

Working safely within role and resources

Scope competence and limits

A request to take responsibility can arrive before anyone has described what that responsibility requires. A ward needs cover, a clinic has expanded, or a service has begun accepting patients whose needs differ from its original purpose. The request may sound reasonable because the doctor has managed difficult situations before. Experience is relevant, but it does not answer whether the proposed work can be done safely in the circumstances now present. The decision concerns the combination of the person, the task and the setting.

Good medical practice requires doctors to recognise the limits of their competence. Its emergency duty is also qualified by the doctor's safety, capability and the availability of other care. These requirements belong together: a doctor must offer help appropriate to those circumstances while recognising when additional expertise or a different setting is needed. The requirement to help does not establish competence for every intervention that the emergency might require.^[3]

Consider three questions separately. Have I learned to do this work? Have I maintained the relevant capability? Can I exercise that capability with the resources available here? A doctor may answer the first two confidently while identifying a serious difficulty with the third. An experienced proceduralist may lack suitable monitoring or assistance. A senior generalist may recognise a condition requiring treatment that the service cannot provide. Neither situation is adequately described by asking whether the individual is a sufficiently senior doctor.

Scope is also more precise than a specialty label. It includes the patient population, complexity, interventions, degree of independence and circumstances in which advice is needed. Write a short scope statement before accepting a materially different duty. For example: the doctor undertakes independent assessment of the agreed patient group, uses specified investigations, and accesses named specialist advice for defined problems. Then describe what would require direct review elsewhere. Such a statement should allow another clinician to understand the arrangement without knowing the doctor's reputation.

The recurring case in this chapter is a composite teaching example. Dr Elena Morris is a Specialist working in an English community service designed for planned recovery care. A revised referral process begins bringing patients who need more frequent medical reassessment and urgent investigations. Elena has substantial relevant experience, but the service's staffing, diagnostic access and escalation arrangements have not been redesigned. The case does not describe the author, any real employer or identifiable patients.

Elena first distinguishes a development need from an organisational gap. She can identify deterioration and initiate measures within her competence. She cannot create an unavailable diagnostic service by accepting more responsibility. If unfamiliar treatment is proposed, she may also need supervised learning and an assessment of readiness. Those are separate problems with separate solutions. Training is useful when capability is missing; it is not a substitute for equipment, timely advice or an agreed receiving pathway.

A return after extended leave provides another example. A doctor may retain deep knowledge while needing supervised reorientation to a changed system or procedure. A sensible plan names the work to be resumed, the support available, the evidence of readiness and a review point. It avoids a binary choice between immediate full independence and permanent restriction. A limitation that can be addressed should lead to a development arrangement, not an unsupported assumption about the doctor's future career.

There are also occasions when uncertainty becomes apparent after work has started. The useful response is to describe the uncertainty promptly and ask for the necessary help. Earlier acceptance does not prevent reassessment. Explain what has changed: new information, unexpected complexity, absent support or an emerging personal limitation. Colleagues can then contribute to a decision based on the current position. Concealing the change to preserve an impression of confidence makes it harder for the team to adapt.

The scope check therefore has five fields: the duty; relevant current capability; required support; the boundary for additional help; and the person who can agree the arrangement. Complete it for a proposed change, not for every routine consultation. Where an important field remains unanswered, make that the subject of the discussion. The purpose is to turn a vague concern about being comfortable with the work into an explicit account of what safe practice requires. Keep the agreed version with the role documents so that later expansion is visible.

Invite a relevant peer to test the proposed boundary against realistic cases. They may identify an assumption the doctor has missed or confirm that the concern is well founded. Record the resulting clarification, including any development activity, rather than collecting reassurance alone.

Responsibility without resources

Resources include much more than the number of doctors on a rota. A clinical decision may depend on observations taken reliably, access to the previous record, equipment that functions, an interpretable investigation and somebody able to act on its result. Time and authority are resources too. A doctor can have the knowledge to identify the right next step while lacking the authority to change admissions, redirect work or obtain additional cover. Asking that doctor to be responsible does not itself supply any of these missing elements.

The GMC's leadership guidance expects doctors to use resources fairly and effectively, with responsibilities proportionate to their roles. Those who allocate resources have additional obligations to understand the management arrangements and account for patient safety in their decisions. A management role does not remove professional accountability. These principles support a practical distinction between using what is available and deciding what a service must provide.^[47]

In Elena's service, the first resource map follows one patient journey. A referral arrives, information is reviewed, acceptance is decided, the patient travels, observations are taken, medical assessment occurs and an investigation may be needed. For each step, the team names the person, information and facility required. It then repeats the exercise outside ordinary daytime arrangements. The second map exposes dependencies that the first concealed: a laboratory collection schedule, access to previous results and uncertainty about who can authorise urgent transfer.

This exercise is more useful than an isolated assertion that the service needs more senior cover. The missing capability may be timely physical assessment rather than telephone advice. A clinician available remotely may help interpret information but cannot perform an examination through a telephone call. Conversely, an additional doctor on site may not resolve a diagnostic bottleneck. Specify the function before proposing the post. That allows staffing, diagnostic, nursing and operational options to be compared against the same clinical requirement.

Availability needs a practical definition. A number on a contact list proves that a route has been written down; it does not establish that the

intended person is rostered, reachable or able to attend. Ask how competing calls are handled, who acts if the first contact does not respond and how the team obtains help during predictable absence. Test arrangements using a discussion exercise with the people who will operate them. Discovering an unanswered question during preparation is considerably easier to manage than discovering it during deterioration.

Capacity is similarly different from headcount. Two clinicians may have overlapping clinics, supervisory responsibilities and travel. Their names on the same weekly schedule do not make both available for an unexpected assessment. Map the intervals in which a particular function can be delivered, then identify foreseeable collisions. A job plan should make such demands visible, but an unresolved job-plan question does not suspend the need for an interim clinical arrangement. The contractual and operational discussions need to proceed alongside each other.

Information access deserves its own test. Can the receiving team see the referral, recent changes, medication history, pending investigations and the reasoning behind the proposed transfer? A technically accessible record may still be incomplete or difficult to navigate. Ask a colleague unfamiliar with the patient to locate the material needed for the next decision. The exercise assesses the actual information pathway, rather than whether an organisation can truthfully say that it has an electronic record.

Equipment needs an equally practical assessment. Its presence does not establish that somebody can use it, consumables are available or maintenance is current. Ask what happens when it fails and whether staff know the alternative. A service accepting work dependent on that equipment needs a workable contingency, not merely an entry in an inventory or procurement plan.

Decision rights should be written in ordinary language. Who can change the proposed destination? Who can request another assessment before transfer? Who can suspend a particular pathway while a serious defect is corrected? Who resolves disagreement between services? The answer may involve several professionals and an operational manager. It should not depend on finding the most persuasive person on duty. When authority is divided, record the shared decision process and the route for urgent unresolved differences.

A scope and resource safety check can be kept to one page. Its first column describes the work being promised to patients. The second records the capability and resources needed. The third states what is actually available, including important differences by time of day. The fourth identifies the gap, its possible effect and the interim arrangement. A final

column names the decision owner and review date. Avoid a single green tick for a service whose essential components have not been examined individually.

The check should also recognise what works. Reliable nursing observation, established referral relationships or rapid access to advice may provide valuable protection. Recording these strengths helps distinguish a wholly unsuitable model from a viable model needing specific changes. It also prevents a risk discussion becoming a competition between professional groups. The central question is whether the combined arrangements support the patients being accepted, including predictable variation and absence. Responsibility becomes more workable when its supporting conditions can be described and tested.

Immediate clinical action

When a patient is deteriorating, the first task is the clinical response. A disagreement about staffing, payment or service design can be important without being the immediate priority. Establish the patient's current needs, provide help within competence, obtain appropriate assistance and arrange escalation according to the situation. A risk email sent yesterday does not manage today's deterioration. Equally, a successful response today does not settle whether the underlying service arrangement is sustainable.

Elena is asked to review a newly arrived patient whose condition has changed during transfer. She obtains the information needed for assessment, asks the team to activate the relevant local escalation route and contacts the service capable of providing the additional care required. The example deliberately contains no treatment algorithm: the clinical response depends on the patient and current clinical guidance. The organisational lesson is that immediate care and the record of the pathway problem have different purposes and both need attention.

A brief spoken escalation should make the required decision clear. Identify the patient through the approved clinical channel, explain the change, state what has been done, describe the limitation and ask for a specific response. For example, an urgent physical review may be needed because remote advice cannot resolve the present uncertainty. Agree what happens while help is arranged and who will review progress. A conversation that ends with somebody being aware of the situation may still leave the necessary action unallocated.

If the usual contact cannot respond, use the next appropriate route with urgency proportionate to the clinical risk. Repeating the same unanswered call without reconsidering the plan can consume the available time. Record

the attempts, but do not confuse a list of attempts with a completed escalation. The person receiving the concern needs enough information to understand why a different response is now required. The local escalation policy should help identify the route; clinical judgement remains necessary when events do not follow its expected sequence.

Where two patients need attention simultaneously, make the conflict visible. Describe the competing needs to the relevant senior or operational colleague and seek additional cover or redistribution. Do not silently promise incompatible response times. Prioritisation should follow clinical need, with an explicit plan for the patient whose assessment must wait. The GMC places clinical need at the centre of decisions within the doctor's control and requires action where inadequate systems seriously compromise safety or dignity.^[3]

The clinical record should allow the next professional to continue care. Describe findings, relevant uncertainty, the decisions made, communication with the patient or those appropriately involved, the agreed actions and arrangements for review. The separate escalation record can capture the operational contacts and service limitation without turning the patient's notes into a dispute about colleagues. Both records should be factual. Identify an inference as an inference; do not record an assumed refusal when the other person actually described a different proposed plan.

An operational entry might read: the required investigation was unavailable within the necessary clinical timeframe; the receiving clinician and duty manager were contacted; an alternative assessment route was agreed; the team responsible for observation while awaiting transfer was identified. This wording explains the problem and response. It is more useful than saying that the organisation accepts all risk. A declaration cannot transfer every professional obligation, and it gives the next clinician little help with the patient's immediate needs.

Handover is part of the response, especially when the doctor must leave for another emergency or the shift ends. State what remains unresolved, what result is awaited, who will receive it and what change requires further escalation. Confirm that the receiving colleague understands the task rather than relying entirely on a sent message. Where a handover cannot be completed, seek help to establish a safe arrangement. Merely placing an item on a list does not demonstrate that somebody is able to act on it.

Pending investigations illustrate the importance of closing the loop. If a patient moves, the result may still arrive in the original service. Identify who will review it and how relevant information will reach the receiving team. If the expected result does not arrive, agree who will check its status. A

completed transfer can otherwise conceal an unfinished clinical task, particularly when each team reasonably expects the other to receive an automated notification.

After the immediate episode, complete the relevant incident report and any additional clinical communication required by the facts. Do not rewrite the original record to make the sequence look more orderly. If a later factual correction or additional entry is needed, identify it transparently through the approved system. The useful chronology includes uncertainty and imperfect information because those were part of the decision. It should show what was known at the time, what action followed and what became apparent afterwards.

Recurring system risk

A single difficult episode may reflect an unusual combination of events. Several apparently different episodes may reveal the same underlying dependency. The task is to distinguish these possibilities without waiting for preventable harm. Start with a precise description of the recurring feature. In Elena's case, the issue is not simply that patients are more complex. It is that the revised admission pathway repeatedly creates a need for urgent reassessment and investigation that the receiving service has not been organised to meet.

Choose a small, useful set of observations. These might include referrals requiring clarification, missing clinical information, delayed access to a necessary review and unplanned transfers associated with unavailable facilities. Define each measure so that colleagues count the same event in the same way. Include the period reviewed and the number of relevant patients or referrals. Five delayed reviews among ten cases and five among a thousand describe different frequencies, although either may include a serious individual event.

Do not infer causation from a simple count. An unplanned transfer may be appropriate evidence of a functioning escalation pathway rather than failure. Examine the reason, timing and preceding decisions. Similarly, a low incident count can mean few problems, poor reporting or a definition that excludes the concern. Combine incident records with staff accounts, relevant clinical review and operational information. The aim is a defensible description of the pattern, not a statistic impressive enough to end the discussion.

England's Patient Safety Incident Response Framework emphasises learning and improvement through proportionate responses and attention to systems. It does not make a full investigation of every incident the default.

Use the organisation's applicable arrangements to decide the response; the English framework should not be presented as the governing process for the other UK nations. ^[48] The practical implication for the doctor is to provide information that helps the organisation understand how work occurred, including the conditions that shaped it.

For a small review, agree access and handling arrangements before collecting information. Use authorised clinical and governance systems. A personal spreadsheet containing patient identifiers can create a new problem while trying to investigate another. Where a summary does not need identifiable information, use aggregated or properly anonymised material. Keep a reference to the authorised source record so that an appropriate reviewer can examine the case without circulating its details widely. The chapter's tools are structures for thought, not permission to establish a private clinical database.

Then separate the hazard from the possible outcome. A missing escalation contact is a hazard; delayed treatment is a possible consequence. The fact that no injury was documented during the review period does not remove the missing contact. Equally, describing the worst imaginable outcome without explaining the pathway to it can weaken a credible concern. Explain how the gap could produce harm, which patients are exposed and what existing controls interrupt that sequence. Ask whether those controls are dependable or rely on informal personal availability.

A risk register entry should support decisions. It needs a clear description, current controls, gaps, an accountable owner and a plan for review under the organisation's system. The score is only one part of that record. A high score without an action owner may produce anxiety without change; a reduced score unsupported by a changed condition may create false reassurance. Ask what evidence would justify changing the assessment. If a control is an additional clinician, has that clinician actually started and are the necessary hours covered?

In Elena's review, colleagues find that an experienced nurse routinely identifies missing information and telephones the sending service. That work has prevented several problems. It is both a strength and a warning. The formal pathway should provide the information; the service currently depends on one person's vigilance to repair it. Record the repair work rather than treating successful outcomes as proof that the original process is adequate. A resilient arrangement should continue to function when that colleague is absent.

Present the pattern to the governance forum capable of influencing the underlying process. Bring a concise account of the agreed pathway,

observed departures, patient consequences or potential consequences, existing protections and proposed changes. Ask for a recorded decision, responsible person and review date. If another forum must decide, establish who will take the matter there. A discussion becomes operationally useful when there is a route from the evidence to a person able to alter the condition.

Follow-up should test the relevant change rather than count meetings. If the concern was absent review cover, examine whether cover became available when needed. If it was incomplete handover, examine the information received. Keep the original concern and subsequent evidence linked so that the issue is neither repeatedly reopened from memory nor closed simply because time has passed. A persistent risk may need escalation beyond the first forum, but the accumulated record should make that escalation clearer and more focused.

Small numbers require careful interpretation, not inactivity. Explain what the available sample can show and what remains uncertain. An evident missing safeguard can justify a practical correction while further information is collected. Set a proportionate review period instead of waiting indefinitely for a statistically persuasive adverse outcome.

Delegation supervision and team capability

Team capability depends on the match between the task, the person and the support around them. Professional titles provide useful information but cannot answer every question about an individual's current competence. A doctor new to a service may need help with local systems; an experienced nurse or allied professional may hold substantial expertise in a defined area. The practical discussion should describe the work, legal or professional boundaries where relevant, and the supervision needed. It should avoid both automatic deference and automatic dismissal based on title.

The GMC distinguishes delegation, where a colleague provides care on the delegating professional's behalf, from referral, where another professional or service takes over part or all of care. Its guidance makes accountability specific: the doctor remains accountable for the decision, instructions and safety steps, and for overall management when they are the responsible clinician. Appropriate delegation does not make the doctor automatically accountable for every action or omission of the recipient. The recipient also has responsibilities for accepting and carrying out the task safely. ^[7]

That distinction is useful when a rota says that a junior colleague covers a service with senior support. What work is being delegated? Does the junior

doctor have the relevant experience? What supervision is required and how will it be accessed? Is the senior doctor providing advice, attending when necessary or retaining a defined responsibility for the patient group? An arrangement can be described as supervised while leaving these practical matters unresolved. Write them down before relying on the label.

Elena and a colleague rehearse an evening referral. The receiving doctor explains what information they would gather, what they can decide independently and what would prompt a call. Elena describes what she can provide remotely and the circumstances requiring a different response. They discover that the existing document assumes she can attend immediately, although the rota makes no such provision. The exercise identifies a design problem before either clinician has to interpret an ambiguous promise during an urgent episode.

Instructions should include the purpose of the task and the point at which the plan must be reconsidered. Asking somebody to check a result leaves uncertainty about what checking means. Does the person need to confirm that the test occurred, interpret its significance, communicate it or arrange treatment? Allocate those steps deliberately. For important or unfamiliar tasks, ask the colleague to explain the plan in their own words. This tests shared understanding without turning every conversation into a formal assessment.

Document material changes to that allocation where the team can find them. An agreement reached verbally on one shift should not leave the next shift following an obsolete plan.

Supervision also consumes capacity. A senior doctor repeatedly interrupted to advise several colleagues may no longer have the uninterrupted time assumed for another task. Record that pattern when reviewing the job plan and service design. Creating a supervisory role on paper without allocating availability can increase uncertainty for everyone. Consider predictable peaks, absence cover and the supervisor's own clinical commitments. If supervision is essential to safe delivery, its interruption or disappearance needs an alternative arrangement just as any other essential service component does.

The receiving professional needs a usable route to say that the task cannot safely be completed. Encourage early questions and a clear account of the difficulty. Perhaps the patient is more unwell than expected, essential information is missing or the requested action exceeds current capability. Respond to the new information before considering whether the original allocation was appropriate. A team that treats every request for help as a

disappointing performance creates an incentive to conceal uncertainty until the choices become narrower.

Cross-professional work requires particular clarity about responsibility for prescribing, investigation requests, interpretation and follow-up. Do not assume that access to a computer function establishes professional authority or that a local custom changes the relevant regulatory boundary. Where a proposed role redesign alters these tasks, obtain the appropriate professional and governance review. For routine collaboration, the immediate objective remains straightforward: every clinically necessary action should have an identifiable person who understands it, can undertake it and knows where further help is available.

At handover, transfer an actionable plan rather than an undifferentiated list. State the current issue, next task, expected timing, escalation trigger and receiving person. If care is divided between services, make the division understandable to the patient as well as the team. The strongest arrangements allow a competent new colleague to enter the service and discover how responsibility operates without having to decode unwritten relationships.

Service pressure and moral distress

Repeated exposure to care that falls short of what a doctor believes patients need can be deeply unsettling. The distress may include frustration, guilt, anger or a sense of having become complicit in an arrangement the doctor has challenged. The term moral distress can help describe that experience, but it should not become a diagnosis applied casually to colleagues. Ask what the person is experiencing, what situation is producing it and what support they want. The emotional response and the underlying service concern both deserve attention.

Pressure can distort the way a doctor interprets responsibility. After an adverse event, it may feel as though greater personal effort would have prevented every difficulty. A careful review asks what was within the doctor's control, what depended on others and what options were actually available. This is not a search for excuses. It makes learning more accurate. Otherwise the proposed remedy may be an unrealistic promise to work faster, stay later or remain constantly reachable while the missing service provision remains unchanged.

Fatigue requires an operational response as well as personal recognition. HSSIB's investigation of staff fatigue identifies risks to patients and staff and describes weaknesses in how healthcare organisations recognise and manage those risks. It treats fatigue as a system issue requiring attention to

working conditions and organisational arrangements. Its findings concern the English system and do not establish a uniform contractual rule for every UK doctor. ^[49] The relevant question for an individual is what action is needed when fatigue compromises safe work now.

A practical discussion can be specific: the doctor describes the work already undertaken, the difficulty concentrating or functioning, the next scheduled duties and the cover required. Contact the appropriate senior or operational colleague to agree an immediate arrangement and a safe handover. Consider safety after the shift, including travel, rather than assuming the risk ends at the hospital door. Repeated episodes should feed into a review of actual workload, recovery and on-call arrangements, alongside any personal health assessment that is appropriate.

Support has several functions. Occupational health can help assess the relationship between health and work and advise on adjustments. The doctor's own treating clinician addresses personal healthcare needs. A trusted colleague or mentor can help examine a difficult experience, and professional support services may provide additional assistance. A trade union adviser addresses employment questions; a medical defence organisation can advise on professional obligations and medicolegal concerns. Choosing the right function helps avoid expecting one conversation to solve every part of the problem.

Elena recognises that she has begun checking messages on days away from the service because she worries that nobody else will notice a problem. The habit is understandable, but it masks the absence of a dependable cover arrangement. She records the tasks that prompted contact and asks the service to establish a rota-based route. She also discusses the effect on her wellbeing with an appropriate professional. The objective is a system in which her absence is planned, not an assurance that she will remain available indefinitely.

A colleague may disagree about how serious the problem is. Treat that as information to examine rather than evidence of indifference. They may see a different part of the work or have access to support others do not. Compare the actual circumstances and the standard being applied. Conversely, repeated reassurance that everyone is under pressure does not answer a documented resource gap. Return to the concrete condition, the possible effect and the change needed, while keeping the personal impact visible.

An immediate support plan can remain brief: the current difficulty, the person providing help, the temporary adjustment and the review point. It should not require the doctor to disclose private health details to an entire team. A separate service plan addresses the operational risk. Keeping these

plans connected but distinct allows recovery without implying that the concern arose only because the doctor was distressed. It also allows improvement work to continue without making an exhausted clinician its sole owner.

Agree who will check that the temporary arrangement is working. A supportive conversation can lose its effect when the next rota reproduces the same exposure. Review the work actually undertaken, the support received and whether a further adjustment is needed.

Raising concerns

Raising a concern begins with stating what needs attention and why. It does not require a doctor to complete an investigation before speaking. The GMC expects concerns about patient safety to be raised through appropriate channels on an honest, reasonable basis; immediate serious risk needs an immediate report. Where the local route is unsuitable or inadequate, its guidance identifies circumstances for approaching a relevant external body. Keep a record of the concern and the steps taken.^[37]

Start with the local policy and the urgency of the issue. A clinical director, medical director, governance lead or another designated person may be the appropriate first contact. If that individual is implicated in the concern, use an alternative route identified by the policy or obtain advice about the next step. A process designed for routine correspondence should not delay urgent clinical action. Nor should a doctor's uncertainty about the ultimate investigation route prevent a clear report to somebody able to address immediate risk.

In England, NHS England's national speak up policy sets a minimum standard for local Freedom to Speak Up policies. The local version supplies organisational contacts and implementation details. A Freedom to Speak Up guardian can help a worker navigate speaking up, but the doctor should establish who will investigate the issue and who can change the service. The route for support and the authority for operational decisions may involve different people.^[50]

In Wales, use the Welsh Government's Speaking Up Safely framework alongside the employer's current raising-concerns procedure. The framework supports rather than replaces existing procedures and addresses organisational culture, responding to concerns and monitoring what follows. Do not assume that the English national policy or a particular English job title defines the Welsh route. Find the named local contact and establish how the concern will be recorded, which process will handle it and how feedback will be provided.^[51]

Scotland has National Whistleblowing Standards overseen by the Independent National Whistleblowing Officer, a role undertaken by the Scottish Public Services Ombudsman. The standards describe a framework for NHS service providers handling whistleblowing concerns and extend beyond directly employed staff to others delivering NHS services. Use the provider's arrangements and the INWO information to identify the appropriate route and any next stage. This is a distinct system, not a Scottish name for England's Freedom to Speak Up policy. ^[52]

In Northern Ireland, the Department of Health's HSC Whistleblowing Framework and Model Policy provides the national reference alongside the employer's current policy. Its model includes alternatives where raising an issue with the line manager is unsuitable, including designated advisers or advocates and relevant governance or HR contacts. Follow the current local arrangements rather than treating an illustrative model contact as a person already appointed in every organisation. ^[53]

The language of speaking up is wider than the legal category of a protected disclosure. In Great Britain, Acas explains that legal whistleblowing protection depends on relevant conditions, including reasonable belief that the disclosure concerns specified wrongdoing and is in the public interest. A personal grievance does not automatically satisfy those conditions. Northern Ireland has its own statutory framework and official guidance; the Labour Relations Agency provides employment advice there. Obtain individual advice when protection or possible detriment becomes an issue. ^{[54][55]}

The escalation record can use seven prompts: what was observed; when and where it occurred; why it matters; which patients or service functions are affected; immediate action already taken; the decision requested; and who received the concern. Add the agreed response, owner and date when known. Distinguish direct observation from information supplied by another person. Where the concern overlaps with a grievance, state that overlap openly while making the patient-safety issue intelligible in its own right. Avoid guessing motives.

After a meeting, send a short factual confirmation through the appropriate secure channel. State your understanding of the agreed action and invite correction if it differs from the recipient's understanding. This is especially useful when several concerns were discussed together and only some could be decided by those present.

Ask about confidentiality before assuming anonymity. A confidential concern is handled with limits on disclosure; an anonymous concern does not identify its source. Either arrangement may have practical limits,

particularly where a detailed event is readily recognisable or action requires speaking with other people. Discuss how information will be shared and what support is available. Do not promise a colleague secrecy that prevents necessary safety action. Explain the limits and seek appropriate advice on the particular circumstances.

Medical defence organisations can help doctors consider professional obligations and the wording or route of a concern. The MDU's guidance emphasises raising concerns appropriately and seeking advice, particularly before wider disclosure.^[56] Employment representation may also be needed if the doctor experiences adverse treatment. Keep a factual chronology and seek advice promptly; do not assume that continuing an internal process settles or preserves every external legal option. Public statements and social media require particular care because confidentiality and legal protection are not resolved by the sincerity of the concern.

If the response remains inadequate, return to the evidence: what risk persists, which action was promised and what has actually happened? Ask for the next responsible level and obtain advice about external routes where necessary. The appropriate body depends on whether the concern concerns an individual professional, an organisation or another regulated activity. Sending the same broad allegation to many bodies can obscure that distinction. A focused, properly directed concern gives the recipient a clearer basis for action.

From concern to service change

An effective concern creates the conditions for a decision. It tells the reader what is happening, why it matters and what must now be agreed. A long chronology may be necessary as supporting evidence, but the decision-maker usually needs a concise service-risk brief first. This is particularly important when the person receiving the concern did not design the pathway and does not share the clinical team's background knowledge. Write for that reader without removing the detail needed to understand the risk.

Begin with the gap between the intended service and its current work. Elena's brief states that a recovery service is receiving patients needing an intensity of review and investigation beyond its established arrangements. It identifies the changed referral process, the functions that are unavailable and the resulting delays or additional transfers. It does not accuse an unnamed group of disregarding safety. The concern is serious because the work and its supporting conditions no longer match, regardless of how that mismatch arose.

The next paragraph describes the current protections and their limitations. These may include clinical triage, experienced staff, telephone advice and escalation to another service. Explain which protections are reliable and which depend on informal availability or repeated workaround. Then state the residual problem. This prevents an apparently reassuring list of controls from being mistaken for evidence that the entire pathway is safe. A control can reduce a risk without removing the need for further action.

Offer a small number of realistic options. For Elena's service, one is to retain its previous patient group while the wider pathway is redesigned. Another is a defined expansion supported by additional assessment capacity, agreed diagnostics and an effective escalation arrangement. A third may be a staged change with narrower initial criteria and explicit review. These are illustrative options, not recommendations for a particular NHS service. Each must be assessed against the needs of patients who would otherwise remain elsewhere.

Compare options using the same questions. What care can be delivered, by whom and when? What new resource or agreement is required? What risks remain? What effect will the option have on the sending service and patients awaiting care? Who can authorise it? An option that transfers delay to another part of the pathway may still be preferable, but that consequence should be visible. The aim is an honest comparison of whole-pathway effects rather than improving one service's figures by moving the problem.

The brief should distinguish an interim arrangement from the intended model. Temporary changes need an owner, start point, review date and a means of stopping or modifying them if they fail. A permanent solution may require recruitment, training or commissioning decisions that cannot be delivered immediately. That delay should not leave the interim period undefined. State what can happen now, what must wait and how the team will respond to cases outside the agreed arrangement while the larger change is developed.

Name the circumstances requiring an earlier review so that the calendar does not override deteriorating conditions.

Before implementation, test the proposed model with a small set of realistic situations. Use an ordinary referral, an incomplete referral, unexpected deterioration and simultaneous demands on the same clinician. Include an absence or equipment failure. Ask the actual receiving, sending and operational teams to walk through their actions. The test is not successful because everybody agrees with the diagram. It is successful when each necessary action has an identified person, the information reaches them

and unresolved dependencies are corrected before patients rely on the process.

Choose review measures that correspond to the original concern. If the problem was timely reassessment, measure the relevant interval and examine outliers. If incomplete information was central, sample the handovers received. Include a balancing measure so that improvement in one place does not conceal worsening elsewhere. Staff and patient accounts can reveal problems missed by simple counts. Specify who will collect the information through approved systems and who will decide whether it supports continuation, modification or a different model.

At the review meeting, distinguish completed actions from demonstrated effects. Publishing a policy is an action. Showing that staff understand and can operate it is evidence about implementation. Showing that the original problem has reduced without a new unacceptable consequence is evidence about effect. All three matter, but they answer different questions. A service can finish its action list while leaving the practical difficulty substantially unchanged. Closure should therefore refer to the condition that prompted the concern, not only to the paperwork produced afterwards.

Elena's contribution need not make her the permanent owner of every improvement. The service-risk brief names clinical, operational and executive responsibilities according to the decisions each person can make. Her agreed role may include clinical advice and a defined review, with time recognised in the job plan. Continuing responsibility for staffing or pathway coordination belongs with the designated owners. This makes the improvement more sustainable and preserves an intelligible account of what she is expected to deliver.

The final test is whether another team could use the arrangements during Elena's absence. Patients should receive appropriate assessment, colleagues should know their responsibilities and unresolved concerns should reach somebody able to act. The doctor has helped connect immediate care, evidence, organisational decisions and review. That is the practical purpose of working safely within role and resources: professional responsibility remains active, while the conditions required to discharge it are made explicit and pursued through a workable service arrangement.