Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
T: 02890 251005 | E: info@usi.org.uk | W: www.urologyservicesinquiry.org.uk

Dr Richard Wright
C/O
Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

29 April 2022

Dear Sir,

Re: The Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust

Provision of a Section 21 Notice requiring the provision of evidence in the form of a written statement

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

You will be aware that the Inquiry has commenced its investigations into the matters set out in its Terms of Reference. The Inquiry is continuing with the process of gathering all of the relevant documentation from relevant departments, organisations and individuals. In addition, the Inquiry has also now begun the process of requiring individuals who have been, or may have been, involved in the range of matters which come within the Inquiry's Terms of Reference to provide written evidence to the Inquiry panel.

The Urology Services Inquiry is now issuing to you a Statutory Notice (known as a Section 21 Notice) pursuant to its powers to compel the provision of evidence in the form of a written statement in relation to the matters falling within its Terms of Reference.

The Inquiry is aware that you have held posts relevant to the Inquiry's Terms of Reference. The Inquiry understands that you will have access to all of the relevant information required to provide the witness statement required now or at any stage

throughout the duration of this Inquiry. Should you consider that not to be the case, please advise us of that as soon as possible.

The Schedule to the enclosed Section 21 Notice provides full details as to the matters which should be covered in the written evidence which is required from you. As the text of the Section 21 Notice explains, you are required by law to comply with it.

Please bear in mind the fact that the witness statement required by the enclosed Notice is likely (in common with many other statements we will request) to be published by the Inquiry in due course. It should therefore ideally be written in a manner which is as accessible as possible in terms of public understanding.

You will note that certain questions raise issues regarding documentation. As you are aware the Trust has already responded to our earlier Section 21 Notice requesting documentation from the Trust as an organisation. However if you in your personal capacity hold any additional documentation which you consider is of relevance to our work and is not within the custody or power of the Trust and has not been provided to us to date, then we would ask that this is also provided with this response.

If it would assist you, I am happy to meet with you and/or the Trust's legal representative(s) to discuss what documents you have and whether they are covered by the Section 21 Notice.

You will also find attached to the Section 21 Notice a Guidance Note explaining the nature of a Section 21 Notice and the procedures that the Inquiry has adopted in relation to such a notice. In particular, you are asked to provide your evidence in the form of the template witness statement which is also enclosed with this correspondence. In addition, as referred to above, you will also find enclosed a copy of the Inquiry's Terms of Reference to assist you in understanding the scope of the Inquiry's work and therefore the ambit of the Section 21 Notice.

Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

If there is any difficulty in complying with this time limit you must make application to the Chair for an extension of time before the expiry of the time limit, and that application must provide full reasons in explanation of any difficulty.

Finally, I would be grateful if you could acknowledge receipt of this correspondence and the enclosed Notice by email to Personal Information redacted by the USI.

Please do not hesitate to contact me to discuss any matter arising.

Yours faithfully

Personal information redacted by USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

Tel: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

Issued by Urology Services Inquiry on 29 April 2022. Annotated by the Urology Services Inquiry.

THE INDEPENDENT PUBLIC INQUIRY INTO
UROLOGY SERVICES IN THE
SOUTHERN HEALTH AND SOCIAL CARE TRUST

Chair's Notice

[No 43 of 2022]

pursuant to Section 21(2) of the Inquiries Act 2005

WARNING

If, without reasonable excuse, you fail to comply with the requirements of this Notice you will be committing an offence under section 35 of the Inquiries Act 2005 and may be liable on conviction to a term of imprisonment and/or a fine.

Further, if you fail to comply with the requirements of this Notice, the Chair may certify the matter to the High Court of Justice in Northern Ireland under section 36 of the Inquiries Act 2005, where you may be held in contempt of court and may be imprisoned, fined or have your assets seized.

TO:

Dr Richard Wright
C/O
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.

2. The Notice requires you to do the acts set out in the body of the Notice.

3. You should read this Notice carefully and consult a solicitor as soon as possible about it.

4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.

5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by **noon on 10th June 2022.**

APPLICATION TO VARY OR REVOKE THE NOTICE

AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **noon on 3rd June 2022**.

Upon receipt of such a claim the Chair will then determine whether the Notice should be revoked or varied, including having regard to her obligations under section 21(5) of the Act, and you will be notified of her determination.

Dated this day 29th April 2022

Signed: 

Christine Smith QC

Chair of Urology Services Inquiry

SCHEDULE
[No 43 of 2022]

General

1. Having regard to the Terms of Reference of the Urology Services Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of sub-paragraph (e) of those Terms of Reference concerning, inter alia, 'Maintaining High Professional Standards in the Modern HPSS' ('MHPS Framework') and the Trust's investigation. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order using the form provided.

2. Provide any and all documents within your custody or under your control relating to paragraph (e) of the Terms of Reference except where those documents have been previously provided to the Inquiry by the SHSCT. Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. If you are in any doubt about the documents previously provided by the SHSCT you may wish to contact the Trust's legal advisors or, if you prefer, you may contact the Inquiry.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. When answering the questions set out below you will need to equip yourself with a copy of *Maintaining High Professional Standards in the Modern HPSS' framework ('MHPS')* and the '*Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance' ('Trust Guidelines').*

Policies and Procedures for Handling Concerns

4. In your role as Medical Director what, if any, training or guidance did you receive with regard to:
    I. The MHPS framework;
    II. The Trust Guidelines; and
    III. The handling of performance concerns generally.

5. In your role as Medical Director what, if any, training or guidance did you provide or arrange on the MHPS framework and the Trust Guidelines to be provided to:

    I. Clinical Managers;
    II. Case Investigators;
    III. designated Board members; and
    IV. Any other relevant person under the MHPS framework and the Trust Guidelines.

6. The Inquiry is interested in your experience of handling of concerns regarding any staff member. Prior to your involvement in respect of the case of Mr O'Brien, specify whether you ever have had occasion to implement or apply MHPS and/or the Trust Guidelines in order to address performance concerns and outline the steps taken.

7. Outline how you understood the role of Medical Director was to relate to and engage with the following individuals under the MHPS Framework and the Trust Guidelines:
    I. Clinical Manager;
    II. Case Manager;
    III. Case Investigator;
    IV. Chief Executive;
    V. Service Director;
    VI. HR Director;
    VII. Designated Board member,
    VIII. The clinician who is the subject of the investigation; and
    IX. Any other relevant person under the MHPS framework and the Trust Guidelines, including any external person(s) or bodies.

8. With regard to Section I paragraph 29 of the MHPS framework, what processes or procedures existed within the Trust to provide a clear audit route for initiating and tracking the progress of investigations, their costs and resulting actions? Who was responsible for ensuring such processes were in place and what role, if any, did you have as the Medical Director in relation to these matters?

9. Fully describe your role with regard to the establishment, responsibilities and functioning of the 'Oversight Group,' as referred to at paragraph 2.5 of the 2010 Guidelines. Further, please outline how your role differed from that of other regular attendees at the 'Oversight Group' namely:

    I. Assistant Director – Medical Directorate;
    II. Service Director;
    III. HR Director; and
    IV. Medical Staffing Manager.

Handling of Concerns relating to Mr O'Brien

10. In respect of concerns raised regarding Mr Aidan O'Brien:

    I. When did you first become aware that there were concerns in relation to the performance of Mr O'Brien?
    II. If different, also state when you became aware that there would be an investigation into matters concerning the performance of Mr O'Brien?
    III. Who communicated these matters to you and in what terms?
    IV. Upon receiving this information what action did you take?

11. Were the concerns raised, registered or escalated to the Chief Executive as required by Section I paragraph 8 of MHPS and paragraph 2.3 of the Trust Guidelines? If so, explain how, by whom and when this was done, and outline what information was provided to the Chief Executive. If this was not done, explain why not?

12. Outline all interactions you, or your office had with NCAS with regard to Mr O'Brien including the purpose of any interaction, the date of the interaction, the information shared with NCAS, any advice provided by NCAS and the steps taken to act on that advice, if any. If advice was provided by NCAS but not acted upon, explain why.

13. Outline the circumstances and the process by which you understand concerns in relation to Mr O'Brien came to be discussed by the Oversight Group on 13th September 2016 and address the following:

    I. From what source did the concerns and information discussed at that meeting emanate?
    II. What do you understand to have been decided at that meeting?
    III. What if any action did you take on foot of same?
    IV. If no action was taken, please explain why and refer to all relevant correspondence.

14. Outline when and in what circumstances you became aware of the following Serious Adverse Incident investigations and that they raised concerns about Mr O'Brien, and outline what action you took upon becoming aware of those concerns:

    I. Patient [redacted] (RCA [redacted]
    II. The care of five patients (RCA [redacted]); and
    III. Patient [redacted] (RCA [redacted].

15. Outline the circumstances and the process by which you understand concerns in relation to Mr O'Brien came to be discussed by the Oversight Group on 22 December 2016 and address the following:

    I. What information was before the Oversight Group on that date, and from what source did the information discussed at that meeting emanate?
    II. What do you understand to have been decided at that meeting, and what action was to take place following that meeting?
    III. What steps did you take as Medical Director to ensure that those actions took place?

16. With reference to specific provisions of Section I of the MHPS Framework and the Trust Guidelines, outline all steps you took as Medical Director once a decision had been made to conduct an investigation into Mr Aidan O'Brien's practice in line with that Framework and Guidelines.

17. What role or input, if any, did you have in relation to the formulation of the Terms of Reference for the formal investigation to be conducted under the MHPS Framework and Trust Guidelines in relation to Mr O'Brien? Outline all steps you took, information you considered and advice you received when finalising those Terms. Describe the various iterations or drafts of the Terms of Reference and the reasons for any amendments, and indicate when and in what manner these were communicated to Mr O'Brien.

18. When, and in what circumstances, did you first became aware of concerns, or receive any information which could have given rise to a concern that Mr O'Brien may have been affording advantageous scheduling to private patients.

19. With regard to the Return to Work Plan / Monitoring Arrangements dated 9th February 2017, see copy attached, outline your role, as well as the role of any other responsible person, in monitoring Mr O'Brien's compliance with the Return to Work Plan and provide copies of all documentation showing the discharge of those roles with regard to each of the four concerns identified, namely:

    I. Un-triaged referrals to Mr Aidan O'Brien;
    II. Patient notes tracked out to Mr Aidan O'Brien;
    III. Undictated patient outcomes from outpatient clinics by Mr Aidan O'Brien; and
    IV. The scheduling of private patients by Mr Aidan O'Brien

20. What is your understanding of the period of time during which this Return to Work Plan/Monitoring Arrangements remained in operation, and which person(s) were responsible for overseeing its operation in any respect?

21. With specific reference to each of the concerns listed at (19) (i)-(iv) above, indicate if any divergences from the Return to Work Plan were identified and, if so, what action you took to address and/or escalate same.

22. On what basis was it decided that Dr Khan, Case Manager, and yourself, in your role of Medical Director, would respond to representations lodged by Mr O'Brien with the designated Board member on 7th February 2017 and 6th March 2017 respectively.

23. Explain the circumstances which led to Mr Colin Weir being asked to step down from his role of Case Investigator in February 2017.

24. Section I paragraph 37 of MHPS sets out a series of timescales for the completion of investigations by the Case Investigator and comments from the Practitioner. From your perspective as Medical Director, what is your understanding of the factors which contributed to any delays with regard to the following:

    I. The conduct of the investigation;
    II. The preparation of the investigator's report;
    III. The provision of comments by Mr O'Brien; and
    IV. The making of the determination by the Case Manager.

Outline and provide all documentation relating to any interaction which you had with any of the following individuals with regard to any delays relating to matters (I) – (IV) above, and in doing so, outline any steps taken by you in order to prevent or reduce delay:

A. Case Manager
B. Case Investigator;
C. Designated Board member;
D. the HR Case Manager;
E. Mr Aidan O'Brien; and
F. Any other relevant person under the MHPS framework and the Trust Guidelines.

25. Outline what steps, if any, you took during the MHPS investigation, and outline the extent to which you were kept appraised of developments during the MHPS investigation?

MHPS Determination

26. Outline the content of all discussions you had with Dr Ahmed Khan, regarding his Determination under Section I paragraph 38 of MHPS.

27. On 28 September 2018, Dr Ahmed Khan, as Case Manager, made his Determination with regard to the investigation into Mr O'Brien. This Determination, inter alia, stated that the following actions take place:

    I. The implementation of an Action Plan with input from Practitioner Performance Advice, the Trust and Mr O'Brien to provide assurance with monitoring provided by the Clinical Director;
    II. That Mr O'Brien's failing be put to a conduct panel hearing; and
    III. That the Trust was to carry out an independent review of administrative practices within the Acute Directorate and appropriate escalation processes.

With specific reference to each of the determinations listed at (I) – (III) above address:

A. Who was responsible for the implementation of each of these actions?
B. To the best of your knowledge, outline what steps were taken to ensure that each of these actions were implemented; and
C. If applicable, what factors prevented that implementation.
D. If the Action Plan as per 27(I) was not implemented, fully outline what steps or processes, if any, were put in place to monitor Mr O'Brien's practice, and identify the person(s) who were responsible for these? Did these apply to all aspects of his practice and, if not, why not?

Implementation and Effectiveness of MHPS

28. Having regard to your experience as Medical Director, in relation to the investigation into the performance of Mr Aidan O'Brien, what impression have you formed of the implementation and effectiveness of MHPS and the Trust Guidelines both generally, and specifically as regard the case of Mr O'Brien?

29. To what extent were you able to effectively discharge your role as Medical Director under MHPS and the Trust Guidelines in the extant systems within the Trust? What obstacles did you encounter when performing this role and what, if anything, could be done to strengthen or enhance that role.

30. Having had the opportunity to reflect, outline whether in your view the MHPS process could have been better used in order to address the problems which were found to have existed in connection with the practice of Mr O'Brien.

31. Outline any and all discussions you had during your tenure as Medical Director with regard to the updating or amending of the MHPS Framework. Specify who was involved in these discussions, what changes or amendments were proposed and what, if any factors, prevented those discussions for leading to the updating or amending of the MHPS Framework.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

UROLOGY SERVICES INQUIRY

See letter from SHSCT to USI dated 31 January 2023 at WIT-91875 to WIT-91880 detailing corrections to this witness statement. Annotated by Urology Services Inquiry.

USI Ref: Notice 43 of 2021

Date of Notice: 29th April 2022

Witness Statement of: Dr Richard Wight

I, Dr Richard Wright, will say as follows:-

This response has been compiled with the assistance of Mr Mark Haynes (AMD Surgery) and Mr Francis Rice (former Chief Executive) only in respect of the provision of information concerning the date of the initial notification by Mr Haynes to me of the issues involved and my subsequent meeting with Mr Rice.

General

1. ***Having regard to the Terms of Reference of the Urology Services Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of sub-paragraph (e) of those Terms of Reference concerning, inter alia, 'Maintaining High Professional Standards in the Modern HPSS' ('MHPS Framework') and the Trust's investigation. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order using the form provided.***

1.1 My knowledge of and involvement in the MHPS process in respect of Mr O'Brien has been set out in detail in my response to Section 21 Notice No. 27 of 2022, in particular in my answers to Questions 1 (from para 1.4 to 1.21), 49, 54, 55, 60, 63,

64 and 70. In ease of the Inquiry, I do not propose to repeat that text here. Rather, I confirm that I seek to rely upon it as my answer to Question 1 of this Section 21 Notice.

1.2 In light of the above, and by way of very brief summary, my involvement in the MHPS process can be summarised as follows:

a. I had some limited involvement (which I cannot now recall) in early 2016 in what was an informal attempt at Directorate level to resolve issues with Mr O'Brien by way of Mrs Trouton writing a letter to him setting out the various concerns.

b. I had no other involvement (as far as I can recall)) until September 2016 when concerns of the same type were raised by Mr Haynes with me.

c. From that point until February 2018 [redacted] I had an involvement in a number of relevant matters including the Oversight Committee considering the issues with Mr O'Brien, engagement with NCAS, recommending that an MHPS formal investigation be undertaken, meeting with Mr O'Brien to advise him of this, overseeing his exclusion from and return to work under control and supervision in 2017, and sourcing an expert to undertake SAI and RCA work in respect of issues related to Mr O'Brien.

d. I no longer had a relevant role at the time when the MHPS process concluded with Dr Khan's report and only became aware of the contents of his report (and the contents of Dr Chada's report) in very recent times in the context of my engagement with this Public Inquiry.

2. ***Please also provide any and all documents within your custody or under your control relating to the terms of reference of the Urology Services Inquiry ("USI"), except where those documents have been previously provided to the USI by the SHSCT. Please also provide or refer to any documentation you consider relevant to any of your answers, whether in***

answer to Question 1 or to the questions set out below. If you are in any doubt about the documents previously provided by the SHSCT you may wish to contact the Trust's legal advisors or, if you prefer, you may contact the Inquiry.

3. ***Unless you have specifically addressed the issues in your reply to Question 1 above, answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. When answering the questions set out below you will need to equip yourself with a copy of Maintaining High Professional Standards in the Modern HPSS' framework ('MHPS') and the 'Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance' ('Trust Guidelines').***

Policies and Procedures for Handling Concerns

4. ***In your role as Medical Director what, If any, training or guidance did you receive with regard to:***
   - ***I. The MHPS framework;***
   - ***II. The Trust Guidelines; and***
   - ***III. The handling of performance concerns generally.***

4.1 I was involved in applying the MHPS process throughout my time as Associate Medical Director in the Belfast Health and Social Care Trust between 2010-2015 and then as Medical Director in the Southern Health and Social Care Trust 2015-2018.

4.2 During that period, I had experience of many MHPS cases (more than 30). In Belfast I would often have acted as Case Investigator or Case Manager as defined by the MHPS process but in SHSCT my role was more so focused in the Oversight team.

4.3 I have included in this response a summary of courses that I attended and received but also courses that I delivered and helped to create. The rationale for this is that, in creating and/or delivering such a course, there is often more learning than if one is simply a passive receptor of information. The direct engagement with other participants and the opportunities for group learning with question and answer sessions is often a much more powerful means of learning than simply receiving information.

4.4 I have also included evidence of attending courses where available.

4.5 I helped devise and deliver training sessions to medical trainees in association with the Health and Social Care Leadership Centre from 2013-2015 as part of the regional leadership and management course. This would have included a brief introduction to the MHPS process.

4.6 On 30th April 2014, I attended the Revalidation Skills Development Workshop at BHSCT.

4.7 On 4th December 2015, I attended the Onboard Training offered by David Nicholl which included discussion of governance issues. Please find attached certificate *located at S.21 43 of 2022, Attachments- Appendix 1*.

4.8 During March 2016 and 2017, I lectured at the Staff Grade and Associate Specialist (SAS) regional conference hosted by the SHSCT. I covered some of the issues related to MHPS in those lectures but only on a superficial level. Please find attached *located at S.21 43 of 2022 attachments- Appendix 2*.

4.9 Between 5-6th July 2016, I attended the National Patient Safety Conference in Manchester. There were several sessions where the MHPS process was discussed.

4.10 On 28th June 2016, I jointly delivered a talk at the NHS Confederation conference on clinical leadership which including some discussion around MHPS.

4.11 In October 2016, the SHSCT ran a Quality Improvement event which including a session on raising concerns.

4.12 In 2016-17, I developed a new guideline for the Trust regarding how to handle concerns with medical staff together with Zoe Parks (Head of Medical Staffing at SHSCT).

4.13 From 7-8th March 2017, I attended a specific MHPS training workshop run by National Clinical Assessment Service (NCAS). Please find attached *located at S.21 43 of 2022 attachments- Appendix 3*.

4.14 In 2017 we began delivering our Trust Development Programme for Senior Medical Staff which specifically included a section on MHPS and other means of raising and acting on concerns. Please find attached located at *S.21 43 of 2022 attachments- Appendix 4.*

5. In your role as Medical Director what, if any, training or guidance did you provide or arrange on the MHPS framework and the Trust Guidelines to be provided to:

- ***I. Clinical Managers;***
- ***II. Case Investigators***
- ***III. designated Board members; and***
- ***IV. Any other relevant person under the MHPS framework and the Trust Guidelines.***

5.1 I & II) Please see my answer to question 4. Training for Case Investigators and Case Managers was provided mainly through the Trust Development Programme for Senior Medical Staff along with individually tailored NCAS training (which I also I attended). This was the programme that I developed in association with the Human Resources department and the Health and Social Care Leadership Centre. I partly delivered this, although we utilised expertise from across the Trust and also expertise from NCAS. This would have been reviewed as part of a doctor's annual appraisal of their entire medical practice including leadership and investigative roles.

5.2 III) The Board members would have received some, albeit more limited, training as part of the Trust Board development days which were arranged by the Trust Chair such as the 'On Board' training described above in paragraph 4.

5.3 IV) The MHPS process would have frequently been discussed at regular Associate Medical Director team meetings and via 1:1 encounters with Clinical Directors. In my case this would have helped to keep the MHPS process fresh in my mind.

6. The Inquiry is interested in your experience of handling of concerns regarding any staff member. Prior to your involvement in respect of the case of Mr O'Brien, specify whether you ever have had occasion to implement or apply MHPS and/or the Trust Guidelines in order to address performance concerns and outline the steps taken.

6.1 Please see my answer to question 4. I was involved as a Case Investigator on several occasions whilst working as an Associate Medical Director in Belfast HSC Trust between 2010 and 2015. I also was appointed to the role of Case Manager on multiple occasions during this time. This included several relatively high-profile issues including the failings within the Dental Service and Immunology Service in Belfast which resulted in major patient call backs. As Associate Medical Director, I was involved in various MHPS cases in an oversight capacity on behalf of the Medical Director. During my time as Medical Director in SHSCT we may have had up to 3 or 4 MHPS investigations being processed at any one time. This will be reflected in the minutes of the Oversight meetings which have been provided.

7. Outline how you understood the role of Medical Director was to relate to and engage with the following individuals under the MHPS Framework and the Trust Guidelines:

I. Clinical Manager;
II. Case Manager;
III. Case Investigator;
IV. Chief Executive;
V. Service Director;
VI. HR Director;
VII. Designated Board member,
VIII. The clinician who is the subject of the investigation;

IX. Any other relevant person under the MHPS framework and the Trust Guidelines, including any external person(s) or bodies.

7.1 i) A Clinical Manager could relate to the Clinical Director or Associate Medical Director. I would have appointed several of them at different times as Case Manager or Case Investigator. I would have been involved in establishing training for them through our leadership development course at the Southern Health and Social Care Trust as outlined in paragraph 4. Occasionally, the CD or AMD may themselves be the subject of an MHPS investigation. In this situation I would usually ensure that the Case Manager was at least of similar grade or indeed greater seniority than the doctor under investigation.

7.2 ii) In many situations the Medical Director would actually take on the role of Case Manager However, I preferred to delegate the role to one of the Associate Medical Director team. It would not have been practical for me to case manage all the MHPS investigations. I also preferred to separate the Medical Director role from Case Manager as the Medical Director may be needed to function independently of the investigating team to implement some of the recommendations. One other advantage was that I could ensure the Case Manager had no line management responsibility for the individual being investigated. Once the Case Manager was established, I would not get involved in the process until it was completed unless the Case Manager requested assistance.

7.3 iii) As part of the Oversight team, I would recommend and appoint a Case Investigator. I would meet with them to explain the task in hand but then I would expect the Case Manager to interact directly with them. In this specific situation, the initial Case Investigator (Mr Weir) was appointed in this specific case as he was a Clinical Director with experience in managing difficult issues within the Surgical team and was already partly briefed on the relevant issues as he had prepared the preliminary report into the issues arising. We believed this would help to produce a timely report. After representations from Mr O'Brien to Mr Wilkinson (the designated NED), I agreed with Mrs Toal (Human Resources

Director) to change the Case Investigator. After reflecting we believed that Mr Weir, as Clinical Director, would be better utilized addressing the triage and other issues identified within the urology team whilst we would appoint a new Case Investigator who had no other involvement in the case and was unknown to any of the key individuals involved. Dr Chada (the new case Investigator) was an Associate Medical Director with extensive experience in carrying out similar MHPS investigations. I would have interacted with her on multiple occasions over the relevant time period, however, not specifically in relation to the Urology MHPS investigation. I do recall asking her on at least one occasion how the MHPS investigation was proceeding and hearing that the investigation was behind schedule because of difficulty in agreeing interview dates with Mr O'Brien. I was not surprised or unduly concerned as in my experience this is a common area of difficulty with MHPS investigations.

7.4 iv) I would brief the Chief Executive regarding any active MHPS cases. I specifically would have met with them to ask them to appoint a designated Board member in discussion with the Board Chair. One of the issues for me was the rapid turnover of Chief Executives at the time. During this MHPS investigation there were three different post-holders but across 5 different periods of time in the following order: Francis Rice, Stephen McNally, Francis Rice, Stephen McNally, and Shane Devlin. This was highly unusual and largely attributed to two separate spells of Personal information redacted by USI leave on the part of Francis Rice.

7.5 v) The Service Director would have been asked to attend any relevant Oversight meetings or to send a deputy when she was unavailable. Usually, it would be the Service Director who might bring concerns to me. Of course, I would be meeting regularly with the Service Director regarding other issues and specifically on a weekly basis at Senior Management Team Meetings. We would have occasional 1:1 meetings about issues of mutual concern. The Service Director would be key in ensuring relevant operational issues were carried forward. In this case, this was relevant to ensuring the identified issues were addressed in the Directorate and ensuring the back to work plan was implemented and monitored. Please see

Oversight Group Notes Action Points 13 9 2016 Oversight Group Notes ***Bates Reference TRU-00025-TRU-00027*** *and Oversight Group Notes 26 01 2017 Oversight Group Notes* ***bates reference TRU-00037-TRU-00040****.*

7.6 vi) The HR Director jointly chaired the Oversight meetings with me when they were called. They would have agreed with me who would be recommended as Case Manager and Case Investigator. Potentially, they might be involved in implementing some of the recommendations of the final MHPS report such as potentially establishing a disciplinary panel.

7.7 vii) I would request the Chief Executive and Trust Board Chair would nominate a designated Board member, often a Non-Executive Director (NED). Usually, there would be no cause for any further interaction with the designated person but, in this instance, Mr O'Brien contacted him directly as he was entitled to do. I would potentially respond to any questions or issues that the NED would bring to me and, if requested, keep them informed of the progress of the case investigation.

7.8 viii) I met with Mr O'Brien on 30th December2016 to personally inform him that we were embarking upon an MHPS process formal stage and to explain the reasons. I also informed him of his temporary exclusion from work. I followed that up with a letter recording that encounter and I then later responded to him on 13th March 2017 after he wrote to me with a number of issues regarding the process. Please find attached *located at Relevant to HR/Evidence after 4th November/ Reference 77/ S.Hynds No 77/20161230 Attachment letter to AOB 30th December and Dr Wright's S21 Evidence 30th May 2022 20161228.*

7.9 I contacted the NCAS representative on two occasions to discuss Mr O'Brien's temporary exclusion and then his return to work, in December 2016 and January 2017 respectively.

7.10 ix) I would also have had contact with other potentially relevant people. For example, in the O'Brien case I would have asked Mr Simon Gibson (my Assistant

Director) to arrange the dates for, and keep the minutes of, the Oversight meetings .He also would have contacted NCAS on a number of occasions before and after my meeting with Mr O'Brien on the 30th December 2016, to discuss and record the Oversight team's approach to the issues raised. In this role he would have been acting on behalf of the Medical Director.

7.11 In Answers (i) to (ix) above I have attempted to explain how I understood my role vis-à-vis each of the 9 classes of person mentioned in the question.

7.12 Now in this next section, I summarise how this worked in practice in the context of this specific case.

7.13 In my role as Medical Director I jointly chaired the Oversight Committee along with Mrs Toal (Director of Human Resources). We would invite the relevant operational director to take part *viz* Mrs Gishkori (Director of Acute Services). Mrs Toal and I decided to include Mr O'Brien as one of doctors to be considered in the September 2016 meeting and in subsequent meetings thereafter. This was following concerns that had been escalated to us from Acute Services via Mr Haynes (AMD).

7.14 The specific concerns that Mr O'Brien had not responded to Mr Mackle and Mrs Trouton's letter of March 2016 were escalated to me by Mr Haynes (Associate Medical Director) and Mrs Gishkori (Acute Services Director). This was in keeping with the Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance 2010 and in keeping with 'MHPS in the Modern HPSS 2005'. Please find attached *located at S21 No 43 of 2022, Attachments, Appendix 5.*

7.15 After the December 22nd 2016 Oversight Meeting we recommended beginning the formal MHPS stage and recommended delegating the role of Case Manager to Dr Khan, an experienced Associate Medical Director. It was my normal custom and practice to delegate the role of Case Manager to one of our Associate Medical Director team. Mr Weir was initially appointed Case Investigator.

7.16 The Service Director (Mrs Gishkori) would have been engaged with us as part of the Oversight team formal minuted meetings. When Mrs Gishkori was unable to attend, then her Assistant Director (initially Mrs Trouton, and then Mr Carroll) attended on her behalf and reported back to her.

7.17 As part of my role, I would have asked Mr Rice (Chief Executive) to liaise with the Trust Board Chair (Mrs Brownlee) to appoint a Non-Executive Director as the designated board member to oversee the process from a Trust Board perspective.

7.18 As part of the Oversight team, we would have received the final report of the Case Manager, however, I personally had left the Trust and retired just as this was presented in August 2018. I did not therefore read either the Case Investigator's report or the Case Manager's determination until 9th May 2022, 4 years after I had left the organisation, and only then in the context of preparation for answering the two Section 21 Notices served upon me by the Public Inquiry.

7.19 I would have been available for advice and information for the Non-Executive Director designated board member if needed.

7.20 I would have initially liaised with NCAS before excluding Mr O'Brien from work and before his return. Thereafter Dr Khan (Case Manager and subsequently acting Medical Director) was the point of contact.

7.21 In keeping with MHPS 2005 process I met with Mr O'Brien on 30th December 2016 to inform him of his exclusion and the next steps in the process. In this particular situation Mr O'Brien wrote to me with some comments after that meeting which I largely accepted and responded to him in writing on 13th March 2017.

75. With regard to Section I paragraph 29 of the MHPS framework, what processes or procedures existed within the Trust to provide a clear audit route for initiating and tracking the progress of investigations, their costs and resulting actions? Who was responsible for ensuring such processes were in place and what role, if any, did you have as the Medical Director in relation to these matters?

8.1 The Oversight Team was the forum for tracking the progress of the investigation and ensuring that decisions were taken regarding resulting actions. The financial implications of any given MHPS investigation were not formally assessed by this group, but for any MHPS case that function would fall within the remit of the

Operational Director responsible as they are the budget holder for the service (Mrs Gishkori in this case). Ultimately the Trust's Senior Executive Team, of which the Medical Director, Director of Human Resources, Service Directors and Finance Director and Chief Executive are a part, would have carried overall responsibility.

8.2 My understanding is that the Trust did not break down costs on an individual MHPS case basis at that time.

8.3 I would have been responsible for initiating any investigation along with Mrs Toal (Human resources Director) as Co-chair of the Oversight committee. The Case Manager was directly responsible for tracking its progress. I also note that section 2.10 of the 2010 guidelines suggests that the NED may have a role in ensuring momentum is maintained. However, in the many years of my involvement of MHPS process, I have never before witnessed NED becoming involved until this case. In my opinion, it would probably be beneficial if this role was exercised more frequently.

9. Fully describe your role with regard to the establishment, responsibilities and functioning of the 'Oversight Group,' as referred to at paragraph 2.5 of the 2010 Guidelines. Further, please outline how your role differed from that of other regular attendees at the 'Oversight Group' namely:

I. Assistant Director – Medical Directorate;
II. Service Director;
III. HR Director; and
IV. Medical Staffing Manager.

9.1 I was the Co-Chair of the Oversight group with Mrs Vivienne Toal (Director of Human Resources). Mrs Toal and I would jointly decide which cases were to be discussed and invite the relevant service director to the team meetings. The group was supported administratively by my Assistant Director, Simon Gibson. We would invite other appropriate staff in specific circumstances where their input would be helpful, e.g., Mr Haynes (Associate Medical Director) and Mr Carroll (Assistant Director) in this instance. As Medical Director, I had additional responsibility as I was the doctor's Responsible Officer (RO) under the GMC Revalidation process.

9.2 Decisions would be taken jointly by Mrs Toal, myself, and the relevant Service Director. Mr Gibson was present as support but not in a decision-making role.

9.3 I am not entirely clear what is meant by the 'medical staffing manager'. This is not a term that I would use. Mrs Siobhan Hynds was appointed Senior Human Resources Manager to support the investigation administratively.

9.4 Mrs Martina Corrigan was the Head of Service. She would have been asked to provide information or context to the Oversight Team's deliberations and to the Case Manager regarding Mr O'Brien's compliance with this return to work plan

Handling of Concerns relating to Mr O'Brien

10. In respect of concerns raised regarding Mr Aidan O'Brien:

I. When did you first become aware that there were concerns in relation to the performance of Mr O'Brien?

II. If different, also state when you became aware that there would be an investigation into matters concerning the performance of Mr O'Brien?

III. Who communicated these matters to you and in what terms?

IV. Upon receiving this information what action did you take?

I, II, III & IV

10.1 Mrs Trouton (Assistant Director for Surgery) mentioned that there were difficulties with Mr O'Brien triaging patients and other administration issues at a meeting in January 2016. As indicated in my statement in response to Section 21 Notice No. 27 of 2022, I do not recall the detail of this meeting but I understand that we agreed that she should write to Mr O'Brien describing her concerns and asking him to amend his practice in line with that of his colleague Urological Surgeons. This meeting was informal and not minuted.

10.2 As far as I can recall the next discussion I had regarding this issue was with Mr Haynes (Initially Clinical Director, then Associate Medical Director) in September 2016 when he became AMD for Surgery, in which he shared that an

investigation, carried out by Mr Weir (CD), revealed the issues to be more extensive than previously appreciated.

10.3 Mr Haynes informed me of his concerns by telephone in September 2016. It was apparent that the local informal attempts to resolve the matters had not succeeded. He related that he had been informed that there were major triage backlog issues with Mr O'Brien's referrals and that there were other issues such as non-compliance with patient record keeping from outpatient notes. He explained that this was a potentially very serious problem and needed to be addressed urgently. These matters had come to light as Mr O'Brien was on sick leave and he and his other Urology consultant colleagues had been seeing Mr O'Brien's patients during that time. He agreed that we should establish an Oversight Committee meeting to consider the issues raised.

10.4 It was at that point that, after discussion with Mrs Toal (Co-chair of the Oversight Committee and Director of HR), we placed Mr O'Brien's case on the agenda for the next Oversight committee meeting in September 2016.

10.5 The Oversight team was constituted on 13th September 2016 to consider the issues raised by Mr Haynes The Acute Services Director was asked to produce an action plan to deal with them. (See minutes of Oversight meeting 16th September 2016). An MHPS investigation was considered appropriate. Mrs Gishkori was asked to meet with Mr O'Brien to inform him of our decision. Unfortunately, Mr O'Brien went on Personal Information redacted by the HSI leave before this could happen. Subsequently there were several follow up Oversight Committee meetings in October, December and January 2017 which progressed each of these issues which were untriaged referrals, notes being kept at home, undictated clinical outcomes and the management of private patients..

10.6 As Medical Director, I was Co-chair of the Oversight Committee. We initially reviewed a preliminary report by Mr Weir and the preliminary findings of a Serious Adverse Incident that was underway, and decided to proceed formally at the Oversight Team meeting on 22nd December 2016. This entailed excluding Mr

O'Brien and commencing the formal stage of the MHPS process. I contacted NCAS and discussed the case prior to meeting Mr O'Brien on 30th December 2016. A written action plan to address the backlog and other governance issues was to be developed by Mr Carroll (Assistant Director Surgery) and Dr Boyce (Governance lead).

11. Were the concerns raised, registered or escalated to the Chief Executive as required by Section I paragraph 8 of MHPS and paragraph 2.3 of the Trust Guidelines? If so, explain how, by whom and when this was done, and outline what information was provided to the Chief Executive. If this was not done, explain why not?

11.1 I cannot be sure of the exact date I first mentioned the MHPS issues informally to Mr Rice (Chief Executive) but I believe there were some brief conversations after the first Oversight meeting in September 2016. I formally raised the concerns with Mr Rice (Chief Executive) after the Oversight meeting on 22nd December 2016. After this meeting I went to Mr Rice's office in Trust HQ and informed him of our recommendation. This was to begin a formal MHPS process to look at the issues raised around Mr O'Brien's patient administration including untriaged patients, dictation of clinic notes and the whereabouts of patient records.

11.2 I informed him that we were intending to exclude Mr O'Brien from work initially for a period of four weeks and requested that he, in liaison with the Trust Chair, should identify a designated Non Executive Director in keeping with MHPS procedure. I verbally outlined the situation and the recommendations of the Oversight Committee meeting. This meeting with the Chief Executive occurred at some point between 22nd December and 29th December 2016. However, I cannot be sure of the exact date.

12.Outline all interactions you, or your office had with NCAS with regard to Mr O'Brien including the purpose of any interaction, the date of the interaction, the information shared with NCAS, any advice provided by NCAS and the steps taken to act on that advice, if any. If advice was provided by NCAS but not acted upon, explain why.

12.1 When concerns were brought to my attention in early September 2016 I asked Mr Gibson (Assistant Director, Medical Director's office) to liaise with NCAS regarding the matter on 7th September. He received a letter from Colin Fitzpatrick, NCAS advisor, on 13th September (*located at Relevant to MDO/Evidence after 4 November MDO/Reference no 77/no 77 – Simon Gibson/20160928 Email Dr A O'Brien attachment.pdf*) reflecting that discussion. Once the decision to proceed with the MHPS formal investigation was made I telephoned NCAS on 28th December 2016 to discuss the case and possible exclusion. We agreed that this would be for 4 weeks only. This was confirmed by a letter from Grainne Lynn (NCAS adviser) to me dated 29th December 2016. I later telephoned NCAS to advise them that Mr O'Brien would be returning to work under supervision. (I received an email from Mr Simon Gibson on 30 May 2017 copying me into correspondence from NCAS to him but it is encrypted and I am not sure what it referred to). I believe Dr Khan, as Case Manager, interacted further with NCAS. The NCAS team were content with this approach at this time.

13.Outline the circumstances and the process by which you understand concerns in relation to Mr O'Brien came to be discussed by the Oversight Group on 13th September 2016 and address the following:

I. From what source did the concerns and information discussed at that meeting emanate?

II. What do you understand to have been decided at that meeting?
III. What if any action did you take on foot of same?
IV. If no action was taken, please explain why and refer to all relevant correspondence.

13.1 i) Mr Haynes, (Associate Medical Director Surgery, representing Acute Services) contacted me by telephone to inform me that Acute services had evidence that there were ongoing issues with Mr O'Brien's patient administration that had not been possible to resolve informally. He agreed that the matter should now be considered by the Oversight meeting. I concurred that these issues were worthy of

discussion by the Oversight team. I organised a meeting of the Oversight Team on 13th September 2016.

13.2 ii) Simon Gibson (Assistant Director Medical Director's office) was instructed to draft a letter for Colin Weir (Clinical Director) and Ronan Carroll (Assistant Director) to present to Mr O'Brien.

13.3 Esther Gishkori (Acute Director) was instructed to meet with Colin Weir, Ronan Carroll and Simon Gibson to confirm actions required in letter.

13.4 The meeting at which the letter would be presented was to take place 19th September 2016 and the purpose was to inform Mr O'Brien that the Trust was intending to proceed with an informal investigation under MHPS within a 4-week timescale.

13.5 Mr O'Brien was to be informed that, potentially, a formal investigation might follow if significant issues were confirmed.

13.6 iii) These actions, however, did not occur at this time as Mrs Gishkori pointed out in an email that Mr O'Brien was about to go off on Personal Information redacted by the USI leave and requested that she be given a few more weeks to resolve the issues at hand.

13.7 iv) I responded by email asking for confirmation of Acute Services' action plan to address the issues raised before an answer to their request could be given. However, events took their course and Mr O'Brien went on Personal Information redacted by the USI leave before a formal meeting could be convened. A follow up Oversight meeting was convened on 12th October 2016 when Mrs Gishkori indicated that she would address the issues raised regarding Mr O'Brien upon his return from Personal Information redacted by the USI leave.

14. Outline when and in what circumstances you became aware of the following Serious Adverse Incident investigations and that they raised concerns about Mr O'Brien, and outline what action you took upon becoming aware of those concerns:

I. Patient Patient 10 ***(RCA*** Personal information redacted by USI ***),***
II. The care of five patients (RCA Personal information redacted by USI ***); and***

III. Patient Patient 16 ***(RCA*** Personal information redacted by USI ***.***

14.1 i) With regards to "SAI/RCA Personal information redacted by USI - I was aware of the ongoing work on this case from November 2016 when Mr Haynes spoke to me about same. This was the trigger case which was referred to in the Oversight Committee's Minutes from its December 2016 meeting. It was one of the main factors which led the Oversight Team to institute a formal MHPS process. We did not have the final report however we were satisfied that we had enough information from the SAI which was shared by Mr Glackin via Mr Haynes to cause significant concern.

14.2 II. and III) RCA Personal information redacted by USI and RCA Personal information redacted by USI were not specifically known to me until I was approached by the Acute Governance Team to source an external expert who could conduct complex RCA reviews. I believe this was in May of 2017 as there is an email chain from Ronan Carroll to Dr Chada on 8th May 2017 which I have been copied into indicating the need for further SAIs and looking for an external chair. I am unable to recall the exact date. I was made aware at that time that significant incidents had been identified in relation to Mr O'Brien's patient administration, but I had not seen any of the detail. I recommended that Dr Johnston, a retired colleague with whom I had worked with in Belfast Trust, would be an appropriate expert to carry out the RCA investigations.

14.3 I did not see the SAI/RCA of any of these reports until they were provided to me on the 9th May 2022 in Craigavon at Trust Headquarters, along with the findings of the Case Manager. I note that these incidents were all initially raised in 2016 before the MHPS investigation began and the restrictions on Mr O'Brien's practice were implemented.

15. Outline the circumstances and the process by which you understand concerns in relation to Mr O'Brien came to be discussed by the Oversight Group on 22 December 2016 and address the following:

- ***I. What information was before the Oversight Group on that date, and from what source did the information discussed at that meeting emanate?***
- ***II. What do you understand to have been decided at that meeting, and what action was to take place following that meeting?***
- **III. *What steps did you take* as Medical Director to ensure that those actions took place?**

15.1 i) At the Oversight meeting on 22nd December 2016, any ongoing case(s) were discussed as a matter of usual practice. A report was presented by Mr Carroll in relation to the issues affecting Mr O'Brien. Dr Boyce summarised issues of concern that were emerging from an ongoing SAI (Personal information redacted by USI). Please see 2016 12/22 oversight group notes (**Bates Reference TRU-00033-TRU-00034**).

15.2 ii) It was noted that Mr O'Brien had been scheduled to return to work from sick leave on 2nd January 2017 but that in the meantime an SAI had come to light involving one of Mr O'Brien's patients. Initial enquiries had identified 318 untriaged patient referrals resulting in some delays in seeing patients over the previous year. There appeared to be some patients' notes at Mr O'Brien's home address with little evidence of a clear management plan.

15.3 There was a backlog of 60 undictated clinics with unclear action plans for 600 patients.

15.4 Given the weight of these findings, taken together with the SAI findings, it was agreed to proceed to exclude Mr O'Brien as there was a real possibility that he might return from sick leave earlier than expected. This exclusion was instituted under MHPS guidelines for an initial period of four weeks after discussing with NCAS and then meeting Mr O'Brien in person on 30th December 2016.

15.5 A written action plan was requested from the Acute Services Team to address the issues identified.

15.6 The Case Investigator was appointed as (initially) Mr Weir (CD) and Case Manager, Dr Khan (AMD Paediatrics).

15.7 iii) I spoke to the Chief Executive, Mr Rice, and the Chair of the Trust, Mrs Brownlee, to inform them of our decision to begin a formal MHPS process and arranged to meet Mr O'Brien on 30th December to inform him of our decision. It would primarily have been the responsibility of Mrs Gishkori (Acute Services Director) to ensure that her Directorate action plan was implemented but we did review progress in this area at the Oversight Meeting held on January 10th 2017.

Please see 2017 01 10 oversight group notes (**Bates Reference TRU-00035-TRU-00036**).

16.v With reference to specific provisions of Section I of the MHPS Framework and the Trust Guidelines, outline all steps you took as Medical Director once a decision had been made to conduct an investigation into Mr Aidan O'Brien's practice in line with that Framework and Guidelines.

16.1 At the Oversight meeting 22nd December 2016, on behalf of Acute Services, Mr Carroll provided us with information regarding the issues raised regarding Mr O'Brien's patients. He specifically addressed the likely extent of the issues.

16.2 I discussed the possible course of action with NCAS before I met Mr O'Brien on 30th December 2016.

16.3 We sought an assurance from Acute Services that there was an action plan being implemented to mitigate risk and protect patients.

16.4 We considered if exclusion was required and decided that in the interests of Mr O'Brien, the patients involved, and the investigating team that an exclusion was temporarily necessary to allow the initial investigation to proceed as fast as possible and protect patients from any possible harm.

16.5 I spoke to the Chief Executive and the Chair of the Trust Board and asked for a designated Board member to be appointed. Mr John Wilkinson was subsequently appointed as the Non-Executive Director to the case.

16.6 The Chief Executive agreed with my recommendation to appoint Dr Khan as Case Manager and Mr Weir as Case Investigator.

16.7 I contacted NCAS initially by phone to ask for advice and assistance before meeting Mr O'Brien on 30th December 2016. A preliminary investigation then proceeded. We ensured that Mr O'Brien was able to bring a friend for support to the meeting. Mrs O'Brien attended in that capacity.

16.8 I met with Mr O'Brien on 30th December 2016 to explain our approach. This meeting was formally minuted by Lynne Hainey (Human Resources Manager) with a follow up letter sent to Mr O'Brien a few days later.

16.9 Mr Khan as Case Manager arranged for the terms of reference to be shared with Mr O'Brien and Mr Weir the Case Investigator.

16.10 The report took much longer than the recommended 4 weeks. Unfortunately, in my experience, that is not unusual. Much of the initial delay was due to scheduling interviews with staff and indeed agreeing dates with Mr O'Brien himself. A decision was taken to change the Case Investigator after representations were made by Mr O'Brien to the designated NED, John Wilkinson. Mrs Toal and I considered the need for an investigator without any line management responsibilities for Mr O'Brien, as Mr Weir was Mr O'Brien's acting Clinical Director. I then asked Dr Neta Chada (Associate Medical Director for Mental Health and Learning Disability) to take on the role as Case Investigator. She accepted the role.

16.11 Before the report was presented, I had to take a period of Personal information redacted by HSI leave Personal Informa [redacted] from 23rd February 2018 until late April 2018. When I was on Personal information redacted by HSI leave, I decided to retire from full time NHS work in August 2018 to pursue a new direction. Mr Devlin (the new Chief Executive) asked me to come back to carry out a number of reviews around medical recruitment and job planning instead of returning as Medical Director. I accepted this role returning to work at the end of April 2018. Dr Khan was appointed as interim Medical Director. From February 2018, I therefore played no further role in the process in respect of Mr O'Brien.

17. What role or input, if any, did you have in relation to the formulation of the Terms of Reference for the formal investigation to be conducted under the MHPS Framework and Trust Guidelines in relation to Mr O'Brien? Outline all steps you took, information you considered and advice you received when finalising those Terms. Describe the various iterations or drafts of the Terms of Reference and the reasons for any amendments, and indicate when and in what manner these were communicated to Mr O'Brien.

The Terms of Reference were agreed by Mrs Toal and I after being drafted by Mr Simon Gibson (Assistant Director) after discussion with NCAS in early January 2017. I have been unable to clarify the exact date or details concerning any possible differing iterations

18. ***When, and in what circumstances, did you first became aware of concerns, or receive any information which could have given rise to a concern***

that Mr O'Brien may have been affording advantageous scheduling to private patients.

18.1 This issue regarding private patients first was recorded in the Oversight Meeting minutes of 10th January 2017. A review of Trans Urethral Resection of Prostate (TURP) patients identified 9 patients who had been seen privately as outpatients, then had their procedure carried out within the NHS, and noted that the waiting times for those patients seemed less than expected and in non-chronological order. This review was brought by Mr Ronan Carroll (Assistant Director) to the Oversight Meeting after the issue was highlighted by Mr Haynes (Associate Medical Director, Surgery).

19. With regard to the Return to Work Plan / Monitoring Arrangements dated 9th February 2017, see copy attached, outline your role, as well as the role of any other responsible person, in monitoring Mr O'Brien's compliance with the Return to Work Plan and provide copies of all documentation showing the discharge of those roles with regard to each of the four concerns identified, namely:

I. Un-triaged referrals to Mr Aidan O'Brien;
II. Patient notes tracked out to Mr Aidan O'Brien;
III. Undictated patient outcomes from outpatient clinics by Mr Aidan O'Brien; and

IV. The scheduling of private patients by Mr Aidan O'Brien

19.1 The role of monitoring Mr O'Brien's return to work fell primarily to his line management in Acute Services. My role as part of the Oversight Team was initially to consider updates from Acute Services as to how this was working and then delegate that function to the Case Manager, Dr Khan. These updates were raised at Oversight Meetings by Mr Carroll and Mrs Gishkori. During my time as Medical Director the reports that we were receiving were encouraging in that they suggested good compliance with the monitoring arrangements. I note that this was also Dr Khan's conclusion when he made his final MHPS deliberation. I was no longer involved in the MHPS process after February 2018.

20. What is your understanding of the period of time during which this Return to Work Plan/Monitoring Arrangements remained in operation, and which person(s) were responsible for overseeing its operation in any respect?

20.1 Before Mr O'Brien returned to work after his period of Personal Information redacted by the USI leave and then temporary exclusion, the Acute Services Director (Mrs Gishkori) and her team were asked to produce a return-to-work plan for Mr O'Brien. This was presented to Mr O'Brien at a face to face meeting with Dr Khan (Case Manager) on 9th February 2017. In addition, Acute Services put monitoring arrangements in place which appeared to be working well for as long as I was involved in the process until February 2018. I requested that Mr O'Brien should be signed off by Occupational Health as fit before his return to work after the exclusion was lifted on 27th January 2017

20.2 The key individuals involved in monitoring this phase were Mrs Gishkori (Acute Services Director), Mr Ronan Carroll (Assistant Director), Mrs Martina Corrigan, (Head of Service responsible for Urology) and Mr Colin Weir (Clinical Director). Dr Khan as Case Manager would have received ongoing reports of compliance as the investigation was ongoing.

21. With specific reference to each of the concerns listed at (19) (i)-(iv) above, indicate if any divergences from the Return to Work Plan were identified and, if so, what action you took to address and/or escalate same.

21.1 The supervision of the return-to-work plan was primarily the responsibility of the Acute Services team including Mrs Martina Corrigan (Service Manager) with oversight from Dr Khan (Case Manager). I was not made aware of any significant divergences from the return-to-work plan during my tenure as Medical Director until February 2018, when I went on Personal information redacted by USI leave and then retired. I have now seen an e-mail trail between Martina Corrigan (Service Manager) to Ronan Carroll (Assistant Director) in May 2018 indicating good compliance with the plan although acknowledging that at that stage there were still some case notes unaccounted for. I note that, in the Case Manager's final report, Dr Khan concluded that there were no patient safety issues and that Mr O'Brien's compliance was good.

22. On what basis was it decided that Dr Khan, Case Manager, and yourself, in your role of Medical Director, would respond to representations lodged by Mr O'Brien with the designated Board member on 7th February 2017 and 6th March 2017 respectively.

22.1 Given the questions that Mr O'Brien had raised regarding the Case Investigator and other issues, the only people empowered to respond quickly and effectively would be the Medical Director and Case Manager. There was no meeting where such a pathway was discussed as far as I am aware and no written policy was developed or implemented. This approach simply was the most logical and quickest way of dealing with the issues raised. In all of the MHPS cases that I had been involved with previously the designated board member had never been approached. In my experience, this issue had never arisen before.

***23. Explain the circumstances which led to Mr Colin Weir being asked to step down from his role of Case Investigator in February 2017*.**

23.1 There were a number of considerations. I understand Mr O'Brien had made some representations to Mr Wilkinson (NED) expressing reservations about Mr Weir conducting the investigation. I do not know the detail of these reservations but suspect that it may be because Mr Weir was his direct line manager as Clinical Director. In an email that I sent to Dr Khan (Case Manager) on February 21st 2017, I [redacted] I had sought after Mr O'Brien had expressed concerns to Mr Wilkinson regarding the role of Mr Weir as Case Investigator. Upon considering the operational need for Mr Weir to be involved in the implementation and monitoring of Mr O'Brien's return to work plan, it seemed counter-intuitive that someone so closely involved with managing the issues should also be conducting the investigation. In considering the matter, there was a balance to be struck between the advantages of the Clinical Director investigating (who would be familiar with many of the issues) in contrast to an investigator who was unknown to the doctor.

23.2 Having considered the matter with Mrs Toal (Human Resources Director and Co-chair of the Oversight committee), we agreed that it was better to lean towards the latter as our guiding principle in this particular case and, as such, we were content to make the switch to a new Case Investigator. This was also of benefit to

SHSCT as it allowed Mr Weir to concentrate on operational matters in his role as Clinical Director. My impression at the time was that all parties, including Mr O'Brien, were content with this decision.

24. Section I paragraph 37 of MHPS sets out a series of timescales for the completion of investigations by the Case Investigator and comments from the Practitioner. From your perspective as Medical Director, what is your understanding of the factors which contributed to any delays with regard to the following:

I. The conduct of the investigation;
II. The preparation of the investigator's report;
III. The provision of comments by Mr O'Brien; and
IV. The making of the determination by the Case Manager.

Outline and provide all documentation relating to any interaction which you had with any of the following individuals with regard to any delays relating to matters (I) – (IV) above, and in doing so, outline any steps taken by you in order to prevent or reduce delay:

1. ***Case Manager***
2. ***Case Investigator;***
3. ***Designated Board member;***
4. ***the HR Case Manager;***
5. ***Mr Aidan O'Brien; and***
6. ***Any other relevant person under the MHPS framework and the***

Trust Guidelines

24.1 By the time the Case Manager presented his report in August 2018 I was no longer Medical Director. Indeed, I only read the Case Investigator's report and Case Manager's determination on 9th May 2022 for the first time

24.2 i) The initial witness list shared by the Case Investigator in her report suggested that the last interviews would be completed by 05 June 2017. Mr

O’Brien rescheduled several attempts at planning meeting dates and was slow to respond to requests for comments from the Case Investigator. Mr O’Brien’s comments were finally received on 2 April 2018 more than a year after the start of the investigation.

24.3 ii) The Case Investigator conducted the investigation as rapidly as was possible given the difficulty in obtaining timely responses from Mr O’Brien.

24.4 iii) Mr O’Brien was slow to provide his comments in a timely manner which significantly slowed the progress of the investigation.

24.5 iv) I have no understanding of why Dr Khan’s report was delayed by a few months from receiving the Case Investigator’s report.

24.6 Unfortunately, in my experience working across three of the five acute Trusts in Northern Ireland during my professional life, MHPS investigations are almost never completed within the timescales laid out in the guidance. In my opinion, the timescales are unrealistic and unachievable except in the simplest of cases.

24.7 One of the main reasons for delay is the availability of senior staff to attend interview with the investigating team and the time that the investigator has available themselves to conduct interviews within a busy clinical job. Doctors, in particular, have heavy clinical commitments and are always reluctant to cancel or defer patient interactions. I can understand this. A timetable for interview was initially produced that seemed manageable but for various reasons sometimes proved too ambitious.

24.8 However, in this case these were minor issues. The main cause of delay in producing the investigator’s report was Mr O’Brien himself who repeatedly deferred interview appointments and then was slow to respond to requests for his comments.

24.9 In my opinion, there is a fine line between forcing the pace of the investigation and reasonably responding to clinicians’ requests for deferring interviews so as not to disadvantage patients or appear unnecessarily intimidating.

24.10 On reflection, as I have stated elsewhere, a dedicated team of investigators who had more time available to them for the investigation, may have been able to complete the process quicker, however, throughout 2016-2018 we were very reliant

upon our Associate Medical Directors to perform this function, all of whom also had onerous clinical commitments.

24.11 I had retired as Medical Director when the Case Manager made their conclusions and recommendations so I cannot meaningfully comment on the timing of these except to say that a faster conclusion would have been in the interests of all parties.

24.12 I am unaware as to why the determination of the Case Manager took until August 2018 as I had no input into this case after February 2018. I am, however aware that Dr Khan was asked to take on many of the functions of the Medical Director during and after my period of Personal Information redacted by HSI leave in February 2018 and could understand if the onerous workload that ensued may have been an issue.

24.13 I don't believe I have any documentation to produce in relation to these delays.

25. ***Outline what steps, if any, you took during the MHPS investigation, and outline the extent to which you were kept appraised of developments during the MHPS investigation?***

25.1 It is the Case Manager's role to oversee the progress of the investigation. It was my normal practice that the Medical Director, having delegated the Case Manager role, should not get involved in the MHPS process until the Case Manager reported their final recommendations. In this particular situation, I had retired as Medical Director by February 2018 before the conclusions and recommendations were presented.

25.2 In my opinion, there are good reasons for Medical Director to remain detached from the day to day running of the MHPS investigation. It may be that the Medical Director could be involved in implementing some of the recommendations such as participating in a potential disciplinary panel or referral to NCAS. In my view it is usually better not to be involved in the writing of, or the process around, the production of the recommendations.

25.3 I would have met both Dr Khan and Dr Chada in 1:1 meetings to review their work as AMDs on a few occasions during the investigation period. Although not the main focus of the meeting, I would have inquired as to how things were progressing

up until I went on Personal information redacted by HSI leave in February 2018. I was aware that there had been some delays in process largely due to Mr O'Brien's reticence to agree interview dates.

MHPS Determination

26. Outline the content of all discussions you had with Dr Ahmed Khan, regarding his Determination under Section I paragraph 38 of MHPS.

26.1 I was on Personal information redacted by HSI leave in February 2018 and then retired from the Trust in August 2018. I had no role in the case from February 2018 and did not discuss the matter with Dr Khan after that. I did not know what the nature of the MHPS determination was until I was given access to these documents in order to produce this statement on 9th May 2022.

27. On 28 September 2018, Dr Ahmed Khan, as Case Manager, made his Determination with regard to the investigation into Mr O'Brien. This Determination, inter alia, stated that the following actions take place:

I. The implementation of an Action Plan with input from Practitioner Performance Advice, the Trust and Mr O'Brien to provide assurance with monitoring provided by the Clinical Director;
II. That Mr O'Brien's failing be put to a conduct panel hearing ;and
III. That the Trust was to carry out an independent review of administrative practices within the Acute Directorate and appropriate escalation processes.

With specific reference to each of the determinations listed at (I) – (III) above address:

1. ***Who was responsible for the implementation of each of these actions?***
2. ***To the best of your knowledge, outline what steps were taken to ensure that each of these actions were implemented; and***
3. ***If applicable, what factors prevented that implementation.***
4. ***If the Action Plan as per 27(I) was not implemented, fully outline what steps or processes, if any, were put in place to monitor Mr O'Brien's***

practice, and identify the person(s) who were responsible for these? Did these apply to all aspects of his practice and, if not, why not?

27.1 I left the Trust in August 2018 and was not present when the report completed. I had not been in the role of Medical Director from February 2018 after a period of Personal information redacted by HSI leave so I cannot comment on specific issues related to this.

Implementation and Effectiveness of MHPS

28. Having regard to your experience as Medical Director, in relation to the investigation into the performance of Mr Aidan O'Brien, what impression have you formed of the implementation and effectiveness of MHPS and the Trust Guidelines both generally, and specifically as regard the case of Mr O'Brien?

28.1 I was present at the introduction of the process and the instigation of the MHPS investigation but had left the Trust by the time the report was published. I cannot comment on what happened to delay its final production or indeed the actions taken thereafter.

28.2 Once the issue was brought to the Oversight Team's attention for consideration, I believe that the MHPS process initially worked well in a complex and difficult situation. However, I believe the issues should have been escalated to the Oversight Team earlier. In retrospect, the time period to complete the MHPS process was too slow (as is often the case). The reasons for this are often complex and not easily resolved. More dedicated programmed activity (PA) time for investigators to carry out their function might be helpful. A pool of trained Case Investigators and Case Managers external to the Trust and readily available would likely make the process quicker. Improved guidance around how to deal with a doctor who is not responding to the inquiry team in a timely manner may be helpful. I have no knowledge of any of the delays after February 2018.

28.3 More robust guidance could be provided for Case Investigators to deal with situations where the doctor under investigation does not respond to reasonable requests for interview dates and then does not return comments in a timely manner.

28.4 The updated Trust guidelines were only finalised in October 2017 and were therefore too late for most of this process. Having considered same, in general, I believe they are helpful in clarifying the process as it stands.

29. To what extent were you able to effectively discharge your role as Medical Director under MHPS and the Trust Guidelines in the extant systems within the Trust? What obstacles did you encounter when performing this role and what, if anything, could be done to strengthen or enhance that role.

29.1 I believe I was able to discharge my role as Medical Director under MHPS appropriately. I was well supported by my own team (Simon Gibson, Assistant Director) in particular. I acted promptly once I was alerted to the gravity of the issue in September 2016 and followed MHPS guidance. I enjoyed good relations with the senior Human Resource team and in particular Mrs Toal (Human Resources Director) with whom I co-chaired the Oversight meetings. Francis Rice, Stephen McNally and then Shane Devlin in turn were all appropriately supportive as Chief Executives. There would, however, have been better continuity if there had not been such a turnover of Chief Executives. Once the issue of ongoing unresolved patient administration issues were raised with us by Acute Services, I believe we took prompt action to protect Mr O'Brien, his patients, and the Trust. I have tried to discourage doctors from managing issues of concern informally for prolonged periods and hopefully have helped to change the mindset by introducing formal training in this area for all medical leaders within the Trust.

29.2 I did not encounter any specific obstacles to progressing the investigation.

29.3 In the future I would further develop training for all relevant staff in MHPS process. I would argue for more protected time in job plans for Case Investigators and Case Managers.

29.4 I had brought a proposal to Senior Management Team for in Spring 2018 for the creation of two deputy medical director posts one of whom would have specific responsibility for professional matters. I believe this would have improved our Trust performance in the area of case management. Unfortunately, for mostly financial reasons this proposal was not supported at that time. I understand there has been some progress in this area since I left the Trust in August 2018

30. Having had the opportunity to reflect, outline whether in your view the MHPS process could have been better used in order to address the problems which were found to have existed in connection with the practice of Mr O'Brien.

30.1 When I conducted my review of job planning for doctors in SHSCT in 2018, the findings made clear that clinical leaders were not granted sufficient programmed activity time within their job plans to carry out duties such as Case Investigator and Case Manager on top of their onerous and pressurising clinical duties. In my opinion, this should be appropriately resourced and addressed through the job planning process and more realistic Programmed Activity (PA) allocations identified. This would help in concluding the investigations quicker.

30.2 I believe the time-frames listed under the MHPS process are unrealistic and should be amended based on experience. However, I would have expected that most investigations could be conducted at least within a three-month time frame if properly resourced and supported.

30.3 In some examples of MHPS investigations, I might have suggested better training for the Case Investigator. However I note that in this specific example, the Case Investigator's report was - in my opinion - thorough and balanced. As a result, I don't believe that this was a relevant factor in this case.

30.4 On reflection, we should not have appointed Mr Weir as Case Investigator initially. As he was Mr O'Brien's Clinical Director, he was too closely involved in his day-to-day practice. We acknowledged that error when we changed the Case Investigator within a few weeks of the issues being raised, demonstrating that we were a responsive team who listened to reasonable points made by Mr O'Brien.

30.5 On reflection, I should have been more fastidious about making a file note of every informal contact or discussion I had in relation to the case. There is a trade off with this approach. In my opinion, if doctors believed I was doing this every time they spoke to me, they would potentially be less open about discussing their concerns.

31. Outline any and all discussions you had during your tenure as Medical Director with regard to the updating or amending of the MHPS Framework. Specify who was involved in these discussions, what changes or amendments were proposed and what, if any factors, prevented those discussions for leading to the updating or amending of the MHPS Framework.

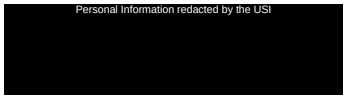
31.1 I had no discussion that I can recall during my tenure as Medical Director regarding updating the MHPS Framework as this is something that is decided at DOH NI level and cannot be unilaterally changed by the Trust. However, some years earlier when I was an Associate Medical Director in Belfast Health and Social Care Trust, I took part in a regional review which I believe was led by Mr Mervyn Barclay (former HR Co Director of BHSCT) which looked in depth at the MHPS process to try and improve it. I believe the review engaged with multiple interested parties at the time including the GMC, BMA and DOH. I cannot recall what exactly happened to the report but don't believe it was ever acted upon.

31.2 My team in SHSCT, under the leadership of Mrs Zoe Parks (Medical Workforce Lead), produced a new guidance document for handling Concerns about Doctor's performance (October 2017) within the Trust which I believe made the MHPS process simpler to understand when it was introduced. It also clarified informal resolution paths. Although this had been in preparation for some time it was not formally launched until after this particular MHPS process had begun in 2016/17. *This can be located at Ongoing Discovery March 2022/MDO/Document No 66/_SHSCT - Guidelines for Handling Concerns about Doctors OCTOBER 2017.pdf.*

31.3 In response to needs expressed by clinicians, my team, in association with HSC Leadership Centre and our own Trust HR team developed a bespoke training programme for medical leaders which included a specific module on dealing with concerns including the MHPS process. This received positive feedback from all involved. At the time it was the only course of its kind in the province. During those sessions there would have been considerable feedback captured from clinicians involved.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: 

Date: 16/06/2022

S21 43 of 2022

Witness statement of: Dr Wright

Table of Attachments

Appendix	Document Name
1	On-board training certificate
2	20170425 Third Regional SAS Conference
3	20161214 E re Case Investigator Training A
4	Final Brochure AMD and CD Development Programme January 2017
5	20161228 E re MHPS to Dr K-A2

Onboard

essential support for board members

ON BOARD TRAINING

CERTIFICATE OF ATTENDANCE

This Certificate records that

Dr Richard Wright

attended the On Board training programme on

4th December 2015

and is hereby deemed to have met the national minimum training requirement to serve on the Board of a public body

David Nicholl LLB CPFA
Chief Executive

This Certificate is valid for three years from the date of the course

Southern Health and Social Care Trust
Quality Care - for you, with you

THIRD REGIONAL SAS CONFERENCE

Patient Safety In Our Hands

Patient Safety – Protecting the Patient – Protecting Ourselves

Tuesday 25th April 2017, Seagoe Hotel, Portadown

8.45 am	**Registration**
9.15 am	**Welcome** *Mr Francis Rice, Interim Chief Executive, Southern H&SC Trust*
9.30 pm	**Patient Safety and the General Medical Council** *Professor Terence Stephenson, DM, FRCP, FRCPCH* *Consultant Paediatrician and Chair of the General Medical Council*
10.15 am	**Death Certification and Impact of M&M Meetings on Patient Safety** *Dr Julian R Johnston, MD, FFARSCI, FRCA* *Medical Adviser Death Certification Policy &Legislation Unit, Department of Health*
10.45 am	**Tea / Coffee / Scones**
11.15 am	**Patient Safety Meetings, Handover Rounds and Their Impact in Medical Management of Patients** *Dr Mark Roberts, FRCP, Consultant Acute Physician AMU, Southern H&SC Trust*
11.45 am	**DNR Directives - Appropriate Uses in Care of Dying** *Dr Patricia McCaffrey, FRCP, Consultant Elderly Care, Southern H&SC Trust*
12.30 pm	**Lunch**
1.30 pm	**Role of the Pharmacist in Patient Safety** *Dr Tracey Boyce, PhD, Director of Pharmacy, Southern H&SC Trust*
2.15 pm	**Infection Control and Antibiotic Stewardship – Developments in the Southern Trust and Impact on Patient Safety** *Dr Donna Muckian, Specialty Doctor Staff Grade in General Medicine & Diabetes, Trust Clinician to the Antibiotic Stewardship Team, Southern H&SC Trust*
2.45 pm	**Tea / Coffee**
3.15 pm	**Recognition / Awareness of Risk and Suicide Prevention in Assessment of Patients** *Dr Chris Southwell, Consultant Psychiatrist, Southern H&SC Trust*
3.45 pm	**Self-Awareness and Patient Safety** *Dr Richard Wright, Medical Director, Southern H&SC Trust*
4.15 pm	**Close**

APPROVED for 5 EXT CLINICAL CPD CREDITS code: 111126

Raffle in aid of Marie Curie Southern Trust Charity of the Year on the day

National Clinical Assessment Service

Case investigator training workshop

For Southern Health and Social Care Trust

Tuesday 07 – Wednesday 08 March 2017

09:15-16:45 (Day 1) and 09:00-16:00 (Day 2)

Seagoe Parish Centre, 46 Seagoe Road, Portadown, BT63 5HS

DRAFT DELEGATE PROGRAMME

This two-day workshop has been designed specifically for anyone who undertakes the case investigator role in investigations about practitioners, which may emerge from the processes underpinning revalidation or from concerns raised about performance. The workshop is interactive and uses case studies to explore and develop the key skills and knowledge required by case investigators.

Learning objectives

By the end of the two-day programme, delegates will be able to:

- Explore how concerns about a practitioner's practice arise and identify the most common factors affecting performance
- Explain why the decision to investigate is made and suggest other options to resolve performance concerns
- Describe roles and responsibilities of those involved in investigations
- Plan for an investigation which meets national requirements
- Describe the principles of robust and meaningful terms of reference and know how to work within them
- Collect, review and weight evidence
- Conduct an investigative interview using a structured approach
- Recognise the key skills and attributes of a case investigator
- Recognise their own limits of competence and access sources of support and expertise
- Reference relevant national/local standards
- Write an investigation report with conclusions
- Describe the potential legal challenges to an investigation.

Pre-reading

Questions to consider prior to attending the workshop:

- What is the role of the Case Investigator?
- When might an investigation of a concern be necessary?
- What is the purpose of an investigation?

Draft programme

This programme is indicative of the content areas which will be covered. Timings are flexible and will be tailored to focus on areas of particular interest to delegates.

Facilitators: Dr Colin Fitzpatrick, Senior Adviser (NI) and Dr Grainne Lynn, Adviser, National Clinical Assessment Service

DAY 1

08:45-09:15	*Registration and refreshments*
09:15	Welcome, introductions and overview of the workshop
09:35	**Dealing with concerns about a practitioner's practice:** • Performance concerns • Overview of investigations • Frameworks for managing concerns: - Toolkit for managing performance concerns in primary care - PLR - MHPS • Workshop A: Dealing with concerns about a practitioner's practice.
10:45-11:00	*Break and refreshments*
11:00	**Investigation roles and responsibilities:** • Case investigators • Case managers • Responsible officers • Decision making groups • Other stakeholders/parties, including clinical experts • Supporting the practitioner.
11:30	**Starting the investigation:** • Linking with the case manager • Terms of reference • Planning the investigation • Principles of investigation • Bias and prejudice (perceptions and reality).
12:00-12:45	*Lunch*
12:45	**Workshop B: Critiquing terms of reference and responding to a case manager's request.**

13:45*	**Gathering evidence:** • Sources of potential evidence • Evidence log • Documentary evidence • Evidence/comments from the practitioner • National and peer standards and guidance • Weighting and judging evidence • Workshop C: Investigation of Dr Purple – review of documentary evidence.
	**Refreshments available from 15:15*
15:45	**Gathering evidence:** • Collecting evidence from interviews • Inviting witnesses to interviews • Structuring interviews • Workshop D: Investigation of Dr Purple – interviewing witnesses (trainer-led role play).
16:35	Briefing on homework
16:45	*Close*
Homework	**Approx 1 hour to be undertaken in advance of Day 2** Prepare for Workshop E: Investigation of Dr Purple – interviewing witnesses (delegate-led role play)

DAY 2

09:00-09:15	*Registration and refreshments*
09:00	Review of day 1 – learning points
09:10*	**Workshop E: Investigation of Dr Purple – interviewing witnesses (delegate-led role play)**
	**Refreshments available at 11:00*
11:15	**Report writing:** • Drafting a witness statement • Following up with witnesses • Structure • Workshop F: Investigation of Dr Purple – report writing.
12:45-13:30	*Lunch*
13:30	**Workshop F: Investigation of Dr Purple – report writing (cont)**
14:00	**Supporting the practitioner**
14:05	**What happens next?** • Presenting the management case • Consideration of report • Outcomes • Remediation.
14:25	**Responding to legal challenges – the role of the case investigator**
14:40-14:55	*Break and refreshments*
14:55	**Workshop G: Investigation of Dr Purple - responding to legal challenge**
15:40	**Support for case investigators**
15:50	**Review of learning**
16:00	*Close*

Learning methods

There will be a number of opportunities for delegates to discuss and explore their own experiences and case studies in an appropriately confidential setting. Case studies will be used as learning tools for individual skills development and sharing of learning and experience.

NCAS' Statement of principles

During the workshop NCAS will present fictional learning material, which has been compiled through NCAS' work, to enable the sharing of your and NCAS' experiences of dealing with concerns about practitioner's performance. When discussing your own experience of cases, please make every effort to ensure that any information which identifies individuals or organisations is removed and fully anonymised. If you do hear information about a case which leads to, or gives the impression of, identification of the details of the case please treat this information as **strictly confidential**.

For more information about NCAS' Statement of principles please access our website on http://www.ncas.nhs.uk/events/confidentiality-principles/

Southern Health and Social Care Trust
Quality Care - for you, with you

Medical Director's Office

Trust Development Programme for Associate Medical Directors and Clinical Directors - 2017

January 2017

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Message from the Medical Director

Dear Colleagues

It is with great pleasure that I announce the launch of our Trust Development Programme for Associate Medical Directors and Clinical Directors.

This programme is the product of several months planning with colleagues from within my own office and also the Trust's Education, Learning and Development Team. A short-life working group was established, the remit of which was to review the role descriptors of both AMDs and CDs and, as a result, a series of key subject areas were identified. These subjects cover many of the domains proposed in the 'Framework for Generic Professional Capabilities' in the Association of Medical Royal College's and the General Medical Council's public consultation document (click here) each of which have specific themes and required outcomes (see figure 1 below).

Figure 1: Proposed Framework for Generic Professional Capabilities

Further, the GMC's Core Guidance "Leadership and Management for all Doctors" (GMC, 2012 click here) states that being a good doctor means more than simply being a good clinician. In their day-to-day role doctors can provide leadership to their colleagues and vision for the organisations in which they work and for the profession as a whole. However, unless doctors are willing to contribute to improving the quality of services and to speak up when things are wrong, patient care is likely to suffer. This guidance sets out the wider management and leadership responsibilities of doctors in the workplace including:

- Responsibilities relating to employment issues
- Teaching and training
- Planning, using and managing resources
- Raising and acting on concerns
- Helping to develop and improve services

The subjects within this development programme also encompass the domains of the NHS Healthcare Leadership Model which is contained within page 12 of this brochure.

I very much hope you enjoy the programme which consists of four modules being held over four full days, one day per month. Each of the days will be held twice to ensure that all AMDs and CDs can attend all four days. Dates and booking arrangements are on page 11.

I look forward to seeing you during the programme.

Dr Richard Wright
Medical Director

Module 1: Taking Your Service Forward

Quality Improvement

AIMS/OBJECTIVES:

- Understand Quality Improvement Models and how they are applicable to the AMD / CD role.
- Understand how to complete Quality Improvement Projects and be aware of the tools available to assist.

DESIRED OUTCOMES:

- By the end of this session, participants will feel confident in fostering an ethos of continuous improvement and reflection.

Developing Business Cases / Service Improvement Plans

AIMS/OBJECTIVES:

- Understand the principles of developing a Business Case / Service Improvement Plan.
- Understand how to work with colleagues when taking forward implementation plans.

DESIRED OUTCOMES:

- By the end of this session participants will be able to contribute effectively to the development and implementation of business cases / service improvement plans through evidence-based decision-making.

Overview of Budget Management

AIMS/OBJECTIVES:

- To provide participants with an overview of financial / budgetary management and common terminology.

DESIRED OUTCOMES:

- By the end of this session participants will be more confident in understanding and managing budgets, including their legal requirements and responsibilities.

HEALTHCARE LEADERSHIP MODEL DIMENSIONS COVERED BY MODULE 1: TAKING YOUR SERVICE FORWARD

Inspiring Shared Purpose

- Valuing a service ethos.
- Curious about how to improve services and patient care.
- Behaving in a way that reflects the principles and values of the NHS.

Influencing For Results

- Deciding how to have a positive impact on other people.
- Building relationships to recognise other people's passions and concerns.
- Using interpersonal and organisational understanding to persuade and build collaboration.

Evaluating Information

- Seeking out varied information.
- Using information to generate new ideas and make effective plans for improvement or change.
- Making evidence-based decisions that respect different perspectives and meet the needs of all service users

Module 2: Delivering Quality Care

Information Governance

AIMS/OBJECTIVES:

- To provide an overview of legal, statutory and personal responsibilities in relation to all aspects of Information Governance.

DESIRED OUTCOMES:

- By the end of this session, participants will be fully aware of their own and the Trust's responsibilities in relation to Information Governance and the legal implications of non-compliance.

Clinical and Social Care Governance / Safety, Risk and Improvement

AIMS/OBJECTIVES:

- Participants will have the opportunity to consider a range of information and consider how this information informs CSCG priorities within their area of responsibility.

DESIRED OUTCOMES:

- By the end of the session, participants will be fully aware of their own and the organisations responsibilities in relation to Clinical and Social Care Governance.
- Participants will have an opportunity to review and update their areas of responsibility and present CSCG priorities/work plan.

HEALTH CARE LEADERSHIP MODEL DIMENSIONS COVERED BY MODULE 2: DELIVERING QUALITY CARE:-

Evaluating Information

- Seeking out varied information.
- Using information to generate new ideas and make effective plans for improvement or change.
- Making evidence-based decisions that respect different perspectives and meet the needs of all service users.

Inspiring Shared Purpose

- Valuing a service ethos.
- Curious about how to improve services and patient care.
- Behaving in a way that reflects the principles and values of the NHS.

Module 3: Leading Your Team (Day 1)

Job Planning

AIMS/OBJECTIVES:

- To equip participants with the knowledge and skills to effectively manage medical job planning and appraisal within their specialty/division.
- To ensure effective development and delivery of education and research within the specialty / division.

DESIRED OUTCOMES:

- By the end of this session participants will be able to develop effective and accurate job plans to meet the needs of both medical staff and the Trust.

Managing Doctors in Training / Medical Education

AIMS/OBJECTIVES:

- To understand the structure of Medical Education and Training for doctors in training.
- To manage the interfaces and boundaries between the Trust and NIMDTA.
- To be clear on the roles and responsibilities of all medical staff who train junior doctors.
- To be able to implement and monitor Modernising Medical Careers and EWTD for junior doctors.

DESIRED OUTCOMES:

- By the end of this session participants will have acquired the necessary skills and knowledge to be able them to effectively manage doctors in training.

Management of Sickness Absenteeism

AIMS/OBJECTIVES:

- To understand the Trust's Sickness Absenteeism Policy and Procedures and your responsibilities as a manager.
- To understand the role of Occupational Health vis-à-vis sickness absence management.

DESIRED OUTCOMES:

- By the end of this session participants will understand the Trust's Sickness Absenteeism processes and will be aware of their responsibilities when managing staff absences.

Raising and Acting on Concerns / Maintaining High Professional Standards / Disciplinary Procedures

AIMS/OBJECTIVES:

- To be able to manage potential underperformance of medical staff within your specialty / division.
- To be able to take necessary action to address underperformance or unacceptable behaviour.
- To be able to identify and take appropriate action for doctors in difficulty.

DESIRED OUTCOMES:

- By the end of this session participants will have the necessary skills to enable them to identify and act upon concerns at an early stage. They will be aware of MHPS and Disciplinary processes and their involvement in these as well as the protocol to follow for doctors in difficulty.

HEALTHCARE LEADERSHIP MODEL DIMENSIONS COVERED BY MODULE 3: LEADING YOUR TEAM (DAY 1)

Leading With Care

- Having the essential personal qualities for leaders in health and social care.
- Understanding the unique qualities and needs of a team.
- Providing a caring, safe environment to enable everyone to do their jobs effectively.

Developing Capability

- Building capability to enable people to meet future challenges.
- Using a range of experiences as a vehicle for individual and organisational learning.
- Acting as a role model for personal development.

Holding to Account

- Agreeing clear performance goals and quality indicators.
- Supporting individuals and teams to take responsibility for results.
- Providing balanced feedback.

Module 3: Leading Your Team (Day 2)

Teamwork / Engaging and Empowering Staff / Effective Induction

AIMS/OBJECTIVES:

- To be able to understand the principles of effective team working.
- To promote inclusivity, respect and build capability within the team to meet future challenges.
- Have an understanding of the five 'Fundamentals of Civility'.

DESIRED OUTCOMES:

- By the end of this session participants will have the necessary skills to facilitate all individuals within the team to work towards a common goal and to fully promote engagement.

Conflict Management

AIMS/OBJECTIVES:

- To understand various approaches and techniques when managing conflict.

DESIRED OUTCOMES:

- By the end of this session participants will have acquired the necessary skills to confidently address areas / incidents of conflict.

Negotiation and Communication Skills

AIMS/OBJECTIVES:

- To effectively foster multi-disciplinary / inter-divisional team working and promote good working relationships.
- To further develop the above on a specialty / division, Trust, regional and national level.

DESIRED OUTCOMES:

- By the end of this session participants will have the skills to actively promote and develop good working relationships and networks on a local, regional and national level.

HEALTHCARE LEADERSHIP MODEL DIMENSIONS COVERED BY MODULE 3: LEADING YOUR TEAM (DAY 2)

Sharing the Vision

- Communicating a compelling and credible vision of the future in a way that makes it feel achievable and exciting.

Engaging The Team

- Involving individuals and demonstrating that their contributions and ideas are valued and important for delivering outcomes and continuous improvements to the service.

Developing Capability

- Building capability to enable people to meet future challenges.
- Using a range of experiences as a vehicle for individual and organisational learning.
- Acting as a role model for personal development.

Influencing For Results

- Deciding how to have a positive impact on other people.
- Building relationships to recognise other people's passions and concerns.
- Using interpersonal and organisational understanding to persuade and build collaboration.

Connecting Our Service

- Understanding how health and social care services fit together and how different people, teams or organisations interconnect and interact.

Module Dates

Module	First Date Module Being Held	Second Date Module Being Held
Module 1: Taking Your Service Forward	Monday 27th February 2017	Tuesday 14th March 2017
Module 2: Delivering Quality Care	Wednesday 22nd March 2017	Monday 10th April 2017
Module 3: Leading Your Team (Day 1)	Friday 28th April 2017	Thursday 18th May 2017
Module 3: Leading Your Team (Day 2)	Tuesday 23rd May 2017	Wednesday 7th June 2017

- **All Modules will take place in the Seagoe Parish Centre, Portadown and will run from 9.30 am sharp to 4.30 pm. Please ensure you arrive at the venue no later than 9.15 am each day.**

- **It is expected that all Associate Medical Directors and Clinical Directors will attend each of the four modules on either one of the dates.**

- **Please email** [redacted] **with your chosen date for each of the four modules no later than Friday 13th January 2016.**

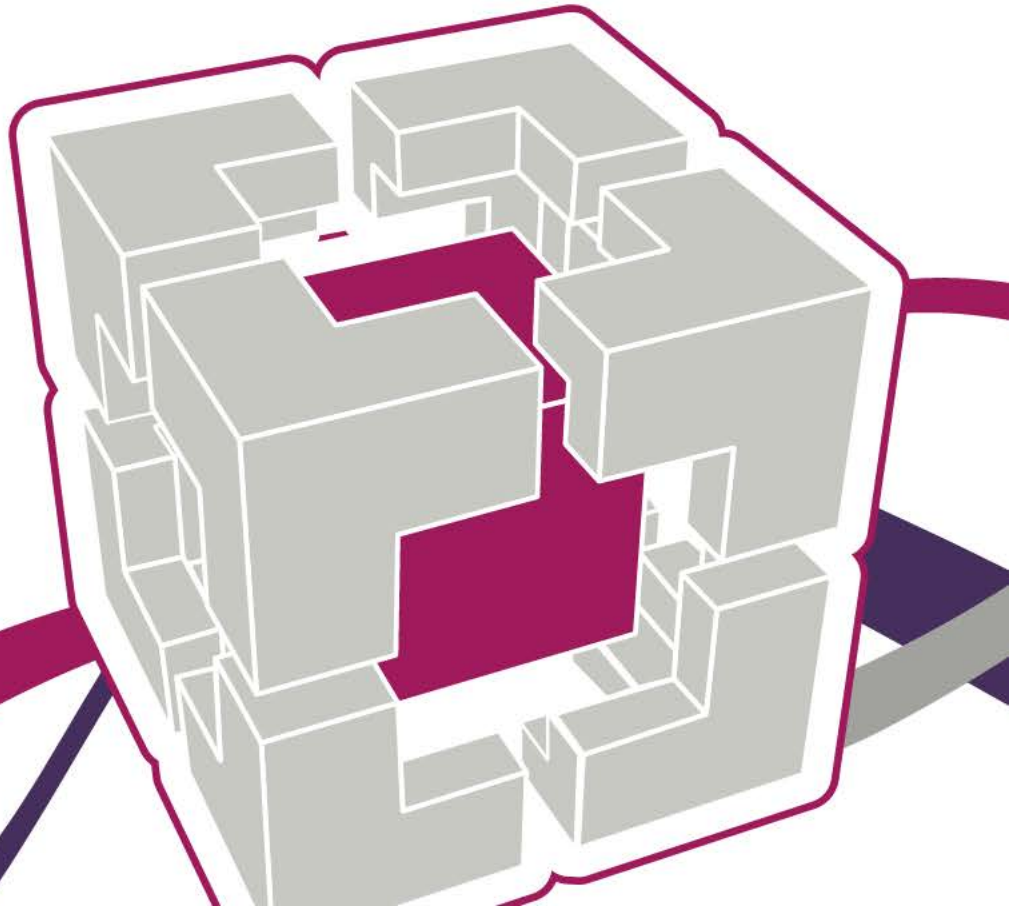
NHS Healthcare Leadership Model

NHS
Leadership Academy

Version 1.0

Healthcare Leadership Model

The nine dimensions of leadership behaviour



www.leadershipacademy.nhs.uk

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NHS Leadership Academy (2013), *The Healthcare Leadership Model*, version 1.0, Leeds: NHS Leadership Academy.

Introduction

Who the model is for

The Healthcare Leadership Model is to help those who work in health and care to become better leaders. It is useful for everyone – whether you have formal leadership responsibility or not, if you work in a clinical or other service setting, and if you work with a team of five people or 5,000. It describes the things you can see leaders doing at work and is organised in a way that helps everyone to see how they can develop as a leader. It applies equally to the whole variety of roles and care settings that exist within health and care.

We want to help you understand how your leadership behaviours affect the culture and climate you, your colleagues, and teams work in. Whether you work directly with patients and service users or not, you will realise what you do and how you behave will affect the experiences of patients and service users of your organisation, the quality of care provided, and the reputation of the organisation itself. The nature and effect of a positive leadership style can be summed up as:

Figure 1 : The nature and effect of a positive leadership style

The structure of the model

The Healthcare Leadership Model is made up of nine 'leadership dimensions', each of which has its own page in this document. There is a brief description of what the dimension is about and why it is important, and a section that says 'what it is not' to provide further clarity.

For each dimension, leadership behaviours are shown on a four-part scale which ranges from 'essential' through 'proficient' and 'strong' to 'exemplary'. Although the complexity and sophistication of the behaviours increase as we move up the scale, the scale is not tied to particular job roles or levels. So people in junior roles may find themselves to be within the 'strong' or 'exemplary' parts of the scale, and senior staff may find themselves in the 'essential' or 'proficient' parts. Similarly, you may find where you judge yourself to be may vary depending on the dimension itself. For example, you may be mostly 'strong' in a few dimensions, 'exemplary' in one, and 'essential' or 'proficient' in others. This may be appropriate depending on your job role, or it may show that there are areas that need some development or that are a particular strength.

Within these scales, the leadership behaviours themselves are presented as a series of questions. The questions are short descriptions of what the leadership dimension looks like at each part of the scale. These are the questions that guide leaders' thoughts and result in effective leadership behaviour. They are written in the 'first person' (Do I . . . ?), but are not meant to be answered with a simple 'yes' or 'no'. Instead, they should help you explore your intentions and motivations, and see where your strengths and areas for development may lie. You may also want to think about what evidence you could provide to support your answers.

Research[1] has shown that all nine dimensions of the model are important in an individual's leadership role. However, the type of job you have, the needs of the people you work with, and the context of your role within your organisation will all affect which dimensions are most important for you to use and develop.

The importance of personal qualities

'…the most important element… comes from a combination of emotional expressiveness, self-confidence, self-determination and freedom from internal conflict'[2]

The way that we manage ourselves is a central part of being an effective leader. It is vital to recognise that personal qualities like self-awareness, self-confidence, self-control, self-knowledge, personal reflection, resilience and determination are the foundation of how we behave. Being aware of your strengths and limitations in these areas will have a

[1] Please see Appendix 1 for more information on the research behind the Healthcare Leadership Model.
[2] Bass, B.M (1992), in M. Syrett and C. Hogg (Editors), Frontiers of Leadership. Oxford: Blackwell.

Figure 2 : The impact of personal qualities on the experience of care

direct effect on how you behave and interact with others, and they with you. Without this awareness, it will be much more difficult (if not impossible) to behave in the way research has shown that good leaders do. This, in turn, will have a direct impact on your colleagues, any team you work in, and the overall culture and climate within the team as well as within the organisation. Whether you work directly with patients and service users or not, this can affect the care experience they have. Working positively on these personal qualities will lead to a focus on care and high-quality services for patients and service users, their carers and their families (see Figure 2).

While personal qualities have not been separately highlighted in the Healthcare Leadership Model, you will find them throughout the various dimensions. It is important to realise that areas identified for development within the model may be as much about how you manage yourself as about how you manage your behaviour and relate to other people.

How to use this document

The document illustrates the leadership behaviours expected for all staff in healthcare, so you can use it to help you think about your own leadership behaviours. It will also help you carry out appraisals, and to write documents such as personal and professional development plans, recruitment criteria and processes, educational standards and curricula and training programme materials and criteria.

However, for personal use we are also developing other tools that will more directly help you apply the Healthcare Leadership Model. For example, a self-assessment tool and a 360-degree feedback tool are in development and will have a greater focus on helping individuals to assess their leadership behaviours and more fully understand their leadership development. Please visit www.leadershipacademy.nhs.uk/leadershipmodel for up-to-date information on these tools, as well as other supporting materials.

We would be very interested to hear from anyone using the Healthcare Leadership Model in their work and are planning to collect examples of best practice so that we can share these more widely. If you are interested in sharing how you are using the model, please contact us at leadershipmodel@leadershipacademy.nhs.uk.

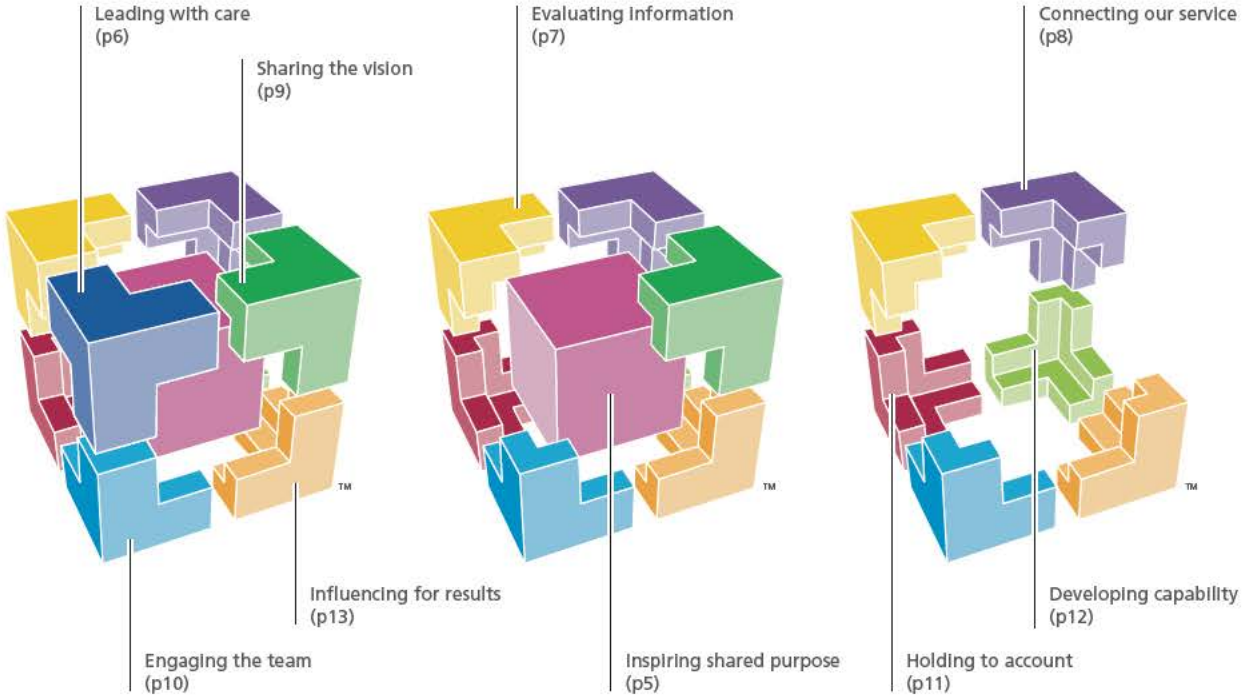
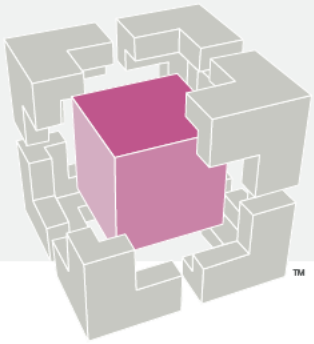


Figure 3 : The nine dimensions of the Healthcare Leadership Model



Inspiring shared purpose

What is it?

- Valuing a service ethos
- Curious about how to improve services and patient care
- Behaving in a way that reflects the principles and values of the NHS

Why is it important?

Leaders create a shared purpose for diverse individuals doing different work, inspiring them to believe in shared values so that they deliver benefits for patients, their families and the community

What is it not?

- Turning a blind eye
- Using values to push a personal or 'tribal' agenda
- Hiding behind values to avoid doing your best
- Self-righteousness
- Misplaced tenacity
- Shying away from doing what you know is right

Essential

Staying true to NHS principles and values

Do I act as a role model for belief in and commitment to the service?

Do I focus on how what I do contributes to and affects patient care or other service users?

Do I enable colleagues to see the wider meaning in what they do?

Proficient

Holding to principles and values under pressure

Do I behave consistently and make sure that others do so even when we are under pressure?

Do I inspire others in tough times by helping them to focus on the value of their contribution?

Do I actively promote values of service in line with NHS principles?

Strong

Taking personal risks to stand up for the shared purpose

Do I have the self-confidence to question the way things are done in my area of work?

Do I have the resilience to keep challenging others in the face of opposition, or when I have suffered a setback?

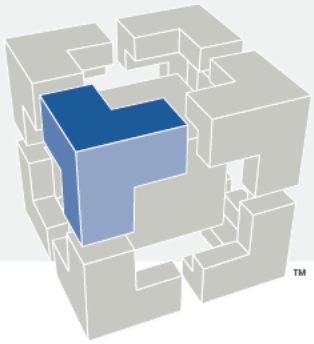
Do I support my team or colleagues when they challenge the way things are done?

Exemplary

Making courageous challenges for the benefit of the service

Do I have the courage to challenge beyond my remit even when it may involve considerable personal risk?

Do I take the initiative and responsibility to put things right outside my remit if I see others fearing to act?



Leading with care

What is it?

- Having the essential personal qualities for leaders in health and social care
- Understanding the unique qualities and needs of a team
- Providing a caring, safe environment to enable everyone to do their jobs effectively

Why is it important?

Leaders understand the underlying emotions that affect their team, and care for team members as individuals, helping them to manage unsettling feelings so they can focus their energy on delivering a great service that results in care for patients and other service users

What is it not?

- Making excuses for poor performance
- Avoiding responsibility for the wellbeing of colleagues in your team
- Failing to understand the impact of your own emotions or behaviour on colleagues
- Taking responsibility away from others

Essential

Caring for the team

Do I notice negative or unsettling emotions in the team and act to put the situation right?

Do my actions demonstrate that the health and wellbeing of my team are important to me?

Do I carry out genuine acts of kindness for my team?

Proficient

Recognising underlying reasons for behaviour

Do I understand the underlying reasons for my behaviour and recognise how it affects my team?

Can I 'read' others, and act with appropriate empathy, especially when they are different from me?

Do I help my colleagues to make the connection between the way they feel and the quality of the service they provide?

Strong

Providing opportunities for mutual support

Do I care for my own physical and mental wellbeing so that I create a positive atmosphere for the team and service users?

Do I help create the conditions that help my team provide mutual care and support?

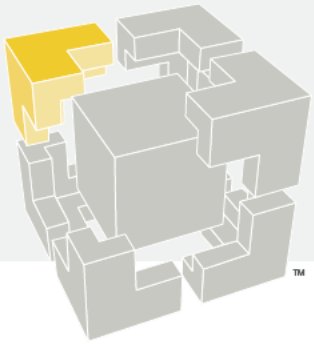
Do I pay close attention to what motivates individuals in my team so that I can channel their energy so they deliver for service users?

Exemplary

Spreading a caring environment beyond my own area

Do I take positive action to make sure other leaders are taking responsibility for the emotional wellbeing of their teams?

Do I share responsibility for colleagues' emotional wellbeing even when I may be junior to them?



Evaluating information

What is it?

- Seeking out varied information
- using information to generate new ideas and make effective plans for improvement or change
- making evidence-based decisions that respect different perspectives and meet the needs of all service users

Why is it important?

Leaders are open and alert to information, investigating what is happening now so that they can think in an informed way about how to develop proposals for improvement

What is it not?

- Failing to look beyond the obvious
- Collecting data without using it
- Thinking only about your own measures or experience
- Reluctance to look for better ways of doing things
- Ignoring problems by ignoring data
- Using research as a weapon

Essential

Gathering data

Do I collect feedback from service users?

Do I collect and record the essential data for my area of work accurately and on time?

Am I regularly thinking about ways to do my job more effectively?

Can I see patterns that help me to do things better, more efficiently or with less waste?

Proficient

Scanning widely

Do I look outside my area of work for information and ideas that could bring about continuous improvement?

Do I establish ongoing methods for measuring performance to gain a detailed understanding of what is happening?

Do I spot future opportunities and risks, and test resulting plans with external stakeholders to improve them?

Strong

Thinking creatively

Do I conduct thorough analyses of data over time and compare outcomes and trends to relevant benchmarks?

Do I see the relevance of seemingly unrelated ideas which could be made useful in my area of work?

Do I creatively apply fresh approaches to improve current ways of working?

Exemplary

Developing new concepts

Do I develop strategies based on new concepts, insights, or perceptive analysis?

Do I create improved pathways, systems or processes through insights that are not obvious to others?

Do I carry out, or encourage, research to understand the root causes of issues?

Connecting our service

What is it?

Understanding how health and social care services fit together and how different people, teams or organisations interconnect and interact

Why is it important?

Leaders understand how things are done in different teams and organisations; they recognise the implications of different structures, goals, values and cultures so that they can make links, share risks and collaborate effectively

What is it not?

- Being rigid in your approach
- Thinking about only your part of the organisation
- Believing only your view is the right one
- Thinking politics is a dirty word
- Failing to engage with other parts of the system
- Focusing solely on the depth of your area at the expense of the broader service

Essential

Recognising how my area of work relates to other parts of the system

Do I understand the formal structure of my area of work and how it fits with other teams?

Do I keep up to date with changes in the system to maintain efficiency?

Do I hand over effectively to others and take responsibility for continuity of service provision?

Proficient

Understanding the culture and politics across my organisation

Do I understand the informal 'chain of command' and unwritten rules of how things get done?

Do I know what I need to do and who to go to so that well-judged decisions are made in my organisation?

Do I understand how financial and other pressures influence the way people react in my organisation?

Strong

Adapting to different standards and approaches outside my organisation

Am I connected to stakeholders in a way that helps me to understand their unspoken needs and agendas?

Am I flexible in my approach so I can work effectively with people in organisations that have different standards and approaches from mine?

Do I act flexibly to overcome obstacles?

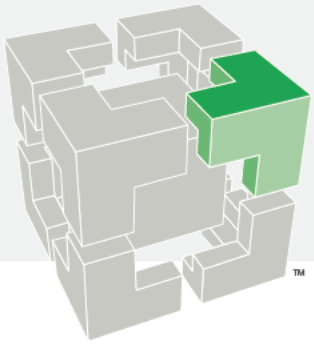
Exemplary

Working strategically across the system

Do I build strategic relationships to make links across the broader system?

Do I understand how complex connections across the health economy affect the efficiency of the system?

Do I understand which issues affect decisions across the system so that I can anticipate how other stakeholders will react?



Sharing the vision

What is it?

Communicating a compelling and credible vision of the future in a way that makes it feel achievable and exciting

Why is it important?

Leaders convey a vivid and attractive picture of what everyone is working towards in a clear, consistent and honest way, so that they inspire hope and help others to see how their work fits in

What is it not?

- Saying one thing and doing another
- Talking about the vision but not working to achieve it
- Being inconsistent in what you say
- Avoiding the difficult messages

Essential

Communicating to create credibility and trust

Am I visible and available to my team?

Do I communicate honestly, appropriately and at the right time with people at all levels?

Am I helping other people appreciate how their work contributes to the aims of the team and the organisation?

Do I break things down and explain clearly?

Proficient

Creating clear direction

Do I help people to see the vision as achievable by describing the 'journey' we need to take?

Do I use stories and examples to bring the vision to life?

Do I clearly describe the purpose of the job, the team and the organisation and how they will be different in the future?

Strong

Making long-term goals desirable

Do I encourage others to become 'ambassadors' for the vision and generate excitement about long-term aims?

Do I find ways to make a vivid picture of future success emotionally compelling?

Do I establish ongoing communication strategies to deal with the more complex and difficult issues?

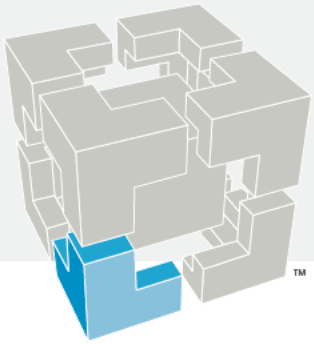
Exemplary

Inspiring confidence for the future

Do I display confidence and integrity under robust and public criticism?

Do I describe future changes in a way that inspires hope, and reassures staff, patients and the public?

Do I explain controversial and complex plans in a way that different groups can hear, understand and accept?



Engaging the team

What is it?

Involving individuals and demonstrating that their contributions and ideas are valued and important for delivering outcomes and continuous improvements to the service

Why is it important?

Leaders promote teamwork and a feeling of pride by valuing individuals' contributions and ideas; this creates an atmosphere of staff engagement where desirable behaviour, such as mutual respect, compassionate care and attention to detail, are reinforced by all team members

What is it not?

- Building plans without consultation
- Autocratic leadership
- Failing to value diversity
- Springing ideas on others without discussion

Essential

Involving the team

Do I recognise and actively appreciate each person's unique perspectives and experience?

Do I listen attentively to my team and value their suggestions?

Do I ask for contributions from my team to raise their engagement?

Proficient

Fostering creative participation

Do I ask for feedback from my team on things that are working well and things we could improve?

Do I shape future plans together with my team?

Do I encourage my team to identify problems and solve them?

Strong

Co-operating to raise the game

Do I enable my team to feed off each other's ideas, even if there is a risk the ideas might not work?

Do I encourage team members to get to know each other's pressures and priorities so that they can co-operate to provide a seamless service when resources are stretched?

Do I offer support and resources to other teams in my organisation?

Exemplary

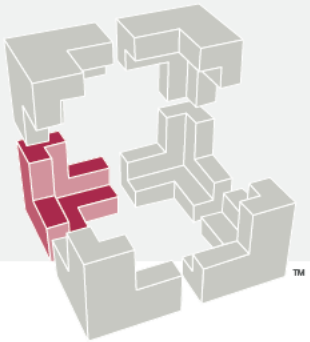
Stretching the team for excellence and innovation

Do I stretch my team so that they deliver a fully 'joined-up' service, and so give the best value they can?

Do I support other leaders to build success within and beyond my organisation?

Do I create a common purpose to unite my team and enable them to work seamlessly together to deliver?

Do I encourage my team to deliver on the shared purpose, as much as on their individual targets?



Holding to account

What is it?

- Agreeing clear performance goals and quality indicators
- Supporting individuals and teams to take responsibility for results
- Providing balanced feedback

Why is it important?

Leaders create clarity about their expectations and what success looks like in order to focus people's energy, give them the freedom to self-manage within the demands of their job, and deliver improving standards of care and service delivery

What is it not?

- Setting unclear targets
- Tolerating mediocrity
- Making erratic and changeable demands
- Giving unbalanced feedback (too much praise or too little)
- Making excuses for poor or variable performance
- Reluctance to change

Essential

Setting clear expectations

Do I take personal responsibility for my own performance?

Do I specify and prioritise what is expected of individuals and the team?

Do I make tasks meaningful and link them to organisational goals?

Do I make sure individual and team goals are SMART[1]?

Proficient

Managing and supporting performance

Do I challenge ways of thinking and encourage people to use data to support their business planning and decision making?

Do I set clear standards for behaviour as well as for achieving tasks?

Do I give balanced feedback and support to improve performance?

Do I act quickly to manage poor performance?

Strong

Challenging for continuous improvement

Do I constantly look out for opportunities to celebrate and reward high standards?

Do I actively link feedback to the overall vision for success?

Do I notice and challenge mediocrity, encouraging people to stop coasting and stretch themselves for the best results they can attain?

Exemplary

Creating a mindset for innovative change

Do I encourage a climate of high expectations in which everyone looks for ways for service delivery to be even better?

Do I share stories and symbols of success that create pride in achievement?

Do I champion a mindset of high ambition for individuals, the team and the organisation?

[1] SMART stands for Specific, Measurable, Achievable, Relevant, Timed

Developing capability

What is it?

- Building capability to enable people to meet future challenges
- Using a range of experiences as a vehicle for individual and organisational learning
- Acting as a role model for personal development

Why is it important?

Leaders champion learning and capability development so that they and others gain the skills, knowledge and experience they need to meet the future needs of the service, develop their own potential, and learn from both success and failure

What is it not?

- Focusing on development for short-term task accomplishment
- Supporting only technical learning at the expense of other forms of growth and development
- Developing yourself mainly for your own benefit
- Developing only the 'best' people

Essential

Providing opportunities for people development

Do I often look for opportunities to develop myself and learn things outside my comfort zone?

Do I understand the importance and impact of people development?

Do I build people development into my planning for my team?

Proficient

Taking multiple steps to develop team members

Do I explore and understand the strengths and development needs of individuals in my team?

Do I provide development opportunities for other people through experience and formal training?

Do I look for and provide regular positive and developmental feedback for my team to help them focus on the right areas to develop professionally?

Strong

Building longer-term capability

Do I explore the career aspirations of colleagues in my team and shape development activities to support them?

Do I provide long-term mentoring or coaching?

Do I spot high-potential colleagues or capability gaps in my team and focus development efforts to build on or deal with the situation?

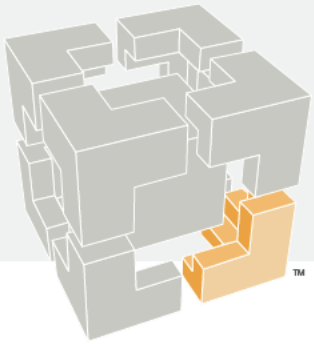
Exemplary

Creating systems for succession to all key roles

Do I create the conditions in which others take responsibility for their development and learn from each other?

Do I take a strategic approach to people development based on the future needs of the NHS?

Do I share in broad organisational development and succession planning beyond my area of work?



Influencing for results

What is it?

- Deciding how to have a positive impact on other people
- Building relationships to recognise other people's passions and concerns
- Using interpersonal and organisational understanding to persuade and build collaboration

Why is it important?

Leaders are sensitive to the concerns and needs of different individuals, groups and organisations, and use this to build networks of influence and plan how to reach agreement about priorities, allocation of resources or approaches to service delivery

What is it not?

- Being insular
- Pushing your agenda without regard to other views
- Only using one influencing style
- Being discourteous or dismissive

Essential

Engaging with others to convince or persuade

Am I respectful in all circumstances?

Do I listen to different views?

Do I share issues and information to help other people understand my thinking?

Do I develop and present well-reasoned arguments?

Do I avoid jargon and express myself clearly?

Proficient

Adapting my approach to connect with diverse groups

Do I adapt my communication to the needs and concerns of different groups?

Do I use stories, symbols and other memorable approaches to increase my impact?

Do I check that others have understood me?

Do I create formal and informal two-way communication channels so I can be more persuasive?

Strong

Developing collaborative agendas and consensus

Do I use 'networks of influence' to develop consensus and buy-in?

Do I create shared agendas with key stakeholders?

Do I use indirect influence and partnerships across organisations to build wide support for my ideas?

Do I give and take?

Exemplary

Building sustainable commitments

Do I contribute calmly and productively to debates arising from strongly-held beliefs, even when my own emotions have been excited?

Do I build enough support for the idea or initiative to take on a life of its own?

Do I act as an ambassador for my organisation to gain reputational influence by sharing experiences and best practice nationally and internationally?

Appendix I How the Healthcare Leadership Model has been developed

The Healthcare Leadership Model has been developed by the NHS Leadership Academy, working with the Hay Group and colleagues from the Open University. It is an evidence-based research model that reflects:

- the values of the NHS
- what we know about effective leadership
- what we have learned from the Leadership Framework (2011)
- what our patients and communities are now asking from us as leaders

This appendix explains how the model was developed and gives more information on how the research was carried out.

1 Secondary Research (March – April 2013)

The aim of the secondary research was to:

- understand what existing research has already said about leadership more generally, and
- help identify what then needs to be different for healthcare, for the NHS, and for the NHS in the current environment.

John Storey and Richard Holti of the Open University, working with Hay Group, carried out a review of current literature and research on leadership models and behaviours, including international as well as private-sector learning. You can see Holti and Storey's paper at www.leadershipacademy.nhs.uk/leadershipmodel

The Hay Group then developed Storey and Holti's findings into a draft behavioural model. As part of this stage, Hay Group drew on the following:

- their own knowledge of leadership in the NHS and elsewhere
- comparison of research data with health system competency models in Hay Group's competency database
- analysis of NHS leaders' assessment data
- analysis of the differences in behaviours between line managers and senior individual professionals

2 Primary Research (April – June 2013)

The aim of the primary research stage was to identify sample leadership behaviours at different levels of intensity and sophistication using the draft model created from the secondary research. This stage consisted of two sets of interviews:

- strategic interviews with people who have extensive experience of leaders in the NHS
- interviews with leaders across the NHS at a variety of levels to gather detailed examples of how they lead and how this delivers results

The sample of interviewees for both sets of interviews was selected by the NHS Leadership Academy working with their Local Delivery Partners (LDPs). The strategic interviews were carried out by staff in the NHS. Hay Group assessors carried out the interviews with leaders, using a focused interview technique. Hay Group then coded all the interviews against the draft leadership model, and carried out a thematic analysis.

3 Drafting (June 2013)

The aim of the drafting stage was to take everything we had learned from the previous two stages to create a more refined draft. The format we used was a 'concept formation' workshop, attended by the NHS Leadership Academy and Hay Group. Here we brought the various data points together to produce a 'working draft' of the leadership model. The data points included:

- the themes from Holti & Storey's research paper
- data sets from both sets of interviews
- data with health system competency models in the Hay Group competency database, and
- thematic analysis of NHS leaders' assessment data

In particular, we used evidence from the interviews to produce the leadership behaviour descriptions you see in the model.

4 Testing (June – August 2013)

The aim of the testing stage was to check with the intended audience of the model (staff in healthcare) that it would be relevant and user-friendly across various roles and contexts. This stage consisted of a number of focus groups, conducted by the NHS Leadership Academy and LDPs, involving a cross-section of staff at various levels working in various contexts. Additional stakeholders, such as colleagues in clinical professional bodies and those working in education, were also invited to provide feedback on the draft model.

The NHS Leadership Academy then analysed and themed the feedback from the focus groups. The feedback was overwhelmingly positive, and improvement points (largely relating to the most accessible language for the model) were acted upon in an updated version of the draft model. This then went through a plain English review, with relevant amendments made.

5 Finishing (August – October 2013)

The final stage was to finalise 'version 1/version 2013' of the Healthcare Leadership Model. This stage consisted of colleagues from Hay Group incorporating the final feedback into a final version of the model, which was signed off by the NHS Leadership Academy. The Academy then worked with designers to produce relevant graphics and finalise the design of this document.

Appendix II Limitations of the Healthcare Leadership Model

A note on the limitations of the Healthcare Leadership Model and plans to keep the model refreshed

The Healthcare Leadership Model (2013) is, as was intended, an evidence-based model which was created using the process described in Appendix I.

In a different economic climate, the NHS Leadership Academy may have chosen to invest more heavily in a wider number of staff interviews to create the first version of the model. However, we have taken the view that the most cost-effective and productive path to take was to interview a small sample of leaders (49 in total) in 2013, and to use this data with the secondary research to create 'version 1' of the model.

The intention therefore is not that this model is 'set in stone' and will still be appropriate for healthcare staff in 2023. Instead, the intention is to make ongoing updates to the model, to make sure it remains as relevant to staff in two or five years' time, as it is to them today. The process of updating the model will be likely to follow a shortened version of the process described in Appendix I, probably taking into account any major new pieces of secondary research and by conducting future sets of interviews and focus groups.

This more flexible and innovative approach will result in future versions being available over the next few years. You could describe this as being similar to the software updates on a smartphone: people can get all the benefits of being able to update their software, while keeping a 'core' product that remains recognisable, rather than having a 'static' product which quickly becomes out of date. In the same way, we intend the Healthcare Leadership Model to adapt and be regularly updated to provide healthcare staff with the most relevant leadership support today and in the future.

Maintaining High Professional Standards in the Modern HPSS

A framework for the handling of concerns about doctors and dentists in the HPSS

Department of Health, Social Services & Public Safety
November 2005

MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE MODERN HPSS

A framework for the handling of concerns about doctors and dentists in the HPSS

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INTRODUCTION

1. This document introduces the new framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist, and any subsequent action when deciding whether there needs to be any restriction or suspension placed on a doctor's or dentist's practice.

2. Throughout this framework where the term "performance" is used, it should be interpreted as referring to all aspects of a practitioner's work, including conduct, health and clinical performance. Where the term "clinical performance" is used, it should be interpreted as referring only to those aspects of a practitioner's work that require the exercise of clinical judgement or skill.

3. Under the Directions on Disciplinary Procedures 2005, HPSS organisations must notify the Department of the action they have taken to comply with the framework by 31 January 2006.

4. The framework is in six sections and covers:

   I. Action when a concern first arises

   II. Restriction of practice and exclusion from work

   III. Conduct hearings and disciplinary procedures

   IV. Procedures for dealing with issues of clinical performance

   V. Handling concerns about a practitioner's health

   VI. Formal procedures – general principles

5. Local conduct procedures will apply to all concerns about the conduct of a doctor or dentist.

Background

6. There has been some concern in the past about the way in which complaints about doctors and dentists have been handled. Developing new arrangements for dealing with medical and dental staff performance has become increasingly important in order to address these concerns and to reflect the new systems for quality assurance, quality improvement and patient safety being introduced in the HPSS.

7. The National Clinical Assessment Authority (NCAA) was established to improve arrangements for dealing with poor clinical performance of doctors. The Department entered into a service level agreement with the NCAA in October 2004 to provide advice and guidance to the HPSS. Since April 2005,

the NCAA has become a division of the National Patient Safety Agency, and is now known as the National Clinical Assessment Service (NCAS).

8. The new approach set out in the framework builds on four key elements:

- appraisal[1] and revalidation – processes which require practitioners to maintain the skills and knowledge needed for their work through Continuing Professional Development (CPD);
- the advisory and assessment services of the NCAS – aimed at enabling HSS Bodies[2] to handle cases quickly and fairly - reducing the need to use disciplinary procedures to resolve problems;
- tackling the blame culture – recognising that most failures in standards of care are caused by systems' weaknesses, not individuals per se;
- new arrangements for handling exclusion from work as set out in Sections I and II of this framework.

9. To work effectively these need to be supported by a culture and by attitudes and working practices which emphasise the importance of doctors and dentists maintaining their competence; and which support an open approach to reporting and addressing concerns about doctors' and dentists' practice. The new approach recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through disciplinary action. However, it is not intended to weaken accountability or avoid disciplinary action where the situation warrants this approach.

The new framework

10. At the heart of the new arrangements is a co-ordinated process for handling concerns about the safety of patients posed by the performance of doctors and dentists when this comes to the attention of the HPSS. Whatever the source of this information the response must be the same –

- to ascertain quickly what has happened and establish the facts;
- to determine whether there is a continuing risk;
- to decide whether immediate action is needed to manage the risk to ensure the protection of patients;
- to put in place action to address any underlying problem.

[1] Appraisal is a structured process which gives doctors an opportunity to reflect on their practice and discuss, with a suitably trained and qualified appraiser, any issues arising from their work, and their development needs.

[2] In the Direction and Framework "HSS bodies" means: HSS Trusts, HSS Boards and Special Agencies

Under these new mechanisms, exclusion from work must be used only in the most exceptional circumstances.

11. All HSS bodies must have procedures for handling concerns about an individual's performance. These procedures must reflect the framework in this document and allow for informal resolution of problems where deemed appropriate. Concerns about the performance of doctors and dentists in training should be handled in line with those for other medical and dental staff with the proviso that the Postgraduate Dean should be involved in appropriate cases from the outset. The onus still rests with the employer for the conduct of the investigation and any necessary action.

SECTION I. ACTION WHEN A CONCERN FIRST ARISES

INTRODUCTION

1. The management of performance is a continuous process to ensure both quality of service and to protect clinicians. Numerous ways exist in which concerns about a practitioner's performance can be identified, through which remedial and supportive action can be quickly taken before problems become serious or patients harmed, and which need not necessarily require formal investigation or the resort to disciplinary procedures.

2. Concerns about a doctor or dentist's performance can come to light in a wide variety of ways, for example:

   - concerns expressed by other HPSS staff;
   - review of performance against job plans and annual appraisal;
   - monitoring of data on clinical performance and quality of care;
   - clinical governance, clinical audit and other quality improvement activities;
   - complaints about care by patients or relatives of patients;
   - information from the regulatory bodies;
   - litigation following allegations of negligence;
   - information from the police or coroner;
   - court judgements; or
   - following the report of one or more critical clinical incidents or near misses.

3. All allegations, including those made by relatives of patients, or concerns raised by colleagues, must be properly investigated to establish the facts and the substance of any allegations. Unfounded or malicious allegations can cause lasting damage to a doctor's reputation and career. Where allegations raised by a fellow HPSS employee are shown to be malicious, that employee should be subject to the relevant disciplinary procedures.

SUMMARY OF KEY ACTIONS NEEDED

4. The key actions needed at the outset can be summarised as follows:

   - clarify what has happened and the nature of the problem or concern;
   - consider discussing case with NCAS on the way forward;
   - consider if urgent action needs to be taken to protect the patient/s;
   - consider whether restriction of practice or exclusion is required;

- if the case can be progressed by mutual agreement consider if an NCAS assessment would help;
- if a formal approach under conduct or clinical performance procedures is required, appoint a case investigator;
- consider whether further action is required under the conduct, clinical performance or health procedures.

PROTECTING THE PUBLIC

5. From the outset, a fundamental consideration is the continued safety of patients and the public. Whilst exclusion from the workplace may be unavoidable it should not be the sole or first approach to ensuring patient safety. Alternative ways to manage risks, avoiding exclusion, include:
   - arranging supervision of normal contractual clinical duties;
   - restricting the practitioner to certain forms of clinical duties;
   - restricting activities to non clinical duties. By mutual agreement the latter might include some formal retraining;
   - sick leave for the investigation of specific health problems.

6. In the vast majority of cases when action other than immediate exclusion can ensure patient safety the clinician should always initially be dealt with using an informal approach. Only where a resolution cannot be reached informally should a formal investigation be instigated. This will often depend on an individual's agreement to the solutions offered. It is imperative that all action is carried out without any undue delay.

DEFINITION OF ROLES

7. The Board, through the Chief Executive, has responsibility for ensuring that these procedures are established and followed. Board members may be required to sit as members of a disciplinary or appeal panel. Therefore, information given to the board should only be sufficient to enable the board to satisfy itself that the procedures are being followed. Only the "*designated Board member* "should be involved to any significant degree in the management of individual cases.

8. The key individuals that may have a role in the process are summarised below:-
   - Chief Executive (CE) – **all** concerns must be registered with the CE who, should a formal investigation be required, must ensure that the following individuals are appointed;
   - the "*designated Board member*" – this is a non-executive member of the Board appointed by the Chairman of the Board, to oversee the case to ensure that momentum is maintained and consider any

representations from the practitioner about his or her exclusion or any representations about the investigation;

- Case Manager – this is the individual who will lead the formal investigation. The Medical Director will normally act as the case manager but he/she may delegate this role to a senior medically qualified manager in appropriate cases. If the Medical Director is the subject of the investigation the Case Manager should be a medically qualified manager of at least equivalent seniority;
- Case Investigator – this is the individual who will carry out the formal investigation and who is responsible for leading the investigation into any allegations or concerns, establishing the facts, and reporting the findings to the Case Manager. He / she is normally appointed by the CE after discussion with the Medical Director and Director of HR and should, where possible, be medically qualified;
- the Director of HR 's role will be to support the Chief Executive and the Medical Director.

INVOLVEMENT OF NCAS

9. At any stage in the handling of a case, consideration should be given to the involvement of the NCAS. The NCAS has developed a staged approach to the services it provides HSS Trusts and practitioners. This includes:
   - immediate telephone advice, available 24 hours;
   - advice, then detailed supported local case management;
   - advice, then detailed NCAS performance assessment;
   - support with implementation of recommendations arising from assessment.

10. Employers or practitioners are at liberty to make use of the services of NCAS at any point they see fit. However, where an employing body is considering exclusion or restriction from practice the NCAS must be notified, so that alternatives to exclusion can be considered. Procedures for immediate and formal exclusion are covered respectively in Sections I and II of this framework.

11. The first stage of the NCAS's involvement in a case is exploratory – an opportunity for local managers or practitioners to discuss the problem with an impartial outsider, to look afresh at a problem, and possibly recognize the problem as being more to do with work systems than a doctor's performance, or see a wider problem needing the involvement of an outside body other than the NCAS.

12. The focus of the NCAS's work on assessment is likely to involve performance difficulties which are serious and/or repetitive. That means:

- clinical performance falling well short of recognized standards and clinical practice which, if repeated, would put patients seriously at risk;
- alternatively, or additionally, issues which are ongoing or recurrent.

13. A practitioner undergoing assessment by the NCAS must co-operate with any request from the NCAS to give an undertaking not to practice in the HPSS or private sector other than their main place of HPSS employment until the NCAS assessment is complete. The NCAS has issued guidance on its processes, and how to make such referrals. This can be found at www.ncaa.nhs.uk. See also circular HSS(TC8) 5/04.

14. Failure on the part of either the clinician or the employer to co-operate with a referral to the NCAS may be seen as evidence of a lack of willingness to resolve performance difficulties. If the practitioner chooses not to co-operate with such a referral, and an underlying health problem is not the reason, disciplinary action may be needed.

INFORMAL APPROACH

15. The first task of the clinical manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available. As a first step, preliminary enquiries are essential to verify or refute the substance and accuracy of any concerns or complaints. In addition, it is necessary to decide whether an informal approach can address the problem, or whether a formal investigation is needed. This is a difficult decision and should not be taken alone but in consultation with the Medical Director and Director of HR, taking advice from the NCAS or Occupational Health Service (OHS) where necessary.

16. The causes of adverse events should not automatically be attributed to the actions, failings or unsafe acts of an individual alone. Root cause analyses of individual adverse events frequently show that these are more broadly based and can be attributed to systems or organizational failures, or demonstrate that they are untoward outcomes which could not have been predicted and are not the result of any individual or systems failure. Each will require appropriate investigation and remedial actions.

17. In cases relating primarily to the performance of a practitioner, consideration should be given to whether a local action plan to resolve the problem can be agreed with the practitioner. The NCAS can advise on the practicality of this approach. This may involve a performance assessment by the NCAS if considered appropriate – (Section IV paragraph 7 refers). If a workable remedy cannot be determined in this way, the Medical Director, in consultation with the clinical manager, should seek the agreement of the practitioner to refer the case to the NCAS for consideration of a detailed performance assessment.

IMMEDIATE EXCLUSION

18. When significant issues relating to performance are identified which may affect patient safety, the employer must urgently consider whether it is necessary to place temporary restrictions on an individual's practice. Examples of such restrictions might be to amend or restrict the practitioner's clinical duties, obtain relevant undertakings eg regarding practice elsewhere or provide for the temporary exclusion of the practitioner from the workplace.

19. An immediate time limited exclusion may be necessary

- to protect the interests of patients or other staff;
- where there has been a breakdown in relationships within a team which has the potential to significantly endanger patient care.

20. The NCAS must, where possible, be informed prior to the implementation of an immediate exclusion. Such exclusion will allow a more measured consideration to be undertaken. This period should be used to carry out a preliminary situation analysis and to convene a case conference involving the clinical manager, the Medical Director and appropriate representation from Human Resources.

21. The authority to exclude a member of staff must be vested in a nominated manager or managers of the Trust. These should include, where possible, the CE, Medical Director and the Clinical Directors for staff below the grade of consultant. For consultants it should include the CE and Medical Director. The number of managers involved should be the minimum number of people consistent with the size of the organisation and the need to ensure 24 hour availability of a nominated manager in the event of a critical incident. The clinical manager seeking an immediate exclusion must explain to the nominated manager why the exclusion is justified.

22. The clinical manager having obtained the authority to exclude must explain to the practitioner why the exclusion is justified (there may be no formal allegation at this stage), and agree a date up to a maximum of four weeks at which the practitioner should return to the workplace for a further meeting

23. Immediate exclusion should be limited to the shortest feasible time and in no case longer than 4 weeks. During this period the practitioner should be given the opportunity to state their case and propose alternatives to exclusion e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction. The clinical manager must advise the practitioner of their rights, including rights of representation.

24. All these discussions should be minuted, recorded and documented, and a copy given to the practitioner.

25. The 4 week exclusion period should allow sufficient time for initial investigation to determine a clear course of action, including the need for formal exclusion.

26. At any point in the process where the Medical Director has reached a judgment that a practitioner is to be the subject of an exclusion, the regulatory body should be notified. Guidance on the process for issuing alert letters can be found in circular HSS (TC8) (6)/98. This framework also sets out additional circumstances when the issue of an alert letter may be considered.

27. Section II of this framework sets out the procedures to be followed should a formal investigation indicate that a longer period of formal exclusion is required.

FORMAL APPROACH

28. Where it is decided that a formal approach needs to be followed (perhaps leading to conduct or clinical performance proceedings) the CE must, after discussion between the Medical Director and Director of HR, appoint a Case Manager, a Case Investigator and a designated Board member as outlined in paragraph 8. The seniority of the Case Investigator will differ depending on the grade of practitioner involved in the allegation. Several Case Investigators should be appropriately trained, to enable them to carry out this role.

29. All concerns should be investigated quickly and appropriately. A clear audit route must be established for initiating and tracking progress of the investigation, its' costs and resulting action.

30. At any stage of this process - or subsequent disciplinary action - the practitioner may be accompanied to any interview or hearing by a companion. The companion may be another employee of the HSS body; an official or lay representative of the BMA, BDA, defence organisation, or friend, work or professional colleague, partner or spouse. The companion may be legally qualified but he or she will not, however, be acting in a legal capacity.

The Case Investigator's role

31. The Case Investigator:

- must formally, on the advice of the Medical Director, involve a senior member of the medical or dental staff[3] with relevant clinical experience in cases where a question of clinical judgment is raised during the investigation process;
- must ensure that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided. Patient confidentiality needs to be maintained. It is the responsibility of the Case Investigator

[3] Where no other suitable senior doctor or dentist is employed by the HSS body a senior doctor or dentist from another HSS body should be involved.

to judge what information needs to be gathered and how (within the boundaries of the law) that information should be gathered;

- must ensure that sufficient written statements are collected to establish the facts of the case, and on aspects of the case not covered by a written statement, ensure that there is an appropriate mechanism for oral evidence to be considered where relevant;
- must ensure that a written record is kept of the investigation, the conclusions reached and the course of action agreed by the Medical Director with advice from the Director of HR;
- must assist the designated Board member in reviewing the progress of the case.

32. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work. They may not be a member of any disciplinary or appeal panel relating to the case.

33. The Case Investigator has wide discretion on how the investigation is carried out, but in all cases the purpose of the investigation is to ascertain the facts in an unbiased manner. Information gathered in the course of an investigation may clearly exonerate the practitioner, or provide a sound basis for effective resolution of the matter.

The Case Manager's role

34. The Case Manager is the individual who will lead the formal investigation. The Medical Director will normally act as the case manager but he/she may delegate this role to a senior medically qualified manager in appropriate cases. If the Medical Director is the subject of the investigation the Case Manager should be a medically qualified manager of at least equivalent seniority

35. The practitioner concerned must be informed in writing by the Case Manager, that an investigation is to be undertaken, the name of the Case Investigator and the specific allegations or concerns that have been raised. The practitioner must be given the opportunity to see any correspondence relating to the case together with a list of the people whom the Case Investigator will interview. The practitioner must also be afforded the opportunity to put their view of events to the Case Investigator and given the opportunity to be accompanied.

36. If during the course of the investigation, it transpires that the case involves more complex clinical issues (which cannot be addressed in the Trust), the Case Manager should consider whether an independent practitioner from another HSS body or elsewhere be invited to assist.

Timescale and decision

37. The Case Investigator should, other than in exceptional circumstances, complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 working days. The Case Manager must give the practitioner the opportunity to comment in writing on the factual content of the report produced by the Case Investigator. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the Case Manager within 10 working days of the date of receipt of the request for comments. In exceptional circumstances, for example in complex cases or due to annual leave, the deadline for comments from the practitioner should be extended.

38. The report should give the Case Manager sufficient information to make a decision on whether:

- no further action is needed;
- restrictions on practice or exclusion from work should be considered;
- there is a case of misconduct that should be put to a conduct panel;
- there are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer;
- there are concerns about the practitioner's clinical performance which require further formal consideration by NCAS ;
- there are serious concerns that fall into the criteria for referral to the GMC or GDC;
- there are intractable problems and the matter should be put before a clinical performance panel.

CONFIDENTIALITY

39. Employers must maintain confidentiality at all times, and should be familiar with the guiding principles of the Data Protection Act. No press notice can be issued, nor the name of the practitioner released, in regard to any investigation or hearing into disciplinary matters. They may only confirm that an investigation or disciplinary hearing is underway.

40. Personal data released to the Case Investigator for the purposes of the investigation must be fit for the purpose, and not disproportionate to the seriousness of the matter.

TRANSITIONAL ARRANGEMENTS

41. On implementation of this framework, the new procedures must be followed, as far as is practical, for all existing cases taking into account the stage the case has reached.

SECTION II. RESTRICTION OF PRACTICE & EXCLUSION FROM WORK

INTRODUCTION

1. This part of the framework replaces the guidance in HSS (TC8) 3/95 (Disciplinary Procedures for Hospital and Community Medical and Hospital Dental Staff - Suspensions). Under the Directions on Disciplinary Procedures 2005, HPSS employers must incorporate these principles and procedures within their local procedures. The guiding principles of Article 6 of the Human Rights Act must be strictly adhered to.

2. In this part of the framework, the phrase “exclusion from work” has been used to replace the word “suspension” which can be confused with action taken by the GMC or GDC to suspend the practitioner from the register pending a hearing of their case or as an outcome of a fitness to practice hearing.

3. The Directions require that HSS bodies must ensure that:

   - exclusion from work is used only as an interim measure whilst action to resolve a problem is being considered;
   - where a practitioner is excluded, it is for the minimum necessary period of time: this can be up to but no more than four weeks at a time;
   - all extensions of exclusion are reviewed and a brief report provided to the CE and the board;
   - a detailed report is provided when requested to the designated Board member who will be responsible for monitoring the situation until the exclusion has been lifted.

MANAGING THE RISK TO PATIENTS

4. Exclusion of clinical staff from the workplace is a temporary expedient. Under this framework, exclusion is a precautionary measure and not a disciplinary sanction. Exclusion from work should be reserved for only the most exceptional circumstances.

5. The purpose of exclusion is:

   - to protect the interests of patients or other staff; and/or
   - to assist the investigative process when there is a clear risk that the practitioner’s presence would impede the gathering of evidence.

6. It is imperative that exclusion from work is not misused or seen as the only course of action that could be taken. The degree of action must depend on the nature and seriousness of the concerns and on the need to protect patients, the practitioner concerned and/or their colleagues.

THE EXCLUSION PROCESS

7. **Under the Directions, an HSS body cannot require the exclusion of a practitioner for more than four weeks at a time.** The justification for continued exclusion must be reviewed on a regular basis and before any further four-week period of exclusion is imposed. Under the framework key officers and the Board have responsibilities for ensuring that the process is carried out quickly and fairly, kept under review and that the total period of exclusion is not prolonged.

Key aspects of exclusion from work

8. Key aspects include:

- an initial "immediate" exclusion of no more than four weeks if warranted as set out in Section I;
- notification of the NCAS before immediate and formal exclusion;
- formal exclusion (if necessary) for periods up to four weeks;
- ongoing advice on the case management plan from the NCAS;
- appointment of a designated Board member to monitor the exclusion and subsequent action;
- referral to NCAS for formal assessment, if part of case management plan;
- active review by clinical and case managers to decide renewal or cessation of exclusion;
- a right to return to work if review not carried out;
- performance reporting on the management of the case;
- programme for return to work if not referred to disciplinary procedures or clinical performance assessment;
- a right for the doctor to make representation to the designated Board member

9. The authority to exclude a member of staff must be vested in a nominated manager or managers of the Trust. As described for immediate exclusion, these managers should be at an appropriately senior level in the organisation and should be the minimum number of people consistent with the size of the organisation and the need to ensure 24 hour availability of a nominated manager in the event of a critical incident. It should include the CE, Medical Director and the Clinical Directors for staff below the grade of consultant. For consultants it should include the CE and Medical Director.

Exclusion other than immediate exclusion

10. A formal exclusion may only take place in the setting of a formal investigation after the Case Manager has first considered whether there is a case to answer and then considered, at a case conference (involving as a minimum the clinical manager, Case Manager and Director of HR), whether there is reasonable and proper cause to exclude. **The NCAS must be consulted where formal exclusion is being considered.** If a Case Investigator has been appointed he or she must produce a preliminary report as soon as is possible to be available for the case conference. This preliminary report is advisory to enable the Case Manager to decide on the next steps as appropriate.

11. The report should provide sufficient information for a decision to be made as to whether:

    (i) the allegation appears unfounded; or

    (ii) there is a misconduct issue; or

    (iii) there is a concern about the practitioner's clinical performance; or

    (iv) the complexity of the case warrants further detailed investigation before advice can be given.

12. Formal exclusion of one or more clinicians must only be used where:

    a. there is a need to protect the safety of patients or other staff pending the outcome of a full investigation of:

    - allegations of misconduct;
    - concerns around the functioning of a clinical team which are likely to adversely affect patients;
    - concerns about poor clinical performance; or

    b. the presence of the practitioner in the workplace is likely to hinder the investigation.

13. Members of the case conference should consider whether the practitioner could continue in or (where there has been an immediate exclusion) return to work in a limited capacity or in an alternative, possibly non-clinical role, pending the resolution of the case.

14. When the practitioner is informed of the exclusion, there should, where practical, be a witness present and the nature of the allegations of concern should be conveyed to the practitioner. The practitioner should be told the reason(s) why formal exclusion is regarded as the only way to deal with the case. At this stage the practitioner should be given the opportunity to state their case and propose alternatives to exclusion (e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction). The practitioner may be accompanied to any interview or hearing by a companion

(paragraph 30 of Section I defines companion). All discussions should be minuted, recorded and documented and a copy given to the practitioner.

15. The formal exclusion must be confirmed in writing immediately. The letter should state the effective date and time, duration (up to 4 weeks), the content of the allegations, the terms of the exclusion (e.g. exclusion from the premises, see paragraph 19, and the need to remain available for work paragraph 20) and that a full investigation or what other action will follow. The practitioner and their companion should be informed that they may make representations about the exclusion to the designated Board member at any time after receipt of the letter confirming the exclusion.

16. In cases when disciplinary procedures are being followed, exclusion may be extended for four-week reviewable periods until the completion of disciplinary procedures, if a return to work is considered inappropriate. The exclusion should still only last for four weeks at a time and be subject to review (see paras 26 – 31 relating to the review process). The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon the employment, as soon as the original reasons for exclusion no longer apply.

17. If the Case Manager considers that the exclusion will need to be extended over a prolonged period outside of his or her control (for example because of a police investigation), the case must be referred back to the NCAS for advice as to whether the case is being handled in the most effective way. However, even during this prolonged period the principle of four-week review must be adhered to.

18. If at any time after the practitioner has been excluded from work, the investigation reveals that either the allegations are without foundation or that further investigation can continue with the practitioner working normally or with restrictions, the Case Manager must lift the exclusion and notify the appropriate regulatory authorities. Arrangements should be in place for the practitioner to return to work with any appropriate support (including retraining after prolonged exclusion) as soon as practicable.

Exclusion from premises

19. Practitioners should not be automatically barred from the premises upon exclusion from work. Case Managers must always consider whether a bar is absolutely necessary. The practitioner may want to retain contact with colleagues, take part in clinical audit, to remain up to date with developments in their specialty or to undertake research or training. There are certain circumstances, however, where the practitioner should be excluded from the premises. There may be a danger of tampering with evidence, or where the practitioner may present a serious potential danger to patients or other staff

Keeping in contact and availability for work

20. Exclusion under this framework should be on full pay provided the practitioner remains available for work with their employer during their normal contracted hours. The practitioner should not undertake any work for other organisations, whether paid or voluntary, during the time for which they are being paid by the HPSS employer. This caveat does not refer to time for which they are not being paid by the HPSS employer. The practitioner may not engage in any medical or dental duties consistent within the terms of the exclusion. In case of doubt the advice of the Case Manager should be sought. The practitioner should be reminded of these contractual obligations but would be given 24 hours notice to return to work. In exceptional circumstances the Case Manager may decide that payment is not justified because the practitioner is no longer available for work (e.g. abroad without agreement).

21. The Case Manager should make arrangements to ensure that the practitioner may keep in contact with colleagues on professional developments, take part in CPD and clinical audit activities with the same level of support as other doctors or dentists in their employment. A mentor could be appointed for this purpose if a colleague is willing to undertake this role. In appropriate circumstances Trusts should offer practitioners a referral to the Occupational Health Service.

Informing other organisations

22. Where there is concern that the practitioner may be a danger to patients, the employer has an obligation to inform other organisations including the private sector, of any restriction on practice or exclusion and provide a summary of the reasons. Details of other employers (HPSS and non-HPSS) may be readily available from job plans, but where it is not the practitioner should supply them. Failure to do so may result in further disciplinary action or referral to the relevant regulatory body, as the paramount interest is the safety of patients. Where a HPSS employer has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer[4].

23. Where the Case Manager has good grounds to believe that the practitioner is practicing in other parts of the HPSS, or in the private sector in breach or defiance of an undertaking not to do so, they should contact the professional regulatory body and the CMO of the Department to consider the issue of an alert letter.

24. No practitioner should be excluded from work other than through this new procedure. Informal exclusions, so called ‘gardening leave’ have been

[4] HSS bodies must develop strong co-partnership relations with universities and ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with joint appointments.

commonly used in the recent past. **No HSS body may use "gardening leave" as a means of resolving a problem covered by this framework.**

Existing suspensions & transitional arrangements

25. On implementation of this framework, all informal exclusions (e.g. 'gardening leave') must be transferred to the new system of exclusion and dealt with under the arrangements set out in this framework.

KEEPING EXCLUSIONS UNDER REVIEW

Informing the board of the employer

26. The Board must be informed about an exclusion at the earliest opportunity. The Board has a responsibility to ensure that the organisation's internal procedures are being followed. It should, therefore:

- receive a monthly statistical summary showing all exclusions with their duration and number of times the exclusion had been reviewed and extended. A copy must be sent to the Department (Director of Human Resources).
- receive an assurance from the CE and designated board member that the agreed mechanisms are being followed. Details of individual exclusions should not be discussed at Board level.

Regular review

27. The Case Manager must review the exclusion before the end of each four week period and report the outcome to the Chief Executive[5]. The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon their employment, at any time providing the original reasons for exclusion no longer apply. The exclusion will lapse and the practitioner will be entitled to return to work at the end of the four-week period if the exclusion is not actively reviewed.

28. The HSS body must take review action before the end of each 4-week period. The table below outlines the various activities that must be undertaken at different stages of exclusion.

[5] It is important to recognise that Board members might be required to sit as members of a future disciplinary or appeal panel. Therefore, information to the Board should only be sufficient to enable the Board to satisfy itself that the procedures are being followed. Only the designated Board member should be involved to any significant degree in each review. Careful consideration must be given as to whether the interests of patients, other staff, the practitioner, and/or the needs of the investigative process continue to necessitate exclusion and give full consideration to the option of the practitioner returning to limited or alternative duties where practicable.

Stage	Activity
First and second reviews (and reviews after the third review)	Before the end of each exclusion (of up to 4 weeks) the Case Manager reviews the position. • The Case Manager decides on the next steps as appropriate. Further renewal may be for up to 4 weeks at a time. • Case Manager submits advisory report of outcome to CE and Medical Director. • Each review is a formal matter and must be documented as such. • The practitioner must be sent written notification of the outcome of the review on each occasion.
Third review	If the practitioner has been excluded for three periods: • A report must be made by the Medical Director to the CE: - outlining the reasons for the continued exclusion and why restrictions on practice would not be an appropriate alternative; and if the investigation has not been completed - a timetable for completion of the investigation. • The CE must report to the Director of Human Resources at the Department, who will involve the CMO if appropriate. • The case must be formally referred back to the NCAS explaining: - why continued exclusion is thought to be appropriate; - what steps are being taken to complete the investigation at the earliest opportunity. • The NCAS will review the case and advise the HSS body on the handling of the case until it is concluded.
6 month review	If the exclusion has been extended over 6 months, • A further position report must be made by the CE to

	the Department indicating: - the reason for continuing the exclusion; - anticipated time scale for completing the process; - actual and anticipated costs of the exclusion. The Department will consider the report and provide advice to the CE if appropriate.

29. Normally there should be a maximum limit of 6 months exclusion, except for those cases involving criminal investigations of the practitioner concerned. The employer and the NCAS should actively review those cases at least every six months.

The role of the Department in monitoring exclusions

30. When the Department is notified of an exclusion, it should confirm with the NCAS that they have been notified.

31. When an exclusion decision has been extended twice (third review), the CE of the employing organisation (or a nominated officer) must inform the Department of what action is proposed to resolve the situation.

RETURN TO WORK

32. If it is decided that the exclusion should come to an end, there must be formal arrangements for the return to work of the practitioner. It must be clear whether clinical and other responsibilities are to remain unchanged, what duties and restrictions apply, and any monitoring arrangements to ensure patient safety.

SECTION III. GUIDANCE ON CONDUCT HEARINGS AND DISCIPLINARY PROCEDURES

INTRODUCTION

1. This section applies when the outcome of an investigation under Section I shows that there is a case of misconduct that must be put to a conduct panel (paragraph 38 of section 1). Misconduct covers both personal and professional misconduct as it can be difficult to distinguish between them. The key point is that all misconduct issues for doctors and dentists (as for all other staff groups) are matters for local employers and must be resolved locally. All misconduct issues should be dealt with under the employer's procedures covering other staff where conduct is in question.

2. It should be noted that if a case covers both misconduct and clinical performance issues it should usually be addressed through a clinical performance procedure (paragraph 5 of Section IV refers).

3. Where the investigation identifies issues of professional misconduct, the Case Investigator must obtain appropriate independent professional advice. Similarly where a case involving issues of professional misconduct proceeds to a hearing under the employer's conduct procedures the panel must include a member who is medically qualified (in the case of doctors) or dentally qualified (in the case of dentists) and who is not currently employed by the organisation. [6]

4. Employers are strongly advised to seek advice from NCAS in misconduct cases, particularly in cases of professional misconduct.

5. HSS bodies must develop strong co-partnership relations with universities and ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with joint appointment contracts.

CODES OF CONDUCT

6. Every HPSS employer will have a Code of Conduct or staff rules, which should set out acceptable standards of conduct and behaviour expected of all its employees. Breaches of these rules are considered to be "misconduct". Misconduct can cover a very wide range of behaviour and can be classified in a number of ways, but it will generally fall into one of four distinct categories:

   - a refusal to comply with the requirements of the employer where these are shown to be reasonable;
   - an infringement of the employer's disciplinary rules including conduct that contravenes the standard of professional behaviour required of

[6] Employers are advised to discuss the selection of the medical or dental panel member with the appropriate local professional representative body eg for doctors in a hospital trust the local negotiating committee

doctors and dentists by their regulatory body[7];

- the commission of criminal offences outside the place of work which may, in particular circumstances, amount to misconduct;
- wilful, careless, inappropriate or unethical behaviour likely to compromise standards of care or patient safety, or create serious dysfunction to the effective running of a service.

EXAMPLES OF MISCONDUCT

7. The employer's Code of Conduct should set out details of some of the acts that will result in a serious breach of contractual terms and will constitute gross misconduct, and could lead to summary dismissal. The code cannot cover every eventuality. Similarly the Labour Relations Agency (LRA) Code of Practice provides a non-exhaustive list of examples. Acts of misconduct may be simple and readily recognised or more complex and involved. Examples may include unreasonable or inappropriate behaviour such as verbal or physical bullying, harassment and/or discrimination in the exercise of their duties towards patients, the public or other employees. It could also include actions such as deliberate falsification or fraud.

8. Failure to fulfil contractual obligations may also constitute misconduct. For example, regular non-attendance at clinics or ward rounds, or not taking part in clinical governance activities may come into this category. Additionally, instances of failing to give proper support to other members of staff including doctors or dentists in training may be considered in this category.

9. It is for the employer to decide upon the most appropriate way forward, including the need to consult the NCAS and their own sources of expertise on employment law. If a practitioner considers that the case has been wrongly classified as misconduct, he or she (or his/her representative) is entitled to use the employer's grievance procedure. Alternatively, or in addition, he or she may make representations to the designated Board member.

10. In all cases where an allegation of misconduct has been upheld consideration must be given to referral to GMC/GDC.

ALLEGATIONS OF CRIMINAL ACTS

Action when investigations identify possible criminal acts

11. Where an employer's investigation establishes a suspected criminal action in the UK or abroad, this must be reported to the police. The Trust investigation should only proceed in respect of those aspects of the case that are not directly related to the police investigation underway. The employer must consult the police to establish whether an investigation into any other matters

[7] In case of doctors, *Good Medical Practice.* In the case of dentists, *Maintaining Standards.*

would impede their investigation. In cases of fraud, the Counter Fraud & Security Management Service must be contacted.

Cases where criminal charges are brought not connected with an investigation by an HPSS employer

12. There are some criminal offences that, if proven, could render a doctor or dentist unsuitable for employment. In all cases, employers, having considered the facts, will need to determine whether the employee poses a risk to patients or colleagues and whether their conduct warrants instigating an investigation and the exclusion of the practitioner. The employer will have to give serious consideration to whether the employee can continue in their current duties once criminal charges have been made. Bearing in mind the presumption of innocence, the employer must consider whether the offence, if proven, is one that makes the doctor or dentist unsuitable for their type of work and whether, pending the trial, the employee can continue in their present duties, should be allocated to other duties or should be excluded from work. This will depend on the nature of the offence and advice should be sought from an HR or legal adviser. Employers should, as a matter of good practice, explain the reasons for taking such action.

Dropping of charges or no court conviction

13. If the practitioner is acquitted following legal proceedings, but the employer feels there is enough evidence to suggest a potential danger to patients, the Trust has a public duty to take action to ensure that the practitioner does not pose a risk to patient safety. Where the charges are dropped or the court case is withdrawn, there may be grounds to consider allegations which if proved would constitute misconduct, bearing in mind that the evidence has not been tested in court. It must be made clear to the police that any evidence they provide and is used in the Trust's case will have to be made available to the doctor or dentist concerned.

SECTION IV. PROCEDURES FOR DEALING WITH ISSUES OF CLINICAL PERFORMANCE

INTRODUCTION & GENERAL PRINCIPLES

1. There will be occasions following an adequate investigation where an employer considers that there has been a clear failure by an individual to deliver an acceptable standard of care, or standard of clinical management, through lack of knowledge, ability or consistently poor performance. These are described as clinical performance issues.

2. Concerns about the clinical performance of a doctor or dentist may arise as outlined in Section I. Advice from the NCAS will help the employer to come to a decision on whether the matter raises questions about the practitioner's performance as an individual (health problems, conduct difficulties or poor clinical performance) or whether there are other matters that need to be addressed. If the concerns about clinical performance cannot be resolved through local informal processes set out in Section I (paragraphs 15 – 17) **the matter must be referred to the NCAS before consideration by a performance panel** (unless the practitioner refuses to have his or her case referred).

3. Matters which may fall under the perfomance procedures include:

   - out moded clinical practice;
   - inappropriate clinical practice arising from a lack of knowledge or skills that puts patients at risk;
   - incompetent clinical practice;
   - inappropriate delegation of clinical responsibility;
   - inadequate supervision of delegated clinical tasks;
   - ineffective clinical team working skills.

   Wherever possible such issues should be dealt with informally, seeking support and advice from the NCAS where appropriate. The vast majority of cases should be adequately dealt with through a plan of action agreed between the practitioner and the employer.

4. Performance may be affected by ill health. Should health considerations be the predominant underlying feature, procedures for handling concerns about a practitioner's health are described in Section V of this framework.

How to proceed where conduct and clinical performance issues are involved

5. It is inevitable that some cases will involve both conduct and clinical performance issues. Such cases can be complex and difficult to manage. If

a case covers more than one category of problem, it should usually be addressed through a clinical performance hearing although there may be occasions where it is necessary to pursue a conduct issue separately. It is for the employer to decide on the most appropriate way forward having consulted with an NCAS adviser and their own source of expertise on employment law.

Duties of employers

6. The procedures set out below are designed to cover issues where a doctor's or dentist's standard of clinical performance is in question[8].

7. As set out in Section I (paras 9 - 14), the NCAS can assist the employer to draw up an action plan designed to enable the practitioner to remedy any limitations in performance that have been identified during the assessment. The employing body must facilitate the agreed action plan (agreed by the employer and the practitioner). There may be occasions when a case has been considered by NCAS, but the advice of its assessment panel is that the practitioner's performance is so fundamentally flawed that no educational and/or organisational action plan has a realistic chance of success. In these circumstances, the Case Manager must make a decision, based upon the completed investigation report and informed by the NCAS advice, whether the case should be determined under the clinical performance procedure. If so, a panel hearing will be necessary.

8. If the practitioner does not agree to the case being referred to NCAS, a panel hearing will normally be necessary.

HEARING PROCEDURE

The pre-hearing process

9. The following procedure should be followed before the hearing:

- the Case Manager must notify the practitioner in writing of the decision to arrange a clinical performance hearing. This notification should be made at least 20 working days before the hearing, and include details of the allegations and the arrangements for proceeding including the practitioner's rights to be accompanied, and copies of any documentation and/or evidence that will be made available to the panel. This period will give the practitioner sufficient notice to allow them to arrange for a companion to accompany them to the hearing if they so wish;
- all parties must exchange any documentation, including witness statements, on which they wish to rely in the proceedings no later than 10 working days before the hearing. In the event of late evidence being presented, the employer should consider whether a new date

[8] see paragraphs 5 and 6 in section 6I on arrangements for small organisations

should be set for the hearing;

- should either party request a postponement to the hearing, the Case Manager should give reasonable consideration to such a request while ensuring that any time extensions to the process are kept to a minimum. Employers retain the right, after a reasonable period (not normally less than 30 working days from the postponement of the hearing), and having given the practitioner at least five working days notice, to proceed with the hearing in the practitioner's absence, although the employer should act reasonably in deciding to do so;
- Should the practitioner's ill health prevent the hearing taking place, the employer should implement their usual absence procedures and involve the Occupational Health Department as necessary;
- witnesses who have made written statements at the inquiry stage may, but will not necessarily, be required to attend the clinical performance hearing. Following representations from either side contesting a witness statement which is to be relied upon in the hearing, the Chairman should invite the witness to attend. The Chairman cannot require anyone other than an employee to attend. However, if evidence is contested and the witness is unable or unwilling to attend, the panel should reduce the weight given to the evidence as there will not be the opportunity to challenge it properly. A final list of witnesses to be called must be given to both parties not less than two working days in advance of the hearing.
- If witnesses who are required to attend the hearing, choose to be accompanied, the person accompanying them will not be able to participate in the hearing.

The hearing framework

10. The hearing will normally be chaired by an Executive Director of the Trust. The panel should comprise a total of 3 people, normally 2 members of the Trust Board, or senior staff appointed by the Board for the purpose of the hearing. At least one member of the panel must be an appropriately experienced medical or dental practitioner who is not employed by the Trust.[9] No member of the panel or advisers to the panel should have been previously involved in the investigation. In the case of clinical academics, including joint appointments, a further panel member may be appointed in accordance with any protocol agreed between the employer and the university.

11. Arrangements must be made for the panel to be advised by:
    - a senior member of staff from Human Resources;
    - an appropriately experienced clinician from the same or similar clinical specialty as the practitioner concerned, but from another HPSS employer;

[9] Employers are advised to discuss the selection of the medical or dental panel member with the appropriate local professional representative body eg for doctors in a hospital trust the local negotiating committee.

- a representative of a university if provided for in any protocol agreed between the employer and the university.

It is important that the panel is aware of the typical standard of competence required of the grade of doctor in question. If for any reason the selected clinician is unable to advise on the appropriate level of competence, a doctor from another HPSS/NHS employer, in the same grade as the practitioner in question, should be asked to provide advice. In the case of doctors in training the postgraduate dean's advice should be sought.

12. It is for the employer to decide on the membership of the panel. A practitioner may raise an objection to the choice of any panel member within 5 working days of notification. The employer should review the situation and take reasonable measures to ensure that the membership of the panel is acceptable to the practitioner. It may be necessary to postpone the hearing while this matter is resolved. The employer must provide the practitioner with the reasons for reaching its decision in writing before the hearing can take place.

Representation at clinical performance hearings

13. The hearing is not a court of law. Whilst the practitioner should be given every reasonable opportunity to present his or her case, the hearing should not be conducted in a legalistic or excessively formal manner.

14. The practitioner may be represented in the process by a companion who may be another employee of the HSS body: an official or lay representative of the BMA, BDA, defence organisation or work or professional colleague. Such a representative may be legally qualified but they will not, however, be representing the practitioner formally in a legal capacity. The representative will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any witness evidence.

Conduct of the clinical performance hearing

15. The hearing should be conducted as follows:

- the panel and its advisers, the practitioner, his or her representative and the Case Manager will be present at all times during the hearing. Witnesses will be admitted only to give their evidence and answer questions and will then retire;
- the Chairman of the panel will be responsible for the proper conduct of the proceedings. The Chairman should introduce all persons present and announce which witnesses are available to attend the hearing;
- the procedure for dealing with any witnesses attending the hearing shall be the same and shall reflect the following:

- the witness to confirm any written statement and give any supplementary evidence;
- the side calling the witness can question the witness;
- the other side can then question the witness;
- the panel may question the witness;
- the side which called the witness may seek to clarify any points which have arisen during questioning but may not at this point raise new evidence.

The order of presentation shall be:

- the Case Manager presents the management case, calling any witnesses. The procedure set out above for dealing with witnesses shall be followed for each witness in turn. Each witness shall be allowed to leave when the procedure is completed;
- the Chairman shall invite the Case Manager to clarify any matters arising from the management case on which the panel requires further clarification;
- the practitioner and/or their representative shall present the practitioner's case, calling any witnesses. The procedure set out above for dealing with witnesses shall be followed for each witness in turn. Each witness shall be allowed to leave when the procedure is completed;
- the Chairman shall invite the practitioner and/or representative to clarify any matters arising from the practitioner's case on which the panel requires further clarification;
- the Chairman shall invite the Case Manager to make a brief closing statement summarising the key points of the case;
- the Chairman shall invite the practitioner and/or representative to make a brief closing statement summarising the key points of the practitioner's case. Where appropriate this statement may also introduce any grounds for mitigation;
- the panel shall then retire to consider its decision.

Decisions

16. The panel will have the power to make a range of decisions including the following:

<u>Possible decisions made by the clinical performance panel</u>

- a finding that the allegations are unfounded and practitioner exonerated. Finding placed on the practitioner's record;
- a finding of unsatisfactory clinical performance. All such findings require a written statement detailing:

- the clinical performance problem(s) identified;
- the improvement that is required;
- the timescale for achieving this improvement;
- a review date;
- measures of support the employer will provide; and
- the consequences of the practitioner not meeting these requirements.

In addition, dependent on the extent or severity of the problem, the panel may:

- issue a written warning or final written warning that there must be an improvement in clinical performance within a specified time scale together with the duration that these warnings will be considered for disciplinary purposes (up to a maximum of two years depending on severity);
- decide on termination of contract.

In all cases where there is a finding of unsatisfactory clinical performance, consideration must be given to referral to the GMC/GDC.

It is also reasonable for the panel to make comments and recommendations on issues other than the competence of the practitioner, where these issues are relevant to the case. The panel may wish to comment on the systems and procedures operated by the employer.

17. A record of all findings, decisions and written warnings should be kept on the practitioner's personnel file. Written warnings should be disregarded for disciplinary purposes following the specified period.

18. The decision of the panel should be communicated to the parties as soon as possible and normally within 5 working days of the hearing. Given the possible complexities of the issues under deliberation and the need for detailed consideration, the parties should not necessarily expect a decision on the day of the hearing.

19. The decision must be confirmed in writing to the practitioner within 10 working days. This notification must include reasons for the decision, clarification of the practitioner's right of appeal (specifying to whom the appeal should be addressed) and notification of any intent to make a referral to the GMC/GDC or any other external/professional body.

APPEALS PROCEDURES IN CLINICAL PERFORMANCE CASES

Introduction

20. Given the significance of the decision of a clinical performance panel to warn or dismiss a practitioner, it is important that a robust appeal procedure is in place. Every Trust must therefore establish an internal appeal process.

21. The appeals procedure provides a mechanism for practitioners who disagree with the outcome of a decision to have an opportunity for the case to be reviewed. The appeal panel will need to establish whether the Trust's procedures have been adhered to and that the panel, in arriving at their decision, acted fairly and reasonably based on:

- a fair and thorough investigation of the issue;
- sufficient evidence arising from the investigation or assessment on which to base the decision;
- whether in the circumstances the decision was fair and reasonable, and commensurate with the evidence heard.

It can also hear new evidence submitted by the practitioner and consider whether it might have significantly altered the decision of the original hearing. The appeal panel, however, should not re-hear the entire case but may direct that the case is re-heard if it considers it appropriate (see paragraph 24 below).

22. A dismissed practitioner will, in all cases, be potentially able to take their case to an Industrial Tribunal where the fairness of the Trust's actions will be tested.

The appeal process

23. The predominant purpose of the appeal is to ensure that a fair hearing was given to the original case and a fair and reasonable decision reached by the hearing panel. The appeal panel has the power to confirm or vary the decision made at the clinical performance hearing, or order that the case is re-heard. Where it is clear in the course of the appeal hearing that the proper procedures have not been followed and the appeal panel determines that the case needs to be fully re-heard, the Chairman of the panel shall have the power to instruct a new clinical performance hearing.

24. Where the appeal is against dismissal, the practitioner should not be paid, from the date of termination of employment. Should the appeal be upheld, the practitioner should be reinstated and must be paid backdated to the date of termination of employment. Where the decision is to re-hear the case, the practitioner should also be reinstated, subject to any conditions or restrictions in place at the time of the original hearing, and paid backdated to the date of termination of employment.

The appeal panel

25. The panel should consist of three members. The members of the appeal panel must not have had any previous direct involvement in the matters that are the subject of the appeal, for example they must not have acted as the designated board member. These members will be:

Membership of the appeal panel

- an independent member (trained in legal aspects of appeals) from an approved pool.[10] This person is designated Chairman;
- the Chairman (or other non-executive director) of the employing organisation who must have the appropriate training for hearing an appeal;
- a medically qualified member (or dentally qualified if appropriate) who is not employed by the Trust[11] who must also have the appropriate training for hearing an appeal.

In the case of clinical academics, including joint appointments, a further panel member may be appointed in accordance with any protocol agreed between the employer and the university

26. The panel should call on others to provide specialist advice. This should normally include:

- a consultant from the same specialty or subspecialty as the appellant, but from another HPSS/NHS employer [12];
- a senior Human Resources specialist.

It is important that the panel is aware of the typical standard of competence required of the grade of doctor in question. If for any reason the selected clinician is unable to advise on the appropriate level of competence, a doctor from another HPSS employer in the same grade as the practitioner in question should be asked to provide advice. Where the case involves a doctor in training, the postgraduate dean should be consulted.

27. The Trust should convene the panel and notify the appellant as soon as possible and in any event within the recommended timetable in paragraph 29. Every effort should be made to ensure that the panel members are acceptable to the appellant. Where in rare cases agreement cannot be reached upon the constitution of the panel, the appellant's objections should be noted carefully. Trusts are reminded of the need to act reasonably at all stages of the process.

[10] See Annex A.
[11] Employers are advised to discuss the selection of the medical or dental panel member with the local professional representative body eg in a hospital trust the local negotiating committee.
[12] Where the case involves a dentist this may be a consultant or an appropriate senior practitioner.

28. It is in the interests of all concerned that appeals are heard speedily and as soon as possible after the original performance hearing. The following timetable should apply in all cases:

- appeal by written statement to be submitted to the designated appeal point (normally the Director of HR) within 25 working days of the date of the written confirmation of the original decision;
- hearing to take place within 25 working days of date of lodging appeal;
- decision reported to the appellant and the Trust within 5 working days of the conclusion of the hearing.

29. The timetable should be agreed between the Trust and the appellant and thereafter varied only by mutual agreement. The Case Manager should be informed and is responsible for ensuring that extensions are absolutely necessary and kept to a minimum.

Powers of the appeal panel

30. The appeal panel has the right to call witnesses of its own volition, but must notify both parties at least 10 working days in advance of the hearing and provide them with a written statement from any such witness at the same time.

31. Exceptionally, where during the course of the hearing the appeal panel determines that it needs to hear the evidence of a witness not called by either party, then it shall have the power to adjourn the hearing to allow for a written statement to be obtained from the witness and made available to both parties before the hearing reassembles.

32. If, during the course of the hearing, the appeal panel determines that new evidence needs to be presented, it should consider whether an adjournment is appropriate. Much will depend on the weight of the new evidence and its relevance. The appeal panel has the power to determine whether to consider the new evidence as relevant to the appeal, or whether the case should be re-heard, on the basis of the new evidence, by a clinical performance hearing panel.

Conduct of appeal hearing

33. All parties should have all documents, including witness statements, from the previous performance hearing together with any new evidence.

34. The practitioner may be represented in the process by a companion who may be another employee of the HSS body; an official or lay representative of the BMA, BDA, defence organisation, or work or professional colleague. Such a representative may be legally qualified but they will not, however, be representing the practitioner formally in a legal capacity. The representative

will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any written evidence.

35. Both parties will present full statements of fact to the appeal panel and will be subject to questioning by either party, as well as the panel. When all the evidence has been presented, both parties shall briefly sum up. At this stage, no new information can be introduced. The appellant (or his/her companion) can at this stage make a statement in mitigation.

36. The panel, after receiving the views of both parties, shall consider and make its decision in private.

Decision

37. The decision of the appeal panel shall be made in writing to the appellant and shall be copied to the Trust's Case Manager such that it is received within 5 working days of the conclusion of the hearing. The decision of the appeal panel is final and binding. There shall be no correspondence on the decision of the panel, except and unless clarification is required on what has been decided (but not on the merits of the case), in which case it should be sought in writing from the Chairman of the appeal panel.

Action following hearing

38. Records must be kept, including a report detailing the performance issues, the practitioner's defence or mitigation, the action taken and the reasons for it. These records must be kept confidential and retained in accordance with the clinical performance procedure and the Data Protection Act 1998. These records need to be made available to those with a legitimate call upon them, such as the practitioner, the Regulatory Body, or in response to a Direction from an Industrial Tribunal.

Annex A

APPEAL PANELS IN CLINICAL PERFORMANCE CASES

Introduction

1. The framework provides for the appeal panel to be chaired by an independent member from an approved pool trained in legal aspects of appeals.

2. It has been agreed that it would be preferable to continue to appoint appeal panel chairmen through a separately held Northern Ireland wide list rather than through local selection. The benefits include:

   - the ability to secure consistency of approach through national appointment, selection and training of panel chairmen; and
   - the ability to monitor performance and assure the quality of panellists.

3. The following provides an outline of how it is envisaged the process will work.

Creating and administering the list

4. The responsibility for recruitment and selection of panel chairs to the list will lie with the Department, who will be responsible for administration of the list

5. Recruitment to the list will be in accordance with published selection criteria drawn up in consultation with stakeholders, including the BMA, BDA, defence organisations, and the NCAS. These stakeholders will also assist in drawing up the selection criteria and in seeking nominations to serve.

6. The Department of Health Social Services and Public Safety, in consultation with employers, the BDA and the BMA will provide a job description, based on the Competence Framework for Chairmen and Members of Tribunals, drawn up by the *Judicial Studies Board*. The framework, which can be adapted to suit particular circumstances sets out six headline competencies featuring the core elements of law and procedure, equal treatment, communication, conduct of hearing, evidence and decision making. Selection will be based on the extent to which candidates meet the competencies.

7. Panel members will be subject to appraisal against the core competencies and feedback on performance provided by participants in the hearing. This feedback will be taken into account when reviewing the position of the panel member on the list.

8. The level of fees payable to panel members will be set by the Department and paid locally by the employer responsible for establishing the panel.

9. List members will be expected to take part in and contribute to local training events from time to time. For example, training based on generic tribunal skills along the lines of the Judicial Studies Board competencies and /or seminars designed to provide background on the specific context of HPSS disciplinary procedures.

SECTION V. HANDLING CONCERNS ABOUT PERFORMANCE ARISING FROM A PRACTITIONER'S HEALTH

INTRODUCTION

1. This section applies when the outcome of an investigation under Section I shows that there are concerns about the practitioner's health that should be considered by the HSS body's Occupational Health Service (OHS) and the findings reported to the employer.

2. In addition, if at any stage in the context of concerns about a practitioner's clinical performance or conduct it becomes apparent that ill health may be a factor, the practitioner should be referred to OHS. Employers should be aware that the practitioner may also self refer to OHS.

3. The principle for dealing with individuals with health problems is that, wherever possible and consistent with maintaining patient safety, they should be treated, rehabilitated or re-trained (for example if they cannot undertake exposure prone procedures) and kept in employment, rather than be lost from the HPSS.

HANDLING HEALTH ISSUES

4. On referral to OHS, the OHS physician should agree a course of action with the practitioner and send his/her recommendations to the Medical Director and a meeting should be convened with the Director of HR, the Medical Director or Case Manager, the practitioner and case worker from the OHS to agree a timetable of action and rehabilitation (where appropriate)[13]. The practitioner may be accompanied to these meetings (as defined in Section I, para 30). Confidentiality must be maintained by all parties at all times.

5. The findings of OHS may suggest that the practitioner's health makes them a danger to patients. Where the practitioner does not recognise that, or does not comply with measures put in place to protect patients, then exclusion from work must be considered. The relevant professional regulatory body must be informed, irrespective of whether or not the practitioner has retired on the grounds of ill health.

6. In those cases where there is impairment of clinical performance solely due to ill health or an issue of conduct solely due to ill health, disciplinary procedures (as outlined in Section IV), or misconduct procedures (as outlined in Section III) would only be considered in the most exceptional of circumstances, for example if the individual concerned refuses to co-operate with the employer

[13] In the absence of a Medical Director organisations should put in place appropriate measures as part of agreed arrangements for small organisations to ensure the appropriate level of input to the process. See section vi.

to resolve the underlying situation e.g. by refusing a referral to the OHS or NCAS.

7. A practitioner who is subject to the procedures in Sections III and IV may put forward a case on ill health grounds that proceedings should be delayed, modified or terminated. In those cases the employer should refer the practitioner to OHS for assessment as soon as possible and suspend proceedings pending the OHS report. Unreasonable refusal to accept a referral to, or to co-operate with OHS, may give separate grounds for pursuing disciplinary action.

RETAINING THE SERVICES OF INDIVIDUALS WITH HEALTH PROBLEMS

8. Wherever possible the Trust should attempt to continue to employ the individual provided this does not place patients or colleagues at risk. The following are examples of actions a Trust might take in these circumstances, in consultation with OHS and having taken advice from NCAS and/or NIMDTA if appropriate.

Examples of action to take

- sick leave for the practitioner (the practitioner to be contacted frequently on a pastoral basis to stop them feeling isolated);
- remove the practitioner from certain duties;
- make adjustments to the practitioner's working environment;
- reassign them to a different area of work;
- arrange re-training for the practitioner;
- consider whether the Disability Discrimination Act (DDA) applies (see below), and, if so, what other reasonable adjustments might be made to their working environment.

DISABILITY DISCRIMINATION ACT (DDA)

9. Where the practitioner's health issues come within the remit of the DDA, the employer is under a duty to consider what reasonable adjustments can be made to enable the practitioner to continue in employment. At all times the practitioner should be supported by their employer and OHS who should ensure that the practitioner is offered every available resource to enable him/her to continue in practice or return to practice as appropriate.

10. Employers should consider what reasonable adjustments could be made to the practitioner's workplace conditions, bearing in mind their need to negate any possible disadvantage a practitioner might have compared to his/her non-disabled colleagues. The following are examples of reasonable adjustments an employer might make in consultation with the practitioner and OHS.

Examples of reasonable adjustment

- make adjustments to the premises;
- re-allocate some of the disabled person's duties to another;
- transfer employee to an existing vacancy;
- alter employee's working hours or pattern of work;
- assign employee to a different workplace;
- allow absence for rehabilitation, assessment or treatment;
- provide additional training or retraining;
- acquire/modify equipment;
- modifying procedures for testing or assessment;
- provide a reader or interpreter;
- establish mentoring arrangements.

11. In some cases retirement due to ill health may be necessary. Ill health retirement should be approached in a reasonable and considerate manner, in consultation with the practitioner, OHS, and HPSS Superannuation Branch**.**

Note. Special Professional Panels (generally referred to as the "three wise men") were set up under circular TC8 1/84. This part of the framework replaces those arrangements and any existing panels should be disbanded.

SECTION VI. FORMAL PROCEDURES – GENERAL PRINCIPLES

TRAINING

1. Employers must ensure that managers and Case Investigators receive appropriate training in the operation of formal performance procedures. Those undertaking investigations or sitting on disciplinary or appeals panels must have had formal equal opportunities training before undertaking such duties. The Trust Board must agree what training its staff and its members have completed before they can take a part in these proceedings.

HANDLING OF ILLNESS ARISING DURING FORMAL PROCEEDINGS

2. If an excluded employee or an employee facing formal proceedings becomes ill, they should be subject to the employer's usual sickness absence procedures. The sickness absence procedures can take place alongside formal procedures and the employer should take reasonable steps to give the employee time to recover and attend any hearing. Where the employee's illness exceeds 4 weeks, they must be referred to the OHS. The OHS will advise the employer on the expected duration of the illness and any consequences the illness may have for the process. OHS will also be able to advise on the employee's capacity for future work, as a result of which the employer may wish to consider retirement on health grounds. Should the employment be terminated as a result of ill health, the investigation should still be taken to a conclusion and the employer form a judgement as to whether the allegations are upheld.

3. If, in exceptional circumstances, a hearing proceeds in the absence of the practitioner, for reasons of ill-health, the practitioner should have the opportunity to provide written submissions and/or have a representative attend in his absence.

4. Where a case involves allegations of abuse against a child or a vulnerable adult, the guidance issued to the HPSS in 2005, "Choosing to Protect – A Guide to Using the Protection of Children Northern Ireland (POCNI) Service", gives more detailed information.

PROCESS FOR SMALLER ORGANISATIONS

5. Many smaller organisations may not have all the necessary personnel in place to follow the procedures outlined in this document. For example, some smaller organisations may not employ a medical director or may not employ medical or dental staff of sufficient seniority or from the appropriate specialty. Also, it may be difficult to provide senior staff to undertake hearings who have not been involved in the investigation.

6. Such organisations should consider working in collaboration with other local HPSS organisations (eg other Trusts) in order to provide sufficient personnel

to follow the procedures described. The organisation should be sufficiently distant to avoid any organisational conflict of interest and any nominee should be asked to declare any conflict of interest. In such circumstances the HPSS organisation should contact the Department to take its advice on the process followed and ensure that it is in accordance with the policy and procedures set out in this document.

TERMINATION OF EMPLOYMENT WITH PROCEDURES UNFINISHED

7. Where the employee leaves employment before formal procedures have been completed, the investigation must be taken to a final conclusion in all cases and performance proceedings must be completed wherever possible, whatever the personal circumstances of the employee concerned.

8. There will be circumstances where an employee who is subject to proceedings puts forward a case, on health grounds, that the proceedings should be delayed, modified or terminated. In such cases the employer is expected to refer the doctor or dentist to the OHS for assessment as soon as possible. Unreasonable refusal to accept a referral to, or to co-operate with, the OHS under these circumstances, may give separate grounds for pursuing disciplinary action.

9. Every reasonable effort must be made to ensure the employee remains involved in the process. If contact with the employee has been lost, the employer should invite them to attend any hearing by writing to both their last known home address and their registered address (the two will often be the same). The employer must make a judgement, based on the evidence available, as to whether the allegations are upheld. If the allegations are upheld, the employer must take appropriate action, such as requesting the issue of an alert letter and referral to the professional regulatory body, referral to the police, or the Protection of Children and Vulnerable Adults List (held by the Department of Employment and Learning).

GUIDANCE ON AGREEING TERMS FOR SETTLEMENT ON TERMINATION OF EMPLOYMENT

10. In some circumstances, terms of settlement may be agreed with a doctor or dentist if their employment is to be terminated. The following good practice principles are set out as guidance for the Trust:

- settlement agreements must not be to the detriment of patient safety;
- it is not acceptable to agree any settlement that precludes involvement of either party in any further legitimate investigations or referral to the appropriate regulatory body.

INFORMAL PROCESS