients or their relatives.

These definitions are not exhaustive and are offered as illustrations only.

2.5 The Working Group recognised that the differentiation between “personal” and “professional” conduct was difficult. Under current disciplinary procedures, the group’s attention was drawn to the recent agreement developed in 2000 between the BMA and employers in Scotland, to resolve differences as quickly as possible as to whether allegations should be considered under “personal” or “professional” conduct (Annex B).

2.6 The Group also suggested that, in future, it would be helpful to remove the distinction between “personal” and “professional” conduct, and that a new and simplified category of “conduct” be introduced. The majority of the Group suggested that the profession and management should take steps to agree this at a national level, with a view to simplifying and speeding up the investigatory process.

2.7 It was also recognised that where there were particular professional issues involving doctors or dentists, any investigatory or disciplinary hearing should have doctors or dentists on the panel.

2.8 Any action that might threaten safety of patients should be considered for referral to the GMC/GDC, once local investigations have been completed.

3. INVESTIGATING AND TACKLING DIFFICULTIES

Prevention of problems if possible

3.1 For doctors or dentists in training a poorly performing individual is one who does not fulfil the standards expected of a trainee in that discipline at the particular stage of training, and who may have inadequate skills and knowledge for his or her level of training.

3.2 For trainees with possible poor performance or inappropriate behaviour, the aim should be early identification and intervention, followed by appropriate, supportive rehabilitation measures. In support of this primary aim, the Working Group saw it as essential that **all medical and dental staff in training in the hospital sector, from Pre-Registration House Officer (PRHO) to Specialist Registrar (SpR) should have a continuous career portfolio which is retained by the trainee. A copy file should be held in the relevant Deanery.** Every doctor in training should, at the outset of their placement, establish training and educational objectives with their Educational Supervisor and these should be recorded. Appraisal should take place at regular intervals. At the end of the placement an assessment should be carried out by the Educational Supervisor and the outcome recorded in the portfolio. The portfolio should hold all documented evidence of the trainee's educational and clinical competence, his/her achievements and any concerns expressed by the Educational Supervisor. It should be a condition of employment that the trainee must present the complete portfolio to the Educational Supervisor. This will fit in with proposals by the GMC that, for revalidation purposes, doctors should have a personal portfolio throughout their career.

3.3 The Group recommended that **any instances of individual poor performance should lead to a critical examination of:** -

- **that doctor's working hours and patterns of work, to determine whether or not these are part of the underlying cause;**
- **any health issues affecting the trainee ; and**
- **the training and supervision of the trainee – whether there are personality clashes, and whether the trainer is operating effectively etc.**

Specific Issues for Different Training Grades

Specialist Registrar (SpR) and Senior House Officer (SHO) grades

3.4 Regular appraisal should be seen as an essential part of the training process and the quality assurance process. The Record of In Training Assessment (RITA) system, with an appropriate appeal mechanism is already in place for SpRs and this will shortly be extended to the SHO grade. Although the RITA is not an appraisal in itself, the mechanics of carrying out the RITA process allows valuable discussion to

take place around the individual's training to date and the plans for the subsequent period.

3.5 The SHO RITA will apply to all SHOs on the GMC and GDC Registers, who are occupying posts which have educational approval and are also approved by the Postgraduate Dean, no matter what their specialty. This will include SHOs working in hospital as part of a vocational training scheme for general practice, overseas doctors, and research fellows with honorary SHO status. The Group was of the opinion that the SHO RITA would address some of the problems that currently exist in the SHO grade. It is important to bear in mind that a poorly performing SHO is not necessarily a bad doctor, but it may be that the individual is training in a specialty for which they are not suited (for example training for surgery, yet lacking manual dexterity).

3.6 The Group also recognised that not all SHO posts are part of a training programme. The SHO grade is currently being reviewed on a UK basis and this should result in the elimination of non-standard posts which do not have educational approval. For the current SHO posts, when performance or disciplinary issues are raised, the Group suggests that NHS Management follow the guidelines outlined later in this section.

GP Registrars

3.7 The Group commended the processes that are already in place for GP Registrars. The individual's career portfolio should provide a continuous record from PRHO to completion of vocational training and should be available to the GP Trainer.

3.8 In general practice training, the registrar is subject to regular formative assessment undertaken by the GP trainer. Each GP registrar participates in one to one tutorials, and one component of these tutorials and other educational activity within the practice will be formative assessment. This is carried out by a variety of methods including random and problem case analysis, video analysis of consultations, analysis of prescribing habits, analysis of referral letters and the use of specific tools to aid assessment. Formative assessment procedures are laid down in all Deaneries. All GP trainers should follow these procedures, have well-developed assessment skills and keep good training records.

3.9 Formative assessment may uncover problems. When the GP trainer has concerns about any aspect of GP registrar performance, the trainer is encouraged to alert the Director of Postgraduate General Practice Education or an Associate Adviser in General Practice as early as possible. Where problems are identified, a plan should be drawn up with the GP registrar, the GP trainer and the Director to address the registrar's difficulties.

3.10 At the completion of vocational training, the registrar must satisfy the requirements for satisfactory completion of training laid down by the Joint Committee for Postgraduate Training in General Practice (JCPTGP). These currently encompass the following:

- assessment of knowledge – MCQ examination;
- submission of a written project;
- assessment of consultation skills – submission of a video of consultations or a simulated surgery, analysed by independent GP assessors; and
- structured Trainers' report.

3.11 If a GP registrar fails any element of this assessment, the individual will not be granted a Certificate of Satisfactory Completion of Vocational Training. The Director of Postgraduate General Practice Education may grant up to an additional twelve months remedial training but the registrar is still required to pass all elements of summative assessment before being granted a certificate which allows him/her to practice independently as a general practitioner.

Pre Registration House Officers (PRHOs)

3.12 Documentation to assess PRHO competence has been developed by the Scottish Council for Postgraduate Medical and Dental Education (SCPMDE) in conjunction with the University Medical Schools in Scotland. The assessment documentation is currently being reviewed and refined.

Health Issues

3.13 It is crucial that **issues of health are considered very early on in any process dealing with poor performance, to allow any underlying problems to be tackled. Junior doctors should be registered with a local GP. GP registrars should not register in their training practice, but with an independent GP.** It is very important for all doctors and dentists in training that there is co-operation with any recommendations made by their GP or the Occupational Health Service. Doctors also need to be educated about and encouraged to use counselling services as the need arises.

3.14 Useful information on where to find help and support for doctors with health-related problems is contained at Annex C.

3.15 The Group believe that Occupational Health and Safety Services (OHSS) need a higher profile and expressed their concern about the slightly negative image that using these services currently presented for staff. The Scottish Executive's report

Towards a Safer, Healthier Workplace examined the role of OHSS for all NHS staff, including doctors and dentists. It states: -

“The OHSS must provide a confidential service to staff. Management must demonstrate a clear commitment to protecting the confidentiality of employee information obtained through the OHSS. OHSS policies and procedures must give staff confidence that the service exists to assist the individual and is not a tool of management. All staff should have access to confidential advice from an OHSS from outwith their immediate area if necessary.”

However, it is also recognised that problems arise as doctors in training move regularly from one job to another. All too often a move to a new post involves a different employer whose occupational health is provided by a different service. At present, occupational health records do not follow NHS employees and as a consequence, all information collected about a doctor is, in effect, lost. OHSS records are highly confidential and whilst it would be open to an employee to offer OHSS records to a prospective employer, this could not be insisted upon as a condition of employment. The Group recommends that this issue be examined, with a view to addressing the matter of information transfer.

Transfer of OHSS information, with the doctor’s consent, is currently being piloted in England by the use of smart cards. This will contain essential health information relating to pre-employment health checks such as the doctor’s current immunisation status. The Occupational Health and Safety Strategy Implementation Group (OHSSIG) is following the smart card pilots in England with a view to adopting a similar arrangement in Scotland. **The Group supports the action of the OHSSIG and commends the use of smart cards, with the doctor’s consent, as a possible way of addressing occupational health information transfer in this context.**

Mentoring

3.16 It is important that mechanisms for providing encouragement and mentoring, as well as educational support, are developed. The Group suggests that **each hospital site should have at least one designated senior clinician who will act as a trainee’s mentor, but who will not be part of the Trust management structure.** Such a person can act as a confidential and trusted helper for trainees with problems. Some suggested guidelines for the role of mentors are attached at Annex D.

3.17 Postgraduate tutors and specialty-based college tutors already have an important role in mentoring, and it may be appropriate for some of them to fulfil this function and liaise with the educational supervisor as necessary.

Training the Trainers

3.18 Poor performance can arise due to a breakdown in the relationship between trainer and trainee. The Mentor mentioned in the previous section could mediate in such cases and help identify “poorly performing trainers”. However, consideration

should also be given to training the trainers. This could cover such areas as the development of communication skills, coaching skills, assessment and appraisal skills, training in equal opportunities and employment law issues. Such training will be of use to the trainers themselves as well as the trainees. The Specialist Training Authority (STA), as part of its requirement for the recognition of trainers will in the future be looking for evidence that the individual has acquired some skills in this area. GMC revalidation will also be looking for similar evidence of competence.

Conduct

3.19 In certain situations of poor performance, the way forward is clear for all concerned. This would include, for example, a situation where the trainee had committed a potential criminal offence. Disciplinary action should not however be taken automatically against the employee because he/she has been charged with or convicted of a criminal offence. Each situation requires to be considered individually on the basis of whether the employee's conduct warrants action because of its employment implications or because it is unacceptable to other employees. It is not always necessary to await the outcome of any prosecution before taking any action. In such circumstances, it is recommended that the Procurator Fiscal should be consulted in order to establish whether any proceedings proposed by the Health Board or Trust would be prejudicial to a fair trial.

3.20 This is an issue for Trusts under their disciplinary codes. Doctors should be treated in the same way as other staff, but bearing in mind their professional responsibilities.

Short term contracts

3.21 Medical and dental staff on short-term contracts and who are not part of a recognised training scheme are more problematic. Although the proposed SHO RITA will eventually tackle this to an extent, current problems must still be dealt with.

3.22 Disciplinary procedures instigated by one employer cannot legally be continued by another employer. Internal Trust or Health Board disciplinary procedures are specific to the employer who instigates these procedures. The appropriate method of ensuring that a "new" Board or Trust does not take on an employee without knowing that he or she was subject to disciplinary action by his or her former employer is to ensure that references are taken up before the employee is allowed to commence work. The points made with reference to locum doctors and dentists in paragraph 7.1 are also relevant here. These are that:

- **a reference is obtained from the last post in which the doctor had been employed, leaving no gaps;**

- **the reasons for any gaps in employment are clearly understood;**
- **employers take their responsibilities for this process seriously;**
- **employers do not offer employment “subject to satisfactory references”;**
- **moves are made towards a culture where references are open and structured round the person specification for the post; and**
- **references given are honest and objective.**

Protocols and Route Map

3.23 In summary, there is a need to:-

- aim for early identification of problems within a supportive environment;
- put in, where possible, appropriate and supportive, corrective measures; and
- for doctors and dentists in training whose performance or conduct gives cause for concern, create a clear, robust process that is fair to all parties involved.

With these aims in mind the Group have developed protocols which they suggest should be adopted by Trusts and Deaneries in dealing with poorly performing trainees. These protocols address and expand the issues discussed above. They are attached at Annex E.

Also attached at Annex E are route maps, which the Group feels could provide a useful guide for those dealing with poorly performing trainees.

Transfer of Information

3.24 The Group considered the legal position in relation to the transfer of disciplinary and occupational health records between employers, and noted that, within the current legal framework, it is not possible to provide for the transfer of these records between employers, without the consent of the employee concerned.

4. ROLES AND RESPONSIBILITIES

4.1 The Group felt that, at present, there was some lack of clarity about who should take the lead and responsibility for dealing with poorly performing trainees. The responsibilities need to be agreed by all stakeholders and be clearly defined, so that the whole system deals with poor performance in a supportive and fair manner and is evenly applied throughout Scotland.

Role of trainee

4.2 Trainees must recognise their role and responsibilities in the process of identifying, assessing and coming to terms with any poor performance or conduct. Some suggestions of how trainee doctors and dentists could deal with these issues include: -

- by participating and co-operating in the appraisal process;
- by realising their limitations;
- by ensuring their individual career portfolio is kept up to date;
- by acknowledging and respecting the procedures and rules set out by the employer;
- by being prepared to ask for help from other colleagues;
- by joining an appropriate professional body, such as the BMA/BDA;
- by joining a defence union;
- by registering with an independent GP and looking after their health needs; and
- by co-operating with Occupational Health Services;

Role of medical and dental schools

4.3 It should be recognised that the seeds of poor performance are sometimes sown at medical and dental school. Any system for dealing with poor performance should be compatible with what is in place in medical and dental schools, if difficulties are to be prevented, rather than treated. With the permission of the individual student, there should be transfer of information between those responsible for undergraduate and postgraduate training. This should be *without prejudice* to the individual trainee, and is meant to provide appropriate support for those who have been identified at undergraduate level as being in need of assistance.

4.4 It is important to engender a culture, which makes it acceptable to recognise one's own limitations, and to be able to ask for help. Intervention should be seen as supportive rather than threatening.

Role of colleagues

4.5 Colleagues in all healthcare professions have a responsibility for patient safety. All NHS employers should have efficient systems in place for staff to raise their concerns without fear (NHS Circular GEN (1993) 10). These should be a core component of local employment policies and procedures.

4.6 However, from the point of view of the person against whom complaints have been made, anonymity of a complainant can only be tenable at the very earliest stages of investigation. The principle that an individual has the right to know his/her accuser and the nature of the accusation must be upheld.

This might lead to reluctance on the part of junior staff to criticise a senior member of staff who could influence their future career. Trusts should be encouraged to develop guidelines to deal with this specific issue. **An atmosphere of openness and support and a culture of "no blame" should be encouraged by Trusts.**

Role of Trust Staff

4.7 NHS Management

The Trust (the Clinical Group Director in the first instance) and the Postgraduate Dean should work closely together with regard to managing poorly performing doctors.

The Medical Director should normally take the lead in issues relating to conduct, capability, health, discipline and grievances.

The HR Director should ensure that **systems are in place to allow staff to speak freely about any concerns they may have about their own performance or that of others** and be involved at the earliest stage when problems are initially raised. Problems shared at an early stage may allow remedies to be put in place which do not involve any disciplinary process. The disciplinary process should be the last resort.

Hospital management should ensure that time is available for educational supervisors to carry out training, development and appraisal commitments.

4.8 Senior Medical Staff

Postgraduate Clinical Tutors must take the lead in ensuring that all trainees have their own career portfolio.

Educational Supervisors need to ensure that they use appraisal systems in an honest and constructive manner. Of particular importance is the role of the supervising consultant, who should ensure that he or she brings to the attention of those who need to know any concerns about junior staff under his or her charge.

Role of SCPMDE and Postgraduate Deans

4.9 The Postgraduate Dean will be expected to take the lead in educational and professional issues and in arranging and delivering targeted training. Postgraduate Tutors and Educational Supervisors should inform the Postgraduate Dean of unresolved concerns about any individual. For general practice trainees, Directors of Postgraduate GP Training will appraise the Postgraduate Dean of any complex or unresolved issues.

Role of the Medical Royal Colleges

4.10 If problems are identified in relation to poor performance then the trainee might require additional supervision or training in their particular specialty. This is likely to be set in motion through the Postgraduate Deanery but the Speciality Adviser or Programme Director for Specialist Registrars, would be the person who would coordinate and oversee any additional training. This process is already in place through the RITA system for SpRs. At SHO level, training should be organised by the College Tutor within the Trust. This could be incorporated through the SHO RITA scheme. The Royal Colleges also have a significant role to play in the mentoring of trainees as described in Section 3, paragraphs 16 and 17. In dentistry, SHO training will be organised by the Hospital Dental Service Tutor.

Role of BMA/BDA and Medical Defence Unions

4.11 The BMA/BDA and the Medical Defence Unions play a valuable role in advising individual doctors/dentists about terms and conditions matters and their rights. They also will give help in how to deal with allegations of misconduct and poor performance, and will support the individual doctor in any disciplinary hearing. The Group recommended that doctors and dentists in training belong to an appropriate professional group and a medical defence union.

Role of GMC/GDC

4.12 The GMC/GDC is the final destination for cases of poor performance, conduct and health which have not been resolved by any other route, or which may have a criminal aspect. A new Interim Orders Committee now enables the GMC to act quickly to place restrictions on a doctor's registration where it is considered to be in the interests of patient safety, in the public interest, or in the interest of the doctor him/her self, pending a fuller investigation of the charge. The Fitness to Practise Directorate of the GMC is willing to advise Trust Medical Directors whenever formal referral to the GMC is being considered.

5. TARGETED TRAINING

5.1 The remit of the group included examination of the issue of targeted training, not only for doctors and dentists in training, but also for all hospital doctors and dentists. The position of GP registrars has been covered in paragraphs 3.7 to 3.11.

5.2 The implementation of targeted training requires consideration of the following:

For the doctor/dentist in question

- identification of the basis of the problem;
- agreement on the action to be taken;
- agreeing a programme of targeted training (content and duration) with objectives, timing and assessment criteria being part of the agreement; and
- robust appraisal/assessment mechanisms.

For the employing Trust

- who initiates the action?
- where is the training offered?
- duration of targeted training?
- who assesses the outcomes?
- who pays for the training?
- who carries financial liability for the training and any subsequent costs eg employment tribunal?
- consent from/and informing patients; and
- when to notify the GMC/GDC?

It is important to recognise that targeted training is a spectrum and not a discrete entity. It takes place at different levels at different times, and may have a number of financial and staffing implications for the employing Trust.

5.3 In the course of appraisal, most doctors will have some areas identified as requiring development. These can be dealt with and corrective training provided in the course of a doctor's continuing employment in his or her current post, or in

subsequent posts. Costs identified here would be minimal, and met by the employing Trust, and perhaps confined to attending particular courses etc. Any deficiencies identified at this level would not justify referral to the GMC.

In the training grades, failure to correct any deficiencies should lead to formal career counselling. This, in turn, might lead to a change of specialty, or recognition that there was an inability to progress through the training programme and a recommendation to take up a non-consultant career grade or other appointment. For career grade staff, any areas noted at appraisal needing further training should be dealt with as part of the individual doctor's continuing professional development.

5.4 Some doctors may have more significant problems but not so serious as to require referral to the GMC. Doctors identified at this level are more likely to need time out of their regular employment and may need to be placed in a supernumerary position. For such individuals there may be resource implications while targeted training is underway.

5.5 At a third level, there are a few doctors who will have serious deficiencies identified. They will require intensive career assessment, counselling and targeted training. It is likely that such doctors will almost always require to be placed in a supernumerary position. Failure to benefit from targeted training at this level carries a high probability of being referred to the Fitness to Practise procedures of the GMC.

Who is responsible for taking action?

5.6 All doctors have a responsibility to act on deficiencies identified in their colleagues. For those in a training grade, the consultant supervising the training of the doctor should identify and address the problems as they occur. The educational supervisor and/or the Royal College tutor should be involved where formal action requires to be taken. For SHOs and Specialist Registrars, it is not appropriate to wait until the RITA review to take action as, in many instances, the deficiencies can be corrected before the review. For career grade staff who may need targeted training the Medical Director should discuss, at the earliest opportunity, any problem doctors with the Postgraduate Dean.

The Postgraduate Tutor may also be a source of advice and support as it is anticipated that the vast majority of doctors with deficiencies will be dealt with at Trust level. Where the level of concern is such that the continued employment of the doctor might be called into question, Trust management, and particularly the Human Resources Department of the Trust, should be involved at an early stage.

Where is the training offered?

5.7 Wherever possible this should be in a standard post, though on occasions it may be in a supernumerary post in a location to offer the most appropriate targeted training. Agreement for any placement in another Trust requires to be agreed between the host Trust and the receiving Trust.

Duration of targeted training

5.8 An estimate of the duration should be agreed by the Trusts and the Postgraduate Dean concerned before the post is taken up. It is suggested that the maximum period of targeted training should be 12 months.

Who assesses the outcome?

5.9 For training grade doctors this would normally be the educational specialty advisor or College Tutor at the less serious levels. For career grade doctors, individual programmes and arrangements will need to be worked out between the Trusts involved, the Postgraduate Dean, and the appropriate Medical Royal College. Where serious deficiencies have been identified, or where a supernumerary post has been created, assessments would need to be provided by the training consultant and reviewed by a College Tutor/Specialty Advisor and a representative of the Postgraduate Dean.

Who pays for the training?

5.10 Where this involves a training grade doctor, and a supernumerary post is created, the cost will be met by SCPMDE through the Deanery. For career grade doctors with continuing employment in a Trust, the training and assessment programme should be agreed in advance with the Medical Royal College/specialty advisor and the Deanery, to ensure that the training required for the career grade doctor does not take place to the detriment of specialist registrars already in a training programme. The training may take place in the individual's own Trust, but may be in another location. Where employment of other staff is required to cover the absence of the individual career grade doctor who is undergoing targeted training, this would be met by the employing Trust.

Any additional costs of retraining for doctors who have been dismissed on performance grounds would be borne by the individual concerned. Doctors referred from the GMC Fitness to Practise procedures should be managed as appropriate, according to the GMC recommendations. Costs for training grade doctors would be borne by SCPMDE, and for career grade doctors by the employing Trust but only for training which is necessary for the future needs of the Trust.

Financial Liability

5.11 The potential difficulties in placing doctors requiring targeted training should not be underestimated, particularly when this involves more senior clinicians. Busy consultants are hesitant to take on board the significant workload and responsibilities involved and there is also a concern in relation to clinical governance and the potential adverse effects on service throughput.

Where the doctor is in a training grade, financial liability should be borne by the Trust where the targeted training is being provided.

Where the doctor is in a career grade and continues to have a contract of employment, financial liability should be carried by the Trust holding the contract of employment.

Consent and informing patients

5.12 There is probably no difficulty if the doctor is in a training grade, as any work being undertaken should be with appropriate supervision. Problems might arise at a more senior level where significant clinical procedures may be undertaken by the doctor undergoing targeted training. It needs to be made clear to the patient that the doctor is being assessed, but will be closely supervised by a competent consultant in the course of the procedure. Only if the patient agrees to this, and gives informed consent, should the procedure go ahead.

When to notify the GMC

5.13 A decision of this nature is a matter of judgement and there can be no hard and fast rules. At training grade level, the groups involved in coming to such a decision should be the College tutor/regional advisor, the Postgraduate Dean or Director of Postgraduate GP Education, and the Trust Medical Director. For those in career grades, the decision would have to be made between the training supervisor, the College regional advisor and the Trust Medical Director. Usually, it is Trust management who decides to refer an individual to the GMC. For those doctors referred by the GMC for targeted training, reports will be submitted to the GMC and further progress will be determined through GMC arrangements.

Appeal mechanisms for training grade doctors

5.14 For those doctors who are in the specialist registrar grade, there are provisions for an appeal process against an adverse RITA assessment. Similar arrangements are being put in place for the RITA process at SHO level.

Organising targeted training

5.15 Practical suggestions for organising targeted training in the same or a different Trust follow. These will need to be adapted for the different individual circumstances of the training required.

- Targeted training periods should be clearly identified and agreed with the doctor at the outset and should end with a formal assessment, also agreed at the outset. Success in the latter should be followed by a return to normal working (but supervised and audited);
- Targeted training periods should have clearly defined time limits and be specifically targeted to the doctor's identified problem areas. If the doctor wishes retraining in other areas not needed by his or her future employer, this would be at the individual doctor's own expense.
- For career grade doctors, the cost of targeted training should be borne by the employing Trust, while the costs for doctors and dentists in training would come from SCPMDE.
- Prior agreement would need to be reached between the Trusts concerned and the Postgraduate Dean on the timing, duration and content of the retraining programme. If serious problems of clinical competence arise during the targeted training, the receiving Trust can, at its sole discretion, terminate the training agreement. Alternative arrangements will then have to be made to complete the targeted training.
- Regular assessment of the doctor's performance, following a return to work, should be undertaken at 3-monthly intervals for a minimum of 2 years.
- Mentoring should be provided for the doctor undergoing targeted training.
- Patient safety is paramount and the receiving Trust must ensure that doctors undergoing targeted training are adequately supervised and given clear feedback on their performance throughout.
- Any training programmes should be notified to the receiving Trust's Clinical Governance Committee, who should ensure that the quality of patient care is not compromised by these arrangements.
- All agreements should be confirmed in writing, and signed by all relevant parties before targeted training begins.
- In addition to the Deaneries, the appropriate Royal Colleges may provide useful advice when training programmes are being drawn up.
- Not all poorly performing doctors are capable of successful retraining.

6. OTHER SPECIFIC ISSUES

Locum doctors in the training grades

6.1 The issue of poor performance amongst locum doctors, not only in the training grades but also in career grades, was of great concern to the Working Group. Consideration should be given to establishing a Scottish register of locums both for general practice and for hospital work. However, in the meantime, action should be taken at Trust level to ensure that units are staffed to a level that minimises the need to employ locums; and by a more careful use of the reference system. The current system is open to abuse, allowing doctors whose performance gives cause for concern to move around from post to post without proper checks being carried out. This issue needs to be tackled in the system as a whole and the group recommended that:-

- a reference is obtained from the last post in which the doctor had been employed, leaving no gaps;
- the reasons for any gaps in employment are clearly understood;
- employers take their responsibilities for this process seriously;
- employers do not offer employment “subject to satisfactory references”;
- moves are made towards a culture where references are open and structured round the person specification for the post; and
- references given are honest and objective;

Providing appropriate support for doctors from outwith the UK

6.2 Doctors from outwith the UK may experience “culture shock” in working in the NHS. Although there may not be actual instances recorded of poor performance, there may be a perception that such doctors are performing poorly due to differences between their personal culture and the host culture. These differences may include, for example, patterns of speech which are interpreted by patients as being abrupt, behaviour towards colleagues which comes across as being offensive, or a deficit of English language skills which could mean missing important details in a patient’s description of their condition. These are given as examples only, and patience and tolerance will be required by all parties, including patients, in resolving any similar issues.

The Group felt that induction courses for trainees coming from outwith the UK, particularly addressing the cultural differences which might be encountered, would be useful and suggested that SCPMDE look at this issue again, with a view to coming forward with practical suggestions for the Scottish situation.

When dealing with a doctor from outwith the UK who does have a problem with poor performance, the same guidelines should be followed as for doctors from within the UK; i.e. problems should be tackled early on, with a view to supportive intervention and targeted training if necessary. It was however suggested **that involvement of someone from a similar cultural background to address any performance issues that might arise would be a positive and proactive way of dealing with difficulties.**

7. ISSUES SPECIFIC TO DENTISTRY

7.1 The groups of dentists covered in this report are Senior House Officers, Specialist Registrars and Vocational Trainees in General Dental Practice and the Community Dental Service.

SHOs

7.2 The issues of poor performance are similar to those affecting medical SHOs. Dental SHOs are employed by Trusts either in Dental Hospitals or District General Hospitals. At present when issues of poor performance arise, either perceived or real, they are often managed by the trainee moving to a post elsewhere. Although Postgraduate Dental Deans and Directors currently have responsibility for managing the postgraduate education and training of these trainees, the lack of robust systems of appraisal and assessment makes it difficult to intercept poor performers. In future, SHOs in dentistry should be required to undertake assessments of performance, and a portfolio approach to monitoring progress should be adopted. As in medicine, there requires to be a closer working relationship between the service and the Postgraduate Dental Dean's/Director's office in dealing with issues of poor performance.

SpRs

7.3 There are twelve dental specialties and the dual medical/dental specialty of Oral Maxillofacial Surgery. All trainees are subject to the RITA process. A small number of trainees are subject to targeted training (RITA D) or have to repeat part of their programme (RITA E).

7.4 The recommendations in this report regarding medical SHOs and SpRs should apply equally to dental SHOs and SpRs.

Dental Vocational Training (DVT)

7.5 Vocational training is mandatory for all dentists who wish to hold a primary care NHS Trust or island Health Board list number, i.e. for those dentists who wish to practice as principals in the NHS General Dental Services. Dentists who wish to work in private dental practice or in the hospital dental service do not require to undertake DVT.

7.6 The definition of DVT is set out in the NHS (GDS) (Scotland) Regulations 1996, as amended (SI 1996 No 177 and SSI 2000 No.352) and these regulations are the cause of profound difficulties in managing the poor performance of dental vocational trainees. Vocational training in dentistry is defined as "a period of one year's full time employment (or an equivalent period of part time employment) undertaken wholly after 30th September 1993 during which a dentist is employed under a contract of service by an approved trainer, or where the approved trainer is a salaried dentist, under a contract of service with a Health Board or Primary Care NHS Trust, to provide a wide range of dental care and treatment and to attend such

study days as that contract requires”. Specifically there is no need to complete the DVT programme satisfactorily, no method of withholding a VT certificate and no requirement to assess performance. The regulations were produced in a different era of accountability when different attitudes to the management of poor performance prevailed. The situation is also made more complex by the independent contractor status of most General Dental Practitioners (GDPs) and the fact that the trainees are employed in most cases as assistants by the trainers.

7.7 Issues in this area can be summarised as follows:-

- lack of accountability for training;
- those providing education have no formal authority to deal with poor performance;
- no formal mechanism to deal with poor performance except referral to the GDC;
- no requirement to satisfactorily complete DVT;
- no meaningful system of assessment of performance in vocational training;
- no means of insisting upon targeted training; and
- no way of withholding a DVT certificate on grounds of performance;

7.8 Given the need to ensure accountability for training and for patient safety it is necessary to reconsider the existing system. It is suggested that the following are taken forward :-

- **alteration to the dental vocational training regulations and inclusion of the need to complete dental vocational training satisfactorily;**
- **implementation of a robust system of assessment for the training year; and**
- **early discussion with the profession on the proposed changes to regulations**

While recognising that this is an issue for the UK as whole, the group noted that the current system is seriously flawed. The Group recommended that these issues identified above require to be addressed urgently.

Vocational Trainees (VTs) in the Community Dental Service (CDS)

7.9 Trainees in this part of the dental services are employed as salaried community dentists by Primary Care NHS Trusts. The issues affecting poor performers are identical to those affecting dental SHOs and should be similarly managed.

POORLY PERFORMING DOCTORS GROUP: DOCTORS IN TRAINING

MEMBERSHIP

Dr D J Ewing, Scottish Executive (Chairman)

Mr A Boyter, Director of Human Resources, North Glasgow University Hospitals NHS Trust

Mr R Calderwood, Chief Executive, Southern General Hospitals NHS Trust

The Very Reverend G Forbes (lay member)

Mr C French, Scottish Executive Solicitor's Office

Mr T A Hide, BMA Scotland

Mr K Imray, BMA Assistant Secretary

Dr D Love, Scottish General Practitioners Committee

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Mr R Macdonald, Legal Adviser, Scottish Health Service Central Legal Office

Professor N MacKay, Dean of Postgraduate Medicine, West of Scotland

Dr D Maclean, Medical Director, Tayside University Hospitals NHS Trust

Dr W Mathewson, Medical and Dental Defence Union of Scotland

Mr G Perera, Department of Health (Observer)

Dr J Rennie, Dental Director, SCPMDE

Mr G Watson, Medical Director, Ayrshire & Arran Acute Hospitals NHS Trust

Dr S Whyte, Chairman, Academy of Medical Royal Colleges & Faculties

Ms M Wrigley, HR Manager, SCPMDE

Mrs A Roberts, Scottish Executive Health Department (Secretary)

PROCEDURE FOR RESOLVING DIFFERENCES AS TO WHETHER ALLEGATIONS SHOULD BE CONSIDERED UNDER PERSONAL CONDUCT, PROFESSIONAL CONDUCT OR PROFESSIONAL COMPETENCE

The Medical Director in considering whether formal disciplinary proceedings should be taken against a practitioner will consider which of the three definitions is applicable in that case. If he/she considers that the allegations relate to professional conduct or professional competence the matter will be dealt with under the intermediate procedure or the serious disciplinary procedure. If he/she considers that the allegations relate to personal conduct he/she will write to the practitioner with an outline of the allegations and inform the practitioner of the decision. If the practitioner is dissatisfied with the decision he/she may appeal within seven days of receipt of the formal notification to the Classification Appeal Committee.

The Classification Appeal Committee will be convened and will be constituted as follows: -

1. A Chairman, to be drawn from an agreed list, who will be a solicitor and not in the employment of the NHS or the Central Legal Office.
2. A Medical Director from another Trust.
3. A medically (or dentally in appropriate cases) qualified professional who is not a member of the Trust Board or employed by the Trust, and who has been nominated by the Local Negotiating Committee following consultation with the Scottish Secretary of the BMA or Scottish Secretary of the BDA, as appropriate.

All three members must be acceptable to the Trust and to the Local Negotiating Committee.

The practitioner may be accompanied at the appeal by his/her representative. The normal rules of natural justice will apply to the appeal proceedings. The proceedings should normally be completed and the decision confirmed within one month of the first meeting of the Classification Appeal Committee. The Committee's decision shall be binding on both parties.

A formal record of the proceedings, including the reasons for the decision reached, shall be sent to both parties.

SOME ORGANISATIONS WHO PROVIDE HELP WITH HEALTH-RELATED PROBLEMS

The BMA 24-Hour Counselling Service for Doctors – 08459 200169

Callers are able to speak to trained non-medical counsellors. Direct ongoing support or referral to specialised addiction services is offered.

The National Counselling Service for Sick Doctors (Mon-Fri 9.00-5.00) – 0870 2410535

This service provides general information and advice. Callers can be given the name and number of one of the NCSSD medical advisors (including Scottish-based advisors) to whom they can talk in confidence. NCSSD advisors are also available to talk to groups and the media about doctors' health issues.

GMC's Fitness to Practise Division – 0207 580 7642

Can provide informal advice and guidance about involving the GMC's health procedures.

The Sick Doctor's Trust – 01252 345163

A proactive service for addicted physicians. 24-hour advice and intervention service. Facilitates admission to appropriate treatment centres and introduction to support groups.

Dentist Health and Support Group – 0207 487 3119

Provides a confidential service for sick dentists.

The British Doctors' and Dentists' Group (accessed via the Medical Council on Alcoholism) 0207 487 4445. 24-hour helpline – 01252 345163

A support group of recovering medical and dental drug and alcohol misusers. Local groups meet throughout Scotland and the British Isles. Medical students also welcomed.

The Association of Anaesthetists' Doctor Scheme – 0207 631 1650

Operates its own scheme for all anaesthetists, including those in training. There is an Edinburgh-based co-ordinator for the scheme, contactable through the above number.

The Overseas Doctors' Association (0161 456 7828)

Health counselling panel can be helpful for doctors where cultural or linguistic factors are prominent.

Samaritans – 0845 790 9090*

Alcoholics Anonymous – 0845 769 7555*

Scottish Council on Alcohol – 0141 572 6700*

*See telephone directory for local contacts.

GUIDELINES FOR MENTORS

A Mentor will be a senior member of the Trust's medical or dental staff, and who is not part of the Trust management team. He or she should be available to help and guide a trainee who is having problems of a personal or professional nature, and in particular in any disputes with Trust management.

Doctors and dentists in training are both trainees and employees and, as such, are entitled to the statutory and other rights provided by law and by the locally agreed policies and procedures of their employer.

In all matters affecting the trainee's education, training and employment, mentors should ensure that good practice is maintained by the employer in keeping the trainee fully informed and consulted.

Substantial changes to the duties of a trainee may involve changes to the original contract of employment. Therefore, before any decisions regarding duty changes are made, it is imperative that the mentor ensures that the employer fully consults with the trainee(s) being affected by the change.

Trainees have a contractual right to have their grievances heard under the employer's formal grievance procedures. However, good practice dictates that grievances be resolved, if possible, at the lowest level of the employing authority's management structure, and mentors have a significant role in achieving such an outcome.

In situations where professional incompetence is not an issue, and where a trainee's problem involves allegations of personal and/or professional misconduct, the mentor should discuss the issues involved with the Medical Director and the Postgraduate Dean so that he/she is satisfied that the correct procedures for dealing with the problem are being invoked.

A trainee who repeatedly fails to reach the expected standards of a doctor or dentist in training at that stage of assessment may become subject to disciplinary procedures. It is essential, however, before the employer takes any steps to invoke disciplinary procedures that the trainee's mentor is completely satisfied that the guidance set out in the "*Report of the Short-Life Working Group on Poor Performance amongst Doctors and Dentists in Training*" has been followed, and that the employer intends to comply with recognised employment law criteria deployed to achieve fair treatment of an employee.

PROTOCOLS FOR DEALING WITH THE EDUCATIONAL NEEDS OF POORLY PERFORMING DOCTORS AND DENTISTS IN TRAINING

All medical and dental staff trainees must have a continuous career portfolio which is retained by the trainee and which will hold all documented evidence of the trainee's educational and clinical performance and his/her achievements

Trainees will therefore have, within the portfolio, a permanent record of their achievements or otherwise and the standards that they have yet to reach for each of the previous segments of their training, signed by both the Education Supervisor and the trainee. It will be the trainee's responsibility to present this portfolio to his/her next Education Supervisor. Each Educational Supervisor will retain a copy of this.

Where the trainee fails to meet the expected standard of education and/or clinical competence, the Educational Supervisor will draw up an appropriate written programme of targeted training to address this. This will be recorded in the trainee's portfolio with a copy retained by the Educational Supervisor.

It should be a condition of employment that the trainee must present the complete portfolio to the Educational Supervisor. His/her employment will otherwise be deferred until this has taken place.

At the start of a new post the Educational Supervisor should meet the trainee to determine his or her training objectives, building on what the trainee has already achieved. A meeting between the educational supervisor and the trainee will be required on at least three occasions in each six-month segment of training. Two of these meetings should be in the form of an appraisal interview and one meeting should be a formal assessment. The record of each of these meetings will be entered into the portfolio with a copy retained by the Education Supervisor.

In each hospital site there should be a designated senior clinician who will act as a Trainees' Mentor (see also Annex D). The Mentor will liaise with the trainee's Educational Supervisor as and when the trainee considers this to be necessary. Advocacy on behalf of the trainee is necessary to give the trainee independent and appropriate support from an experienced senior clinician throughout any dispute, which may arise between the trainee and his/her Educational Supervisor.

Postgraduate Deans should have a copy of all completed assessment forms held by the Educational Supervisor. Any reports and/or assessments expressing concerns about the trainee should be drawn to the attention of the Dean. Trainees are deemed to have given their consent to these procedures by accepting the place on the training programme.

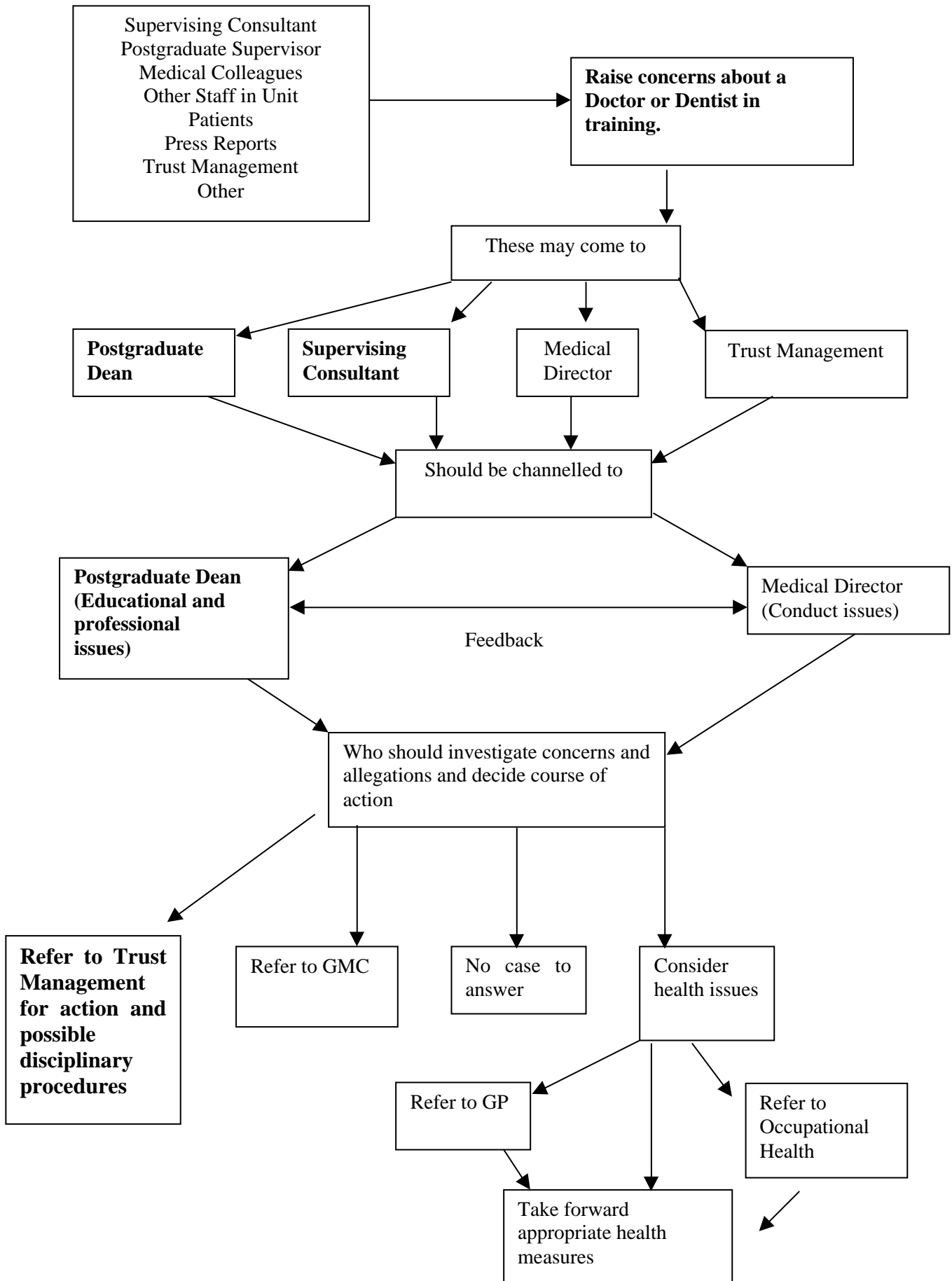
All trainees who are the subject of an adverse assessment by their Educational Supervisor should have the right of appeal to a panel involving the Postgraduate Dean or his/her nominee. Trainees whose programme of training is being

terminated prematurely should have the right of appeal to an independent review panel set up by the Postgraduate Dean. Details for Specialist Registrars are contained in the “Orange Guide” (A Guide to Specialist Registrar Training, February 1998 – section 13). Where SHOs are involved, the same principles should apply.

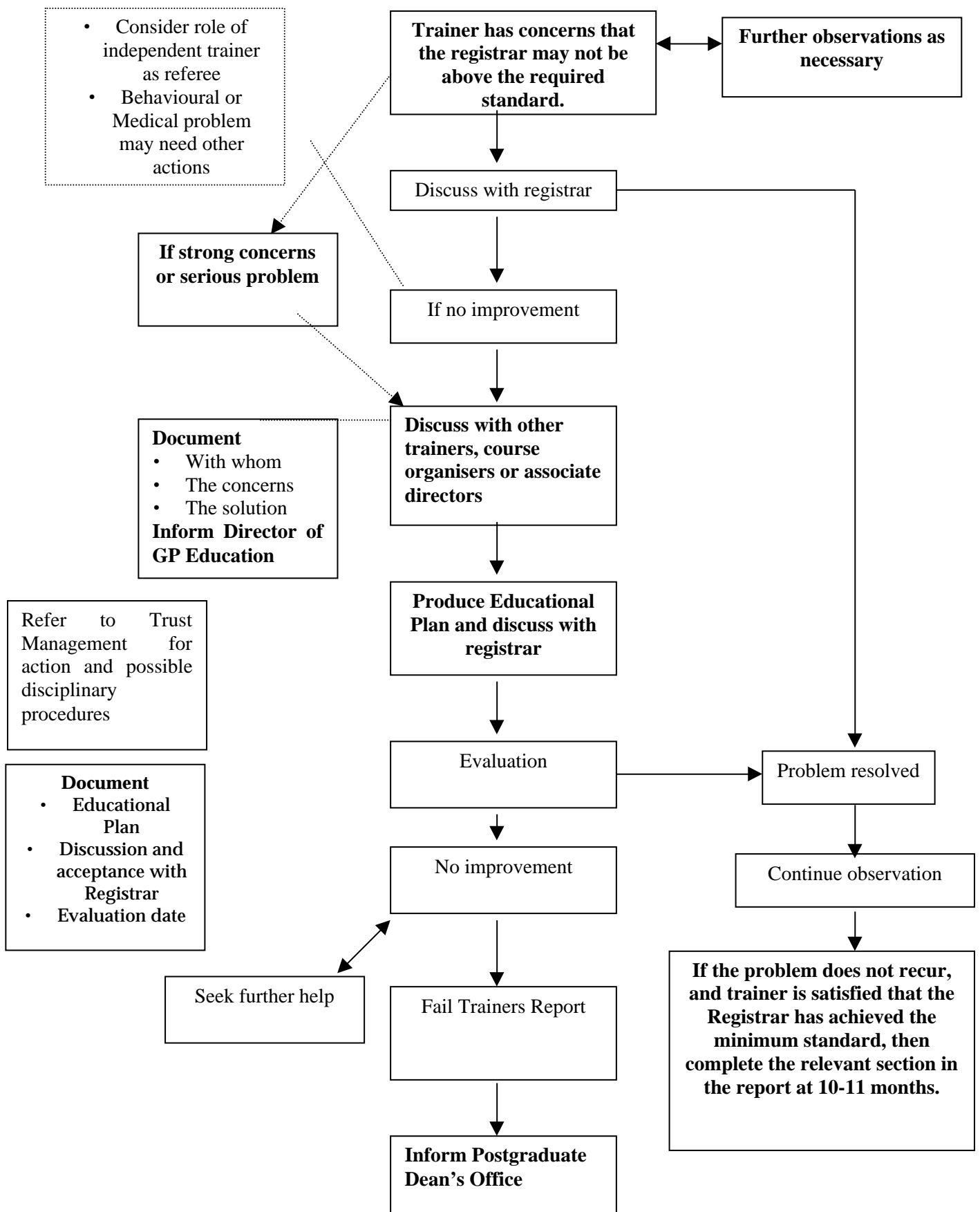
There should be an obligation on all NHS employers to free up medical or dental consultant time to support the above processes. Such dedicated time should be incorporated into all consultant job plans.

All protocols connected with the education and assessment of trainees shall be consistent with NHS equal opportunities policies, anti-discrimination legislation and the statutory rights of trainees as contained in the relevant legislation, i.e. the Employment Rights Act 1996, the Disability Discrimination Act 1996, the Race Relation Act 1976 and the Sex Discrimination Act 1975.

FLOW CHART FOR DEALING WITH CONCERNS ABOUT A DOCTOR OR DENTIST IN TRAINING



FLOW CHART FOR DEALING WITH CONCERNS ABOUT A GP REGISTRAR



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