NHS Resolution

Professional Support and Remediation (PSR) service

Description of terms used in our action plans

1. Introduction

This document describes the terms and activities most commonly included in PSR action plans. This is to help to ensure that their meaning and what is required in the action plan are clear to both the employing/contracting organisation (the healthcare organisation) and the practitioner. The document also explains the roles of those involved in overseeing the programme and their main responsibilities. The definitions and descriptions are those of Practitioner Performance Advice and are specific to our action plans.

NOTE: Patient safety and public protection must be of paramount concern for all those involved in the preparation, implementation, oversight and completion of action plans.

2. Description of roles and responsibilities

Programme manager

The programme manager has overall responsibility for the programme set out in the action plan. The programme manager retains oversight of the plan throughout its duration and is responsible for ensuring that patient safety is protected.

The person assigned to the role of programme manager needs to have sufficient seniority and authority to make decisions about the action plan and the practitioner's progress, for example:

- In secondary care, the programme manager might be the Medical Director or Responsible Officer for the organisation, alternatively a Clinical Director or a person of equivalent seniority.

- In primary care, an identified programme manager for performance may coordinate the programme but responsibility for deciding whether progress has been made and outcomes achieved might rest elsewhere, such as with a Performance Advisory Group (PAG) or Performers List Decision Panel (PLDP).

The programme manager or PAG/PLDP receives reports about the practitioner's progress at set points in the action plan and assesses whether the practitioner has reached the standard expected to enable them to move to the next stage. The rationale for any decision made by the programme manager or PAG/PLDP in this regard should be explained to the practitioner and be clearly documented.

On completion of the action plan, the programme manager or PAG/PLDP makes the decision as to whether the practitioner has demonstrated satisfactory progress and whether they are practising at the level expected in a sustained and consistent way. The level should be that reasonably expected of a clinician in the same specialty at the equivalent grade in a similar role.

Where the remediation or return to work/reskilling programme is taking place at a location outside the healthcare organisation, e.g. with a different employer, the programme manager or PAG/PLDP fulfils this role through effective partnership with the host, usually underpinned by a clear written agreement between the parties.

To support the delivery of the action plan, the programme manager appoints or agrees the appointment of named individuals to the roles described below, based on the case circumstances and what is contained in the plan. It is the responsibility of the programme manager to ensure that these individuals understand their role and responsibilities in relation to the plan.

Clinical supervisor

The clinical supervisor should be an experienced clinician in the same specialty as the practitioner, usually at a senior level such as a consultant in secondary care or an experienced GP trainer for primary care medical practitioners. More than one clinical supervisor can be appointed if needed. The responsibilities of the clinical supervisor include ensuring safe practice, observing performance, providing feedback and monitoring progress against each objective. It is expected that the clinical supervisor is available to the practitioner to provide advice on clinical matters and to support their skills development.

It is for the programme manager to agree with the clinical supervisor which activities carried out by the practitioner should be supervised. (See section below on supervision for more details on the clinical supervisor's expected input.) The clinical supervisor meets with the practitioner in accordance with the level of supervision required, as set out in the action plan.

At each review point identified within the action plan, and on completion of the programme, the clinical supervisor reviews evidence of progress and provides a written report to the programme manager. (A progress review template is supplied with the action plan or is available for download from our website.)

The clinical supervisor's report provides a summary of the work experiences and areas of clinical practice completed by the practitioner, along with the level(s) of supervision received.

The clinical supervisor makes judgements about the standards reached and the improvements/progress made against each of the objectives, with a clear rationale and reference to the information on which the judgements are based (e.g. observation of X cases completed under direct supervision, Y WPBAs and a reflective report).

The report may include information supplied by the practitioner and others involved in the plan, such as feedback from an educational supervisor or confirmation that meetings with a coach and/or mentor have taken place. The clinical supervisor's reports are appended to the action plan.

Educational supervisor

Where the action plan relates to a practitioner who is a trainee, or has a particular focus on the development of knowledge and skills, an educational supervisor may be required.

An educational supervisor is a trainer who is selected and appropriately trained to be responsible for the overall supervision and management of the practitioner's educational progress during the plan. An educational supervisor may assist in making sure that the standards and training suggested within a plan are suitable for the role that the practitioner is expected to fulfil. They may also identify relevant educational activities or courses that would assist the practitioner in their completion of a plan. It is expected that an educational supervisor understands the principles of learning and professional development, the application of standards, workplace based assessments and progress review.

An educational supervisor may be sourced by the healthcare organisation from a Local Education and Training Board or relevant Royal College.

Coach

A coach may be required to help the practitioner reflect, develop self-awareness, learn from mistakes, set goals for change and practise improvements against these goals. (See section on coaching and mentoring below.)

Mentor

A mentor might be regarded as a 'challenging friend' for the practitioner. The mentor may advise on practical strategies to improve performance, or share knowledge and experience in the relevant area particularly if difficulties arise. Meetings with a mentor should be **separate to any supervision and coaching** and the discussions should be confidential as far as is practicably possible within the legal frameworks and with due regard to patient safety. (For more information see section on coaching and mentoring below.)

Assessor

Many of the activities included in an action plan require the input of an assessor. In these cases, the assessor usually observes the practitioner and provides feedback. It is essential that the assessor provides detailed and constructive feedback (both verbal and written) on strengths and areas for improvement, and that the practitioner has the opportunity to ask questions. An assessor may be the clinical supervisor or peers who are trained to assess clinicians.

The use of multiple assessors throughout the duration of the action plan enhances the validity and reliability of the process.

3. Description of activities

Action plans can include a number of different types of activities, depending on the circumstances of the case. Each activity generates information about the practitioner's performance in certain areas. While each piece of information is helpful in informing judgements, it is important that information is gathered from all the activities in the plan and that this is reviewed as a whole. This is to ensure that the outcomes of all activities in the action plan are considered when making judgements and that the practitioner's progress is assessed in the round.

Please note that in cases where a professional regulator has placed conditions or undertakings on the practitioner, we will take account of these in our action plans. For example, where General Medical Council (GMC) conditions or undertakings are present that include supervision, we will ensure that the supervisory arrangements in the action plan fit with the descriptions of supervision used by the GMC. The regulator's conditions or undertakings must always be adhered to by the practitioner.

The type of activities that may be included in an action plan are included below, along with a description of their purpose and what they entail.

Supervision

A **clinical supervisor's** role is to ensure safe practice, to monitor progress against milestones and report this to the programme manager. The monitoring role cannot be over-emphasised. Regular contact with the practitioner ensures timely, robust and reliable feedback can be reported throughout the programme. This will allow early intervention if problems arise.

Remediation or return to work/reskilling programmes describe the level of clinical supervision appropriate for the practitioner based on their individual circumstances, and generally operate on the principle that the degree of supervision can be reduced as the practitioner demonstrates appropriate progress at review points. There are usually different supervision levels contained in action plans drafted by us, as described below:

- **Direct supervision:** Activities carried out by the practitioner involving direct contact with patients should be observed by the clinical supervisor (or a named deputy) to ensure patient safety and public protection. For other activities not involving direct patient contact, the clinical supervisor (or a named deputy) should be present (e.g. same ward or within the practice) to provide support and feedback, as required. For medical practitioners the GMC's description of directly supervised would most closely fit with our description of direct supervision.

- **Indirect supervision:** The clinical supervisor should oversee all activities carried out by the practitioner involving direct contact with patients and directly observe a selection of those activities, to ensure patient safety. This means they do not have to observe every activity but they should be available to

provide support and advice, if required. A selection of activities not involving patient contact should also be observed regularly so that feedback and support can be provided where needed, but not necessarily in every instance. For medical practitioners the GMC's description of close supervision would most closely fit with our description of indirect supervision.

- **Ad-hoc supervision:** The clinical supervisor should observe and provide feedback on activities on an ad-hoc basis, meaning that this can be at the request of the practitioner, to provide guidance and feedback, or at the discretion of the supervisor. The clinical supervisor should be available to provide support and advice, if required but is not required to be on site with the practitioner at all at all times. The GMC's description of supervised would most closely fit with our description of ad-hoc supervision.

NOTE: The full text of the GMC's Glossary for undertakings and conditions is available via this link: https://www.gmc-uk.org/-/media/documents/DC4327_Glossary_of_Terms_used_in_Fitness_to_Practise_Actions_25416199.pdf

Reflective practice

Reflective practice is the application of the skill of reflection with the intention of improving professional practice, usually in the following ways:

- self-assessment of practice/performance in a given situation to identify areas for development and improvement
- looking for learning points within a scenario or situation through reflection and consideration of how the learning might be applied in other situations to enhance performance
- identifying learning/development needs, e.g. as part of the appraisal/personal development plan/revalidation cycle, and planning to address these to improve practice.

A reflective learning log of personal development is a structured way of capturing/evidencing learning, progress against objectives, clinical/behavioural skills and knowledge development. A reflective learning log does not need to include full details of an experience, rather it should be a record of what has been learned, tried and critically reflected upon, as well as showing how the practitioner intends to or already has changed their practice in response. The learning log builds up over the course of the action plan and should be shared with the clinical supervisor at interim and final review points.

NOTE: In line with current guidance, all details of those involved in a reflective event – including patients, their relatives, and colleagues – must be fully anonymised. In addition, precise locations, dates and times should not be specified. See the full Reflective Practice Toolkit for further information: http://www.aomrc.org.uk/wp-content/uploads/2018/08/Reflective_Practice_Toolkit_AoMRC_CoPMED_0818.pdf

4. Professional Activities

- **Continuing Professional Development (CPD)**

CPD is any learning outside of undergraduate education or postgraduate training that helps practitioners maintain and improve their performance. It covers the development of their knowledge, skills, attitudes and behaviours across all areas of their professional practice. It includes both formal and informal learning activities. The purpose of CPD is to help improve the safety and quality of care provided for patients and the public.

Medical practitioners: Continuing professional development - GMC (gmc-uk.org)

Within action plans, CPD may refer to a single activity, course or development action required to support the achievement of the overall aim of the action plan, or the objectives within a plan.

- **Quality Improvement Process (QIP) also described as audit.**

The completion of a quality improvement process (described in some specialties as audit) requires the practitioner to show evidence of their understanding of, and participation in, audit or service improvement activity. A quality improvement process seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.

Within action plans, the parameters of an audit are generally agreed between the practitioner and a clinical supervisor, with the practitioner leading the audit, gathering data and presenting its outcomes, conclusions and resulting plans for change and/or improvement.

5. Workplace based assessments (WPBA)

WPBAs are recommended based on the particular aspects of practice which require feedback, e.g. Case-based Discussion to target knowledge, clinical decision making and clinical management, and Mini Clinical Evaluation Exercise for overall performance within patient encounters.

The number and frequency of WPBAs depend on the nature and significance of the performance concern(s) or length of time away from practice for return to work or reskilling programmes, together with the needs of the practitioner in terms of feedback. WBPAs are also recommended to inform decisions on progress at review points within the programme.

We recommend WPBAs that have been demonstrated as being robust within the healthcare context, and when we select tools we draw upon the work and evidence of the Royal Colleges and the Academy of Medical Royal College.

A description of the most commonly used WPBAs within remediation and return to work/reskilling plans is provided below: further guidance on their effective implementation can be provided by one of our Assessment and Remediation Advisers upon request. Please note that this list is not exhaustive and other tools will be used when appropriate.

- **Scenario-based Discussion (SbD)**

SbD is a formative process and is used to address gaps in knowledge and skills. For example, the practitioner discusses a hypothetical clinical scenario with their clinical supervisor in order to understand the appropriate or expected management of the case. This may be particularly useful in the early stages of remediation or return to work/reskilling plans, or for the discussion of particularly complex or rare case scenarios.

- **Mini Clinical Evaluation Exercise (Mini-CEX)**

Mini-CEX is an established tool which involves the assessor observing the practitioner during a patient encounter, and providing ratings. Judgements of 'Unsatisfactory', 'Satisfactory' or 'Superior' are made about a range of skills, such as examination and diagnosis, technical skills, clinical decision making, communication skills, professionalism, and organisation.

- **Directly Observed Procedural Skills (DOPS)**

DOPS is a tool which focuses primarily on the assessment of a specific clinical procedure. Standardised checklist forms are used by the assessor, following observation of the practitioner completing the procedure to identify areas of good performance and aspects which may need further improvement.

- **Procedure Based Assessment (PBA)**

PBA is a generic assessment tool that is used across all surgical specialties. A PBA aims to measure a surgeon's ability to perform all aspects of a surgical procedure by direct observation in the workplace. A PBA encompasses six areas of competency: consent, preoperative planning, preoperative preparation, exposure and closure, intraoperative technique and postoperative management. A global summary is given which quantifies the practitioner's ability to perform the procedure independently. PBAs are expected to produce clear information for both the supervisor and practitioner about the current level of competence and areas on which to focus in terms of development.

- **Objective Structured Assessment of Technical Skills (OSATS)**

OSATS is another WPBA tool which records judgements on the practitioner's performance with regard to a particular technical skill (including non-technical components such as communication with staff/patients). Although the approach used is similar to Mini-CEX and DOPs, OSATS may be preferred in some specialties

when they are recommended by the relevant Royal Colleges e.g. Royal College of Obstetricians & Gynaecologists and the Royal College of Ophthalmologists.

- **Case-based Discussion (CbD)**

CbD is a tool to assess the knowledge, clinical decision making and clinical management of the practitioner following their presentation of a case and subsequent questioning by the assessor. Although judgements on the standard of performance are recorded, CbD should involve the provision of detailed, structured feedback to the practitioner on their strengths and areas needing improvement.

- **Case-Based Assessment (CBA)**

CBA is a similar approach to CbD in that the practitioner's knowledge, clinical decision making and management of a case are assessed through questions targeting a specific case. However, these questions are derived directly from case information, such as patient records, rather than the practitioner's presentation of a case.

- **Colleague Multi-Source Feedback (MSF)**

MSF is useful in obtaining the views of a range of clinical and non-clinical team members regarding the performance of the practitioner over a period of time. The strength of this tool lies in the qualitative feedback (comments provided by participants) and the practitioner's reflection on this information.

Care should be taken when implementing MSF to maintain the anonymity of participants when providing feedback to the practitioner, and feedback should be obtained from an appropriate number of raters (dependent on the tool used) if using the results to inform decision making about the practitioner's progress. Practitioners should rate themselves in each of the areas within the tool, and reflect upon any differences between their own self-ratings and those of other team members in order to gain insight and develop strategies for improvement.

The use of a coach alongside MSF can be helpful in delivering the feedback to the practitioner, to discuss the comments/ratings of colleagues and to aid reflection.

- **Patient feedback**

Patient feedback (often in the form of a Patient Satisfaction Questionnaire) is used to obtain the views of patients on the performance of the practitioner with regard to non-clinical skills, such as communication and professionalism. Although useful, particularly any free text comments provided by the patient, the ratings are prone to positive bias, and many responses are required (25-30+) to achieve a reliable result. This tool is best used qualitatively, alongside any other information about the practitioner, such as complaints and compliments, and provides information to aid the practitioner's self-reflection.

- **Other WPBAs**

Although some of the above WPBAs may include the assessment of non-clinical skills, such as communication, teamwork and management/leadership skills, other tools exist which focus on these areas alone. Such tools may be included in the action plan and, in these cases, a description of the recommended activity will be provided within the plan.

There is also a range of other WPBAs specific to certain clinical specialties and used by Royal Colleges in their training programmes which may be referred to in the action plans that we draft but are not described in this document. A description of these additional WPBA will be included in our action plans when used.

6. Coaching and mentoring

In the context of professional development of healthcare professionals, and for the purpose of action plans, the following descriptions of coaching and mentoring are used.

Coaching

Coaching is a process which is forward-focused and led by the development needs of the practitioner. For PSR purposes, the practitioners needs are usually identified either by the practitioner themselves or, through an assessment or investigation report.

Coaching in a PSR context is separate to clinical supervision or clinical coaching. It does not involve observing or providing direct feedback on clinical activity (i.e. surgical and technical skills or assessment of patient's condition etc.) and a coach is also different to a mentor.

A coach's aim would be to develop specific non-clinical skills such as, leadership, active listening, communication or teamworking skills or those related to insight, motivation and self-awareness, to support the practitioner's achievement of the objectives within the action plan. A coach would guide a practitioner to develop practical strategies for dealing with situations arising in the workplace, that they can use as part of an action plan and continue to use once the action plan is complete.

The coach and practitioner would usually meet outside the clinical environment at regular intervals over a defined period of time, to develop the practitioner's behaviours.

A coach uses a range of skills, including listening, questioning, relating learning to the practitioner's experience and challenging to promote personal development, balance and effectiveness. Effective coaching can assist the practitioner in changing behaviours and improving their ability to deal with day to day, as well as more challenging situations with a resulting increase in productivity, job satisfaction and feelings of wellbeing. Good coaching can also support improved communication skills, leadership and management and enhance team function.

Coaching is more than feedback. While feedback provides information about what was observed compared to an expected standard, coaching moves beyond feedback to provide actionable suggestions for improvement with the aim of enhancing performance in a specific area.

Coaching is a conversation where someone feels heard and gains new insight into their own work that will make a difference. This means that it is useful in all kinds of work conversations as well as formal coaching. It's all about working simply and empowering someone else to think.

The coach should have suitable training and a clear understanding of the skills or behaviours in question, and how these might be developed. Their role is to support the practitioner to improve their performance through reflection and building strategies for change/improvement which address such issues as insight, motivation, self-awareness, cognition and behaviour. Depending on the requirements of the practitioner, the coach may specialise in certain areas (e.g. leadership) or provide overarching support for the development of insight and self-directed learning.

The practitioner is expected to engage with the coach to expand their awareness and understanding of situations they face, explore options and shift their behaviour in ways that produce positive results. Where coaching is suggested as an intervention within PSR action plans, initial areas for focus will usually be included in the action plan (i.e. leadership, managing stress, communication skills etc.). After the initial sessions the practitioner is expected to identify areas of their behaviours they would like to change or, work experiences that they would like to explore with the coach, with a view to improving their effectiveness through the development of relevant strategies and new behaviours that can be deployed in the workplace.

Coaching is largely a confidential process, although progress reports should be made available to the clinical supervisor and/or programme manager.

The coach might have a clinical background or be a non-clinician with relevant training and experience in the healthcare context and in dealing with senior practitioners. The coach must have had training and experience in coaching techniques, ideally with suitable accreditation. There are different types of coach available and it is important that the person appointed to the role has the right skills and experience to meet the development needs of the practitioner.

Mentor

A mentor provides personal confidential support for a practitioner, in a safe environment outside the line management system.

Mentoring is a developmental process where the mentor offers guidance and help with developing reflective skills, alternative ways to deal with difficulties and to provide challenge to the practitioner in a safe environment. The mentor's role might be described as that of a "challenging friend", providing an environment where the

practitioner can test out options and opportunities outside the clinical situation and explore the best approach to be applied in the workplace.

The mentor should be someone whose views and feedback are likely to be respected by the practitioner (the mentee).

Mentoring is separate from clinical supervision and coaching. It has no formal input to a performance management structure, appraisal or revalidation process. However, for the purposes of PSR action plans it is expected that the practitioner and mentor would confirm to a programme manager at intervals that meetings and other contact arrangements have been maintained and that discussions are professional and productive. The actual topics and conversations between mentor and mentee are confidential and a matter for them only, taking account of legal and regulatory requirements and with due regard to patient safety.

The mentor need not be from the same specialty or healthcare organisation as the practitioner (although they often will be). They should be suitably experienced, have a good understanding of the working environment of the practitioner and have training to fulfil the role. In relation to action plans, it is important that the mentor is acceptable to both the practitioner and healthcare organisation.

The agenda for meetings is generally set by the practitioner, who should note issues arising in the workplace so that they can be explored with the mentor on a regular basis.

The mentor should be available to provide relevant support within an agreed framework, including meeting at scheduled intervals as described in a PSR action plan. Where there is no separate action plan, a formal schedule of meetings/contact should be recorded at the outset of a mentoring arrangement and an agreement covering the scope of relationship between mentor and mentee should be included and signed by both parties. This might include arrangements for ad-hoc or short-notice contact in response to unforeseen situations arising, should the practitioner need support outside of scheduled meetings.

Mentoring arrangements may take place over an extended period. In our experience practitioners undertaking action plans have found access to a mentor to be a valuable support. As a result, the practitioner and mentor may choose to continue their arrangement as an ongoing career support, beyond the point where the action plan has concluded.