Southern Health and Social Care Trust

CONSULTANT JOB PLAN REVIEW TEMPLATE

Job Plan Dates	
This job plan is effective from:	**1st September 2011**
Next Job Plan Review Due on/before:	**1st March 2012**

Personal details:	
Name of doctor: **Mr Aidan O'Brien**	Contract: Type: **Whole Time**
Directorate/Division & Location: **Urology/ Surgery and Elective Care Division**	

On-call rotas only - On-call availability supplement:	
Rota Frequency – i.e. Number of doctors on rota:	**1 : 3**
Rota Category:	**Category A**

For info: *More frequent than or equal to 1 in 4 = Category A: 8% Category B: 3% of basic salary*
Less frequent than 1 in 4 or equal to 1 in 8 = Category A: 5% Category B: 2% of basic salary
1 in 9 or Less frequent = Category A: 3% Category B: 1% of basic salary

Summary of Programmed Activities:		
Direct Patient Care excluding on-call:	**9.56** PA's	
Supporting Professional Activities:	**1.50** PA's	**Specific Roles:**
On-Call Allocation:	***Predictable*** PA's	***Unpredictable*** **1.57** PA's
Any Annualised Activity & Reason	PA's	**Reason:**
Any Additional HCS Responsibilities:	PA's	**Reason:**
Any External Duties:	PA's	**Reason:**
TOTAL PA's:	**12.63 PA's**	

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

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1. OBJECTIVES: Refer to Section 3 in Regional Job Planning Guidance.

Objectives should be specific, measurable, achievable, reasonable and time bound. They may refer to protocols, policies, procedures and work patterns to be followed. Where objectives are set in terms of output and outcome measures, these should be reasonable and agreement should be sought.

Service Developments & Objectives

- Service developments and key targets which will impact on PAs

Personal Objectives

- Objectives against which PA's will be allocated [both DCC and all SPA's]
- E.g. Activity targets specifying an indicative activity for outpatient clinics, theatre lists.
- E.g. Quality objectives incorporating attainment of standards of quality of care.

Team Objectives

- As appropriate to the team job plan e.g. to guarantee to provide a fixed number of clinics or operating lists for the whole team over a year when achievable.

SUPPORTING RESOURCES

Facilities and resources required for delivery of duties and objectives	
1. Staffing support	
2. Accommodation	
3. Equipment	
4. Any other identified resources	

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2. DIRECT CLINICAL CARE (Section 8 in Regional Job Planning Guidance.)
Emergency duties, including work during or arising from on-call, Operating Sessions including preoperative and postoperative care, Ward Rounds, Outpatient activities, Clinical diagnostic work, Other patient treatment, Public health duties, Multidisciplinary meeting about direct patient care, Any administration related to any of the above, including referrals & notes.

3. JOB PLAN TEMPLATE
This job plan is subject to review at least once per year by you and your Clinical manager. In the case of a new employee a review of the job plan will take place 3 months after commencement and annually thereafter.

(If appropriate cut and paste your job plan into this space set out in the following format.)

DAY	TIME	WORK ACTIVITY	LOCATION	HOURS				Total Hours	Prem
				DCC	SPA	APA	EPA		
Mon	8.30 -9.00	Travel **(Weeks 1,2,4 &5)**	BPC	0.375					
	9.00 – 1.00	OPC BPC **(Weeks 1 & 5)**	BPC	1.0					
	9.00 – 1.00	OPC ACH **(Weeks 2 & 4)**	ACH	2.0					
	1.00 – 1.30	Travel **(weeks 1,2,4 & 5)**		0.375				**8.75**	
	9.30 – 1.30	SPA **(week 3)**	CAH		1.0				
	1.30 – 2.00	Lunch							
	2.00 – 2.30	Ward round	CAH	0.5					
	2.30 – 6.00	SPA	CAH		3.5				
Tues	8.30 – 1.00	Day Surgery **(2 weeks per month)**	CAH	2.25					
	9.00 – 1.00	Admin **(2 weeks per month)**	CAH	2.0				**9.75**	
	1.0 - 1.30	Lunch							
	1.30 – 5.30	Outpatients clinic	CAH	4.0					
	5.30-6.00	Ward Round	CAH	0.5					
	6.00 – 7.00	Administration	CAH	1.0					
Wed	8.30 - 9.00	Pre op ward round	CAH	0.5					
	9.00 – 5.00	Theatre	CAH	8.0				**10.5**	
	5.00 – 6.00	Post- op Ward round	CAH	1.0					

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	6.00 – 7.00	Administration	CAH	1.0					
Thurs	8.30 – 9.30	Radiology meeting	CAH	1.0					
	9.30 – 12.00	Grand Ward Round + SPA	CAH	1.0	1.5				
	12.00 – 1.30	Departmental Meeting	CAH	1.5					
	1.30 – 2.15	Lunch						9.75	
	2.15 – 5.00	MDM	CAH	2.75					
	5.00 – 5.30	MDM Admin	CAH	0.5					
	5.30 – 7.00	Administration	CAH	1.5					
Fri	9.00 – 12.00	OFF							
	12.00 – 1.00	Admin	CAH	1.0				5.5	
	1.00-1.30	Ward Round	CAH	0.5					
	1.30-5.30	Specialist clinic	CAH	4.0					
			TOTAL HOURS:	38.25	6			44.25	
			TOTAL PROGRAMMED ACTIVITIES:	**9.56**	**1.5**			**11.06**	

4. EMERGENCY WORKLOAD

Type	Day/Time	Location	Allocated PAs
Predictable Emergency on-call Work*			
Unpredictable Emergency on-call Work*	11.4 hours per week		**1.57**
TOTAL PA's for ON-CALL:		**1.57**	

*Please refer to Medical Staffing / Trust Guidance for method for calculating on-call so that prospective cover is included – this means cover will need to be provided for absent colleagues on annual leave and study leave.

On-call availability Supplement	
On-call Category	A
Agreed on-call Rota Frequency	1:3 Prospective
On-Call Supplement	8%

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5. SUPPORTING PROFESSIONAL ACTIVITIES (Section 9 in Regional Guidance)

- It is expected that PA's including SPA's will normally take place at a consultant's principal place of work if space, equipment and protected time are provided. Alternatives arrangements can be agreed with the Clinical Director.
- The Trust would expect that all consultants have a minimum allocation of 1.5 for supporting professional activities for maintaining a professional career. Where additional SPA's are undertaken to varying degrees by consultants these should be programmed into the Job Plan and agreed with the Clinical Manager.

Please provide full details on SPA responsibilities

6. EXTERNAL DUTIES – Please refer to Trust Guidance on approval for External Duties. An External Duties approval form must be completed on an annual basis.

Please provide full details on External Duties, time frames, funding arrangements etc

7. Additional HPSS Responsibilities – Please refer to Trust Guidance on approval of these duties. An HPSS Additional Responsibilities approval from must be completed on an annual basis.

Please provide full details on these duties, time frames, funding etc

8. PRIVATE PRACTICE & FEE PAYING SERVICES

Type	Please Tick:
You are not currently undertaking regular private practice however if this changes during the year your have agreed to inform the clinical director before any changes are made to your work-plan.	☐
You are currently undertaking regular private practice as outlined in your job plan and will undertake an additional PA if offered, up to a maximum of 11 PA's per week, as detailed in the terms and conditions of service.	☐
You are currently undertaking ad hoc private practice with the Trust and it is agreed that this practice will continue, provided it does not affect the efficiency of multidisciplinary team working. You have agreed to ensure that if any of your agreed NHS activity is displaced due to private	☐

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practice you will carry out in NHS activity at an agreed later stage.	

9. AGREEMENT:

Signed: Doctor		**Signed: Clinical Manager**	
Date:		Date:	
Signed: Associate Medical Director & Director of Service			
Date:			

To be completed and forwarded to:

- **The Medical Staffing Manager, Medical HR, Ground Floor, Trust HQ, CAH**

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Southern Health and Social Care Trust Training Material

Case Study

FIT TO PRACTICE?

1.

The medical director has received an email from a staff grade in the accident and emergency (A&E) department complaining that Dr AB, a specialist registrar (SpR) in paediatrics (a one year locum appointment–training (LAT) has upset one of the junior nursing sisters in the department and has been heard shouting at her and being rude to her. The email points out that this is the third time this has happened over a four month period. The medical director is requested to take action to stop this happening again.

The medical director asks the staff grade to put his concerns in writing but he declines as he says he was in another room at the time and could not hear all that was being said. The medical director then asks whether the nursing sister is prepared to provide a written statement outlining what has been happening. She declines as she says nothing ever happens when nurses complain about doctors, and in any case she has got to work with the doctor in the future. In view of this the medical director decides to take no further action.

Three weeks later the medical director is approached by one of his consultant colleagues who tells him that a senior house officer (SHO) in paediatrics, whom she is supervising, has complained that Dr AB has been making derogatory remarks about her. The SHO feels threatened and bullied. At about the same time the staff grade in the A&E department sends the medical director another email letting him know that another member of the nursing staff has spoken to him to ask his advice as she thought Dr AB smelt of alcohol when Dr AB came down to examine a child the previous evening. She commented that she had been concerned as her speech was slurred and Dr AB seemed rather brusque. She said this had happened on two or three occasions in the previous three weeks.

The medical director advises the consultant to consult the trust harassment and bullying policy that defines harassment and bullying, as it is important that what the SHO perceives as harassment and bullying concurs with the agreed trust definition of such behaviour. He also advises that if the behaviour falls within the agreed definition, the problem should be dealt with in accordance with the trust policy.

The medical director replies to the email and asks the staff grade to ask the nurse to put her concerns in writing. After two weeks the medical director has not received a statement. The medial director therefore decides to speak to the clinical director of Paediatrics who tells him that he has no concerns about Dr AB who is a hard working trainee. He also tells him that he has not had any complaints from any of the staff in the Paediatric department. The medical director decides to speak to the chief nurse and ask her to ask one of the senior nurses to talk to the nursing staff in the A&E department to find out whether there are any genuine concerns. She discovers that the nurse who raised the concerns used to live with the SpR but that she moved out of her flat about three months earlier.

CASE STUDY

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FIT TO PRACTICE?

Comment: *Bullying and harassment are unfortunately becoming an increasingly common problem. Most trusts and deaneries now have a policy for dealing with this behaviour and it is important for all staff to be familiar with their local policies for dealing with the issue. It is also important to agree what constitutes harassment and bullying: firm management is perceived to be good management by some staff and harassment and bullying by others. "The Southern Trust Bullying and Harassment Guidance gives useful advice and definitions of bullying and harassment".*

When a problem presents it is extremely important to keep an open mind and not to make judgements until you have all the facts. The National Patient Safety Agency (NPSA) and NHS Confederation have recently published useful guidance on how to deal with an incident. The guidance includes an incident decision tree (IDT), which is based on work by Professor James Reason. It is strongly recommended that the IDT be followed to guide the initial decision making and risk assessment. This should be followed by an analysis of the problem.

It is almost impossible to take formal action unless you have written signed statements from those involved. A reluctance to put concerns in writing should alert you to the fact that the concerns may be fabricated or embellished. Subsequent disciplinary action, if indicated, will require written statements from those involved. At this stage, in the absence of any written evidence, once you have established that there is no risk to patients, you should deal with the matter informally. It is, however, essential that you document fully the action you have taken and why. Bear in mind what you write is likely to have to be made available to all parties and that this includes email correspondence. In difficult cases take advice from colleagues, if necessary anonymising the case. Clinical and medical directors often find it helpful discussing cases in confidence with other medical managers either from the same or another NHS trust.

CASE STUDY

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FIT TO PRACTICE?

2.
The parents of a 3 year old child write in to complain about the attitude and behaviour of an SpR in paediatrics. They complain that they bought Andrew, their son, up to the A&E department with a cough, shortness of breath, and high fever. They are seen in the department within 30 minutes and told that their son needs a chest *x* ray. Because of pressures in the department he is sent to the paediatric ambulatory care unit before the *x* ray is done and an SHO in paediatrics sees him there. When seen he is apyrexial, has a respiratory rate of 30 per minute, and has no obvious respiratory distress. The SHO does not think the child needs a chest *x* ray but his parents are insistent that one should be done. The SpR is called. She does not think an *x* ray is necessary and advises the parents to take their son home. She does not examine the child. The child's parents reluctantly take him home and write in to complain that the SpR was abrupt and dismissive, failed to examine their child, and failed to listen to their concerns. They also complain that the SpR's speech was slurred and that she smelt of alcohol. The medical director arranges for the complaint to be investigated in accordance with the NHS trust's complaints procedure. This involves obtaining a statement from Dr AB and witness statements from other staff involved.

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FIT TO PRACTICE?

Comment: *It is important that statements are based on the facts and are not based on hearsay evidence or opinion. A response is then sent to the complaint with a suitable apology, if indicated. The aim is to send out a final response within 20 working days. Having responded to the complaint, it is then important to review the incident to see if there are lessons to be learned and whether any action is required to prevent a recurrence. All that most complainants want is an apology and reassurance that lessons have been learned and measures put in place to prevent a recurrence. It is always difficult to judge at what stage you should share information with the doctor concerned, but, as a general principle, any concerns should be discussed openly at an early stage. Such informal discussions may in themselves bring about a change in behaviour, if the doctor concerned has insight. It is important to realise that staff may not put information down in writing, but where there are multiple sources of information—"triangulation"—it would be very difficult for a medical manager not to take action. At this stage it would be appropriate for the medical manager to see the doctor to inform him/her that certain concerns had arisen and that preliminary enquiries were being undertaken to establish the nature of those concerns and whether they were justified. Any inquiry should require those who had previously made verbal comments to provide formal written signed statements. If nobody is prepared to give a statement then it is appropriate for no further action to be taken unless additional information is forthcoming.*

If you feel that formal action is justified, you must take this in accordance with the agreed NHS trust performance and disciplinary procedures. (Southern Trust Guidance for Handling Concerns about Doctors) From June 2005 these have been based on the guidance that has been issued by the Department of Health. (MHPS) The new framework for handling concerns about the safety of patients posed by the performance of doctors and dentists, which come to the attention of an NHS trust, is a coordinated process which aims to ensure that rapid action is taken to remove the source of the risk and that action is put in place to tackle any underlying problem. The new guidance replaces Department of Health Health Circular HC(90), that was used by most NHS trusts to formulate their performance and disciplinary procedures. Concerns about the capability of doctors in training should be considered initially as training issues and the postgraduate dean should be involved from the outset.

Following any incident, an individual will need time to reflect on what has happened and may be distressed and unfit for work. The individual may also require time to prepare and write a statement, so a period of leave is frequently required. Under the new procedures, exclusion from work is seen as only being necessary in the most exceptional circumstances and voluntary restrictions on practice are the normal method by which concerns are handled. There is a requirement for any exclusion to be kept under active review. National Clinical Assessment Authority/Service (NCAS) advice is best sought at an early stage and should be sought in all cases where exclusion is being considered, unless there is an immediate threat to patient safety or there is a police investigation in progress. Such cases are rare and discussion with the police will normally precede the decision to exclude a doctor.

All referrals to the NCAS require the consent of the doctor concerned. Should this not be forthcoming, particularly in cases where considerable concerns have been raised about a doctor's performance, it would be deemed a "reasonable management request" for a doctor to undergo an NCAS assessment. If the doctor refused such a request, this would lead to disciplinary action that would test the reasonableness of that management request. The new guidance sets out the action to be taken when a concern arises, the arrangements for restriction of practice and the exclusion of practitioners from work. The new disciplinary framework covers conduct hearings and dismissal, procedures for dealing with issues of capability, and procedures for handling concerns about a practitioner's health.
If there are concerns about patient safety and that the doctor works for another employer, that employer must also be informed of the concerns. If the doctor is likely to seek work elsewhere, the General Medical Council (GMC) should be informed. Otherwise it is usually best to await the outcome of any investigation before informing the GMC. The threshold for informing the GMC is if there is concern that the doctor's actions are such that they are likely to, or could affect, the doctor's registration. This is also undertaken by the Medical Director

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3.
In this case witnesses confirmed that Dr AB did not smell of alcohol on the night in question and the paediatric nursing staff were of the opinion that Dr AB behaved appropriately with the child's parents. **Approximately a week later the medical director received a telephone call from a consultant at another hospital. He had concerns about Dr AB who had been attending a course at the hospital. He was concerned that during the two day course Dr AB appeared disinterested and at times made comments which were not in context and were inappropriate. Dr AB had been critical of his work colleagues and had not performed to the standard expected of an SpR. She had failed all her assessments on the course and had achieved very low marks in the final written assessment. She was thought by the course staff to have displayed such a seriously deficient performance that they had sought independent advice from the NCAS. The NCAS had advised the consultant to discuss his concerns with Dr AB's employer—hence the telephone call. In addition the consultant had observed Dr AB's speech to be slurred.** **Informal enquiries revealed that Dr AB, who was unmarried, had few close friends and that she was considered by her colleagues to be a young female doctor who drank more heavily than average. She had had difficulty passing her Membership of the Royal College of Paediatrics and Child Health (MRCPCH) examination and had eventually done so after three attempts.**

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FIT TO PRACTICE?

Comment: *The concerns disclosed to date are strongly suggestive of a trainee in serious difficulty and it is important to put the latest findings in context and consider the causes of poor performance and reasons for it. To this end a discussion with the trainee's educational supervisor is required and also with the Royal College of Paediatrics and Child Health (RCPCH) tutor and SpR programme director. In view of the concerns, it is essential that a risk assessment be undertaken to determine whether Dr AB is safe to work and in particular that she is safe to care for patients. To this end confidential discussions are required with consultant colleagues.*

It is always difficult to gauge at what stage the doctor should know about the concerns that have been raised. One view is that the doctor should be made aware of all concerns regardless of whether they are vexatious or genuine. Another is that the doctor should only be made aware of concerns that have been substantiated and are to be investigated formally. In this case it is important that the doctor is aware of the concerns that have been raised and is also aware of the background to those concerns.

If concerns have been raised confidentially, it is important that those raising the concerns agree to their concerns being raised with the doctor and to the source of the concerns being disclosed. Each case needs to be assessed individually and judgments will have to be made as to whether concerns raised in confidence and the source of the concern are disclosed to the doctor. One tactic before hearing concerns is to warn the person who wishes to raise the concern that both the concern and the name of the person raising it may have to be disclosed to the doctor if formal proceedings are instigated. It is also important to ensure that complainants are aware that they will be properly represented and supported should they wish to raise a concern, and that they are informed of this beforehand.

Following an analysis of the problem and a discussion of the possible solutions, a practical way forward should be agreed. This must have the agreement of all those involved, including the trainee.

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FIT TO PRACTICE?

4.
The discussions highlight the real possibility of alcohol or substance abuse. This requires a more detailed assessment and the medical director recommends to Dr AB's educational supervisor that she discuss the situation with Dr AB and with her agreement refers Dr AB for an occupational health assessment, which Dr AB agrees to. The assessment uncovers no evidence of alcohol or substance abuse. During the assessment Dr AB discloses that she has been suffering from headaches. These have not been particularly severe and are attributed to stress. It is decided that Dr AB is fit to continue at work. The medical director recommends closer supervision from the paediatric consultants who agree to do this. **During the next six weeks Dr AB performs her duties satisfactorily and there are no major concerns. On one occasion Dr AB is abrupt with one of her colleagues and is perceived as being difficult over a proposed on-call rota change. She is known to favour going off for long weekends by herself and on this occasion had planned a walking holiday that she did not wish to cancel. During the six week period she is felt by all the staff to be rather more rigid than usual with her behaviour gradually becoming more difficult. This type of behaviour is felt to be in character. By the end of the six week period the majority of Dr AB's close colleagues are openly saying that she has become very difficult to work with, is unhelpful, and is not handing over properly when she goes off duty. They say she always seems to be in a rush to leave the department and on several occasions has been late for work. When questioned she puts this down to problems with the traffic.**

CASE STUDY

FIT TO PRACTICE?

Comment: It is important at this stage to try and quantify the problem and determine whether the situation has reached a threshold requiring more definitive action. The apparent breakdown in communication is worrying and a definite indication that patient safety is being compromised. Handover is now seen as an extremely important part of a junior doctor's daily routine. The question is whether the situation can be contained and dealt with informally or whether more formal action is required. As the SpR will have to work out of hours with no direct supervision, a view will have to be taken on whether she is fit to be on call. To some extent this will depend on the degree of supervision the nursing staff and consultant staff are prepared to undertake and whether the trainee has insight into her problem. It is always difficult to know how much information to share with more junior trainees. It is of the utmost importance that confidentiality is not breached and that trust is maintained. If it is decided that the trainee should not be working, this is a situation that must be handled sensitively. If the trainee is told not to work, the decision must be on the grounds of the risk to patient safety.

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5.
There has been a gradual escalation of the problem during the past three months and following discussion it has been agreed that Dr AB merits closer supervision and should not undertake unsupervised on call. She is therefore taken off the on call rota and a further referral to the occupational health department is deemed necessary. It is suspected that she is suffering from stress. **Dr AB is seen in the occupational health department, this time with the additional information that has become available since her last assessment. She is assessed as being under stress due to a combination of factors and it is decided that she needs two weeks sick leave. She is reassessed at the end of that time and deemed to need another two weeks off. At the end of this time she is reviewed again and as she appears to have improved it is decided that she should have a phased return to work. It is agreed that she will initially only work two days a week and that she will do no on call. The plan is for her to gradually return to full time work over the next six weeks. During the period that she is working part time she is seen by an occupational psychologist and has regular meetings with her educational supervisor. At the end of the six week period she resumes full time work. Towards the end of that week, she has a major seizure while she is seeing a child on the ward. She is admitted to hospital as an emergency and a magnetic resonance imaging brain scan reveals a large frontal lobe tumour. This is subsequently removed surgically and she makes a full recovery.** In Dr AB's case her behaviour problems were caused by a combination of lack of sleep, intermittent headaches, subclinical seizure activity, and stress. She was acutely aware of her underperformance but found her colleagues unsympathetic and unsupportive to the extent that she was unable to confide in them.

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Comment: *The importance of considering health problems in someone who appears to have personality or behaviour problems cannot be overestimated. Even if initial health assessments are negative, the possibility of illness or an organic condition must not be forgotten. Many doctors who have performance difficulties become stressed and the root cause of their problem is overlooked. Although not an issue in this case, bullying and harassment as a cause of poor performance should not be forgotten. A skilled occupational health assessment is a key tool for helping to diagnose and support doctors in difficulty.*
It is now considered a "reasonable management request" to require a doctor, suspected of having health problems, to undergo an occupational health assessment. Refusal may require disciplinary action to be considered.

The GMC, in its publication Good medical practice, sets out the standards that all doctors are expected to adhere to: "Duties of a doctor". Most of the medical Royal Colleges have refined these and made them specialty specific and the RCPCH has published its own guidance. Managers too have their own standards.
Involvement of the relevant deanery is mandatory for any doctor in a formal training scheme. Issues involving locum doctors and doctors "in training", who are not in a formal scheme or recognised post, present particular difficulties. In these circumstances consideration should be given as to whether referral to the GMC is indicated. This is mandatory in all cases where it is judged that the doctor's standards of care do not meet, or may not meet, the standards set out in Good medical practice. In less serious cases, referral to the NCAS or discussion with "the medical agency through which the doctor is employed, should be considered.

Ref: David J Scott *- Arch Dis Child Educ Pract Ed 2005;**90**:ep34-ep39 doi:10.1136/adc.2004.063552*

CASE STUDY

Southern Health and Social Care Trust

Handling concerns about Doctors

Doctors in Difficulty Workshop

October 2013

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Objectives

- To understand the Trust's guidance on Handling Concerns
- To discuss the support available for Consultants
- To clarify each Consultant's role in applying the Guidance
- To highlight the importance of early intervention

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The Context

- The Medical Profession (Responsible Officers) Regulations 2010 – Revalidation started December 2012
- All issues should be managed under Maintaining High Professional Standards Framework – issued under legal direction on Disciplinary Procedures 2005.
- The Trust is responsible for managing performance of all doctors including doctors in training.
- Southern Trust Guidance on Handling Concerns

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What should you do?

- ***Consultants / Educational Supervisor***
  - Ascertain quickly what has happened and why
  - Determine whether immediate action is needed
  - Establish seriousness of concerns, e.g. poor knowledge skills in few areas or serious conduct/ capability problem
  - Minor concerns about capability of doctors in training should normally be considered initially as training issue and managed informally.
  - Liaise appropriately with Clinical Supervisor and DME.
  - Maintain confidentiality & keep full records

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Practical Advice – 5 Golden Rules

- 1) Deal with specific concerns as they arise
- 2) Investigation must follow procedures and be demonstrably fair
- 3) Allegations must be specific enough to investigate
- 4) Think Ahead - NCAS
- 5) Support those involved

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How to raise your concern

- All concerns should firstly be conducted on an informal basis, with preliminary enquiries undertaken to determine the facts.
- Common sense needs to be applied to whether concerns are of sufficient substance that they need to be reported. If in any doubt, report it.
- The Clinical Manager (educational supervisor) should report concerns to the AMD and Director of Service.
- Once a concern of substance has been raised, the AMD/Director should notify the Chief Executive who will appoint an Oversight Group.

Received from SHSCT on 22/11/2022. Annotated by the [illegible] Inquiry.

What the Trust will do

- An HR Case Manager will be allocated to support Clinical Manager
- Screening Process - Clinical Manager and HR Manager undertake preliminary enquiries into the concerns raised and assess what action should be taken
- Oversight Group will be informed of the required action which may be:
  - No action
  - Informal remedial action –perhaps input from NCAS
  - Formal investigation
  - Exclusion / Restriction

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Informal Process

- Local action plan developed and agreed with the doctor
- Advice may be sought from Occupational Health / NCAS
- If a remedy cannot be determined, agreement of the doctor to refer case to NCAS
- Informal plan agreed, implemented and monitored
- Failure on part of doctor to engage with process could result in formal action

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Formal Process

- Chief Executive appoints a Case Manager, Case Investigator & designated Board Member
- Case Manager informs doctor of the specific allegations and name of Case Investigator
- Investigation report completed
- Doctor kept informed and opportunity to comment on report
- Case Manager responsible for deciding on course of action based on investigation report

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Formal Process - Decisions

- No further action required
- Restrictions/Exclusions
- Misconduct case to be put to conduct panel
- Referral to Occupational Health/specialists
- Clinical performance concerns which require further consideration by NCAS
- Serious concerns which are referred to GMC
- Serious clinical performance concerns, matter to be put before a clinical performance panel

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Exclusions / Restrictions

- Exclusion when potential risk to patient care
- Authority to exclude a doctor can ONLY be taken by Chief Executive, Medical Director or AMD.
- Immediate exclusion (when concern first arises) NCAS should be informed
- Formal exclusion (during formal investigation) Trust conference should be convened
- Restrictions should always be considered as an alternative to exclusion

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Employment Law cases for Doctors

- Increasing number of Case Law decisions relating to doctors: Key cases:
  - Dr Mattu v The University Hospitals of Coventry & Warwickshire NHS Trust[2012]EWCA Civ 641 -- Dismissal procedure under MHPS
  - Dr Lim v Royal Wolverhampton NHS Hospitals Trust [2011] EWHC 2178(QB)--injunction to restrain capability hearing, breach of contract, MHPS(10.8.11)
  - Puri v Bradford Teaching Hospitals NHS Trust [2011] EWHC 970(Admin)--composition of panels,Article 6,MHPS,judicial review--High Court Judgment
  - Hameed v Central Manchester University Hospitals NHS Foundation Trust [2010] EWHC 2009(QB)-- fairness of disciplinary process per Article 6,permission to appeal granted--High Court Judgment(30 July 2010)
  - Edwards v Chesterfield Royal Hospital NHS Foundation Trust [2010] EWCA Civ 571 (26 May 2010)-- failure to follow proper disciplinary procedure, breach of contract, damages--Court of Appeal Judgment
  - Kulkarni v Milton Keynes Hospital NHS Foundation Trust & Anor [2009] EWCA Civ 789 (23 July 2009) right to have legal representation at disciplinary hearing:
  - Mark Ali v Belfast Health & Social Care Trust (2008) right to have legal representation at disciplinary hearing:

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Help from HR Managers

- Coaching
- Advice on policy interpretation
- Employment Law expertise
- Provision of Template Letters & Resource Pack to Guide Managers
- Quality checking complex letters
- Involvement in meetings
- Advising on options and assessing risk
- Assisting with the Investigation Report

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NCAS

- Confidential advice to Trusts and doctors
- Contact usually via Medical Director/HR
- Advice: Fresh independent opinion
  - Exclusion: prevent inappropriate exclusion
  - Support for cases managed locally
  - NCAS formal assessment
  - Action Plans and remediation
- Local Case advisors
- Support & Resources

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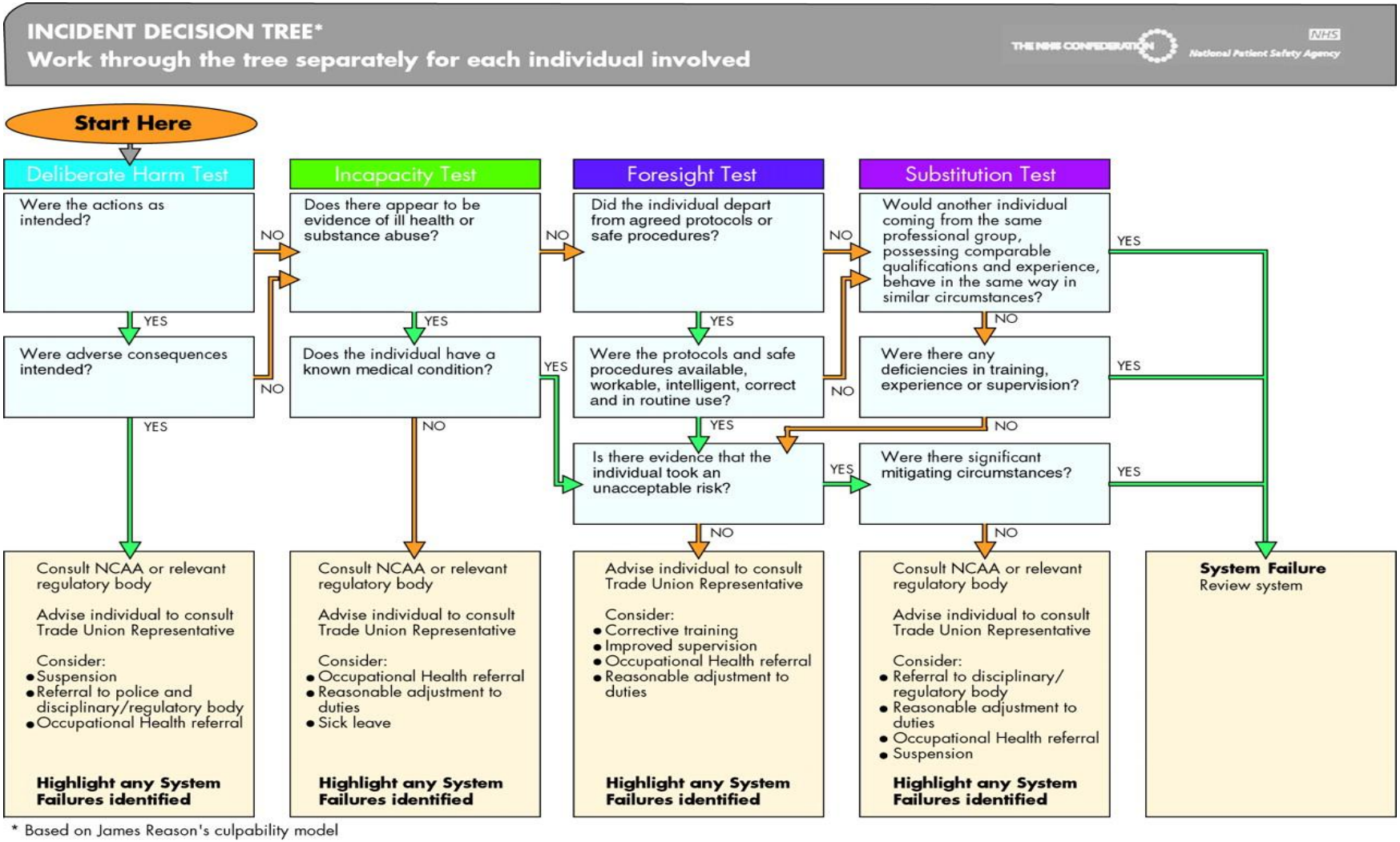
Incident Decision Tree



Received from SHSCT on 22/11/2022. Annotated by the [redacted] Inquiry.

Summary & Conclusion

- 1. Identifying a Trainee in Difficulty
- 2. Meet with that Trainee
- 3. Document concerns & their reflection
  - (Consider support available HR/OH/NCAS)
  - (Escalate appropriate concerns)
- 4. Identify a PDP
- 5. Monitor & Review

Guidelines and resources to assist managers available

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Parks, Zoe

From: Parks, Zoe <[redacted]>
Sent: 02 October 2013 16:10
To: Peile, Lenore
Cc: Jones, Kelly; Weir, Colin
Subject: Handling Concerns Medical Staffing Presentation - Z PARKS - 2.10.13.ppt
Attachments: Handling Concerns Medical Staffing Presentation - Z PARKS - 2.10.13.ppt; image001.jpg

Please see copy of my presentation for tomorrow – if you could ensure this is available on the laptop. Many thanks

Zoe

Mrs Zoe Parks
Medical Staffing Manager
* Southern Health & Social Care Trust
Trust Headquarters
68 Lurgan Road, Portadown. BT63 5QQ ([redacted]
Fax: [redacted]
8 [redacted]

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NHS
National Patient Safety Agency

National Clinical
Assessment Service

DH Department of Health

Handling Concerns about the Performance of Healthcare Professionals: Principles of good practice

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DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Performance
Management	IM & T
Planning	Finance
Clinical	Partnership Working

Document Purpose	Best Practice Guidance	
ROCR Ref:		Gateway Ref: 6340
Title	Handling concerns about the performance of healthcare professionals: principles of good practice	
Author	DH & National Patient Safety Agency	
Publication Date	September 2006	
Target Audience	PCT CEs, NHS Trusts CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of Nursing, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Allied Health Professionals, GPs, Communications Leads	
Circulation List	PCT CEs, NHS Trusts CEs, SHA CEs, Foundation Trust CEs, Medical Directors, Directors of Nursing, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, NDPBs, Independent Healthcare Leads	
Description	This best practice guidance on handling concerns about professional practice has been developed collaboratively by senior individuals of all healthcare professions, regulators, commissioners and patient groups. It will be useful in all settings where healthcare is offered and encompasses everyone whatever their position in the organisation	
Cross Ref	The Regulation of the non-medical healthcare professions Good Doctors, Safer Patients	
Superceded Docs	N/A	
Action Required	N/A	
Timing	N/A	
Contact Details	Maureen Morgan UE&I, Professional Leadership W509, Quarry House Quarry Hill LS2 7UE Personal Information redacted by the USI	
For Recipient's Use		

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Handling Concerns about the Performance of Healthcare Professionals: Principles of good practice

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WIT-90340

FOREWORD FROM CHRISTINE BEASLEY, CHIEF NURSING OFFICER, DEPARTMENT OF HEALTH

Handling Concerns about the Performance of Healthcare Professionals

Healthcare in England benefits enormously from having a dedicated, committed and highly skilled workforce, focused on offering quality care for patients. However, sometimes things go awry and a healthcare professional may find their practice called into question.

If this happens, while the over-riding concern must be for patient safety, practitioners also need to be handled sensitively and feel they are treated fairly. After all, for the overwhelming majority, an episode of sub-standard performance will not spell the end of their career. With the right intervention, most will continue with their work and maintain their contribution into the future.

This document is the result of the deliberations of a cross-agency, multiprofessional working group, set up to define good practice in handling performance concerns applicable to all professional staff, working in all settings where healthcare is delivered.

This is the first time senior individuals from healthcare professions, regulators, commissioners and patient groups have come together to share good practice in this field, to learn from each other and devise a framework that applies to everyone, whatever their position in the organisation.

The initiative is timely, with the recent publication of the reviews of regulation of medical and non-medical healthcare professions undertaken by the Department of Health. These both point to the need for effective local systems for handling concerns raised about a practitioner's performance.

This document is not intended to replace organisations' own policies and procedures. Rather, it outlines key principles and elements for handling performance concerns which should be helpful for managers and for professionals themselves.

We also hope it will be useful for those working in, or managing, smaller or non-traditional settings where professional human resources support may not be at hand.

While the highest standard of patient care remains the overall goal, organisations are also shaped by their sensitivity towards practitioners, not simply when they perform well, but also when things are difficult.

I hope this document will benefit patients by helping to ensure performance concerns are recognised and dealt with at an early stage. It should also benefit practitioners by helping them to do what they most want: to use their professional skills to care for patients.

C Beasley

September 2006
London

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WIT-90341

1. INTRODUCTION

The aims of this publication and its intended audience

For the first time this document brings together common principles for handling performance concerns for all healthcare practitioners in England. It demonstrates that a common approach can be applied across all practitioners and in all settings where healthcare is offered. It promotes a constructive and supportive approach wherever possible.

The document aims to:

- Support the timely and effective handing of performance concerns
- Help to share good practice in handling performance difficulties
- Foster a consistent and fair approach across all healthcare practitioners
- Provide clear information for healthcare practitioners whether they have a concern about the performance of one of their colleagues or are themselves the subject of concern
- Provide a benchmark against which performance procedures can be reviewed
- Help healthcare students and newly qualified practitioners to understand how concerns about performance can be raised and handled.

It is for employers and contracting organisations, managers, strategic health authorities, commissioners, healthcare and health professional regulatory bodies, health practitioners and students working in the range of different settings where healthcare is provided. Its focus is on the handling of performance difficulties among registered healthcare practitioners.

In this document:

Employers and contracting organisations include all organisations, large and small, that employ or contract with health practitioners, e.g. trusts, primary care trusts (PCTs) and independent sector providers. When the term 'employer' is used it includes any contracting organisation.

Managers include the full range of managers from chief executives who have a statutory responsibility for the quality of care provided to patients, to the managers who apply local disciplinary procedures and clinical managers handling possible concerns about performance.

Health practitioners cover allied health practitioners, midwives and nurses, healthcare scientists, dentists, pharmacists and doctors.

Commissioners of health services mean those with responsibility for commissioning health services, primarily PCTs. While most contracts will be with NHS trusts, increasingly commissioning covers a variety of smaller commissions with providers that could include the independent and voluntary sector.

Healthcare and health professional regulatory bodies include bodies such as the Healthcare Commission, the Commission for Social Care Inspection and the eight professional regulatory bodies.

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How the document was developed

The document draws on the experience of leaders and experts in the field together with material from guidance issued to a range of professional groups. A working group was convened by the Chief Nursing Officer and met on four occasions from September 2005 - January 2006. A list of members is provided at Annex 1.

What is covered

Section 2 sets out the principles of effective systems for preventing and handling performance concerns; section 3 outlines good practice for managing concerns about individuals; and section 4 covers several additional areas for consideration.

At the end of the document relevant organisations and sources for this paper are listed (Annexes 2 and 3).

What is not covered

This document is not intended to provide a comprehensive guide on handling concerns about an individual. Detailed local and/or national guidance on performance, disciplinary, capability and regulatory procedures is available for each professional group and should be consulted.

The focus of this paper is on handling concerns about professional performance. However, inevitably, when concerns are raised, there may be a broad range of issues to consider and the response may include the use of procedures to address health, conduct or criminal matters.

If an individual is uncertain about how to proceed with handling a concern, they should seek advice from within their organisation (e.g. from their line manager or Department of Human Resources) or from the regulatory body, or, in the case of doctors and dentists, the National Clinical Assessment Service.

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2. PRINCIPLES FOR HANDLING PERFORMANCE CONCERNS

This section sets out principles for handling performance concerns, and the way in which some of these may be prevented. NHS bodies commissioning services may wish to ensure that these principles are addressed in the performance procedures of service providers in the NHS, independent or voluntary sector.

Concerns about performance may relate to:

- Low standard of work, for example, frequent mistakes, not following a task through, inability to cope with instructions given
- An inability to handle a reasonable volume of work to a required standard
- Unacceptable attitudes to patients
- Unacceptable attitudes to work or colleagues, for example, unco-operative behaviour, poor communication, inability to acknowledge the contribution of others, poor teamwork, lack of commitment and drive
- Poor punctuality and unexplained absences
- Lack of skills in tasks/methods of work required
- Lack of awareness of required standards
- Consistently failing to achieve agreed objectives
- Acting outside limits of competence
- Poor supervision of the work of others when this is a requirement of the post
- A health problem.

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Principle 1 **Patient safety must be the primary consideration**

While good performance procedures will ensure fairness to practitioners, patient safety must be the primary consideration.

Principle 2 **Healthcare organisations are responsible for developing policies and procedures to recognise performance concerns early and act swiftly to address the concerns**

Healthcare practitioners, managers and ultimately trust boards are accountable for patient safety and for the protection of the public. Effective performance procedures serve to maintain the quality and reputation of the service and to protect the welfare of practitioners.

Principle 3 **Policies for handling performance concerns should be circulated to all healthcare practitioners**

Policies should provide comprehensive information about how concerns will be handled.

Policies for handling performance concerns should cover:

- Roles, duties and responsibilities of individual practitioners, line managers, human resource departments and the wider employing organisation
- The duty of a designated senior manager/executive director to take lead responsibility for managing performance difficulties
- The requirement to keep the board, or other relevant body, informed about formal action being taken to address performance concerns
- How concerns will be handled including providing information and support to the practitioner
- Requirements for meticulous record-keeping of all steps in performance procedures
- Reference to disciplinary and other relevant organisational policies and procedures
- Arrangements for protecting the confidentiality of the individual as far as is appropriate
- Circumstances where referral to the regulatory body will be required
- Lay involvement in procedures, where this has been agreed
- The arrangements for individuals who are concerned about the performance of a colleague ('whistleblowing')
- Arrangements for handling anonymous complaints or instances where a person is not prepared to put a concern in writing
- Provision of resources to support any training requirements identified through the performance procedures
- The requirement to pass to a future potential employer information about unresolved performance issues relating to an individual
- Training and support to be provided for managers handling performance concerns.

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Principle 4 **Avoid unnecessary or inappropriate exclusion of practitioners**

Practitioners should continue to work wherever this is compatible with patient safety and the reputation of the service. Where restriction of duties or exclusion is required, this should be an interim measure while an investigation is carried out or further action by a regulatory body is awaited. The designated senior manager/director should be informed.

Principle 5 **Separate investigation from decision-making**

In the interest of fairness it is good practice to separate the process of gathering information about a concern from decision-making about the action required. In addition, where possible the decision-maker should not to be the practitioner's immediate line manager.

Principle 6 **Staff and managers should understand the factors that may contribute to performance concerns**

These may include, for example, personal factors, systems and process issues, the work environment, harassment or education and training. This understanding will help raise awareness of factors that may be putting performance at risk.

Principle 7 **Performance procedures should contribute to the organisational programme for clinical governance**

Information provided through clinical governance activities may raise concerns about the performance of individuals or teams, and the effective handling of performance difficulties is one component of good clinical governance.

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Principle 8 **Good human resources practice will help prevent performance problems**

Policies should be developed to encourage good human resources practice and so to help prevent performance difficulties.

Good human resource practices include:

- Effective recruitment practices that include the requirement for contemporaneous references ahead of a decision to employ, and pre-employment checks that include sight of original certificates, identification, registration status, occupational health assessment and Criminal Records Bureau enhanced disclosure
- Induction for new staff, with special and timely arrangements for staff on temporary or short-term contracts
- Clarity about skills and experience required for the post, and training and support required for any enhanced roles
- Clear definitions of roles and accountabilities
- Procedures to consult and agree any changes in working roles
- Appraisal for all practitioners and effective feedback
- Resources to support agreed education and training requirements
- Training for line managers in effective staff management
- Providing information about how individuals can access the support and advice they need during their employment
- Clear policies for handling concerns about bullying and harassment.

Principle 9 **Healthcare practitioners who work in isolated settings may need additional support**

Practitioners working in isolated settings may lack peer or managerial support. Providing additional opportunities for peer learning or supervision through links to larger organisations will help maintain standards of care.

Principle 10 **Individual healthcare practitioners are responsible for maintaining a good standard of practice**

All healthcare practitioners are responsible for demonstrating their competence, and for maintaining satisfactory standards of practice in line with professional guidance and criteria for registration.

Principle 11 **Commitment to equality and diversity**

Employers, healthcare practitioners and those responsible for delivery of services should be aware of the NHS commitment to equality and the positive recognition of diversity. They should have a clear understanding of how discrimination can occur and how it can be prevented, particularly in relation to raising and handling concerns about performance. This principle applies also to the independent sector offering services to the NHS.

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3. GOOD PRACTICE IN HANDLING CONCERNS

There are a number of key points to be aware of when handling a concern about performance. This section brings together good practice and provides an outline of the following:

- Receiving information about a concern
- Considering the risk to patient safety
- Informing the practitioner
- Support for the practitioner
- Dealing with a concern informally
- Dealing with a concern formally
- Gathering information – undertaking an investigation
- Deciding what to do
- Understanding contributory factors
- Interventions and remedial action
- Review and supplementary information
- Passing information
- Aftermath and rehabilitation.

The vignettes and good practice examples are intended to provide illustrative examples of the way in which difficulties may be handled.

Receiving information about a concern

Information about a concern may come from one or more of a variety of sources. These include:

- A review of patient notes
- A concern expressed by a colleague or 'whistleblower'
- Complaints about care from patients or relatives
- Investigation into a serious untoward incident
- A review of performance against agreed objectives/job competencies
- Annual appraisal
- Clinical audit and other quality improvement activities as part of clinical governance
- Information from a regulatory body
- Litigation following allegations of negligence
- Information from the police or coroner
- The practitioner themselves.

The person receiving information is responsible for taking the matter forward. This may include informing another relevant person, for example, a line manager, or, if

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the individual receiving information is in a position of authority, initiating the process of resolving the matter. The person taking action should be of appropriate seniority and experience with access to appropriate clinical and human resources advice. They should ensure that any concerns are supported by evidence supplied or taken down in writing as early as possible. Employers should have a procedure for handling instances where concerns are raised anonymously or where the person is not prepared to put the concern in writing. Oral or anonymous allegations should be recorded accurately.

Considering the risk to patient safety

The lead officer handling the concern must consider whether the nature of the concern suggests that patient safety may be compromised. It may be appropriate to use a specific tool for assessing risk. If the risk is significant and/or concerns are serious, the options available are:

- Providing supervision of practice until the matter is resolved
- Removing the practitioner from some duties
- Excluding the practitioner from the workplace
- Informing the regulatory body
- Reporting to the police or NHS Counter Fraud and Security Management Service, as appropriate.

VIGNETTE

The importance of taking action early

A nurse was recruited to work in an intensive care unit. During the first few months of his employment there was an occasion when he did not handle controlled drugs appropriately. Soon after this he failed to prepare a ventilator adequately for a patient. His line managers took no action at this point.

Two months later the nurse turned off a patient's ventilator in error.

Exclusion (or suspension) may be appropriate where the concern suggests that a recurrence would put patients at risk and/or the continued presence of the practitioner at the place of work would impede an investigation or intimidate witnesses and/or there may be matters of a criminal nature.

Regulatory bodies differ with regard to the stage at which they wish a case to be referred. If in doubt, contact the relevant regulatory body for advice. For more information about the role of the regulatory bodies please see Section 4, page 20.

Alleged criminal activity or fraud must be reported immediately to the police or NHS Counter Fraud and Security Management Service (NHS CFSMS) respectively. NHS CFSMS will liaise with the police on the conduct of their enquiry. The employer should not normally undertake further investigation of matters relating to possible criminal or fraudulent activity until the police or Counter Fraud Service indicates it is in order for the employer to do so. In both cases the passing of information to third parties should be strictly limited. Crimes and frauds should be reported to the authorities if suspected at any time during the course of the investigation.

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Informing the practitioner

The practitioner should normally be informed immediately about the concern that has been raised (unless fraud or other criminal activity is suspected). An initial meeting will provide an opportunity for the practitioner to hear the concerns and respond; it will help determine what, if any, action needs to be taken.

Support for the practitioner

At each stage in handling a concern the employer should remind the practitioner that an individual to provide personal support and/or a professional representative may accompany them. If a practitioner is excluded from work during an investigation it is important for the organisation to keep in touch, possibly through a 'buddy' system to focus on their welfare.

Dealing with a concern informally

For minor concerns about performance an informal approach may be all that is needed. Here, a discussion with the individual concerned, aimed at improving their performance or conduct, may be sufficient to resolve the issue. Dealing with the matter informally provides the opportunity for both parties to agree the way forward without the use of formal disciplinary or other procedures. Even if an informal approach is taken, the outcome of the discussion and agreement reached should be communicated to the practitioner in writing and notes kept of all meetings held.

GOOD PRACTICE

The role of practising privileges in the independent sector to prevent poor performance

The concept of practising privileges in the independent sector safeguards standards expected of doctors.

A consultant urologist had been granted practising privileges in the independent sector since his retirement from the NHS. During this time, concerns were raised about a number of his cases in which patients had experienced complications. An expert nominated by the consultant's professional body investigated the cases and identified poor judgement leading to the complications. The urologist's operating rights were terminated following the report.

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Dealing with a concern formally

Where informal procedures have not resulted in resolution of the concerns, where the concerns suggest patient safety may be compromised, or a breach of acceptable working practice has occurred, a formal approach will be required. All employers should have procedures for handing disciplinary and capability matters; those handling concerns will need to apply their organisation's policies. Most organisations will also have human resource departments that should be approached to offer advice and support. Individuals working in non-organisational settings may get advice on how to proceed from ACAS www.acas.org.uk

Gathering information – undertaking an investigation

Investigation involves gathering all pertinent facts to help understand the basis of the concern. Information required to clarify the facts should be acquired speedily (normally within four weeks). This may include obtaining written or oral material from staff, patients, users of services and witnesses. It should also include a written or oral statement from the practitioner concerned. Full records should be kept of all information obtained.

Investigation may draw on methods such as root cause analysis and the National Patient Safety Agency incident decision tree.

Deciding what to do

Once the necessary information has been collected a decision will be required about whether the case needs to be taken forward. This should normally be made by individuals who have not taken part in the investigation.

If the case is not to go forward, then the practitioner should be informed, and if they have been excluded, arrangements made to support a prompt return to work (see section on page 19: Aftermath and rehabilitation).

Where a case needs to be taken forward, the practitioner must be informed, in writing, of the exact nature of the allegation, the procedure that is to be followed, the possible sanctions that may be applied and the likely timescales. They should be supplied with the records of statements of individuals who have provided evidence, relevant disciplinary and grievance policies and should be encouraged to seek representation from their professional body/trade union or defence organisation. An employer should seek advice from an HR specialist within the organisation who may, in complex cases, suggest legal advice is also sought.

Understanding contributory factors

Where concerns about performance have arisen it may be helpful, at any stage of the process, to consider why this has happened.

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THINK ABOUT:

The individual's health and other factors

1. Does the individual have a physical or mental illness?
2. Is the individual depressed or suffering other mental illness?
3. Might alcohol or substance misuse be involved?
4. Has there been a recent major life event?

Knowledge, skills and behaviour

5. Is there a difficulty with clinical knowledge and skills?
6. Might a deficiency in education, supervision or continuing professional education be contributing to the problem?
7. Was the practitioner's induction appropriate or sufficient?
8. Does the individual have difficulty understanding the limits of their competence?
9. Is the problem predominantly one of the practitioner's behaviour or attitude?
10. Is this new behaviour or is it an exacerbation of long-standing problems?

The job

11. Have work factors changed?
12. Is there a problem with technological advances or techniques?

The work environment

13. Are there team difficulties?
14. Have there been major organisational changes?
15. Could issues relating to equality and diversity be a problem?
16. Could bullying or harassment be a problem?
17. Are there any systems issues that contributed to the performance difficulty?

Interventions and remedial action

Interventions to improve the practitioner's performance may include the following:

- An educational programme: clinical, personal or organisational skills
- Referral to occupational health with onward referral and follow up of any health problems
- Mentoring by a trusted practitioner
- Supervised practice
- Behavioural coaching
- Modification of duties.

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Normally it will be appropriate to consider any or all of these interventions before moving to termination of employment.

In each case it will be important for the employer and the practitioner to agree and record an action plan that includes the objectives of the intervention, success measures and timescale.

All of the above interventions may carry an additional sanction held in the personal file. This may comprise a time-limited warning of further action, including dismissal, if improvement is not achieved.

VIGNETTE

Planned recovery and support for a pharmacist

An experienced and respected hospital pharmacist working in a high pressure environment was found to have problems with alcohol. She was excluded pending a full investigation.

She was seen by her GP and the occupational health service and eventually acknowledged her problems and accepted help. Her exclusion was changed to sick leave, and a period of rehabilitation began.

A less stressful environment was found for her gradual return to work, which was jointly managed with occupational health using a health plan. The plan enabled occupational health to monitor her with the support of her manager, on an agreed basis. It provided the necessary reassurance that there was no repeat of the problem, and clear guidance for the practitioner.

VIGNETTE

Addressing a concern

A qualified dental nurse found in her new practice that dental nurses took radiographs of patients but that none were qualified to do so. The required local rules were not on display and there was no audit of radiographs. The dentist brushed her comments aside so she contacted the PCT and informed them of her concerns. The PCT involved their dental practice advisor and the local dental committee and an investigation was carried out. This confirmed that the dentist's practice did not reflect current good practice in this area.

The dentist was co-operative and an action plan and education programme were agreed. She attended an Ionizing Radiation (Medical Exposure) (IRME) radiography course and liaised with the clinical audit adviser and the PCT audit facilitator to incorporate audit within the practice. She agreed to regular visits from the dental practice adviser to help with documentation for radiological procedures and other clinical governance responsibilities.

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Where a practitioner has health problems which may have an adverse impact on their performance (for example, alcohol or substance misuse, serious physical or mental illness) steps should be taken to protect patients such as a temporary reassignment of duties and, with their agreement, the practitioner should be referred to occupational health. If they are not willing to co-operate with these steps further action may be needed to protect patients which may ultimately include terminating the practitioner's employment.

In addition the employer should address any team, organisational or wider systems issues that may have been highlighted during the investigation.

VIGNETTE

Working beyond capacity

A concern was raised about the competence of a senior nurse in relation to her clinical skills, documentation, communication and diary management. Her line manager decided to take an informal approach, held meetings with her, created an action plan and moved her office base so that she was close to her manager.

However the nurse did not meet the agreed timescales and a formal meeting with human resources (HR) and the line manager was arranged. Weekly meetings with her manager were arranged and a mentor was identified.

Documentation and diary management continued to be issues along with two periods of long term sickness. Occupational health (OH) became involved. After a year of meetings, training, and HR and OH involvement it was decided that, despite all the clinical and managerial support offered, the practitioner was still not able to work effectively at a senior level and concerns continued which had patient safety implications. A disciplinary hearing was convened. The practitioner received a final written warning; her responsibilities were reduced and a clinical supervisor was identified for her.

She completed a training package and is now functioning competently in a less senior role.

VIGNETTE

Informing the regulatory body

An employer had concerns about the ability of a junior physiotherapist in the areas of assessing patients and manual-handling skills. The employer decided to manage this through their capability process. They provided the junior physiotherapist with increased supervision, mentoring and further training.

The registrant resigned half way through the capability procedures. Her employers still had concerns that her practice is unsafe in some areas. They therefore informed the regulator about their concerns.

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Review and supplementary action

The success of the remedial action should be reviewed at an agreed date. If the measures agreed are not achieved, additional intervention may be needed. This may involve further restriction of practice, changing the practitioner's duties, identifying an alternative post or termination of contract.

Passing information

If an individual's contract of employment is terminated, the regulator should be informed.

If the practitioner leaves their employment during the course of investigation or disciplinary action the employer should:

- Complete the investigations as far as possible to ensure issues of patient and/or staff safety are followed through
- Consider requesting the issue of a professional alert notice (through the strategic health authority)
- Inform the regulator
- Keep a file note on the issue so that future referees inform potential employers that there is an unresolved investigation into the practitioner's performance
- Provide an accurate and fair reference stating that procedures have not been completed, reflecting the current position
- Inform the practitioner concerned, in writing, of action taken.

Aftermath and rehabilitation

If a practitioner has been away from work because of a performance concern, they will need support on their return. The constructive approach of colleagues and team building initiatives can help the team to manage entry back to work, as can training, mentoring and on-going supervision.

GOOD PRACTICE

Clinical Performance Support Unit, Leicestershire, Northamptonshire and Rutland Strategic Health Authority

The Clinical Performance Support Unit (CPSU) has been established as part of the Healthcare Workforce Deanery to assist with handling performance concerns among the medical workforce in primary and secondary care.

The unit acts as a single point of contact for trusts and staff, and helps organisations and individuals manage concerns locally and confidentially. The unit provides individually tailored coaching, clinical and educational supervision. It aims to support practitioners to re-build their careers, while ensuring patient safety and maintaining standards of care.

The CPSU is also working with nursing colleagues to look at the possibility of developing a similar service for nursing staff.

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4. OTHER ISSUES TO CONSIDER

Role of the regulatory bodies

The role of the UK regulators of health practitioners is to protect the public, set standards for entry to the registers, and take action when health practitioners do not meet these standards. The acts covering the various regulatory bodies give each different powers.

In matters of concern about poor performance the role of the regulatory body is to determine whether the practitioner's fitness to practise is impaired and whether it affects their registration. Where there is serious concern about patient safety, referral to the regulatory body should be considered. In some professions the regulator will only be involved if the situation cannot be managed locally; in others the regulator will expect to be involved in all cases where there is a serious risk to patient safety.

The regulator is the only organisation that can take action which pertains to a healthcare practitioner wherever they practise. If an individual leaves employment before a performance concern has been dealt with, the regulatory body should be informed.

Questions to ask in considering referral to the regulatory body:

- Are there concerns about serious risk to patient safety?
- Does that health practitioner offer services elsewhere? Are they, for example, an agency worker who also works for other organisations? Does this raise issues of patient safety?
- Would you have concerns about patient safety if the practitioner left your organisation before your process was completed?

GOOD PRACTICE

Training to report a concern

To help raise awareness amongst students of the need to act on concerns about the practice of a colleague, St George's Medical School, University of London, sets the following assignment for first year medical students:

As a third year medical student you notice that a patient has an adverse reaction because a junior doctor prescribed an excessive dose of a drug. The doctor told the patient that the reaction was due to an allergy to the drug (rather than admit her prescribing error). She did not record the incident in the record and did not report the incident to the consultant.
What are the issues and what should you do?

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4

Whistleblowing: raising a concern about a colleague's performance

Healthcare practitioners have a professional responsibility to act to protect patients if they have reason to suspect that a colleague is not fit to practise because of conduct, health or performance problems. The Public Interest Disclosure Act 1998 gives all staff and others such as agency staff, locums, students, carers and advocates virtually automatic protection for raising a genuine concern at a senior level in their organisation. However individuals may be reluctant to report concerns because they are fearful they will be disciplined, dismissed or disadvantaged as a result. In particular, practitioners can be in a difficult position if they wish to raise a concern about their supervisor or employer. Guidance from NHS Employers (2005) at www.nhsemployers.org/practice/whistleblowing.cfm the Department of Health (2003), and NCAS (2006) at www.ncas.npsa.nhs.uk may be helpful.

Employers should publish their whistleblowing policy based on the provisions in the Public Interest Disclosure Act. The policy should cover, for example, the appointment of 'a whistleblower's friend' who needs to be clearly separate from the investigation process. The policy should also cover steps to ensure the concern is dealt with speedily and protects the individual raising the concern, and also the obligations on the whistleblower to protect the organisation against vexatious claims.

Handling difficulties in teams

Effective team working can help prevent professional isolation and performance difficulties and, where difficulties do arise, members of a uni- or multiprofessional clinical team are often best placed to identify concerns early. Concerns may relate to the performance of individuals and also to the function of a group or team. If concerns relate to the way in which the team functions, or about the service provided by the team, these may be more readily noted by someone outside the team.

VIGNETTE

Adjusting teamwork to take into account individual needs

A 61 year old surgeon, who did not wish to retire until he was 65, told his clinical director that his dexterity had begun to deteriorate. However, he did not believe his clinical or surgical judgement had deteriorated in any way. He suggested that he should no longer carry out operative procedures but that he should take on an additional outpatient session and administrative activities.

Following agreement with the other team members, one of the recently appointed consultant surgeons increased the number of complex procedures she carried out, and a specialist nurse re-aligned her duties to take over less complex cases. This increased multidisciplinary working and allowed the older surgeon to take the lead for another outpatient clinic and to represent the department on two trust-wide committees. It was agreed that the whole department would review arrangements in six months and make any further adjustment necessary.

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The team setting itself may make it difficult for an individual to report because of feelings of loyalty to close colleagues, anxiety about disrupting the functioning of the team or fear of reprisal, particularly if concerns are raised about a more senior colleague. In these circumstances an effective whistleblowing policy will be vital. In addition, those in leadership roles in multiprofessional teams should support the development of an approach which enables each member of the team to feel respected for their skills and able to speak out.

Senior managers will be likely to require training in dealing with matters which may pose barriers to effective multiprofessional working, for example, the different roles and approaches of practitioners, and the range of working methods and professional cultures.

Using locums, agency and bank staff

Locums, agency and bank staff are often used as temporary support for existing core staff so they may be required at times of crisis because of unexpected absences or higher than anticipated workloads. In such circumstances, there is a risk that permanent staff will have little time to oversee the induction of such staff and monitor their performance. Arrangements to ensure adequate appointment, induction and supervision need to be planned well in advance.

Performance of temporary staff should be reviewed at the end of their contract and the practitioner and agency informed of the conclusions. Employers who fail to act regarding concerns about the performance of a temporary member of staff, or who simply resolve not to use that practitioner in the future, are failing in their duty of care to other patients.

Managing locum services

To ensure that temporary staff provide a safe and effective service, employers of locums and commissioners of locum services should:

- Ensure any agency supplying staff meets the necessary standards in terms of taking up references, scrutinising curriculum vitae (CV), checking the practitioner's professional registration, offering training and carrying out pre- employment checks including Criminal Records Bureau checks
- Deal with as few agencies as possible to help organisations develop good relationships with suppliers who understand their needs
- Make sure that a senior member of staff where the temporary member will be working sees their CV wherever possible to verify they have the appropriate skills and competencies for the work
- Plan for appropriate induction and orientation and ensure that all relevant policies and procedures are available
- Arrange appropriate supervision and support
- Include longer term sessional, locum and temporary staff in training programmes to ensure consistency of approach to care.

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Equality and diversity

Employers of healthcare practitioners should be aware of the NHS commitment to equality and the positive recognition of diversity and understand how discrimination can occur and how it can be prevented.

Diversity involves recognising the particular need and contribution of each individual on account of their gender, ethnicity, country of origin, sexual orientation, disability, working pattern, family status or age. The response to these needs in relation to preventing and addressing performance concerns may include, for example:

- Special arrangements for a practitioner with a physical or mental illness
- Additional induction for someone whose training abroad may not have covered all the aspects of the job required and the structure of services in the UK
- Holding educational meetings at a time when part-time or flexi-time staff are most likely to be on duty.

The safety of patients and the needs of the service must however remain paramount.

Clear procedures for identifying and handling performance concerns, that meet the principles set out in this document, will help ensure that difficulties are managed in a way that is fair and supportive across all the healthcare professions. This involves, for example:

- Good practice in preventing problems (through effective selection and induction procedures)
- Early recognition and a supportive approach, providing information to the practitioner about the difficulties and the procedures to be followed
- Effective collection of evidence (rather than proceeding on hearsay) and clear documentation
- Understanding of why certain groups of healthcare practitioners may get into difficulty.

In addition, an employer should provide continuing training for managers and practitioners in equality and diversity, and implement policies to enable effective action to be taken if there is any evidence of bullying or discrimination.

Conclusion

This document has brought together the main principles and practice for handling performance concerns among all professional groups working in healthcare. It will help to ensure equity and fairness in the way staff are treated and will form an important strand in the continuing quest for improving quality and safety for patients.

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ANNEX 1

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Department of Health

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NHS Employers

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The group was co-chaired by **Maureen Morgan** for the Department of Health and **Rosemary Field** for the National Clinical Assessment Service.

Jill Rogers brought together and edited the text of the document.

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ANNEX 2

RELEVANT ORGANISATIONS

ACAS
ACAS provides a variety of sources of information and resources about producing disciplinary and grievance procedures. Resources include seven free e-learning programmes to help individuals and businesses on topics such as discipline and grievance, information and consultation. The site is accessible to both employers and employees.
Contact ACAS at:
Telephone helpline: 08457 474747
Website: www.acas.org.uk

British Dental Association
The British Dental Association (BDA) is the professional association and trade union for dentists in the UK. The BDA develops policies to represent dentists working in every sphere from general practice, through community and hospital settings, to universities and the armed forces.
Contact the BDN at:
Telephone: 020 7935 0875
Email: enquiries@bda.org
Website: www.bda-dentistry.org

British Medical Association
The British Medical Association (BMA) represents doctors from all branches of medicine all over the UK. It is a voluntary association, provides services for members, is an independent trade union and a scientific and educational body.
Contact the BMA at:
Telephone: 020 7387 4499
Website: www.bma.org.uk

The Centre for the Advancement of Interprofessional Education
The Centre for the Advancement of Interprofessional Education (CAIPE) promotes and develops collaboration between practitioners and organisations across the public services and is a resource for interprofessional education. It offers access to research and information and examples of good practice, conferences and it responds to policy documents.
Contact CAIPE at:
Telephone: 020 7554 8539
Email: admin@caipe.org.uk
Website: www.caipe.org.uk

Council for Healthcare Regulatory Excellence
The Council for Healthcare Regulatory Excellence (CHRE) is a statutory overarching body, covering all of the United Kingdom and separate from government, established in 2003. It promotes best practice and consistency in the regulation of healthcare professionals.
Contact the CHRE at:
Telephone: 020 7389 8030
Email: info@chre.org.uk
Website: www.chre.org.uk

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General Chiropractic Council
The General Chiropractic Council (GCC) is a UK-wide statutory body with regulatory powers. Its duties are to regulate chiropractors, set standards for education, conduct and practice, and to develop and promote the profession of chiropractic.
Contact the GCC at:
Telephone: 020 7713 5155
Email: enquiries@gcc-uk.org
Website: www.gcc-uk.org

General Dental Council
The General Dental Council (GDC) is the organisation which regulates dental professionals in the UK.
Contact the GDC at:
Telephone: 020 7887 3800
Email: communications@gdc-uk.org
Website: www.gdc-uk.org

General Medical Council
The General Medical Council (GMC) registers doctors to practise medicine in the UK. Its purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.
Contact the GMC at:
Telephone: 0845 357 8001
Email: gmc@gmc-uk.org
Website: www.gmc-uk.org

General Osteopathic Council
The General Osteopathic Council (GOsC) regulates the profession of osteopathy, sets standards of osteopathic practice and conduct, assures the quality of education, ensures continuing professional education and helps patients with complaints about an osteopath.
Contact the GOsC at:
Telephone: 020 7357 6655
Email: info@osteopathy.org.uk
Website: www.osteopathy.org.uk

General Optical Council
The General Optical Council (GOC) is the statutory body which regulates dispensing opticians and optometrists and those bodies conducting business as optometrists or dispensing opticians. The GOC's main aims are to protect the public and promote high standards of professional conduct and education among opticians.
Contact the GOC at:
Telephone: 020 7580 3898
Email at: goc@optical.org
Website: www.optical.org

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Health Professions Council
The Health Professions Council (HPC) regulates 13 professions: art therapists, biomedical scientists, chiropodists and podiatrists, clinical scientists, dietitians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, prosthetists and orthotists, radiographers, and speech and language therapists. The HPC sets standards covering health professionals' education and training, behaviour, professional skills, and their health.
Contact the HPC at:
Telephone: 020 7582 0866
Email: policy@hcp-uk.org
Website: www.hpc-uk.org

Independent Healthcare Advisory Services
The Independent Healthcare Advisory Services (IHAS) is a subscription-based service for independent healthcare providers which manages the independent sector complaints adjudication service and oversees the effective resolution of complaints.
Contact the IHAS at:
Telephone: 020 7379 7721
Email: sallytaber@independenthealthcare.org.uk
Website: www.independenthealthcare.org.uk

National Clinical Assessment Service
The National Clinical Assessment Service (NCAS) is a division of the National Patient Safety Agency. Its aim is to assist the NHS in handling concerns about the performance of doctors and dentists. NCAS:

- Helps organisations manage concerns about the performance of individual doctors and dentists
- Promotes the development of local and national procedures for preventing, identifying and resolving concerns
- Assesses individual doctors and dentists in order to make recommendations about ways in which their performance should be improved.

Contact the NCAS at:
Telephone: 020 7084 3850
Email: ncas@ncas.npsa.nhs.uk
Website: www.ncas.npsa.nhs.uk

National Patient Safety Agency
The National Patient Safety Agency (NPSA) co-ordinates the efforts of the whole country to report and learn from mistakes and problems that affect patient safety. The NPSA promotes an open and fair culture in the NHS, encouraging all staff to report incidents without undue fear of personal reprimand.
NPSA produces a range of publications including:

- Incident decision tree
- Root cause analysis toolkit and training
- Being open: communicating patient safety incidents with patients and their carers
- Seven steps to patient safety: guide to safer patient care.

Contact the NPSA at:
Telephone: 020 7927 9500
Email: enquiries@npsa.nhs.uk
Website: www.npsa.nhs.uk

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NHS Employers
NHS Employers is the employers' organisation for the NHS in England giving employers throughout the NHS an independent voice on workforce and employment matters. NHS Employers offers a range of events, publications and information.
Contact NHS Employers at:
Telephone: 0113 306 3000
Email: enquiries@nhsemployers.org
Website: www.nhsemployers.org

Nursing and Midwifery Council
The Nursing and Midwifery Council (NMC) has been set up to protect the public by ensuring that nurses and midwives provide high standards of care to their patients and clients. The NMC:

- Maintains a register of qualified nurses, midwives and specialist community public health nurses
- Sets standards for conduct, performance and ethics
- Provides advice for nurses and midwives
- Considers allegations of misconduct, lack of competence or unfitness to practise due to ill health.

Contact the NMC at:
Telephone: 020 7637 7181
Email: communications@nmc-uk.org
Website: www.nmc-uk.org

Royal College of Midwives
The Royal College of Midwives (RCM) Is a trade union and professional organisation run by midwives for midwives. It provides leadership in midwifery, education and representation for members.
Contact the RCM at:
Telephone: 020 7312 3535
Email: info@rcm.org.uk
Website: www.rcm.org.uk

Royal College of Nursing
The Royal College of Nursing (RCN) represents nurses and nursing, promotes excellence in practice and shapes health policies. It supports and protects nurses and nursing staff, represents their interests professionally, and protects their terms and conditions of employment in all employment sectors.
Contact the RCN at:
Telephone: 020 7409 3333
Website: www.rcn.org.uk

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Royal Pharmaceutical Society of Great Britain
The Royal Pharmaceutical Society of Great Britain (RPSGB) is the professional and regulatory body for pharmacists in England, Scotland and Wales. It also regulates pharmacy technicians on a voluntary basis. The primary objectives of the Society are to lead, regulate, develop and represent the profession of pharmacy.
Contact the RPSGB at:
Telephone: 020 7735 9141
Email: enquiries@rpsgb.org
Website: www.rpsgb.org.uk

Public Concern at Work
Since 1993 Public Concern at Work (PCaW) has been influencing the law and practice on whistleblowing at home and abroad. Recognised as an authority by governments, employers, unions and international bodies, Public Concern at Work provides advice on whistleblowing to individuals, organisations and communities.
Contact PCaW at:
Telephone: 020 7404 6609
Email: whistle@pcaw.co.uk
Website: www.pcaw.co.uk

UNISON
UNISON is Britain's biggest trade union. Members are people working in the public sector, for private contractors providing public services and in utilities. UNISON provides members with legal and welfare advice and employment representation. It is also a campaigning organisation.
Contact UNISON at:
Telephone: 0845 355 0845
Website: www.unison.org.uk

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ANNEX 3

SOURCES CONSULTED IN THE PREPARATION OF THIS PUBLICATION

College of Occupational Therapists (2005) ***Code of Ethics and Professional Conduct***. London: COT.

Includes client autonomy and welfare, services to clients, personal and professional integrity and professional competence and standards.

Department of Health (2003) ***Code of Practice for NHS Employers Involved in the International Recruitment of Healthcare Professionals***. London: DH.

A code to promote high standards in recruitment and employment of healthcare professionals from abroad. The code is concerned with the protection of developing countries and promotes structured exchange of healthcare personnel for the mutual benefit of the NHS and healthcare systems around the world.

Department of Health (2003) ***Equalities and Diversity: Strategy and delivery plan to support the NHS***. London: DH.
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4069546&chk=R3IOE8

Department of Health (2003) ***Maintaining High Professional Standards in the Modern NHS: A framework for the initial handling of concerns about doctors and dentists in the NHS***. London: DH.

Sets out a framework for handling concerns about the conduct and performance of medical and dental employees. Agreed by the DH, NHS Confederation, BMA and the BDA. Applies to England.

Department of Health (2005) ***Providing Assurance on Clinical Governance: A practical guide***. London: DH.

Provides an outline approach for internal auditors to follow when carrying out reviews of clinical departments and in areas of clinical activity.

General Optical Council (2005) ***Opticians' Handbook.*** London: *GOC.*

Includes code of conduct for individual registrants and business registrants, fitness to practise, proceedings and appeals and Rules.

General Dental Council (2005) ***Standards Guidance***. London: GDC.

Standards for dentists.

Healthcare Commission (2005) ***Assessment for Improvement: Our approach. Consultation document.*** London: Healthcare Commission.

A proposed approach to assessing the performance of healthcare organisations.

Hunt, G. (1995) ***Whistleblowing in the Health Service: Accountability, law and professional practice***, London: Edward Arnold.

Compares UK experience with that of the US, explores the core issues of accountability and legal rights from the managerial, clinical and public perspectives.

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Independent Healthcare Advisory Services (2006) ***Practising Privileges: Model policy and letter.*** London: IHAS.

The IHAS has examples of letters of agreement, and a model policy on practising privileges.

Independent Healthcare Advisory Services (2006) ***Good Medical Practice in Cosmetic Surgery Procedures***. London: IHAS.

Complements the GMC publication 'Good Medical Practice' with particular reference to cosmetic surgery.

National Audit Office (2003) ***The Management of Suspensions of Clinical Staff in NHS Hospital and Ambulance Trusts in England***. London: NAO.

A review and recommendations about managing suspensions from clinical service.

NHS Employers (2005) ***Briefing: Safer Recruitment. A guide for NHS employers***. London: NHS Employers.

Guidance that covers all pre- and post-appointment checks that employers are required to make before appointing anyone to a position in the NHS.

Nursing and Midwifery Council (2004) ***Reporting Lack of Competence: A guide for employers and managers. Guidance 05 04***. London: NMC.

Describes what lack of competence is, and when to report it. Tells practitioners what evidence to send to support their complaint.

Nursing and Midwifery Council (2004) ***The NMC Code of Professional Conduct. Standards for conduct, performance and ethics.*** London: NMC.

Essential code for nurses and midwives.

NHS Employers/Public Concern at Work (2005) ***Whistleblowing for a Healthy Practice: Whistleblowing: guidance for GPs.*** London: NHS Employers.

Practical advice to give confidence and ability for professionals to demonstrate high standards of clinical care and governance.

NHS Employers (2005) ***The NHS as an Employer of Excellence***. London: NHS Employers.

Outlines the work of the NHS Employers organisation.

National Clinical Assessment Authority (2004) ***Understanding Performance Difficulties in Doctors.*** London: NCAA.

Helps those who deal with performance difficulties among doctors and dentists to make decisions about them.

National Clinical Assessment Authority (2002) ***Handbook for Prototype Phase: General practice in England.*** London: NCAA.

Material developed by a working group and gives an overview of the NCAA GP assessment framework and provides information about effective GP performance procedures.

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National Clinical Assessment Service (National Patient Safety Agency) (2005) ***Back on Track, Restoring Doctors and Dentists to Safe Professional Practice: Consultation and framework document.*** London: NCAS.

The result of a collaboration between professional staff, lay groups and educationalists. It aims to address the challenge of restoring doctors and dentists to safe practice after there have been concerns about their performance.

National Clinical Assessment Service (National Patient Safety Agency) (2006) ***Local GP Performance Procedures***. London: NPSA.

Information about local procedures for handling concerns about the performance of GPs.

National Clinical Assessment Service (National Patient Safety Agency) (2005) ***NCASPlus: How NCAS services can help local managers deal with concerns around the performance of doctors and dentists*** (leaflet). London: NPSA.

National Clinical Assessment Service (2006) ***Concerned about the Performance of a Colleague?*** London: NCAS.

Useful guidance for practitioners about whistleblowing.

Partnership Information Service (2003) ***Management Employee Capability Guideline.*** Edinburgh: Scottish Executive, Health Department.

Guidance for staff throughout Scotland to ensure fair and consistent treatment. All organisations within NHSScotland must meet or exceed the guidelines.

Royal Pharmaceutical Society of Great Britain (2005) ***Raising Concerns: Guidance for pharmacists and registered pharmacy technicians***. London: RPSGB.

Information for pharmacists and pharmacy technicians to help them if they have concerns about a colleague's performance.

Royal Pharmaceutical Society of Great Britain (2005) ***Identifying and Remedying Pharmacist Poor Performance in England and Wales***. London: RPSGB.
Available at: http://www.rpsgb.org.uk/pdfs/pharmpoorperf0501.pdf

Scottish Audit of Surgical Mortality (2005) ***Qualified Confidentiality, Patient Safety and Freedom of Information. Discussion paper.*** Edinburgh: Scottish Audit of Surgical Mortality.

The College of Radiographers (2004) ***Radiography: Statements of professional conduct***. London: The Society of Radiographers.

Gives advice and guidance to all practising members of the College and those studying to gain qualifications in radiography.

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NHS
National Patient Safety Agency

National Clinical
Assessment Service

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Chlorine free paper

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Email: dh@prolog.uk.com

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www.dh.gov.uk/cno
www.ncas.npsa.nhs.uk

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Parks, Zoe

From: Parks, Zoe <Personal Information redacted by the USI>
Sent: 06 January 2012 09:27
To: Weir, Colin
Subject: Handling Concerns about the performance of Health care Professionals - Good Practice
Attachments: DEPT OF HEALTH & NCAS - Handling Concerns about Performance Health care Professionals Principles of good practice.pdf

As discussed

Zoë Parks
Medical Staffing Manager
Southern Health & Social Care Trust
Craigavon Area Hospital
68 Lurgan Road, Portadown

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Email: Personal Information redacted by the USI

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Southern Health and Social Care Trust

Handling concerns about Doctors

Doctors in Difficulty Workshop
2014

Objectives

Southern Health and Social Care Trust

- To understand the Trust's guidance on Handling Concerns
- To discuss practical examples of managing doctors in difficulty.
- To be aware who needs to know when an issue is identified.

The Context

Southern Health and Social Care Trust

Maintaining High Professional Standards in the Modern NHS

- Same disciplinary procedures apply to all doctors and dentists employed in the NHS
- Single process for handling capability issues re professional competence tied in with the National Clinical Assessment Service (NCAS)
- Trust is responsible for managing performance (disciplining) all its medical and dental staff (including doctors in training)
- Postgraduate Dean in NIMDTA is Responsible Officer for Trainees

Take Home Message: Early intervention when concerns first arise is key

What would you do?

CASE STUDY 1

1. Consider Risk
2. Establish the Facts
3. Determine category for concern
4. Action Plan
5. Deal with concern informally
   Or deal with concern formally
6. Remediation & Review

How to raise your concern

- Concerns should be conducted on an informal basis, with preliminary enquiries undertaken to determine the facts. Keep a Record.
- Consideration as to whether concerns are of sufficient substance that they need to be reported. If in any doubt, report it.
- The Clinical Manager (educational supervisor) should report concerns to the AMD and Director of Service.
- Once a concern of substance has been raised, the AMD/Director should notify the Chief Executive who will appoint an Oversight Group.

Practical Advice – 5 Golden Rules

- 1) Deal with specific concerns as they arise
- 2) Investigation must follow procedures and be demonstrably fair
- 3) Allegations must be specific enough to investigate
- 4) Support those involved (OH / NCAS)
- 5) Keep a Record

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Examples – Informal

- Recent complaint letter received by Chief Executive
- Allegations against individual junior doctor relating to patient care
- Preliminary enquiries to verify or refute allegations. Interview with doctor / witnesses
- Investigation of patient came to nothing
- Quickly determined doctor subject to abuse outside of employment.
- Police investigation verified.
- Fraudulent Complaint.
- Support for doctor.
- Matter closed with no further action.
- Information provided to Police.

What would you do?

CASE STUDY 2

Example – Formal Case

- Case alleging junior doctor taking and self-administering medication
- Managed under Formal MHPS Framework
- Case Investigator & Case Manager appointed
- Immediate exclusion from work in line with MHPS
- Formal Investigation
- Found proven case of gross misconduct
- Referral to the GMC
- GMC Registration suspended
- Fitness to Practice Hearing Pending

MHPS Framework

- An HR Case Manager will be allocated to support Clinical Manager
- Screening Process - Clinical Manager and HR Manager undertake preliminary enquiries into the concerns raised and compile an Investigation Report
- Oversight Group will be informed of the required action which may be:
  - No action
  - Informal remedial action : NCAS
  - Formal investigation
  - Exclusion / Restriction

Exclusions / Restrictions

- Exclusion when potential risk to patient care
- Authority to exclude a doctor can **ONLY** be taken by Chief Executive, Medical Director or AMD.
- Immediate exclusion (when concern first arises) NCAS must be informed
- Formal exclusion (during formal investigation) Trust conference should be convened
- Restrictions should always be considered as an alternative to exclusion
- All exclusions must be reviewed in line with MHPS

NCAS

NHS
National Clinical Assessment Service

- Confidential advice to Trusts and doctors
- Contact usually via Medical Director/HR
- Advice: Fresh independent opinion
  - Exclusion: prevent inappropriate exclusion
  - Support for cases managed locally
  - NCAS formal assessment
  - Action Plans and remediation
- Local Case advisors
- Register for Free "Managing Concerns" workshop
  - http://www.ncas.nhs.uk/events/workshops/managing-concerns-workshops/

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Employment Law cases for Doctors

Case Law decisions relating to doctors:

- Key messages arising relate to following proper procedures; rights of representation; constitution of panels; NCAS Performance Assessments.

Recent GMC Cases: Feb 2014

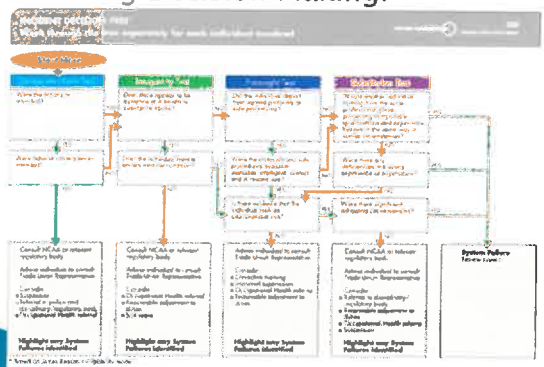
- Locum SHO ENT: Completed a medical questionnaire in which she failed to declare to the Trust that she had previously been declared unfit to undertake exposure prone procedures. Actions misleading & dishonest.
- **GMC Decision: Erased**

Summary & Conclusion

- 1. Identifying a Trainee in Difficulty
- 2. Meet with that Trainee
- 3. Document concerns & their reflection
  - (Consider support available HR/OH/NCAS)
  - (Escalate appropriate concerns)
- 4. Identify a Development Plan
- 5. Monitor & Review
- 6. Keep a Record:

If its not written down – It didn't happen.

Assisting Decision Making:



Graded response to Concerns

Direct Clinical Practice	Personal but affecting Practice	Referral to Organisation	Response
Early concerns about rate of progress	Behaviours causing irritation	Clinical/College Tutor, Clinical Director	Specific educational interventions linked to PDP with assessment of progress
Assessed concerns about progress in gaining competence and proficiency	Personal behaviours affecting clinical practice & team dynamics	Clinical Tutor, Training Programme Director, postgraduate Dean	Educational interventions as above but with enhanced supervision. Use of RITA and counselling
Incompetent practice	Personal behaviour affecting practice	As above but may consider NCAS referral when serious and repetitive. Inform HR	Local investigation, Assessment, advice, counselling. May need to repeat module/year
Incompetent or negligent practice. Abuse of position	Failure to respond to personal health issues or responses shown above	Involve HR Involve NCAS but GMC may also be indicated	Screening leading to review and assessment followed by educational or disciplinary routes
Patient formal complaint. **Serious Adverse Incident**	Suspicion of substance abuse, misuse of hospital facilities	Hospital investigation but involving organisations listed above	Voluntary restriction of practice or exclusion Design of intensive educational programme or conduct route

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Parks, Zoe

From: Porter, Pamela [redacted]
Sent: 06 March 2012 09:10
To: Parks, Zoe
Subject: RE: Waiting List Initiative Claims - Mr A O'Brien

Zoe

Mr O'Brien will receive this payment in is March 2012 salary.

Regards

Pamela

Pamela Porter
Payroll Team Leader
Tel No [redacted]

I have recently been migrated, therefore to ensure I receive your E-mail please retype my email address when replying.

From: Parks, Zoe
Sent: 06 March 2012 07:07
To: Gannon, Oonagh; Porter, Pamela
Subject: Re: Waiting List Initiative Claims - Mr A O'Brien

Mr O'Brien emailed me this morning. Would you be able to advise me when he could expect payment for this?

From: Parks, Zoe
To: Gannon, Oonagh ([redacted]) <[redacted]>;
Porter, Pamela ([redacted]) <[redacted]>
Sent: Fri Feb 24 14:51:29 2012
Subject: Waiting List Initiative Claims - Mr A O'Brien
24 February 2012

Mr A O'Brien,

Re: Waiting List Initiative Claims

You will see from the attached correspondence that Mr A O'Brien recently wrote to Dr Rankin about some changes that had been made to WLI claims that he had submitted for work undertaken between July 2010 to February 2011. These claims were changed by the AMD Mr E Mackle but I have spoken to Mr Mackle and Heather Trouton and it seems there was some misunderstanding about what had been agreed against his job plan. However they have agreed to concede as changes shouldn't have taken place without prior discussion with Mr O'Brien.

Therefore I wish to confirm that it has been agreed that Mr O'Brien should have been paid what was originally included on the WLI forms. I would therefore be grateful if you could arrange to reimburse Mr O'Brien [redacted] x 15 occasions – as shown on the attached forms.

If you have any queries please do not hesitate to contact me.

Many thanks

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Mrs Zoë Parks
Medical Staffing Manager
Southern Health & Social Care Trust
Craigavon Area Hospital
68 Lurgan Road, Portadown

Phone: Personal Information redacted by the USI
Blackberry: Personal Information redacted by the USI
Fax: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: zoe.parks Personal Information redacted by the USI [mailto: Personal Information redacted by the USI]
Sent: 24 February 2012 15:09
To: Parks, Zoe
Subject: Message from KMBT_C220

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Parks, Zoe

From: aidanpobrien [redacted]
Sent: 06 March 2012 23:05
To: Parks, Zoe
Subject: Re: Letter to Dr Rankin 30.1.12

Zoe,

Thanks,

Aidan.

-----Original Message-----
From: Parks, Zoe < [redacted] >
To: aidanpobrien < [redacted] >
Sent: Tue, 6 Mar 2012 7:09
Subject: Re: Letter to Dr Rankin 30.1.12

Mr O,Brien,
I sent the request to Oonagh Gannon and Pamela Porter in Payroll on 24 February. I have asked them to let me know when you can expect payment and will let you know accordingly.
Zoe

_____

From: aidanpobrien [redacted] < [redacted] >
To: Parks, Zoe
Sent: Mon Mar 05 23:54:54 2012
Subject: Re: Letter to Dr Rankin 30.1.12

Dear Zoe,

Thank you for contacting me while in Paris. I look forward to receiving payments in due course. I would be grateful if you would confirm when the claim has been submitted to Payroll so that I may know when to expect imbursement.
With respect to the formal grievance, I confirm that I am entirely happy to suspend the process, hopefully indefinitely, as I have no desire to have anyone face disciplinary enquiry or sanction. However, I do reserve the right to reactivate this process if need be, at any time in the future,

Aidan.

-----Original Message-----
From: Parks, Zoe [redacted] >
To: aidanpobrien < [redacted] >
Sent: Wed, 22 Feb 2012 9:35
Subject: Letter to Dr Rankin 30.1.12

22 February 2012

Mr O'Brien,

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

I am writing further to your letter addressed to Dr G Rankin on 30 January 2012 regarding the payment for waiting list initiative claims. I have been asked to take this issue forward and I would be grateful if you could contact me on Personal Information redacted by the USI when you are available

Many thanks

Zoë Parks

Medical Staffing Manager

Southern Health & Social Care Trust

Craigavon Area Hospital

68 Lurgan Road, Portadown

Phone: Personal Information redacted by the USI

Mobile: Personal Information redacted by the USI

Fax: Personal Information redacted by the USI

Email: Personal Information redacted by the USI

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Southern Health & Social Care Trust archive all Email (sent & received) for the purpose of ensuring compliance with the Trust 'IT Security Policy', Corporate Governance and to facilitate FOI requests.

Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

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Southern Health & Social Care Trust archive all Email (sent & received) for the purpose of ensuring compliance with the Trust 'IT Security Policy', Corporate Governance and to facilitate FOI requests.

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Parks, Zoe

From: Parks, Zoe [redacted]
Sent: 24 February 2012 14:51
To: Gannon, Oonagh; Porter, Pamela
Subject: Waiting List Initiative Claims - Mr A O'Brien
Attachments: SKMBT_C22012022415080.pdf

24 February 2012

Mr A O'Brien,

Re: Waiting List Initiative Claims

You will see from the attached correspondence that Mr A O'Brien recently wrote to Dr Rankin about some changes that had been made to WLI claims that he had submitted for work undertaken between July 2010 to February 2011. These claims were changed by the AMD Mr E Mackle but I have spoken to Mr Mackle and Heather Trouton and it seems there was some misunderstanding about what had been agreed against his job plan. However they have agreed to concede as changes shouldn't have taken place without prior discussion with Mr O'Brien.

Therefore I wish to confirm that it has been agreed that Mr O'Brien should have been paid what was originally included on the WLI forms. I would therefore be grateful if you could arrange to reimburse Mr O'Brien £[redacted] x 15 occasions – as shown on the attached forms.

If you have any queries please do not hesitate to contact me.

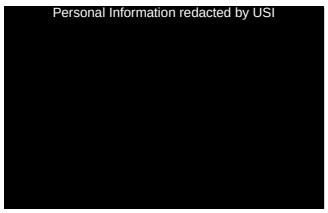
Many thanks

Mrs Zoë Parks
Medical Staffing Manager
Southern Health & Social Care Trust
Craigavon Area Hospital
68 Lurgan Road, Portadown

Phone: [redacted]
Blackberry: [redacted]
Fax: [redacted]
Email: [redacted]

From: zoe.parks[redacted] [mailto:[redacted]]
Sent: 24 February 2012 15:09
To: Parks, Zoe
Subject: Message from KMBT_C220

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.



30 January 2012.

Dr. Gillian Rankin,
Director of Acute Services,
Southern Health and Social Care Trust,
Craigavon Area Hospital,
Craigavon,
BT63 5QQ.

Dear Dr. Rankin,

I wish to take this opportunity to formally submit, in writing, a grievance regarding the deductions made to the payments owed to me on foot of a claim for extra contractual work. These deductions amount to a breach of agreement with management regarding the rate of remuneration for the sessions claimed, a rate subsequently reaffirmed to me by management.

In the autumn of 2010, it was agreed by the Head of ENT and Urology that I would be remunerated one additional sessional payment for conducting combined urodynamic studies and oncology reviews all day Fridays in the Thorndale Unit. I enclose a copy of the claim form submitted 2nd March 2011, consisting of a claim for 15 such sessions in addition to 4 sessions of Inpatient Operating and 2 sessions of Urodynamic Studies completed on Saturdays.

When I received payment of £Personal Information redacted by the USI gross in April 2011, I was unable to recognise the amount. In contacting the Payroll Department, I was advised that payments for additional Friday sessions had been halved, whilst the remaining sessions had not been paid at all. When I enquired why deductions had been made, the Payroll personnel informed me that they were unable to decipher the signature of the person who had made the deductions. For that reason, I was provided with a copy of the claim form (enclosed). It was evident to me that the deductions were made by Mr. Eamon Mackle. I subsequently received payment for the unpaid Saturday sessions in May 2011.

To date, I have not received full payment in respect of these sessions, nor have I received any communication regarding same, apart from verbal confirmation of the agreement.

Agreed it is appropriate

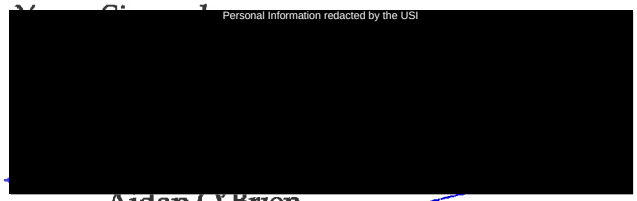
Misunderstanding
should not have happened

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

This has occurred against the background of an earlier claim for urodynamic studies submitted 17th January 2011. I made monthly enquiries until August 2011 regarding lack of payment, only to be advised by Payroll on each occasion that a claim had yet to be received. I wrote to the Head of ENT and Urology in August 2011 to express my concerns. I was advised that the claim had been authorised by Ms. Corrigan, by Ms. Trouton and then by Mr. Mackle, but had been mislaid thereafter. I had to submit yet another claim for those sessions in September 2011, payment received in October 2011, nine months after the initial submission.

The deductions referred to above were a breach of an agreement, and to compound matters, the deductions were made without my authority or knowledge. I am making a formal request to have this matter investigated and to be provided with an explanation as to why these deductions have been made. At the time of writing, I have completed further claim forms for extra contractual work which I have not submitted as I simply do not have the confidence that they will be processed in a proper and timely manner. Finally, I am requesting that management honour the agreement that was made with me by providing full remuneration for the additional sessions that I have undertaken,

Yours Sincerely,



Aidan O'Brien.

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

PAYROLL DEPT
RECEIVED
- 1 APR 2011
SHSCT

Copied 30-03-11
Collected 30-03 @11

CLAIM FORM FOR MEDICAL STAFF FOR EXTRA CONTRACTUAL WORK (e.g. WLI)

Personal details:

Name of doctor: **Aidan O'Brien**	Grade: Consultant ☒ Other ☐ If other, please state:
Specialty/Directorate: **Urology**	Location/Hospital Site: **Craigavon Area Hospital**
Staff Number: Personal Information redacted by the	Contact Number: Personal Information redacted by the USI

Details of additional work:

Day	Date	Hospital Site	Type of workload / session	Agreed Level of Activity with AD	Activity delivered/ Number of cases completed	Start Time	*Rate per session
Friday	23/07/10	CAH	Oncology Backlog Review Clinic	One session ✓	7 cases	9.30	Personal Information redacted by the USI
Friday	30/07/10	CAH	As above	One session ✓	7 cases	9.30	
Friday	24/09/10	CAH	As above	One session ✓	7 cases	9.30	
Friday	08/10/10	CAH	As above	One session ✓	7 cases	9.30	
Friday	22/10/10	CAH	As above	One session ✓	7 cases	9.30	
Friday	29/10/10	CAH	As above	One session	7 cases	9.30	

PTL Rev backlog

** The Rate paid must be in accordance with the SHSCT Local Agreement Policy*

As waiting list payments are paid in accordance with the principle that a consultant cannot be paid twice for the same period of time - please confirm the following:

15 TOTAL PA's in your existing job plan including DCC, ON-CALL, SPA etc.

I confirm that the above extra contractual work does not take place at a time I am paid by the Trust. (Please circle)

Yes **No**

If no, please state reason:

The Trust currently permits consultants to undertake a MAXIMUM of one waiting list initiative session per week during normal working hours (9am-5pm). This must be undertaken at a time not currently paid by the Trust (i.e. outside job plan).

Please confirm:

TOTAL 13 SWE

Will the waiting list session replace an SPA session? (Please circle) **Yes** **No**

If yes please state the nature of the SPA activity and how and when the activity will be redelivered. The suggested alternative time and method of delivery of the work within this SPA should be endorsed by the AMD/Director.

SHSCT
FINANCIAL MANAGEMENT
30 MAR 2011
RECEIVED
INITIALS.....

Comments from AMD/Director:

Personal Information redacted by the USI

APR 1

90382

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

CLAIM FORM FOR MEDICAL STAFF FOR EXTRA CONTRACTUAL WORK (e.g. WLI)

Personal details:

Name of doctor: Aidan O'Brien	Grade: Consultant ☒ Other ☐ If other, please state:
Speciality/Directorate: Urology	Location/Hospital Site: Craigavon Area Hospital
Staff Number: Personal Information redacted by the	Contact Number: Personal Information redacted by the USI

Details of additional work:

Day	Date	Hospital Site	Type of workload / session	Agreed Level of Activity with AD	Activity delivered/ Number of cases completed	Start Time	*Rate per session
Saturday	05/02/11	CAH	Inpatient operating	Two sessions	7 cases	9.00	Personal Information redacted by the USI
Friday	11/02/11	CAH	Oncology Review Backlog Clinic	One session	7 cases	9.30	
Saturday	12/02/11	CAH	Urodynamic Studies	Two sessions	8 cases	9.00	
Friday	18/02/11	CAH	Oncology Review Backlog Clinic	One session	7 cases	9.30	
Friday	25/02/11	CAH	As above	One session	7 cases	9.30	
Saturday	26/02/11	CAH	Inpatient operatingt	Two sessions	6 cases	9.00	

** The Rate paid must be in accordance with the SHSCT Local Agreement Policy*

As waiting list payments are paid in accordance with the principle that a consultant cannot be paid twice for the same period of time - please confirm the following:

15 TOTAL PA's in your existing job plan including DCC, ON-CALL, SPA etc.

I confirm that the above extra contractual work does not take place at a time I am paid by the Trust. (Please circle) yes.

The Trust currently permits consultants to undertake a MAXIMUM of one waiting list initiative session per week during normal working hours (9am-5pm). This must be undertaken at a time not currently paid by the Trust (i.e. outside job plan).

Please confirm:

Will the waiting list session replace an SPA session? (Please circle) Yes (No)

If yes please state the nature of the SPA activity and how and when the activity will be redelivered. The suggested alternative time and method of delivery of the work within this SPA should be endorsed by the AMD/Director.

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

CLAIM FORM FOR MEDICAL STAFF FOR EXTRA CONTRACTUAL WORK (e.g. WLI)

Personal details:

Name of doctor: Aidan O'Brien	Grade: Consultant ☒ Other ☐ If other, please state:
Speciality/Directorate: Urology	Location/Hospital Site: CAH
Staff Number: Personal Information redacted by the	Contact Number: Personal Information redacted by the USI

Details of additional work:

Day	Date	Hospital Site	Type of workload / session	Agreed Level of Activity with AD	Activity delivered/ Number of cases completed	Start Time	*Rate per session
Friday	12/11/10	CAH	Oncology Review Backlog Clinic	One session ✓	7 cases	9.30	Personal Information redacted by the USI
Friday	17/12/10	CAH	As above	One session ✓	7 cases	9.30	
Friday	07/01/11	CAH	As above	One session ✓	7 cases	9.30	
Friday	21/01/11	CAH	As above	One session ✓	7 cases	9.30	
Friday	28/01/11	CAH	As above	One session ✓	7 cases	9.30	
Friday	04/02/11	CAH	As above	One session ✓	7 cases	9.30	

** The Rate paid must be in accordance with the SHSCT Local Agreement Policy*

As waiting list payments are paid in accordance with the principle that a consultant cannot be paid twice for the same period of time - please confirm the following:

15 TOTAL PA's in your existing job plan including DCC, ON-CALL, SPA etc.

I confirm that the above extra contractual work does not take place at a time I am paid by the Trust. (Please circle)

Yes **No**

If no, please state reason:

The Trust currently permits consultants to undertake a MAXIMUM of one waiting list initiative session per week during normal working hours (9am-5pm). This must be undertaken at a time not currently paid by the Trust (i.e. outside job plan).

Please confirm:

Will the waiting list session replace an SPA session? (Please circle) **Yes** **No**

If yes please state the nature of the SPA activity and how and when the activity will be redelivered. The suggested alternative time and method of delivery of the work within this SPA should be endorsed by the AMD/Director.

Comments from AMD/Director:

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

CLAIM FORM FOR MEDICAL STAFF FOR EXTRA CONTRACTUAL WORK (e.g. WLI)

Yes No If no, please state reason:	**Comments from AMD/Director:**

Please confirm, considering all your Trust and non HPSS commitments, if by undertaking the extra contractual work outlined above, you will be working in excess of an average of 48 hours per week (averaged over a 26 week period)? (Please circle)

Yes **No**

If Yes - Please confirm that a signed derogation form, confirming your agreement to opt out of the EWTD maximum 48 hours per week (averaged over a 26 week period) has been forwarded to the Chief Executive.

Yes No

Please note that all consultants have an individual responsibility for the number of hours worked and for ensuring that you do not work additional hours which would prevent you from delivering a safe level of patient care.

I declare that the above entries are a true record and claim for the additional sessions worked; as detailed above.

Signed: [redacted] Date: 02.03.11

Please forward this form to your Assistant Director for verification

Verified by Assistant Director/Director of POC:

Signed: [redacted] Date: 29/3/11

Please forward this form to the Associate Medical Director for final authorisation

Authorised by Associate Medical Director:

Signed: [redacted] Date: 29/3/11

Please send original to Financial Management Department, Lurgan Hospital, Sloan Street, LURGAN and copied to

Parks, Zoe

From: Clegg, Malcolm <[redacted]>
Sent: 01 August 2014 16:09
To: Parks, Zoe
Subject: FW: Urology Rota

FYI

From: Mackle, Eamon
Sent: 01 August 2014 16:00
To: Simpson, John
Cc: Burns, Deborah; Corrigan, Martina; Young, Michael; Hall, Sam; Clegg, Malcolm; Donaghy, Kieran
Subject: Urology Rota

Dear John

Thank you for your letter which I received yesterday regarding the Urology rota. Following my meeting with Kieran I discussed same with Debbie and have had discussions with Martina and Malcolm. As you realise there are only 2 reg doctors working in Urology at present and we have been unable to get any extra staff this past year. To help the dire staffing situation General Surgery took on to cover Urology after 11pm weekdays and after I think 6pm on weekends. General Surgery has also been providing staff to help assist in theatre over the past 6 weeks, while Urology trainees are on leave, to enable major surgery to proceed. The Trust also employs a locum on a large number of evenings throughout each month.
The junior staff were asked to sign the derogation form but never did so. I have been told that we cannot force them to do so.
In August once more we have only 2 Registrars. We have advertised for clinical fellows to help fill the gap. I identified one doctor who may be interested in the post and referred her to Martina, who has discussed her with Malcolm. I gather one of the new Urology registrars has also identified someone so if both work out we will have 4 doctors from probably September. However, if we don't appoint an extra 2 people to the rota I am not sure that it will be possible to reduce hours without reducing the service.

Regards

Eamon

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

UROLOGY REGISTRARS			
RISK	**MITIGATING FACTORS**	**ACCOUNTABILITY**	**STATUS**
There are only two rotational doctors in training within Urology. The Trust has two unfilled middle grade specialty doctor positions and a vacant GP post which we have been unable to fill. The Trust has attempted on numerous occasions to recruit to these posts unsuccessfully. Due to service demands, these two trainees are working on average **59 actual working hours** per week and according to monitoring are in the hospital over 65 hours per week (this figure includes onsite rest periods). There is a patient safety risk associated with these lengthy working hours. There is currently no derogation from the doctors to confirm they agree to work beyond 48 hours/week in accordance with EWTD legislation working hours and as such are working illegally.	• The Urology registrars do not work overnight and generally finish in the hospital at 11pm. From August 2013, the overnight period in urology is now covered by General Surgery registrars. • The Trust intends to attempt recruitment for a Clinical Research Fellow. If this is successful, this will facilitate a reduction in working hours – however previous attempts to fill this grade have not filled. • Intention to ask trainees to complete an opt-out form which in law would permit them to work over 48 hours per week. • Review the existing working pattern to determine if start/finish times can be changed to reduce working hours.	Mr E Mackle, Associate Medical Director Surgery & Elective Care	

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Parks, Zoe

From:	Parks, Zoe
Sent:	28 October 2022 19:11
To:	Parks, Zoe
Subject:	FW: Urology Working Hours
Attachments:	4.2.14 memo to Mr Mackle re Urology.pdf; Meeting to discuss Urology working patterns .eml (93.8 KB)
Importance:	High

-----Original Message-----
From: Parks, Zoe <Personal Information redacted by the USI>
Sent: 03 March 2014 14:16
To: Mackle, Eamon <Personal Information redacted by the USI>
Subject: Urology Working Hours
Importance: High

I am meeting Kieran for my 1:1 next week. Would you be able to advise me of any update on this? I know the position remains challenging.

Thank you

Zoe

From: Parks, Zoe
Sent: 04 February 2014 11:25
To: Mackle, Eamon
Cc: Donaghy, Kieran; malcolm.clegg Personal Information redacted by the USI
Subject: Urology Working Hours
Importance: High

Hi Mr Mackle,

Please see attached memo re Urology – can we discuss the up to date position in relation to this?

Thanks

Zoe

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Parks, Zoe

From: Parks, Zoe
Sent: 28 October 2022 19:21
To: Parks, Zoe
Subject: FW: Urology Working Hours

-----Original Message-----
From: Mackle, Eamon <Personal Information redacted by the USI>
Sent: 04 February 2014 11:43
To: Parks, Zoe <Personal Information redacted by the USI>
Subject: RE: Urology Working Hours

Zoe

I met with Michael early last month and he was to get the derogation signed and reduce their hours but I cant say if it was done

Eamon

From: Parks, Zoe
Sent: 04 February 2014 11:41
To: Mackle, Eamon
Subject: RE: Urology Working Hours

No problem – thank you. Kieran had asked me for an update Zoe

From: Mackle, Eamon
Sent: 04 February 2014 11:41
To: Parks, Zoe
Cc: Corrigan, Martina
Subject: FW: Urology Working Hours
Importance: High

Hi Zoe

In theatre today.

I will chase up with Martina re the issues which I have already raised with Michael Young

Eamon

From: Parks, Zoe
Sent: 04 February 2014 11:25
To: Mackle, Eamon
Cc: Donaghy, Kieran; Clegg, Malcolm
Subject: Urology Working Hours

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Importance: High

Hi Mr Mackle,

Please see attached memo re Urology – can we discuss the up to date position in relation to this?

Thanks

Zoe

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

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

4 February 2014

Mr Mackle
Associate Medical Director
Surgery and Elective Care

Sent Via Email Only

Mr Mackle,

RE: UROLOGY WORKING PATTERNS

Further to our meeting on 20 December 2013, I would be grateful if you could update me on the actions that were discussed so I can provide an update to Kieran.

Consider placing Urology staffing on the Risk register
Action: Mr Mackle

Appointment of a Clinical Fellow
Action Mr Mackle

Completion of a derogation by the two staff concerned.
Action Malcolm/ Mr Mackle

Reduction in the hours worked including when a shift starts and finishes
Malcolm to meet with Martina and Mr Mackle

As you are aware, currently there are two registrars who at times are working in access of 60 hours per week. They work from 8 - 11 and are basically trying to cover the work of 4. At present they are the only group of staff working 60 hours per week. This leads the Trust not to be compliant with current legislation and to be in a particularly venerable position should there be an adverse incident. We don't anticipate there will be any change following February changeover as these two trainees will remain in post and I understand unfortunately there were no applicants for the recent advertisement for clinical research fellow. I know the situation remains very challenging as we are unable to recruit staff.

The Board Liaison Group in the DHSSPS who are responsible for compliance have written to the Trust for an update on our particular challenges within urology and are willing to arrange to meet with us to discuss this in greater detail if this would be helpful. We had put them back in the past as it was hoped the reduction in hours from the surgical registrars covering at night would have reduced the urology working hours, but this hasn't materialized.

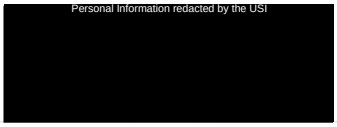
Trust HQ, Craigavon Area Hospital,
68 Lurgan Road, PORTADOWN, Craigavon BT63 5QQ, Email: Personal Information redacted by the USI

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

I would be grateful if you could provide me with an update on your thoughts on how we may be able to achieve a long term sustainable solution and more importantly in the immediate short term, if actions can be taken to reduce the individual working hours of the two training doctors to ensure their weekly working hours are reduced below 56 and that they sign a EWTD derogation form.

Please also advise if a regional meeting with BLG would be useful at this stage to discuss our ongoing challenges in this area.

Many thanks



ZOE PARKS (MRS)
Medical Staffing Manager

Parks, Zoe

From: Parks, Zoe
Sent: 28 October 2022 19:10
To: Parks, Zoe
Subject: FW: Urology Working Hours

-----Original Message-----
From: Parks, Zoe <[redacted]>
Sent: 04 February 2014 11:41
To: Mackle, Eamon <[redacted]>
Subject: RE: Urology Working Hours

No problem – thank you. Kieran had asked me for an update Zoe

From: Mackle, Eamon
Sent: 04 February 2014 11:41
To: Parks, Zoe
Cc: Corrigan, Martina
Subject: FW: Urology Working Hours
Importance: High

Hi Zoe

In theatre today.

I will chase up with Martina re the issues which I have already raised with Michael Young

Eamon

From: Parks, Zoe
Sent: 04 February 2014 11:25
To: Mackle, Eamon
Cc: Donaghy, Kieran; Clegg, Malcolm
Subject: Urology Working Hours
Importance: High

Hi Mr Mackle,

Please see attached memo re Urology – can we discuss the up to date position in relation to this?

Thanks

Zoe

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

Quality Care - for you, with you

Working Time Regulations (Northern Ireland) 1998
48 hour opt-out agreement for Junior Doctors in Training

Name of employee (please print): _____

Staff number: _____

Grade: _____

Specialty: _____

Please provide details of your substantive rota *[i.e. the rota you are currently working]*

W/E frequency: _____

Average actual hours worked: _____

Current Banding: _____

1. I understand that unless I agree otherwise, Regulation 4(1) of the Working Time Regulations (Northern Ireland) 1998[i] *hereafter referred to as 'WTR'* limits the average number of hours I work each week to 48 hours, as calculated over a reference period of 26 weeks. I agree that the 48 hour limit on Working Time shall not apply to me and that I may therefore work for more than an average of 48 hours per week, calculated over a 26 week reference period.

2. I _____ understand that by opting out of the hours limits of the WTR I remain **personally responsible** for complying with the GMC's ***'Good Medical Practice'*** [ii] and that I am responsible for ensuring that I remain fit for work and do not put myself or patients at risk

3. This agreement will apply from _____until_____ although I understand that I may terminate this agreement at any point during this period by giving you 1 month's written notice, or in exceptional circumstances a shorter notice period may be mutually agreed between myself and the Trust.

4. I understand that any additional hours that I work and at the request of my employer will be covered by my employer's Indemnity Scheme.

5. I also understand that any additional work undertaken by me for another employer whilst also in your employment, will not be covered by my employer's Indemnity Scheme. I understand that I am **personally responsible** for ensuring that I am either personally indemnified for this work, or that any such work is covered by the employing authority's indemnity scheme.

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

6. I understand that my employer must be satisfied that any additional work I undertake, either for you or for another employing authority will not conflict with,

    a) my health and safety,
    b) the interests of my employer,
    c) my fitness to practise, or
    d) with the rest requirements of the WTR.

7. I also understand that there can be **no opt-out** from the rest and leave requirements of the WTR.

8. Despite agreeing to opt out of the 48 hour limit imposed by the WTR, I understand that I am still bound to comply with the control of hours stipulated in paragraphs 20, 111a and 111b my Terms and Conditions of Service and in line with my Contract of Employment.

9. Payment for any additional hours undertaken on behalf of my employer will be agreed separately. *[This will be either via an agreed temporary increase in the payment of the banding supplement applicable to the rota I am currently working on, or at an agreed hourly rate.]*

10. I understand that my employer is required to keep an up to date record of all workers who have opted out of the WTR and in order to facilitate this requirement I agree to keep a record of all additional locum hours worked for another employer(s), and if requested at any time, I will produce the record to my employer or to any Health and Safety Official

11. **I understand that I am under no obligation to sign this agreement and do so voluntarily**.

Employee name: _____
(Block capitals)

Employee signature: _____

Agreement start date: _____

Employer signature: _____

- ***Please complete and return this form to the Medical Staffing Department for inclusion in your personal file***

[i] Working Time Regulations (Northern Ireland) 1998 - http://www.legislation.gov.uk/uksi/1998/1833/contents/made

[ii] Good Medical Practice - http://www.gmc-uk.org/guidance/good_medical_practice.asp

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Meeting to discuss Urology Registrars Working Pattern
In attendance: Kieran, Zoe: Malcolm: Mr Mackle
20 December 2013
11:30

Background

Currently within urology there are two registrars who at times are working in access of 60 hours per week. They work from 8 - 11 and are basically trying to cover the work of 4. At present they are the only group of staff working 60 hours per week. This leads the Trust not to be compliant with current legislation and to be in a particularly venerable position should there be an adverse incident

The following action was discussed and agreed:

Need to place this risk on the Directorate risk registrar, in order to achieve this need to complete a risk assessment. It was agreed that Zoe and Malcolm would provide a draft that would then be amended and signed off within the Acute Directorate.

Action: Zoe and Malcolm to draft a risk assessment

Part of that assessment would include a section to reduce the risk, these factors would need further discussion with the parties involved but would include:

Appointment of a Clinical Fellow.
Action Mr Mackle

Completion of a derogation by the two staff concerned.
Action Malcolm/ Mr Mackle

Reduction in the hours worked including when a shift starts and finishes
Malcolm to meet with Martina and Mr Mackle

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Parks, Zoe

From: Corrigan, Martina <[redacted]>
Sent: 20 June 2011 12:40
To: zoe.parks[redacted]
Cc: Malcolm.Clegg[redacted]; eamon.mackle[redacted]
Subject: FW: Draft job plan - Mr O'Brien
Attachments: O'Brien Aidan DRAFT job plan Jun 2011.doc

Hi Zoe,

Can the following amendments be made to Mr O'Brien's Job Plan.

Monday AM week 1 & 4
8.30 – 9.00 - Travel
9.00-1.00 - Outpatient Clinic – Banbridge

Monday AM week 2 & 3
8.30 – 9.00 - Travel
9.00-1.00 - Outpatient Clinic – Armagh

Monday PM – Every week
2.00-4.00 Admin
4.00-6.00 SPA

Friday AM – every week
9.00-1.00 Specialist clinic – CAH

Friday PM – Weeks 1 & 3
1.00-6.00 SPA

Friday PM weeks 2 & 4
OFF

Many thanks

Martina

Martina Corrigan
Head of ENT and Urology
Southern Health and Social Care Trust
Craigavon Area Hospital

Tel: [redacted]
Mobile: [redacted]
Email: [redacted]

From: Clegg, Malcolm

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Sent: 08 June 2011 16:04
To: Corrigan, Martina; Mackle, Eamon
Subject: Draft job plan - Mr O'Brien

Martina/ Mr Mackle,

Draft job plan attached for Mr O'Brien at 10.5 PAs (just!).

Let me know if anything needs changed. Again, objectives will need to be included.

Malcolm

Malcolm Clegg
Medical Staffing Department
Craigavon Area Hospital
Tel: Personal Information redacted by the USI

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Parks, Zoe

From: Parks, Zoe <[redacted]>
Sent: 27 January 2014 08:58
To: Corrigan, Martina
Subject: Dr A O'Brien

Martina - do you know if Mr hall or someone else was working on Dr O'Brien's job plan?

Zoe

-----Original Message-----
From: WordPress [mailto:aidanpobrien[redacted]]
Sent: 24 January 2014 19:45
To: Parks, Zoe
Subject: [your-subject]

Name: Aidan O'Brien
Email: [redacted]
Base: Craigavon Area Hospital
grade: Consultant
Subject: Urology

Message Body:
Yesterday, I accessed for the first time my current job plan on Zircadian, and was taken aback to find that the last job plan, to which I had agreed and signed up to, has been changed with effect from 01 April 2013 to a job plan which has not been implemented, is markedly different from previous job plan, bears little resemblance to it and which I did not sign up to, even though it is indicated on Zircadian system that I had not so. I would be grateful if this could be addressed and remedied.

--
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Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Parks, Zoe

From: Corrigan, Martina <[redacted]>
Sent: 27 January 2014 20:09
To: Parks, Zoe
Subject: RE: Dr A O'Brien

No Zoe,

As far as I was aware there had been nothing more done on urology job plan as we were waiting on the fifth member so as to make team plan work, Malcolm did put this on to Zicardian for Mr Young but was never to be signed of so I am wondering is this where this has come from?

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust

Telephone: [redacted] (Direct Dial)
Mobile: [redacted]
Email: [redacted]

-----Original Message-----
From: Parks, Zoe
Sent: 27 January 2014 08:58
To: Corrigan, Martina
Subject: Dr A O'Brien

Martina - do you know if Mr hall or someone else was working on Dr O'Brien's job plan?

Zoe

-----Original Message-----
From: WordPress [mailto:[redacted]]
Sent: 24 January 2014 19:45
To: Parks, Zoe
Subject: [your-subject]

Name: Aidan O'Brien
Email: [redacted]
Base: Craigavon Area Hospital
grade: Consultant
Subject: Urology

Message Body:
Yesterday, I accessed for the first time my current job plan on Zircadian, and was taken aback to find that the last job plan, to which I had agreed and signed up to, has been changed with effect from 01 April 2013 to a job plan which has not been implemented, is markedly different from previous job plan, bears little resemblance to it and which I did not sign up to, even though it is indicated on Zircadian system that I had not so. I would be grateful if this could be addressed and remedied.

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Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Parks, Zoe

From: Parks, Zoe <[redacted]>
Sent: 27 January 2014 08:58
To: Corrigan, Martina
Subject: Dr A O'Brien

Martina - do you know if Mr hall or someone else was working on Dr O'Brien's job plan?

Zoe

-----Original Message-----
From: WordPress [mailto:[redacted]]
Sent: 24 January 2014 19:45
To: Parks, Zoe
Subject: [your-subject]

Name: Aidan O'Brien
Email: [redacted]
Base: Craigavon Area Hospital
grade: Consultant
Subject: Urology

Message Body:
Yesterday, I accessed for the first time my current job plan on Zircadian, and was taken aback to find that the last job plan, to which I had agreed and signed up to, has been changed with effect from 01 April 2013 to a job plan which has not been implemented, is markedly different from previous job plan, bears little resemblance to it and which I did not sign up to, even though it is indicated on Zircadian system that I had not so. I would be grateful if this could be addressed and remedied.

--
This mail is sent via contact form on http://www.southerndocs.hscni.net

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Parks, Zoe

From: Parks, Zoe
Sent: 28 October 2022 19:17
To: Parks, Zoe
Subject: FW: Dr A O'Brien

From: Parks, Zoe <[redacted]>
Sent: 27 January 2014 08:58
To: Corrigan, Martina <[redacted]>
Subject: Dr A O'Brien

Martina - do you know if Mr hall or someone else was working on Dr O'Brien's job plan?

Zoe

-----Original Message-----
From: WordPress [mailto:[redacted]]
Sent: 24 January 2014 19:45
To: Parks, Zoe
Subject: [your-subject]

Name: Aidan O'Brien
Email: [redacted]
Base: Craigavon Area Hospital
grade: Consultant
Subject: Urology

Message Body:
Yesterday, I accessed for the first time my current job plan on Zircadian, and was taken aback to find that the last job plan, to which I had agreed and signed up to, has been changed with effect from 01 April 2013 to a job plan which has not been implemented, is markedly different from previous job plan, bears little resemblance to it and which I did not sign up to, even though it is indicated on Zircadian system that I had not so. I would be grateful if this could be addressed and remedied.

--
This mail is sent via contact form on http://www.southerndocs.hscni.net

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Parks, Zoe

From: Parks, Zoe
Sent: 28 October 2022 19:52
To: Parks, Zoe
Subject: FW: HPRM: Urology Workforce Planning Report
Attachments: 260517_Peter Barbour_Urology Workforce Planning Report.pdf; Urology Workforce planning report_May 2017.pdf

---

From: Parks, Zoe <Personal Information redacted by the USI>
Sent: 09 June 2017 14:55
To: Clegg, Malcolm <Personal Information redacted by the USI>
Subject: FW: HPRM: Urology Workforce Planning Report

fyi

Personal Information redacted by the USI

Mrs Zoe Parks
Medical Staffing Manager
✉ Southern Health & Social Care Trust
☎ 028 Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
Personal Information redacted by the USI

From: Donnelly, Catherine (DoH) [mailto:Personal Information redacted by the USI]
Sent: 06 June 2017 11:50
To: McAlister, Damian; Weir, Myra; Ann McConnell; Toal, Vivienne; Elizabeth.Brownlees Personal Information redacted by the USI; Montgomery, Erin
Cc: Barbour, Peter; Dunwoody, Alison
Subject: FW: HPRM: Urology Workforce Planning Report

TO HR DIRECTORS

Please find attached final draft of the Urology Medical Workforce Planning Report 2017 – 2024 carried out by the PHA on behalf of the Department. As there is no RWPG to review the draft I am asking HR Directors to continue to carry out this role until such times as a new regional group is established.

I would be grateful if you would send any comments directly to Carolyn Harper and Gillian Rankin and cc to myself Catherine Donnelly for information **on or before the 20 June 2017** so that the report can be finalised by the end of June 2017.

Please do not hesitate to contact me if you have any queries.

Catherine
Catherine Donnelly
Workforce Policy Directorate
Room D1.4
Castle Buildings
Stormont

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

BT4 3SQ
Tel: Personal Information redacted by the USI

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Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Parks, Zoe

From: Wright, Richard <[redacted]>
Sent: 26 June 2017 08:54
To: Toal, Vivienne
Cc: Gishkori, Esther; Walker, Helen; Parks, Zoe; Carroll, Ronan; Haynes, Mark
Subject: Re: RESPONSE BY 15th JUNE: HPRM: Urology Workforce Planning Report

No changes on my part. Richard

Sent from my iPad

On 25 Jun 2017, at 21:42, Toal, Vivienne <[redacted]> wrote:

> Dear all
>
> The deadline for comments has been extended to 30th June.
>
> Has anyone any comments on accuracy or wider points that they would wish us to feed back?
>
> Many thanks
> Vivienne

From: Mallagh-Cassells, Heather
Sent: 06 June 2017 16:36
To: Wright, Richard; Gishkori, Esther; Walker, Helen; Parks, Zoe; Carroll, Ronan; Haynes, Mark; Toal, Vivienne
Cc: Gibson, Simon; White, Laura; Stinson, Emma M; McNally, Stephen; Wright, Elaine
Subject: RESPONSE BY 15th JUNE: HPRM: Urology Workforce Planning Report

6 June 2017

Dear All,

Please find as attached a draft Urology Medical Workforce Planning Report *for comment*.

Can you please send any comments to myself by the **15th June** in order that a combined response can be sent to the DOH by their deadline?

Many thanks.

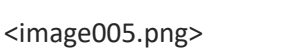
Heather

Heather Mallagh-Cassells
Personal Assistant to Vivienne Toal
Director of Human Resources & Organisational Development
Southern Health & Social Care Trust
[redacted]

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

☎ (028) Personal Information redacted by the USI (Internal: Personal Information redacted by the – prefix by Personal Information redacted by if dialling from legacy telephone)

You can follow us on:



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Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Medical Workforce Planning for Urology

Current Service Context

Urology is a surgical speciality provided within acute hospitals for people with urological conditions including cancers of the urinary tract system. The majority of urological surgery is provided in Altnagelvin, Craigavon, Belfast City and the Ulster Hospitals. Outpatients in the speciality are provided in a larger number of hospital sites for accessibility. All major pelvic clearance surgery is provided through the Belfast Trust service.

There are a range of factors which create service pressures in this speciality, which is small in terms of consultant numbers:

- An aging population. Older people are more frequent users of urology services.
- The numbers of people requiring diagnostics and challenges in providing this within expected waiting times.
- Increase in the incidence of prostate cancer, with an increase in the number of people requiring follow –up
- Increase in the incidence of renal cancer
- Increasing population prevalence of lifestyle factors such as obesity and sedentary behaviour, will increase the incidence of certain conditions seen by urology services such as stress incontinence and erectile dysfunction
- Vacancies in staff grade doctor positions and a national challenge with recruitment to this level
- The migration of N code urology work from general surgeons to urologists as new general surgery consultant appointments are made

Proposed methodology

The approach developed and taken with previous specialities has been to work with clinicians and senior managers in all Trusts, working through an existing Clinical Engagement Group if possible, or setting one up for this purpose. NIMDTA, relevant College representatives and other stakeholders are also involved to develop a consensus on the relevant clinical standards relating to the speciality and alignment to Northern Ireland strategies, which have a direct implication for the numbers of consultants and junior doctors required in Northern Ireland.

The number of doctors at each level is also dependent on the service configuration of acute hospitals and associated services out of hospital.

The current service configuration is used as the baseline to quantify the current numbers of doctors by grade and by hospital in each Trust. The consultant numbers required, with due consideration to predicted retirements and known service

developments are then linked to the number of CCT accredited doctors exiting their training annually in Northern Ireland to identify if these numbers are sufficient /greater or less than required for specific service configurations.

Other national or local developments which impact on the service need to be identified and the workforce implications quantified. Reform and modernisation plans for new access pathways require consideration in this process to identify the implications for the medical workforce. This would include any planned developments to enhance the role of clinical nurse specialists or advanced nurse practitioners in urology which would impact on the current workload of medical staff.

Options of different service configurations and modernisation can be set out in a range of sensitivity analyses quantifying the impact on the medical workforce for each; and these are informed by commissioners where possible.

The medical workforce requirements are set out for the next 5-7 years with predicted new CCT holders and potential retirements, which will result in clarifying the additional number of trainees required over the timescale of the workforce plan. The feasibility of additional trainees requires discussion with NIMDTA regarding the potential for and timing of additional training places and these are then costed for DHSS purposes.

It should be recognised that the workforce plan for doctors in a speciality is a statement of the requirement for doctors in each of the expressed service options. It is not a statement of commissioning intention but rather a statement which is available to commissioners when a decision to change the service model or configuration is being considered.

Key actions required and lead responsibility:

Task	**Lead responsibility**
Collation and analysis of the current workforce of consultants, trainees, middle grades by Trust, to include age bands of consultants	PHA and Trusts
Determination of service standards in use or to be adopted in NI which impact on the service model and the medical workforce	PHA and Clinical group
Determination of known /potential service developments and modernisation opportunities for new ways of working and the workforce impacts eg TYC	PHA and Clinical Group
Task	**Lead responsibility**
Demand and capacity analysis if appropriate	Discussion with HSCB

Potential impact of demographic change until after 2020 and any predictive modelling	PHA
Assessment of the need to consider in the NI context any issues raised in the national Centre for Workforce Intelligence reports for the speciality	PHA
Identification of the NI training position including detailing the current position and trends regarding speciality trainees, allocations and attrition rates	NIMDTA with PHA
Detailed workforce implications by consultant and training grades for the current and potential new service configurations and modernisation plans.	PHA and Clinical Group
Determination of the number of new training posts required to meet the service requirements on an annual basis with costs for the next 5-7 years.	PHA, NIMDTA and Clinical Group

Health and Social Care Board

Directorate of Performance Management and Service Improvement

HSC Board Headquarters
12-22 Linenhall Street
Belfast
BT2 8BS

Tel : Personal Information redacted by the USI
Web Site : www.hscboard.hscni.net

Our Ref: *lmcw004*

Date: *15 June 2016*

Aldrina Magwood
Director of Performance
Trust Headquarters
Craigavon Area Hospital
68 Lurgan Road
Portadown
Craigavon
BT63 5QQ

Medical Workforce Planning for Urology

I refer to the above and wish to advise that we will now commence the development of a medical workforce plan for Urology. This work will be led by Dr Gillian Rankin, Medical Workforce Planning Lead, Public Health Agency and will be linked to the modernisation plans which are already in discussion through the Urology Planning and Implementation Group chaired by the HSCB and supported by the PHA. The proposed methodology, key actions and responsibilities are outlined in Appendix 1.

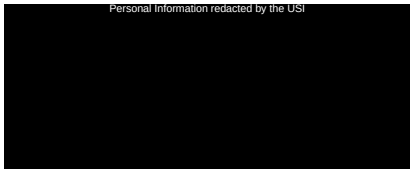
The approach developed and taken with previous specialities has been to work with clinicians and senior managers in all Trusts, working through an existing Clinical Engagement Group if possible, or setting one up for this purpose. We therefore propose that the Trust nominate members of the Urology Pathways and Workforce subgroup would now become members of this group. In the case of the Southern Trust this will be Mr Young and Martina Corrigan, we would be grateful if you could advise of any change to these nominations.

NIMDTA, relevant College representatives, the BMA and other stakeholders will also be involved to develop a consensus on the relevant clinical standards relating to the speciality and alignment to Northern Ireland strategies, which have a direct implication for the numbers of consultants and Junior Doctors required in Northern Ireland.

We will be writing to each of the Trusts to advise of the date of the first meeting. We look forward to working regionally on this important plan.

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Yours sincerely



Lisa McWilliams
Assistant Director of Scheduled Care

Cc Lynne Charlton
Gillian Rankin

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

HSC Public Health Agency

12-22 Linenhall Street
BELFAST
BT2 8BS

Tel: Personal Information redacted by the USI
www.publichealth.hscni.net

BY EMAIL ONLY
Peter Barbour
Deputy Director of Workforce Policy

26 May 2017

Dear Peter,

Re: Urology Workforce Planning Report

I have attached the final draft workforce report for Urology. This report has been developed by the Workforce subgroup of the Urology Planning and Implementation Group which is chaired by the HSCB and supported by the PHA. This group involved clinicians and managers from all Trusts and the TPD from NIMDTA. The report tales account of the potential impact of the early modernisation plans within the service.

If there are any issues of clarification, or comments from Trusts, please contact Dr Gillian Rankin at Personal Information redacted by the USI in the first instance.

Yours sincerely

Personal Information redacted by the USI

DR CAROLYN HARPER
Medical Director/Director of Public Health

CC: Catherine Donnelly
Gillian Rankin

Improving Your Health and Wellbeing

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Urology Medical Workforce Planning Report

Northern Ireland 2017-2024

HSCB and PHA **May 2017**

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

1. Overview

The Medical Director/Director of Public Health for the Public Health Agency/Health and Social Care Board has been asked by the Department of Health (DoH) to take forward medical workforce planning for Northern Ireland for the period until 2019. This was previously under the auspices of the DoH Regional Workforce Planning Group and is currently sponsored by the Director of Workforce Policy, DoH. A Workforce Strategy for the HSC is a key element of ''Delivering Together''. Workforce plans for specialties are being developed speciality by specialty, under the direction of Dr Gillian Rankin. Urology has been identified as one of the current group of workforce plans to be developed.

The Urology Planning and Implementation Group led by the HSCB and PHA has a Workforce Subgroup which has been constituted to include clinicians and senior managers from all Trusts. This subgroup has formed the engagement group for the workforce planning process with the additions of representatives from both NIMDTA and BMA. The group is chaired by Lisa McWilliams, Assistant Director Scheduled Care, HSCB supported by senior HSCB and PHA staff who are leading on the modernisation of urology services, including the further development of Clinical Nurse Specialists. It is recognised that workforce planning is not commissioning, but rather a planning process to ensure the future workforce meets the population's needs through investment in training, where necessary. The membership of the Workforce Subgroup is listed in Appendix A.

A review of urology workforce requirements for 2017-2024 commenced in mid -2016. This work included:

- A stocktake of the current urology medical workforce at all grades working in hospitals in NI
- The identification of a set of principles and standards for urology. These are based on the Royal College of Surgeons and the British Association of Urological Surgeons(BAUS) standards
- The determination of the medical workforce required to deliver the service in line with the agreed principles and standards
- Analysis of the impacts (where possible) of modernisation workstreams and strategic service change
- Analysis of the information from NIMDTA on trainee numbers, recent trends in recruitment of trainees, attrition rates and numbers of trainees exiting per year with CCT accreditation

2. Summary of the Urology Workforce Review

- There are 23 permanent consultants in post with two vacancies and one locum. 26 consultant posts are recurrently funded
- The BAUS guidance for consultants is 1WTE per 60,000 population
- Projected for the population at 2024, the consultant requirement is 32.3WTE

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

- The projected gap between the current constant workforce and the required workforce for the 2024 NI population is 13 (comprised of 5 potential retirements and the gap of 8 consultants between the current numbers and projected numbers based on the BAUS guidance)
- There are 7 predicted new CCT holders by 2022. This leaves a gap of 6 trainees required to meet population needs by 2024, not accounting for any impact on consultant workload of regional modernisation
- An additional 4 trainees could be accommodated as a group in addition to the existing 7 training posts. If these 4 additional training posts are funded from August 2017, the new CCT holders could be ready for consultant posts by 2022 assuming no delay to completion of training
- The further additional 2 trainees may then be required in 2019, after the quantification of the impacts of modernisation in urology on the workload of the consultant

3. **Service context**

The HSCB led the urology review and implementation of the current configuration of urology services in NI. This work was supported by Mr Mark Fordham, Urologist, representing BAUS.

Whilst the current service model has urological surgical inpatient procedures delivered in only four hospitals, there are outpatient clinics and day procedures delivered in the local hospitals across NI to provide improved access for the population. The development of Elective Care Centres in Northern Ireland could impact positively on the length of waiting times for patients through the separation of unscheduled and elective surgical services in this specialty.

The modernisation of urology services is an important element of the work of the Urology Planning and Implementation Group, including exploring the role of the Clinical Nurse Specialist. Clinical pathways for common conditions and reviews for patients with cancer are also being agreed and implemented.

While these developments are expected to have an impact on the current workload of doctors, it is not yet possible to quantify the actual impacts with certainty. It will also take several years to fully implement the role of Clinical Nurse Specialists with training and mentoring requirements.

The workforce subgroup is aware of ongoing discussions between the HSCB, PHA and Trusts regarding the development of a locally delivered robotic surgery service in Northern Ireland. This surgery is currently commissioned by the HSCB from other providers in the UK. Given the current BAUS requirements for additional training in robotic surgery post-CCT,1-2 trainees would require periods of post-CCT training outside of Northern Ireland in order to access appropriate training in this specialist surgical procedure. Training requirements are being considered in discussions

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regarding the future provision of this specialist procedure for the population of Northern Ireland.

4. Principles and service standards

The standard which has been identified in relation to the medical urology workforce is from the Royal College of Surgeons of England. The most recent version of this document is the 2011 report:

'Surgical Workforce 2011. A Report from the Royal College of Surgeons of England in collaboration with the surgical specialty associations' Royal College of Surgeons of England, 2011

Specialty recommendations for England, Wales and Northern Ireland:

'The British Association of Urological Surgeons (BAUS) recommends a consultant workforce ratio of 1:60,000 population.'

Other factors were considered by the workforce group as to what material impact they might have on the BAUS population standard stated above. These factors were:

- Adult N-code work (urology work previously undertaken by General Surgeons)
- Paediatric urological surgery
- BAUS guidance on outpatient clinic templates

These were discussed and it was concluded that no further adjustments to the projected workforce needed to be made to account for these factors at the present time.

5. Current medical staffing across NI

The current consultant and middle grade medical staff are set out in the tables below.

Table 1 Consultant workforce by Trust in NI as at October 2016 and from April 2017

Trust and hospital	Number of permanent consultants by headcount		Number of locum consultants by headcount		Number of vacant funded posts		Total funded posts	
	Oct 16	April 17	Oct 16	April 17	Oct 16	April 17	Oct 16	April 17
Belfast BCH	9	8	-	-	-	1	9	9
South Eastern UHD	3	4	-		1	0	4	4
Southern Craigavon	5	5	-		1	1	6	6

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Western								
Altnagelvin	4	4	1	1	-		5	5
Causeway	2	2	-		-		2	2
Total	**23**	**23**	**1**	**1**	**2**	**2**	**26**	**26**

There are 24 posts filled including one post with a locum and there are 2 vacant consultant posts as at October 2016. Although there are changes to the consultants in 2 Trusts, the totals will remain unchanged at April 2017.

Table 2 Non consultant career grade (NCCG) doctors in urology in NI as at October 2016

Trust	Number of NCCG doctors	Number of vacant posts	Total number of permanently funded posts
Belfast	4 inc 2x Clinical Fellows	-	2.25
South Eastern	2*	-	2
Southern	0**	3**	3
Western	2	1 Altnagelvin	3
Total	**8**	**4**	**10**

***1 doctor currently on maternity leave and a locum covering the vacancy

**1 doctor has started in January 2017 working 0.5WTE

The table below sets out the estimated potential number of retirements in the speciality for the next 8 years. This is based on the assumptions that all surgeons over 60 years will retire, 50% of those between 55-59 years and 25% of those in the 50-54 year age band will retire.

Table 3 Consultant workforce in NI by age band as at October 2016

Trust	Number of consultants in age band 50-54 years	Number of consultants in age band 55-59 years	Number of consultants in age band >60 years	Estimated potential retirements in next 8 years
All Trusts	6	3	2	5

It is estimated that 5 urology surgeons may retire in the period of the next 8 years.

6. Trainees in urology in NI

Table 4 Trainee numbers in urology in NI from 2011 to 2016

Year of entry into specialist training	2012	2013	2014	2015	2016
Total training places	7	7	7	7	7

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

There are 7 training posts across all training grades at a point in time in NI. Doctors are appointed to these posts through a national selection process. If there is a vacancy in one of the training posts this post will be filled on a fixed term basis by a FTSTA or LAT appointment. There are several reasons why a training post may be vacant and these include maternity leave, going on Out of Programme training (OOPT)or Out of Pro gramme Experience (OOPE)and rarely resignation from the training programme. The posts filled by FTSTA or LAT appointments will be used to recruit a trainee at the next selection round.

Table 5 Trainee numbers by Trust at August 2016

Training grade /Trust	Belfast Trust	Northern Trust	South Eastern Trust	Southern Trust	Western Trust	Total
ST3						
ST4						
ST5				1	1	2
ST6						
ST7	1					1
FTSTA/LAT	1			1		2
OOP	2					2
Total	4			2	1	7

The appointment of doctors locally into two FTSTA/LAT posts rather than selection through the national scheme was due to:

- A resignation occurring just outside the annual selection process
- One trainee requiring an extended period of training in order to complete professional examinations

Table 6 Additional CCT holders by year

Year	2012	2013	2014	2015	2016
Number of new CCT holders	-	-	-	1	1

The low number of trainees achieving CCT during the years 2012-2014 was due to a combination of factors such as OOPE, OOPT, maternity leave and 1 trainee needing an extension to training to complete professional examinations.

Table 7 Predicted additional CCT holders by year

Year /grade	2016	2017	2018	2019	2020	2021	2022	2023
ST3		2*						
ST4			2					
ST5	2			2				
ST6		2			2			
ST7	1		2			2		
OOP	2**		2					
Total new CCT		1	2	2			2	

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

holders for year								
Summative total of predicted new CCT holders		**1**	**3**	**5**	**5**	**5**	**7**	

*2 ST3 posts will be appointed to commence speciality training in August 2017
** the two doctors currently on OOPE should both gain CCT in 2018

Within the current funded training programme there should be 7 doctors who gain CCT between 2017 and 2022. This assumes no attrition or delay to the achievement of CCT due to examination failure or a doctor requiring OOPT or taking OOPE.

7. **Future Workforce requirements**

A. Current gap in the consultant workforce to meet the BAUS standards

The BAUS standard is 1WTE for 60,000 population. The projected population for NI at 2024 is 1,939,000[1]. To meet this standard NI requires 32.32WTE at 2024.

There are currently 24 consultants in post including 1 locum consultant, while there are 26 funded consultant posts.

Therefore the WTE gap in headcount is 32.3 – 24 = 8.3WTE

B. Modernisation in urology

The impact of the modernisation workstreams on the consultant workforce is currently not quantified.

However it would be prudent to assume that there could be an impact on workload which may change the overall consultant requirement at 2024 given the gap of 7 years.

C. Requirements in consultant WTE to meet population needs including current vacant posts and retirements

Table 8 Consultant requirements taking account of projected population requirements, vacant posts and potential retirements

A Projected consultant requirements for 2024 population	B Current consultants in post	C Gap in consultant numbers	D Potential retirements	E Total additional consultants by WTE (C+D=E)
32	**24**	**8**	**5**	**13**

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

The total number of additional consultants needed to meet the population needs in 2024 is 13, which includes filling both the current vacant posts and the posts vacated through retirement.

[1] Northern Ireland Statistics Research Agency, Population Projections, available at http://www.nisra.gov.uk/demography/default.asp20.htm

8. Urology trainee requirements to meet projected service needs

Table 9 Additional trainee requirements to meet projected consultant WTE requirement

Projected additional consultant requirements	Current predicted new CCT holders	Gap in new CCT holders
13	7	6

This leaves a remaining balance of 6 additional consultants/trainees required to meet the population needs.

In light of the plans for modernisation within urology services, it is prudent to fund an additional four trainees as a first phase and then to review the need for an additional two trainees once the modernisation work has been further progressed. This review will take account of any material impact which the implementation of the wider role for Clinical Nurse Specialists has had on the consultant workload. If this impact is not material then an additional two trainees should be appointed to meet the projected population need.

Table 10 sets out the initial tranche of 4 trainees required prior to a further review. It is feasible to train an additional four trainees as a single group in addition to the existing trainees, and if funded these posts could be appointed to commence in August 2017 or August 2018. These doctors would potentially gain CCT in 2022 or 2023 assuming no additional period of training is required.

Table 10 Additional trainees by year to meet the projected consultant WTE requirement

Year/ Training grade	2017	2018	2019	2020	2021	2022	2023	2024
ST3	4		2*					
ST4		4		2*				
ST5			4		2*			
ST6				4		2*		
ST7					4		2*	
Total new CCT holders per year						4		2*
Total of predicted new CCT holders						4		6*

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

*additional 2 trainees if required after review of the impacts of modernisation on the consultant workload.

Appendix A

Membership of Workforce Subgroup

Lisa McWilliams, Assistant Director Scheduled Care, HSCB (Chair)

David McCormick, Programme Manager Scheduled Care, HSCB

Dr Catherine Coyle, Physician in Public Health Medicine, PHA

Lynne Charlton, Consultant Nurse, PHA

Hugh O'Kane, Consultant Urologist, Belfast Trust

Chris Thomas, senior manager, Belfast Trust

John McKnight, Consultant Urologist, South Eastern Trust

Maggie Parkes, senior manager, South Eastern Trust

Mark Haynes, Consultant Urologist, Southern Trust

Martina Corrigan, senior manager, Southern Trust

Alex McLeod, Consultant Urologist, Western Trust

Paul Doherty, senior manager, Western Trust

Siobhan Woolsey, Consultant Urologist, NIMDTA TPD

Anthony Dyal, urology specialty trainee, BMA representative

Gillian Rankin, medical workforce planning lead, PHA

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Urology Medical Workforce Planning Report

Northern Ireland 2017-2024

HSCB and PHA **May 2017**

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

1. Overview

The Medical Director/Director of Public Health for the Public Health Agency/Health and Social Care Board has been asked by the Department of Health (DoH) to take forward medical workforce planning for Northern Ireland for the period until 2019. This was previously under the auspices of the DoH Regional Workforce Planning Group and is currently sponsored by the Director of Workforce Policy, DoH. A Workforce Strategy for the HSC is a key element of ''Delivering Together''. Workforce plans for specialties are being developed speciality by specialty, under the direction of Dr Gillian Rankin. Urology has been identified as one of the current group of workforce plans to be developed.

The Urology Planning and Implementation Group led by the HSCB and PHA has a Workforce Subgroup which has been constituted to include clinicians and senior managers from all Trusts. This subgroup has formed the engagement group for the workforce planning process with the additions of representatives from both NIMDTA and BMA. The group is chaired by Lisa McWilliams, Assistant Director Scheduled Care, HSCB supported by senior HSCB and PHA staff who are leading on the modernisation of urology services, including the further development of Clinical Nurse Specialists. It is recognised that workforce planning is not commissioning, but rather a planning process to ensure the future workforce meets the population's needs through investment in training, where necessary. The membership of the Workforce Subgroup is listed in Appendix A.

A review of urology workforce requirements for 2017-2024 commenced in mid -2016. This work included:

- A stocktake of the current urology medical workforce at all grades working in hospitals in NI
- The identification of a set of principles and standards for urology. These are based on the Royal College of Surgeons and the British Association of Urological Surgeons(BAUS) standards
- The determination of the medical workforce required to deliver the service in line with the agreed principles and standards
- Analysis of the impacts (where possible) of modernisation workstreams and strategic service change
- Analysis of the information from NIMDTA on trainee numbers, recent trends in recruitment of trainees, attrition rates and numbers of trainees exiting per year with CCT accreditation

2. **Summary of the Urology Workforce Review**

- There are 23 permanent consultants in post with two vacancies and one locum. 26 consultant posts are recurrently funded
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- The projected gap between the current constant workforce and the required workforce for the 2024 NI population is 13 (comprised of 5 potential retirements and the gap of 8 consultants between the current numbers and projected numbers based on the BAUS guidance)
- There are 7 predicted new CCT holders by 2022. This leaves a gap of 6 trainees required to meet population needs by 2024, not accounting for any impact on consultant workload of regional modernisation
- An additional 4 trainees could be accommodated as a group in addition to the existing 7 training posts. If these 4 additional training posts are funded from August 2017, the new CCT holders could be ready for consultant posts by 2022 assuming no delay to completion of training
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3. **Service context**

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Whilst the current service model has urological surgical inpatient procedures delivered in only four hospitals, there are outpatient clinics and day procedures delivered in the local hospitals across NI to provide improved access for the population. The development of Elective Care Centres in Northern Ireland could impact positively on the length of waiting times for patients through the separation of unscheduled and elective surgical services in this specialty.

The modernisation of urology services is an important element of the work of the Urology Planning and Implementation Group, including exploring the role of the Clinical Nurse Specialist. Clinical pathways for common conditions and reviews for patients with cancer are also being agreed and implemented.

While these developments are expected to have an impact on the current workload of doctors, it is not yet possible to quantify the actual impacts with certainty. It will also take several years to fully implement the role of Clinical Nurse Specialists with training and mentoring requirements.

The workforce subgroup is aware of ongoing discussions between the HSCB, PHA and Trusts regarding the development of a locally delivered robotic surgery service in Northern Ireland. This surgery is currently commissioned by the HSCB from other providers in the UK. Given the current BAUS requirements for additional training in robotic surgery post-CCT,1-2 trainees would require periods of post-CCT training outside of Northern Ireland in order to access appropriate training in this specialist surgical procedure. Training requirements are being considered in discussions

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Total	**23**	**23**	**1**	**1**	**2**	**2**	**26**	**26**

There are 24 posts filled including one post with a locum and there are 2 vacant consultant posts as at October 2016. Although there are changes to the consultants in 2 Trusts, the totals will remain unchanged at April 2017.

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**1 doctor has started in January 2017 working 0.5WTE

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All Trusts	6	3	2	5

It is estimated that 5 urology surgeons may retire in the period of the next 8 years.

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Total training places	7	7	7	7	7

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ST7	1					1
FTSTA/LAT	1			1		2
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Total	4			2	1	7

The appointment of doctors locally into two FTSTA/LAT posts rather than selection through the national scheme was due to:

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Table 6 Additional CCT holders by year

Year	2012	2013	2014	2015	2016
Number of new CCT holders	-	-	-	1	1

The low number of trainees achieving CCT during the years 2012-2014 was due to a combination of factors such as OOPE, OOPT, maternity leave and 1 trainee needing an extension to training to complete professional examinations.

Table 7 Predicted additional CCT holders by year

Year /grade	2016	2017	2018	2019	2020	2021	2022	2023
ST3		2*						
ST4			2					
ST5	2			2				
ST6		2			2			
ST7	1		2			2		
OOP	2**		2					
Total new CCT		1	2	2			2	

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

holders for year								
Summative total of predicted new CCT holders		**1**	**3**	**5**	**5**	**5**	**7**	

*2 ST3 posts will be appointed to commence speciality training in August 2017
** the two doctors currently on OOPE should both gain CCT in 2018

Within the current funded training programme there should be 7 doctors who gain CCT between 2017 and 2022. This assumes no attrition or delay to the achievement of CCT due to examination failure or a doctor requiring OOPT or taking OOPE.

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Therefore the WTE gap in headcount is 32.3 – 24 = 8.3WTE

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However it would be prudent to assume that there could be an impact on workload which may change the overall consultant requirement at 2024 given the gap of 7 years.

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Table 8 Consultant requirements taking account of projected population requirements, vacant posts and potential retirements

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[1] Northern Ireland Statistics Research Agency, Population Projections, available at http://www.nisra.gov.uk/demography/default.asp20.htm

8. Urology trainee requirements to meet projected service needs

Table 9 Additional trainee requirements to meet projected consultant WTE requirement

Projected additional consultant requirements	Current predicted new CCT holders	Gap in new CCT holders
13	7	6

This leaves a remaining balance of 6 additional consultants/trainees required to meet the population needs.

In light of the plans for modernisation within urology services, it is prudent to fund an additional four trainees as a first phase and then to review the need for an additional two trainees once the modernisation work has been further progressed. This review will take account of any material impact which the implementation of the wider role for Clinical Nurse Specialists has had on the consultant workload. If this impact is not material then an additional two trainees should be appointed to meet the projected population need.

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Year/ Training grade	2017	2018	2019	2020	2021	2022	2023	2024
ST3	4		2*					
ST4		4		2*				
ST5			4		2*			
ST6				4		2*		
ST7					4		2*	
Total new CCT holders per year						4		2*
Total of predicted new CCT holders						4		6*

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

*additional 2 trainees if required after review of the impacts of modernisation on the consultant workload.

Appendix A

Membership of Workforce Subgroup

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Lynne Charlton, Consultant Nurse, PHA

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Alex McLeod, Consultant Urologist, Western Trust

Paul Doherty, senior manager, Western Trust

Siobhan Woolsey, Consultant Urologist, NIMDTA TPD

Anthony Dyal, urology specialty trainee, BMA representative

Gillian Rankin, medical workforce planning lead, PHA

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

From: Zoe.Parks[redacted] [mailto:[redacted]]
Sent: 14 July 2021 18:42
To: theresemckernan[redacted]
Cc: Siobhan HYNDS
Subject: Update

Hi Therese

Siobhan has confirmed you still haven't received any of my emails. Sincere apologies. I can assure you they were sent on request and unfortunately I didn't receive any bounce back to notify me you didn't receive them. I knew the first two had gone through so wasn't on alert that there could be any problems.

I had responded on each occasion on the same day as your request or following our phone call, so I assumed all was on order. I now know I should have called you to check - had been working on the assumption you would call me if you needed anything. Again apologies for that.

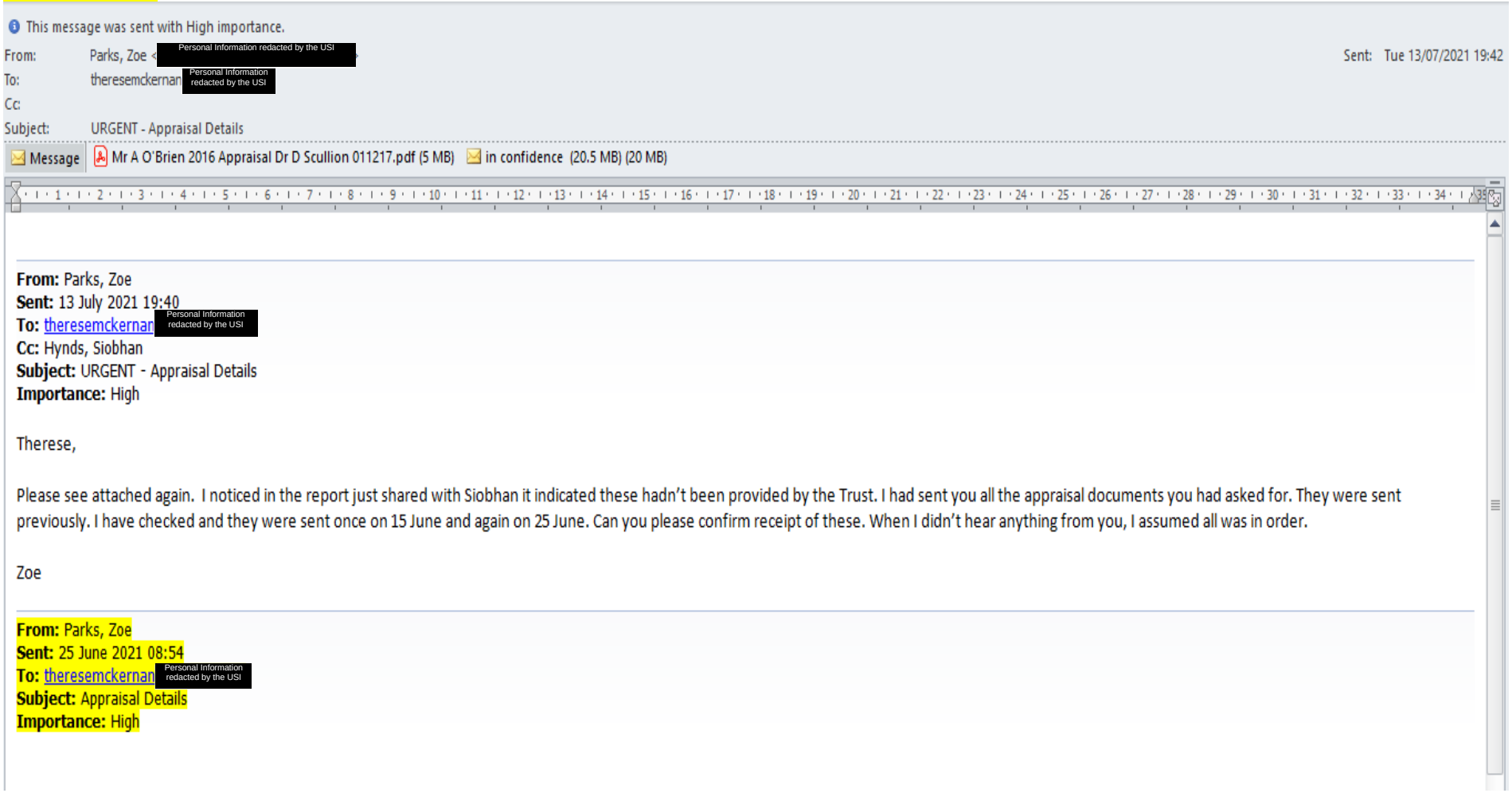
I have printed off all the information today and will post these to you first thing tomorrow morning. I tried 3 separate post offices on my way home from work but unfortunately they had all closed at 5.30.

Apologies for the inconvenience

Zoe

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Sent 13.7.2021



This message was sent with High importance.

From: Parks, Zoe < Personal Information redacted by the USI >
To: theresemckernan Personal Information redacted by the USI
Cc:
Subject: URGENT - Appraisal Details
Sent: Tue 13/07/2021 19:42

Message | Mr A O'Brien 2016 Appraisal Dr D Scullion 011217.pdf (5 MB) | in confidence (20.5 MB) (20 MB)

From: Parks, Zoe
Sent: 13 July 2021 19:40
To: theresemckernan Personal Information redacted by the USI
Cc: Hynds, Siobhan
Subject: URGENT - Appraisal Details
Importance: High

Therese,

Please see attached again. I noticed in the report just shared with Siobhan it indicated these hadn't been provided by the Trust. I had sent you all the appraisal documents you had asked for. They were sent previously. I have checked and they were sent once on 15 June and again on 25 June. Can you please confirm receipt of these. When I didn't hear anything from you, I assumed all was in order.

Zoe

From: Parks, Zoe
Sent: 25 June 2021 08:54
To: theresemckernan Personal Information redacted by the USI
Subject: Appraisal Details
Importance: High

Sent 13.7.21

This message was sent with High importance.

From: Parks, Zoe [Personal Information redacted by the USI]
To: theresemckernan [Personal Information redacted by the USI]
Cc: Hynds, Siobhan
Subject: URGENT - Appraisal Details
Sent: Tue 13/07/2021 19:40

Message | 2014 Appraisal Dr Aidan O'Brien [Dr M Young] 221215.pdf (8 MB) | 2015 Appraisal Dr A O'Brien (Dr M Young) 231216.pdf (7 MB)

Therese,

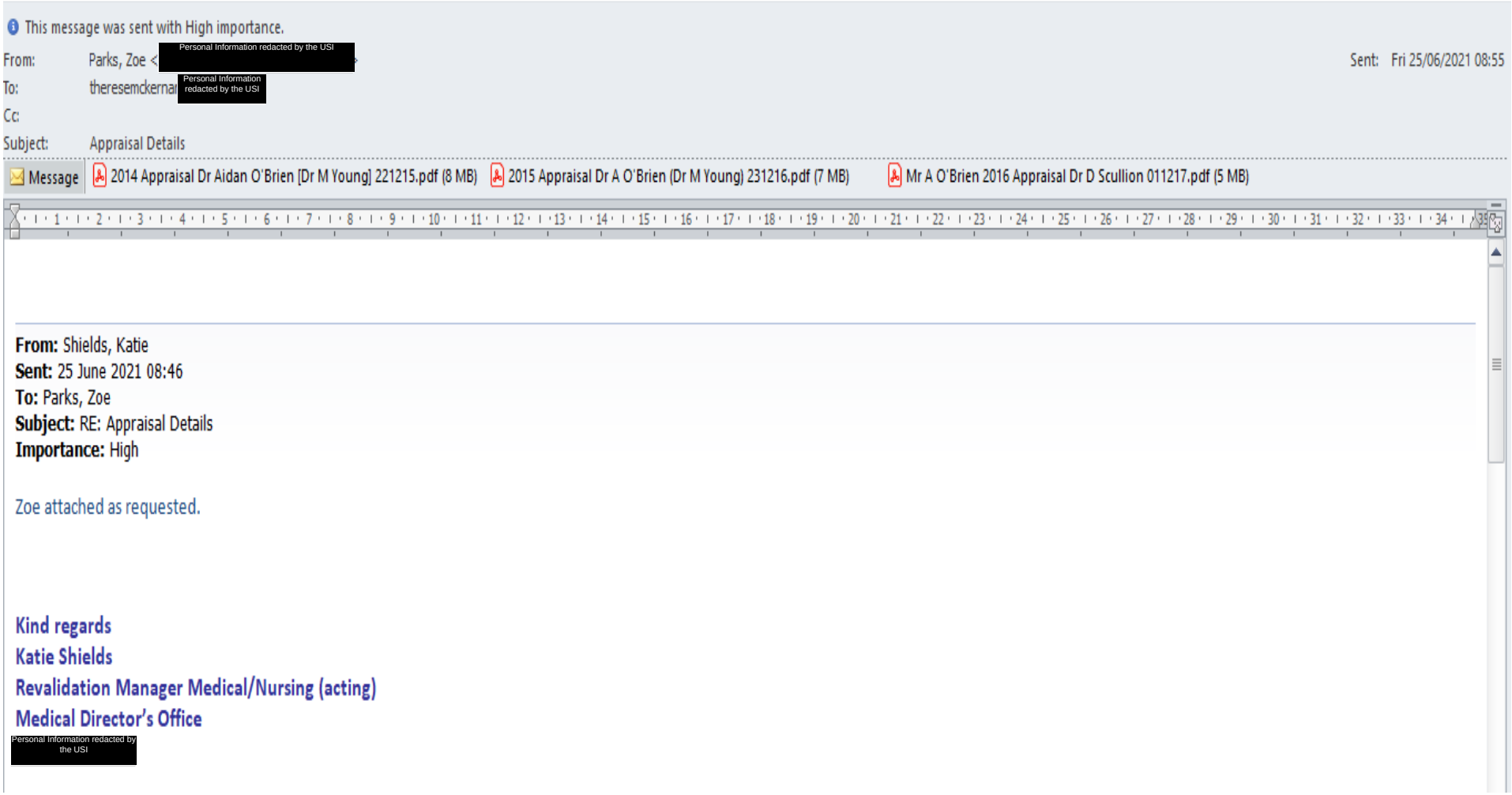
Please see attached again. I noticed in the report just shared with Siobhan it indicated these hadn't been provided by the Trust. I had sent you all the appraisal documents you had asked for. They were sent previously. I have checked and they were sent once on 15 June and again on 25 June. Can you please confirm receipt of these. When I didn't hear anything from you, I assumed all was in order.

Zoe

From: Parks, Zoe
Sent: 25 June 2021 08:54
To: theresemckernan [Personal Information redacted by the USI]
Subject: Appraisal Details
Importance: High

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Sent 25.6.21



This message was sent with High importance.

From: Parks, Zoe < [redacted] >

To: theresemckerna [redacted]

Cc:

Subject: Appraisal Details

Sent: Fri 25/06/2021 08:55

Message | 2014 Appraisal Dr Aidan O'Brien [Dr M Young] 221215.pdf (8 MB) | 2015 Appraisal Dr A O'Brien (Dr M Young) 231216.pdf (7 MB) | Mr A O'Brien 2016 Appraisal Dr D Scullion 011217.pdf (5 MB)

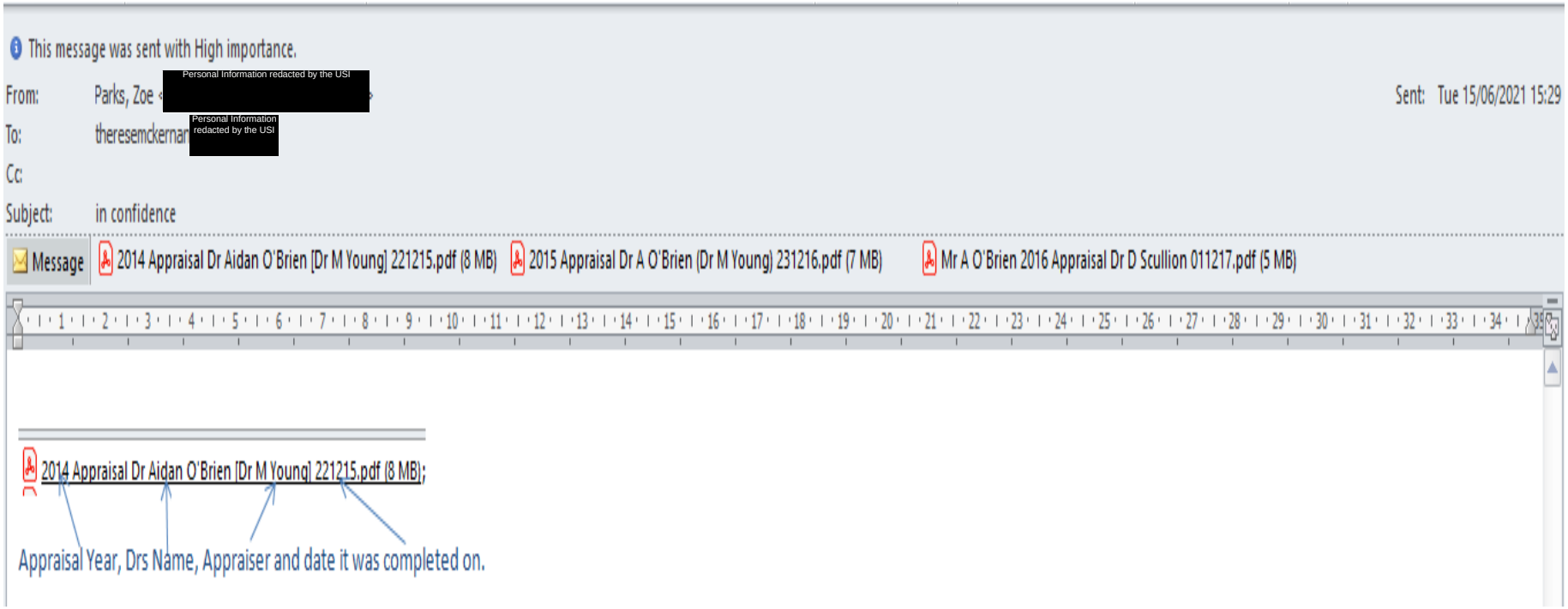
From: Shields, Katie
Sent: 25 June 2021 08:46
To: Parks, Zoe
Subject: RE: Appraisal Details
Importance: High

Zoe attached as requested.

Kind regards
Katie Shields
Revalidation Manager Medical/Nursing (acting)
Medical Director's Office
[redacted]

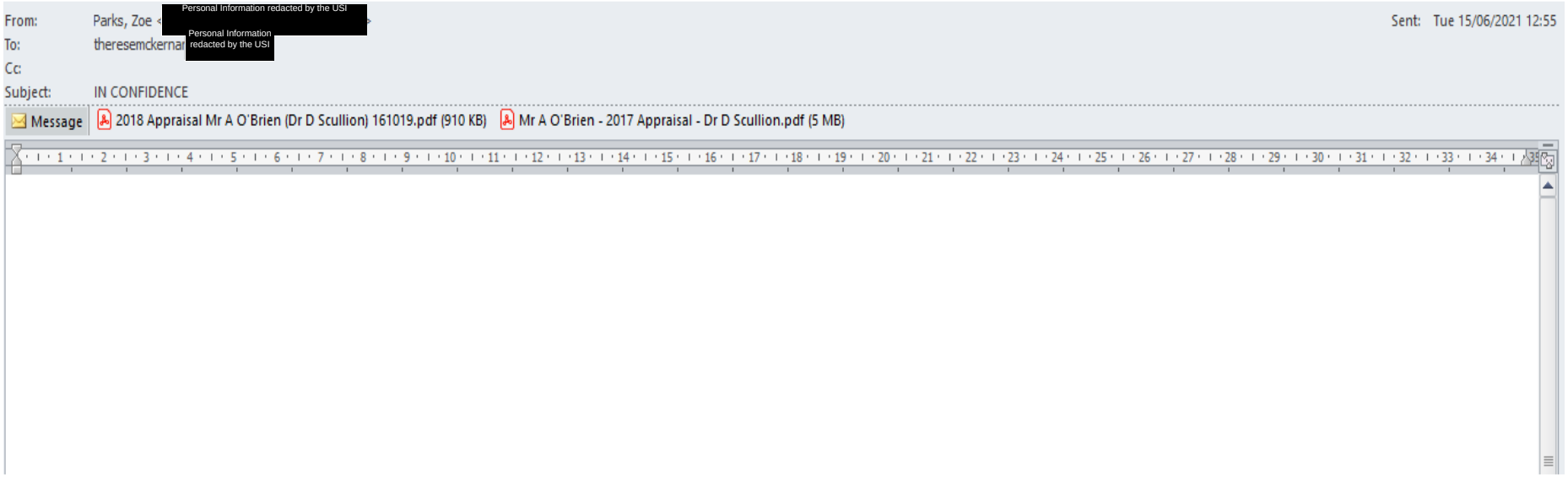
Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

SENT 15 JUNE - 15.29



Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Sent 15.6.21 12.55



From: Parks, Zoe [mailto Personal Information redacted by the USI
Sent: 15 June 2021 12:13
To: theresemckernan Personal Information redacted by the USI
Subject: Would it suit for you to call me now?

Personal Information redacted by the USI

Zoë Parks
Head of Medical HR
Southern Health & Social Care Trust
Tel: Personal Information redacted by the USI

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

From: Therese Mckernan [mailto:[redacted]]
Sent: 10 June 2021 14:00
To: Parks, Zoe
Subject: Re: update
Importance: High

Zoe,
I will phone you as I am travelling out to a meeting now for 230pm.
Therese
Sent from my iPad

From: Parks, Zoe
Sent: 10 June 2021 13.50
To: Therese Mckernan [mailto:[redacted]]
Subject: Re: update
Importance: High

Yes of course. Sorry I didn't pick up any message on my phone. I have a meeting at 2pm but it shouldn't be longer than ½ hour and I'm free all afternoon.

Zoë Parks
Head of Medical HR
Southern Health & Social Care Trust
Tel: [redacted]
Mob: [redacted]

From: Therese Mckernan [mailto[redacted]]
Sent: 10 June 2021 13:48
To: Parks, Zoe
Subject: Re: update
Importance: High

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Zoe,
I don't know if you picked up my call on Tuesday and if this was a response to that?
We hadn't spoken yet about what you were able to access as regards appraisal which Dr O Hare has been most anxious to source. You had said that there was something but not what that might be.
Do you think we could have a call about this please?
Therese

From: Parks, Zoe
Sent: 9 June 2021 12.28
To: Therese Mckernan [mailto[redacted]]
Subject: Re: update
Importance: High

Just checking do you need any further assistance? Please let me know.

From: Parks, Zoe [mailto:[redacted]]
Sent: 02 June 2021 15:30
To: Therese Mckernan
Subject: RE: Review -AOB

Can you give me a ring when you are free. I have obtained some appraisal details but I wanted to check what you needed.

[redacted]

Zoë Parks
Head of Medical HR
Southern Health & Social Care Trust
Tel: [redacted]
Mob: [redacted]

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

From: Therese Mckernan [mailto:[redacted]]
Sent: 27 May 2021 17:35
To: Parks, Zoe
Subject: Re: Review -AOB
Importance: High

Zoe,
Thank you for reply which you sent to in relation to my queries of 14th May. I appreciate the attention you are giving to support this review.
While we asked about the appraisals which were undertaken and you confirmed the dates, in each case we would like to see the details of the appraisals. We have noted that the actual completion date was very well after the year in which they relate to- and we would like to see what was there by way of the discussion with his line manager.
If you could go back to your lead and request this information it would be appreciated and helpful.

In your response you have provided the document titled Trust Guidelines for Handling Concerns about Doctor's and Dentist's Performance from September 2010. This was made available in our pack.
I appreciate also that it refers to an Oversight Committee and indicates:
The CEO will be responsible for appointing an Oversight Group (OG) for the case. It goes on to speak of the membership of this group and what its role is. In the Trust it would seem that there was one oversight group which seems to have been addressing concerns of more than one Consultant?
If there is no established TOR different from what is expressed in the document can you please confirm.

Also was the oversight group Dr Wright, Vivienne Toal, and normally Esther Gishkori?

I had also asked for details of the action plan that is referred to several times in the documents- in both the note of the oversight committee and in emails which are contained in the bundle:

13th September 2016 Oversight Committee- was identifying a problem with AOB.

There followed some emails from Drs Mc Callister and Weir and Esther Gishkori.
Dr Wright's emails quickly thereafter also would suggest that they reached agreement around a 3 month period during which the issues were to be addressed. This was on the back of Dr EG confirming that a plan was in place to "deal with Urology backlog in

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

general and Mr O B's Performance was of course , part of that. Dr EG indicates that they (CMcA and CW) have "plenty of ideas" and that she would like to try their strategy first.

16th September 2021.
There is an email from Colin Weir to Charlie Mc Callister, of 16th September proposing that he as CD and Colin Weir as AMD would implement an action plan and list 8 points- can it be confirmed what happened as regards this?

Dr Wright to HR Director 16th September confirming that the position is to be permitted to run for 3 months to get sorted.

12th October 2016 Oversight Committee
It was noted that Mr O' Brien had not been told of the concerns following the previous oversight Committee, It was also noted that a plan was in place to deal with the range of backlogs within Mr O Brien's practice during his absence.(he was going off for surgery).

22nd December. 2016 Oversight Committee reported as follows:
On 13th September 2016, a range of concerns had been identified, and considered by the oversight committee in relation to Dr O Brien. A formal investigation was recommended and advice sought and received from NCAS. It was subsequently identified that a different approach was to be taken, as reported to the Oversight Committee on 12th October with a clear timeline to address this issue (letters not triaged) will be submitted to the oversight committee on 10th January 2017.

The matter was accelerated in December and AOB excluded before an oversight meeting in January.
It is unclear however whether there was an action plan that was ever discussed with AOB.

Even if there was no discussion around the action plan can we have sight of the action plan - or a confirmation the the detail in the email of from Colin Weir of 16th September was the total of the action plan?

In the timeline document which is included, there is reference April- October 2016, considerations were ongoing about how best to manage the concerns raised with Mr O Brien in the letter of 23rd March. Formal action not to be considered as it was anticipated that the concerns could be resolved informally. There is no evidence in the bundle as to these considerations - who was involved during this period and we would appreciate having an indication as to this 6 month period and specifically who was giving consideration to this.

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Dr O Hare and I would be very appreciative of your guidance on this and any information that you can provide.

Thank you Zoe.

Therese

From: Parks, Zoe [mailto:[redacted]]
Sent: 28 May 2021 20:00
To: Therese Mckernan
Subject: RE: Review -AOB

Therese,

Thanks for your email. I have tried to address what I can below;

Re Appraisal Details
I will speak to Katie Shields who is head of Medical Appraisal/Revalidation to see if she has the details of the actual appraisals. I suspect she will just have copies of the completed appraisal documentation but this may not indicate the involvement of the line manager. In any event, are you seeking copies of the actual completed appraisal paperwork?

Re: Oversight group
Yes I can confirm this is the case- The Oversight Group does have the role to consider concerns of more than one consultant. There were no separate TOR at that time.

Re: Oversight membership
Yes the Oversight group would be at that time Medical Director (Dr Wright), Vivienne (Director of HR) and at that time, Director of Service (so Esther Gishkori for Acute cases)

Re: All queries re Action plan
I don't have a copy of this action plan in the paperwork. Can I suggest that this is something that you may need to ask for from Mr Weir. (Dr C McAllister has since retired from the Trust). His email is [redacted]. Let me know if you would like me to do anything in this regard.

Re: Resolving concerns informally

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Unfortunately I don't have a copy of this detail in the paperwork. If you feel it is appropriate, you may need to speak with the operational managers to seek this information? Dr Wright and Esther Giskori are no longer in post, but I other operational managers. I can also speak to Vivienne to see if she is aware of anything in this regard.

I'm sorry I can't be more helpful with these specific queries, but please do come back to me if I can help or assist in any way.

Personal Information redacted by the USI

Zoë Parks
Head of Medical HR
Southern Health & Social Care Trust
Tel: Personal Information redacted by the USI
Mob: Personal Information redacted by the USI

From: Therese Mckernan [mailto: Personal Information redacted by the USI]
Sent: 27 May 2021 17:35
To: Parks, Zoe
Subject: Re: Review -AOB
Importance: High

Zoe,
Thank you for reply which you sent to in relation to my queries of 14th May. I appreciate the attention you are giving to support this review.
While we asked about the appraisals which were undertaken and you confirmed the dates, in each case we would like to see the details of the appraisals. We have noted that the actual completion date was very well after the year in which they relate to- and we would like to see what was there by way of the discussion with his line manager.
If you could go back to your lead and request this information it would be appreciated and helpful.

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The CEO will be responsible for appointing an Oversight Group (OG) for the case. It goes on to speak of the membership of this group and what its role is. In the Trust it would seem that there was one oversight group which seems to have been addressing concerns of more than one Consultant?
If there is no established TOR different from what is expressed in the document can you please confirm.

Also was the oversight group Dr Wright, Vivienne Toal, and normally Esther Gishkori?

I had also asked for details of the action plan that is referred to several times in the documents- in both the note of the oversight committee and in emails which are contained in the bundle:

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There followed some emails from Drs Mc Callister and Weir and Esther Gishkori.
Dr Wright's emails quickly thereafter also would suggest that they reached agreement around a 3 month period during which the issues were to be addressed. This was on the back of Dr EG confirming that a plan was in place to "deal with Urology backlog in general and Mr O B's Performance was of course , part of that. Dr EG indicates that they (CMcA and CW) have "plenty of ideas" and that she would like to try their strategy first.

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In the timeline document which is included, there is reference April- October 2016, considerations were ongoing about how best to manage the concerns raised with Mr O Brien in the letter of 23rd March. Formal action not to be considered as it was anticipated that the concerns could be resolved informally. There is no evidence in the bundle as to these considerations - who was involved during this period and we would appreciate having an indication as to this 6 month period and specifically who was giving consideration to this.

Dr O Hare and I would be very appreciative of your guidance on this and any information that you can provide.

Thank you Zoe.

Therese

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

From: Parks, Zoe [mailto:[redacted]]
Sent: 18 May 2021 15:08
To: theresemckernan[redacted]
Subject: RE: Review -AOB
Importance: High

Therese,

Apologies for the delay in coming back to you. I have attached our guidance document that would have been in place at the time. It has since been updated – however I suspect this is the version you will need given this was what would have been used at the time for AOB. This is the process that would have been followed. I can send you a more up to date version and/or our current TOR for Oversight if this is required – however these are more recent documents.

In relation to the Oversight Committee, the core membership are the Medical Director, HR Director and relevant service Director for the doctors being discussed. There may be others attending as support or as appropriate, such as Senior Manager within the Medical Directors office, additional HR support.

I have spoken to our Appraisal/Revalidation lead who has confirmed for me that Dr AOB completed the following appraisals
2014 – completed on 16/12/15
2015 – completed 23/12/16
2016 – completed 1/12/17
2017 – completed 31/10/18
2018 – completed 17/10/19

In relation to the grounds of appeal letter – yes the role of the review panel will be to work I accordance with the agreed Terms of Reference.
If you require anything else, please do not hesitate to contact me.

Zoë

Zoë Parks
Head of Medical HR
Southern Health & Social Care Trust
Tel: [redacted]
Mob: [redacted]

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

From: Parks, Zoe [mailto:[redacted]]
Sent: 14 May 2021 15:10
To: theresemckernan[redacted]
Subject: RE: Review -AOB

Thank you for this. I will gather what information we have in relation to this and come back to you
Zoe

From: theresemckernan[redacted] [mailto:[redacted]]
Sent: 14 May 2021 14:43
To: Parks, Zoe
Subject: Review -AOB
Importance: High

Dear Zoe,

Dr O Hare and I talked yesterday about the review.
Initially there is some information that we would like to request which isn't evident form the file.
May we have details of the membership of the Oversight Committee and the terms of reference for this group.
Can we have confirmation around the appraisals in which AOB participated.
There is reference to a plan that had been developed by (Mc Allister and Weir) is it possible to see this plan of to have details of it?

The letter of appeal which was submitted by MO'Brien on behalf of AOB is included in the file- which one would normally focus on if there was an appeal. In this case we have been asked to undertake a review with is not an appeal. While then noting the appeal correspondence we will not be addressing the appeal grounds. If you feel that this approach is not correct can you please advise.

Thank you,
Therese

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

From: Parks, Zoe [mailto:[redacted]]
Sent: 05 May 2021 11:26
To: theresemckernan[redacted]
Subject: RE: Papers for Grievance

Thank you for confirming this. Please come back to me if I can be of any assistance at all.

Zoë Parks
Head of Medical HR
Southern Health & Social Care Trust
Tel: [redacted]
Mob: [redacted]

From: theresemckernan[redacted] [mailto:[redacted]]
Sent: 05 May 2021 11:20
To: Parks, Zoe
Subject: Papers for Grievance
Importance: High

Hello Zoe,

I am just letting you know that at the end of the week I did get the papers which you had kindly sent.
I intend to send off an email to Dr O Hare to see how he would like to progress this and as he suggested to set aside some dates for meetings. As I said to you I don't imagine that this should be your work to do unless we get stuck on something and certainly if more information is needed.

Best wishes,
Therese

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

YEAR	Funded Posts	Consultant Numbers	Temporary Consultant Post	Locums	Recruitment
2008/2009	3	3 Consultants AOB, MY, MA		0	
2009/2010	3	3 Consultants AOB, MY, MA		0	
2010/2011	5	3 Consultants AOB, MY, MA	**October 2011** 1 Consultant KH	0	
2012/2013	5	**Jan – March 2012** 3 Consultants AOB, MY AK **March to July 2012** 2 Consultants AOB, MY **August – Sept 2012** 3 Consultants AOB, MY, AG **Sep – October 2012** 4 Consultants AOB, MY, AG, DC **November 2012** 5 Consultants AOB, MY, AG, DC, AP	1 Consultant KH **August 2012** KH left post	0	**March 2012** Recruitment took place for • 1 Replacement Post (MA) & • 2 New Posts 3 Consultants Appointed AG, DC & AP)
2013/2014	5	**Jan – March 2013** 5 Consultants AOB, MY, AG, DC, AP **April – November 2013** 4 Consultants		**May 2013**	**May 2013** Recruitment took place for

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		AOB, MY, AG, AP **December 2013** 5 AOB, MY, AG, AP, KS		**1 Locum HJ Commenced** **Sept 2013** Locum HJ Left	• 1 Consultant Urologist Replacement Post (DC) (KS Appointed) **November 2013** Recruitment took place for • 1 Consultant Urologist Replacement Post (AP) (Appointed 2 Consultants, 1 at risk MH & JOD but they couldn't start immediately)
2014/2015	6	**Jan – March 2014** 4 Consultants AOB, MY, AG, KS **May – July 2014** 5 Consultants AOB, MY, AG, KS, MH **August – Dec 2014** 6 Consultants AOB, MY, AG, KS, MH, JOD			
2015/2016	6	**Jan – December 2015** 6 Consultants AOB, MY, AG, KS, MH, JOD			No Recruitment took place
2016/2017	6	**Jan – October 2016** 6 Consultants AOB, MY, AG, KS, MH, JOD **October – Dec 2016** 5Consultants AOB, MY, AG, MH, JOD			**November 2016** Recruitment took place for • 1 Temporary Consultant Urologist Replacement Post (KS) Pending Permanent Approval **December 2016** Recruitment took place for • 1 Consultant Urologist Replacement Post (KS) No appointment

2017/2018	6	**Jan – December 2017** 5 Consultants AOB, MY, AG, MH, JOD		**January 2017** Locum Consultant Person Commenced	No Recruitment took place
2018/2019	6	**Jan – December 2018** 5 Consultants AOB, MY, AG, MH, JOD *MH Works 3 Days ST 2 Days BT*	**April 2018** 1 Consultant DH		**Sept 2018** Recruitment took place for • 1 Consultant Urologist Replacement Post (KS) 1 Dr Appointed (MT) Wasn't able to start until Feb 19 due to completion of training.
2019/2020	6	**January 2019** 5 Consultants AOB, MY, AG, MH, JOD **February – July 2019** 6 Consultants AOB, MY, AG, MH, JOD, MT **July – December 2019** 5 Consultants AOB, MY, AG, MH, JOD *MH Works 3 Days ST 2 Days BT*	**May 2019** 1 Consultant DH Left	**January 2019** Locum Consultant Personal Finished **July 2019** Locum Consultant Personal Commenced	**May 2019** Recruitment took place for • 1 Temporary Consultant Urologist Replacement Post (MT, Career Break)
2020/2021	6	**Jan – June 2020** 5 Consultants AOB, MY, AG, MH, JOD **July – December 2020** 4 Consultants MY, AG, MH, JOD		**July 2020** Locum Consultant Person Commenced **Sept 2020**	

		MH Works 3 Days ST 2 Days BT		Locum Consultant Person Finished Locum Consultant SO Commenced **Nov 2020** Locum Consultant NK Commenced	
2021/2022	7	**January – Sept 2021** 4 Consultants MY, AG, MH, JOD **Oct – December 2021** 5 Consultants MY, AG, MH, JOD, MT *MH Works 3 Days ST 2 Days BT*		**June 2021** Locum Consultant SO Finished **July-August 2021** Locum SE Worked **August –Oct 2021** Locum Consultant SO worked	**March 2021** Recruitment took place for • 1 New Consultant Post **May 2021** Recruitment took place for • 2 New Consultant Post (2 Applicants Unsuccessful at Interview) **October 2021** Recruitment took place for • 1 New Consultant Post • 1 Consultant Urologist Replacement Post (AOB) (2 Applicants Unsuccessful at Interview)
2022/202	*7*	**Present** 5 Consultants MY, AG, MH, JOD, MT MH Currently Seconded out and MY LTFT		1 NK still in post	**February 2022** Recruitment took place for • 1 New Consultant Post • 1 Consultant Urologist Replacement Post (AOB)

		MH Works 3 Days ST 2 Days BT			**April 2022** Recruitment took place for • 1 New Consultant Post • 1 Consultant Urologist Replacement Post (AOB) • 1 Consultant Urologist Replacement Post (MY) (2 Applicants Appointed, both accepted and then withdrew) Currently post is with our international agencies for targeted recruitment.

SOUTHERN HEALTH & SOCIAL CARE TRUST

JOB DESCRIPTION

JOB TITLE: Medical Staffing Manager

BAND: 8a

REPORTS TO: Director of Human Resources & Organisational Development

ROLE PURPOSE: To assist the Director and Assistant Director of Human Resources for Acute Services in dealing with medical HR issues across the Trust.

JOB ROLE PURPOSE

To take a lead role in developing and providing a framework where the medical workforce can be managed effectively and that the contribution from the medical body is fully realised within the Trust.

JOB SUMMARY

To provide leadership on all medical workforce issues within the Trust ensuring the provision of a high quality, outcome focused medical HR service to Directorates. To enable Associate Medical Directors, Clinical Directors and Service Managers to develop directorate medical HR strategies for their medical staff which provide business solutions reflecting corporate business plans and objectives.

Key Relationships

- Service Directors
- Medical Director
- Associate Medical Directors/Clinical Directors
- Medical Education Centre
- Consultant staff
- Local Negotiating Committee & BMA
- Northern Ireland Medical & Dental Training Agency (NIMDTA)
- Royal Colleges
- Medical Locum Agencies
- Department of Health
- National Clinical Assessment Service (NCAS)
- General Medical Council (GMC)

Role Responsibility

To provide leadership on all medical workforce issues within the Trust ensuring the provision of a high quality, outcome focused medical HR service to Directorates. To enable Associate Medical Directors, Clinical Directors and Service Managers to develop directorate medical HR strategies for their medical staff which provide business solutions reflecting corporate business plans and objectives.

1. To develop policies and procedures that ensure robust accountability arrangements in the management of the Trust Medical Workforce i.e. Waiting List Initiatives, Job Planning, etc.

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

2. To lead on the development of policies and procedures for medical staff and the consultation or negotiation of such policies with the Local Negotiating Committee representatives.

3. To ensure that the LNC is run effectively and that communication with representatives is maintained.

4. To lead the Medical HR service to ensure that appropriate advice on medical staffing issues is available to all medical staff and managers ensuring consistency of approach and correct application of employment legislation, policies and procedures and terms and conditions of service.

5. To manage the effective operation of the Medical Staffing Team ensuring medical personnel files are maintained. To effectively line manage and develop the medical staffing team members.

6. To lead on disciplinary, capability and sickness matters concerning all medical staff in line with Maintaining High Professional Standards.

7. To develop the ability of Medical Staff and Service Managers to manage performance of their doctors in line with Trust policies and procedures and College requirements.

8. To lead on the achievement of the European Working Time/New Deal regulations supporting Directorates in ensuring compliance. To lead the HR support and contribute creatively to the work of the Hospital at Night and other modernisation projects.

9. To analyse problems and develop creative solutions to rota and leave management. To work alongside the Medical Directors office on the management of medical locums to support the Trusts temporary medical workforce requirements.

10.To work closely with the Medical Education Centre and the Medical Directors office to ensure the Southern Trust is promoted as a place of excellence for training. To work with the MEC team to ensure that there is close working between both departments to meet policy requirements and national drivers.

11. To lead on ensuring all Rotational junior doctor placements 3/4/6/12 month rotations are managed in a smooth and professional manner. To ensure the Medical HR team provide an efficient administrative service including the timely and accurate production of contracts of employments and letters for all rotational doctors in training.

12. Oversee the management of the monitoring and re-banding process which will involve:

- At least twice yearly, monitoring of all Junior Doctors rotas in the Trust and analysing of same utilising the electronic Zircadian system.

- Re-assessing pay bands.
- Liaising with the Finance Department regarding budget adjustments.
- Liaising with Salaries and Wages on payment of appropriate pay bands.
- Communicate to the Clinical Directors and all Junior Doctors the outcome of the monitoring process.
- Co-ordinate responses on New Deal/EWTD requirement to BLG.
- Compile appropriate reports to support funding bids.Work with Medical Director and Clinical Directors to determine the scope for changing working practices.

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

13. To identify Medical Staffing resourcing and retention issues within the Trust, working with the Head of Recruitment Services to identify and implement appropriate solutions.

14.To ensure the Medical HR Team provide an efficient and effective service to Consultants and Service Managers when developing job descriptions/job plans and obtaining the necessary approvals for passing to Recruitment Services for processing.

15.To oversee the Job Planning process for all medical staff and ensure that the documentation is kept up to date and fit for purpose. To provide support, guidance and training on job planning process where appropriate and ensuring facilitation and appeals organised as required by the Consultant and SAS contracts.

16.To lead on the Clinical Excellence, Discretionary Points and Optional Points schemes for medical staff as necessary and to ensure that a smooth, transparent and credible process is followed at all times.

17.To work closely with the Medical Directors office to ensure appropriate induction for medical staff, including locums takes place across the Trust ensuring sufficient robustness to meet audit requirements.

18.To lead on the development of policies and procedures for medical staff and the consultation or negotiation of such policies with the Local Negotiating Committee representatives.

19. To ensure that the LNC is run effectively and that communication with representatives is maintained.

20. To be an authorised signatory for the medical staffing department and to ensure that % invoices are checked and signed off for processing.

21.To lead on the workforce planning agenda for medical staff working with the Medical Director, Director of HR to ensure that the Trust plans are effective in meeting the medical staff agenda. Develop recruitment plans and strategies which ensure that the medical workforce is fit for purpose.

22. Develop knowledge and expertise on procedural and legal requirements relating to the Terms and Conditions of Service for all grades of medical staff, ensuring that the Trust is in compliance with all relevant employment legislation and terms and conditions e.g. new consultant contract, pay protection for doctors in training, optional points - staff grades, handling concerns about doctors' performance, handling re-grading requests, etc.

23. Lead on reviewing all payments and allowances paid to medical staff to ensure the most efficient use of medical resources within The Trust. To identify areas of high staff costs, working with consultants to understand implications of job planning and to help identify and implement approaches to ensure better use of resources.

24. Lead on developing and reviewing guidance for managers on a framework for additional payments and allowances paid to Medical Staff, such as Waiting List Initiatives.

25. Provide expert advice to managers and medical staff in relation to the HR agenda and issues, so that a proactive approach is implemented within the team. Consider implications of regional reviews associated with "Transforming Your Care" and ensure appropriate work is undertaken on managing associated changes with medical staff.

26. Be able to articulate and advise on highly sensitive issues and information promoting the effective management of ER matters in a timely manner.

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

27.Work to a high level of individual integrity and make decisions in the light of HR best practice. Use expert judgement to resolve complex HR matters in consultation with the Director as appropriate.

28. To adopt a HR business partnership approach with medical staff and Service Directors within the Trust.

29. Undertake ad hoc projects, as and when required including to design and present training events, presentation and training events for medical staff.

Banding of Post & Job Family	Essential Criteria	Desirable Criteria
Band 8A Head of Posts[1]	***QUALIFICATIONS & EXPERIENCE*** 1. Hold a HR/Business Management[2], University Degree or recognised Professional Qualification or equivalent qualification **AND** 2 years experience[3] in a Senior HR Role at band 7[4] **OR** have at least 5 years experience in a Senior Role. 2. Have a minimum of 1 years experience in a lead role delivering objectives which have led to a significant[5] Improvement in Service. 3. Have a minimum of 1 years' experience working with a diverse range of internal and external stakeholders in a role which has contributed to the successful implementation of a significant change in initiative. 4. Have a minimum of 2 years' experience in staff management	You are free to insert desirable criteria which will only be used in the event of requiring additional job related criteria to support the management of large files. This should not be any more than 3 or 4 points maximum Please see guidance on intranet on developing a Personnel Specification
Band 8A Head of Posts	***KNOWLEDGE & SKILLS*** 5. Hold a full current license valid for use in the UK and have access to a car on appointment[6]. 6. Have an ability to effectively manage a delegated budget to maximise utilisation of available resources.	

[1] Points 1- 5 will be assessed during Shortlisting; Points 6 - 9 will be assessed at the interview
[2] 'relevant' will be defined <manager should determine what relevant means>
[3] Where necessary managers should define the nature of the experience eg Finance, HR etc.
[4] 'Senior Role' is defined as Band 6/7 or equivalent or above to be determined by the manager
[5] 'Significant' is defined as contributing directly to key Directorate objectives
[6] This criterion will be waived in the case of a suitable applicant who has a disability which prohibits from driving but who is able to organize suitable alternative arrangements in order to meet the requirements of the post in full.

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Banding of Post & Job Family	Essential Criteria	Desirable Criteria
	7. Have an ability to provide effective leadership. 8. Demonstrate evidence of highly effective planning and organisational skills 9. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.	

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

Medical Workforce Plan

2017 – 2018 & beyond

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

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

1. Overview

The Health Service is constantly changing. In order to meet the challenges and pressures we face, it is important that we anticipate and plan for the changes. Fundamental to the achievement of our Trust corporate objectives will be a full permanent medical workforce which has the clinical, managerial and leadership capability to transform the care delivered to our patients.

This plan will explain the key strategies, objectives and priority actions we have set ourselves for the next **three years**. The scope of this plan relates to the HR issues relating to the medical workforce employed by the Southern Health and Social Care Trust.

2. Medical HR Department Priorities Timescales may change

The Medical Staffing Department is currently staffed by 4 staff

- Head of Medical Staffing: 30 hours for the next year
- Medical Staffing Manager: Full time 37.5 hours
- Two Medical Staffing Officers: One full time; one currently part time (approx. 25 hours), phasing back from maternity leave using annual leave over next 6 months

Priority One Issues: Immediate 0-6 months

**** Delivery of recommendations within Internal Audit on Management of Medical Staff 16/17**

To do & Outcome Measures

- SHSCT Job planning Guidance updated and agreed
- Papers for each specialty/division with job planning analysis
- SMT Report actively reporting job planning progress
- Project completed providing 100% compliance re accuracy of payments made to medical staff

**** Strategy to deal with problem junior doctor rotas to mitigate risk of non-compliance/band 3**

To do & Outcome Measures

- Issue new guidance to all doctors re their responsibilities for ensuring compliance
- Develop Zircadian system to allow HOS view access for better operational management
- Training by Medical Staffing to HOS on rota requirements
- Proactively target problem areas in advance of monitoring to mitigate risk where possible
- Devise new rota solution for Surgery/urology/EBT/T&O and develop Business Case

**** Improve Communicate and Engagement with local LNC and junior doctor representatives**

To do & Outcome Measures

- Develop new local agreement on Consultant rate for covering colleagues
- Update and issue new Medical E brief / “Doctors Eye” in collaboration with LNC
- Action plan with new FY1 LNC representative: engage to ensure issues addressed early.

**** Internal management with Medical HR**

To do & Outcome Measures

- Clear work plan for year ahead agreed with ADHR
- PDP Completed for all staff
- E Learning updated by all staff

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Priority TWO Issues: 6 – 9 months

**** Improve integration of Medical HR Team with core HR functions**

To do & Outcome Measures

- Regular review meetings with HR staff in HSC E Locums; Medical Resourcing and Absence Management team to drive forward medical staffing issues.
- Continued strive with HSC E Locums Team on improving conversion from Agency to SHSCT Medical Locum Bank/HSC E Locums
- Work to progress move towards consultants being placed on SHSCT Medical Locum Bank

**** Develop and issue for agreement new Guidance on: Application of Consultant Annual leave and also Responsibilities around management of medical staff sickness**

To do & Outcome Measures

- Guidance agreed and issued on application of consultant/SAS annual leave. System available for each specialty to record this consistently
- More robust system in place for reporting and recording medical staff sickness with less over/under payments reported by Payroll.

Priority THREE Issues: 9 – 12 months

**** Complete a thorough analysis of how our junior medical workforce are working to ensure all efficiencies are being realised. For example; what pay banding is funded; against what we are paying; what inbuilt reliance we have on locums etc.**

Outcome Measures

- Rota solutions set out by specialty/division, paper to highlight the risk and issue communications to NIMDTA/DHSSPS regarding variances in training numbers where necessary.
- Paper to HOS/CD to ensure opportunities are set out.

**** Update and issue the workforce planning paper for SHSCT setting out the key challenges affecting our Medical Workforce in next 0-5 years**

- Updated succinct paper completed and circulated with reference also to the work from Dr Rankin.

**** Develop a robust and appropriate "Medical Managers Toolkit" which would be available to all new medical managers appointed within the Trust; CD's/AMD's**

- Pack would include all the relevant Medical HR guidance on the key issues they face such as application of consultant annual leave; payment rates for internal cover, rules on waiting list initiatives, process for securing a locum doctor, recording of medical staff sickness, maintaining high professional standards.

**** Develop a strategy, working alongside our medical managers (AMDs/CD's) to set out Southern Trust approaches for attracting, retaining, developing and celebrating our medical workforce.**

- Written strategy that has real impact operationally with working examples of ways to improve engagement with the medical workforce; undertaking a medical workforce survey; evidence of "acting" on recommendations, listening to exit interviews, focus groups, quality improvement projects, look at possibility to ring fence PA's for research/development projects, promoting clinical leadership, celebrating successes in new "doctors eye" newsletter/blog to update on developments.

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3. Summary of other Medical Staffing Dept. responsibilities/priorities

Additional Day to Day work: SHSCT currently employs approximately 650 medical staff

Routine work:

- All HRPTS work for medical staff
- All contracts of employment for medical staff
- Management of all junior doctor rotations throughout the year, monitoring of hours and reviewing pay bandings
- All job planning updates; checking/processing of changes and additional PA contracts for all consultants and SAS doctors
- T&C's, payroll and general queries and requests for information for medical staff
- Liaison with service managers for managing workforce, gaps, reviewing job descriptions, reviewing rotas and long term sickness.

Rotational Junior Doctors in Training

- **Ensuring Gaps are filled in timely basis**
- **Reviewing working patterns where gaps are evident**
- **Exploring non-medical solutions; physician associates, MTI's, creating our own rotation to make trust appointments attractive.**
- **Exploring better ways to use locum expenditure to stabilise service.**
- **IT Claims and mitigating future risk; providing guidance/training, need more management on the ground.**
- **FY1 issues from August 17. Ongoing Action Plan**
- **Need to meet with Fy1 DHH.**
- **Non EWTD Compliance: Urology, surgery, T&O, FY1's. & need for Champion in this regard**
- **Lead Employer Model & work with NIMDTA to progress**
- **Expenses and relocation costs**

Consultant Workforce

- **Detailed date by Directorate/division of job plan completion percentages**
- **Meetings to be set up by Directorate/Division to examine Job Planning completion and PA levels.**
- **Need to update job planning guidance**
- **Need to establish Job Planning group – there is a need for clarification on back pay of job plans, annual leave and professional leave electronic system for recording**
- **Job planning Audit Findings: Task and Finish Group for Job Planning**
- **Review of APA's, External Duties, Additional HPSS Responsibilities**
- **Review of on-call supplements**
- **Working with service and clinical managers to ensure job plans meet the needs of the service**
- **Proactive reporting from Zircadian system to service managers on progress and content**
- **Training on Zircadian**

SAS Workforce

- **Trust AS posts application and process for award annually**
- **Discretionary/optional points & Award schemes annually**

Workforce planning/Development

- **Age Profile**
- **CCT anticipated for succession planning**
- **Identify Hard to fill specialties**
- **Exit interviews and turnover of permanent staff**
- **Recording of medical staff sickness & Review payroll process**
- **Aim to develop a workforce report for Directors/HOS re medical workforce**

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Employee Relations

- **Need to establish acceptable rate for consultant internal locums**
- **Review of ongoing local agreements: resident cover etc.**
- **Need to update and issue the Medical Staffing E Brief – and link with LNC**
- **SMT Report template for medical workforce**
- **Casework - Medical ER/MHPS Cases – ongoing**
- **Casework – Consultant Contract Appeal Panels**
- **Medical Management Structure & allowances paid to be reviewed / performance measures**
- **Suite of policies/guidance for our medical managers**
- **Review guidance for Probationary period for medical staff**
- **Review medical contracts of employment & honorary contract**
- **New community Dental contract pending.**

Temporary Staffing

- **Need to develop better understanding and links with HSC E Locums**
- **Need to explore potential for consultants to be added to HSC E Locums locally and regionally**

Recruitment

- **Pending posts up to date and proactive management**
- **Review of linkages with medical resourcing to identify streamlining**
- **International Medical Doctors and package of support / induction**

Other work – for possible cover by Medical Staffing

- **GMC Referral & communications with GMC re cases (currently with head of revalidation)**

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HROD ACTION PLAN FOR 2019/2020

PRIORITY 1 ATTRACTING AND RECRUITING TALENT	PRIORITY 2 SUPPORTING & RETAINING OUR PEOPLE	PRIORITY 3 EMBEDDING A CULTURE OF COLLECTIVE LEADERSHIP	PRIORITY 4 SUPPORTING ORGANISATIONAL TRANSFORMATION	PRIORITY 5 INTERNAL HROD TRANSFORMATION PROGRAMME
2019/20 ACTIVITIES Review existing and develop new recruitment models / apprenticeships Review recruitment documentation e.g. JD, Specs and create libraries Develop skills programme for managers re recruitment and selection Develop new and innovative approaches to attracting and engaging future talent Review and further development of Student Placements e.g. Enthuse Partnership, SRC partnership Develop and enhance our approach to international recruitment	**2019/20 ACTIVITIES** Review and identify actions resulting from staff survey through engagement with staff Review of managers development programmes and training pathways Support implementation of nursing and midwifery workforce action plan Develop medical staffing action plan based on N&M action plan 3 H&WB work streams established (physical, psychological & employee experience) Implementation of OH review	**2019/20 ACTIVITIES** Communicate new HSC Core Values and develop action plan to start to embed values and behaviours. Implementation of Cultural Assessment Tool (baseline measurement) Leadership Conference (for leaders at all levels)	**2019/20 ACTIVITIES** Draft HROD Strategy Develop a model for team based working Support and implement actions to support single employer for junior docs Support transformational agenda in directorates Implement nurse agency reduction and bank incentivisation programme Review 'raising concerns' work 1 year on and determine next steps	**2019/20 ACTIVITIES** Implement new structure HR Development – *individual and teams* - regional programmes, team specific and HPMA Start to embed a culture of shared leadership within and across teams including introduction of HROD Engagement events Develop and embed new HROD governance arrangements and processes Digitalisation/ HR Technology – e.g. e-filing and HROD SharePoint developed for all teams

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MEDICAL HR ACTION PLAN FOR 2019/2020

PRIORITY 1 ATTRACTING AND RECRUITING TALENT	PRIORITY 2 SUPPORTING & RETAINING OUR PEOPLE	PRIORITY 3 EMBEDDING A CULTURE OF COLLECTIVE LEADERSHIP	PRIORITY 4 SUPPORTING ORGANISATIONAL TRANSFORMATION	PRIORITY 5 INTERNAL HROD TRANSFORMATION PROGRAMME
2019/20 ACTIVITIES Develop our approach to International Recruitment – implement a pastoral support role. Devise booklet to welcome to SHSCT. Proactive drive to attract and retain international doctors. Implement formal KPIs around time of recruitment to allow us to measure our ability to respond quickly and effectively. Measure time from resignation to appointment Comprehensive review of all our long term locums and ensure we have active recruitment plans in place to replace long term agency. Aim to convert 10% Review of all letters/paperwork issued to new medical appointments – offer letters to be reviewed. Page Tiger web portal to be launched. On-boarding process for medical recruits reviewed. Review of Job Descriptions (JD Library) to modernise and ensure attractive. 2 SPA's; linked to induction/mentoring.	**2019/20 ACTIVITIES** Set up focus groups/task & finish groups with Service Directors and doctors to improve working lives and establish key themes to encourage retention within the Trust. Establish if a link with appraisal/PDP is possible to pull out any concerns/issues raised that HR can help address Develop a protocol for SAS / Consultants to facilitate rotational opportunities, secondments, CESR support etc. Reviewing locum rates paid to our medical staff to ensure fairness, equity and consistency across specialties. Continue to pursue regional position around consistency of rates. Develop medical staffing action plan based on N&M action plan	**2019/20 ACTIVITIES** Set up and take forward Task & Finish groups with doctors to gain involvement in solution based approach to problem rotas. New Roles, clinical fellows; dealing with gaps. Review of sickness trends to set up a support HUB for doctors –Joy @ work; Fatigue Kit and network to support available, better sign postings – sign posting on Page Tiger. Arrange action based learning sets for all consultants on dealing with difficult issues, complicated job plans, doctors in difficulty, MHPS etc.	**2019/20 ACTIVITIES** Obtain approval and agreement from Directors on direction of travel to build our internal locum medical bank. Fair and consistent rates, review escalation practices, regional work to ensure consistency, improve our ability to report, pursue technology improvements. Hold specialty specific workforce planning meeting to review medical MDT solutions, age profile, new roles, ways of working, transformation. Develop business intelligence data around APAs, job planning in line with new guidance. Improve informative reports to assist with service transformation. Support and implement actions to support single employer for junior doctors	**2019/20 ACTIVITIES** Establish Staff Meetings with medical HR staff to develop and mature new medical HR Integrated unit and explore ways for continuous improvement and sharing ideas. Participate in Lead Employer working group to implement new model for rotational doctors in training. Review and implement succession plan for more senior posts in Medical HR Friday Focus Staff Meetings – Time away from emails; PDP's, training, staff development CPD etc.

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Southern Health and Social Care Trust

Knowledge & Skills Framework (KSF)

Guidance Document

SEPTEMBER 2012

KSF Department
Hill Building
St Luke's Site
Loughgall Road
Armagh
BT61 7NQ

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Knowledge & Skills Framework (KSF)
Guidance Document

1. What is the Knowledge and Skills Framework (KSF)?

The Knowledge and Skills Framework (KSF) is a developmental tool which is designed to provide the basis for career and pay progression within Agenda for Change Pay Bands.

The main purpose of the development review is to look at the way in which an individual member of staff is developing in relation to:

- The duties and responsibilities of their post and current agreed objectives
- The application of knowledge and skills within the workplace
- The consequent development needs of the individual member of staff

KSF was developed and is required to be implemented in partnership between management and trade union side. It defines and describes the knowledge and skills which staff (covered by Agenda for Change Terms and Conditions) need to apply in their work in order to deliver a quality service. It is a *knowledge and skills framework* and therefore, it is essentially a development tool, although KSF will also contribute to decisions about pay progression.

2. Personal Development Review (PDR)

The Trust is committed to the PDR process and regards this as an important component of the Trust's governance process. It contributes towards organisation and service development and provides opportunities for each member of staff to develop their potential. The Trust will ensure that each member of staff knows what is expected of them to ensure that they are clear about their role and responsibilities, their Knowledge and Skills Framework (KSF) Outline and the key aims of their ward/department and the Trust.

The development review is based on an analysis of the individual's application of their knowledge and skills and their development to meet the demands of the post as described in their KSF post outline. It brings together all of the discussions which have taken place throughout the year and enables reviewers and reviewees to reflect on these. It is expected that reviewers will have regular informal discussions with individual staff members throughout the year, providing constructive feedback on the individual's work and related development. The development review meeting is an opportunity to think about this in a structured way.

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If any issues have been identified in the individual's work or development during the year, these should have been addressed at the time they arose; they should not be left until the review meeting. Any disciplinary issues must be dealt with via the normal channels. The guiding principle of the development review process is "no surprises".

Participation in an annual Personal Development Review meeting is mandatory under Agenda for Change. This takes the form of a face-to-face meeting between a manager or (person acting as their reviewer) and an employee (reviewer and reviewee). Normally the manager involved in the meeting will be the one who has most frequent managerial contact with the employee. The role of reviewer may be delegated to another member of staff, this staff member must be competent to carry out the review, must be familiar with the employee's work and normally hold a supervisory position. In cases of the role of reviewer being delegated the line manager must also sign off the PDR and PDP forms in their role of budget holder.

Personal Development Review (PDR) is a process by which a member of staff and their manager or designated professional manager can have a two way discussion about:-

- the duties and responsibilities of their post and current agreed objectives
- the application of knowledge and skills within the workplace
- the consequent development needs of the individual member of staff.

PDRs are completed on a 12 month period – the exact timeframe will depend upon the individual's incremental date. During the foundation period (the first year in post) all staff who have newly joined a payband will have at least two discussions with their reviewer to review progress against the KSF outline for their post. This includes newly appointed or promoted staff joining a payband and also those moving posts within the payband, particularly where this cuts across job families eg from Admin to Social Care.

3. PDR Process

The PDR process is based on a cycle of learning and is repeated each year. It consists of:-

- a joint review between the individual and their reviewer of the individual's work against the demands of their post
- the production of a Personal Development Plan (PDP), which identifies the individual's learning and development needs and interests – the plan is jointly agreed between the individual and their reviewer

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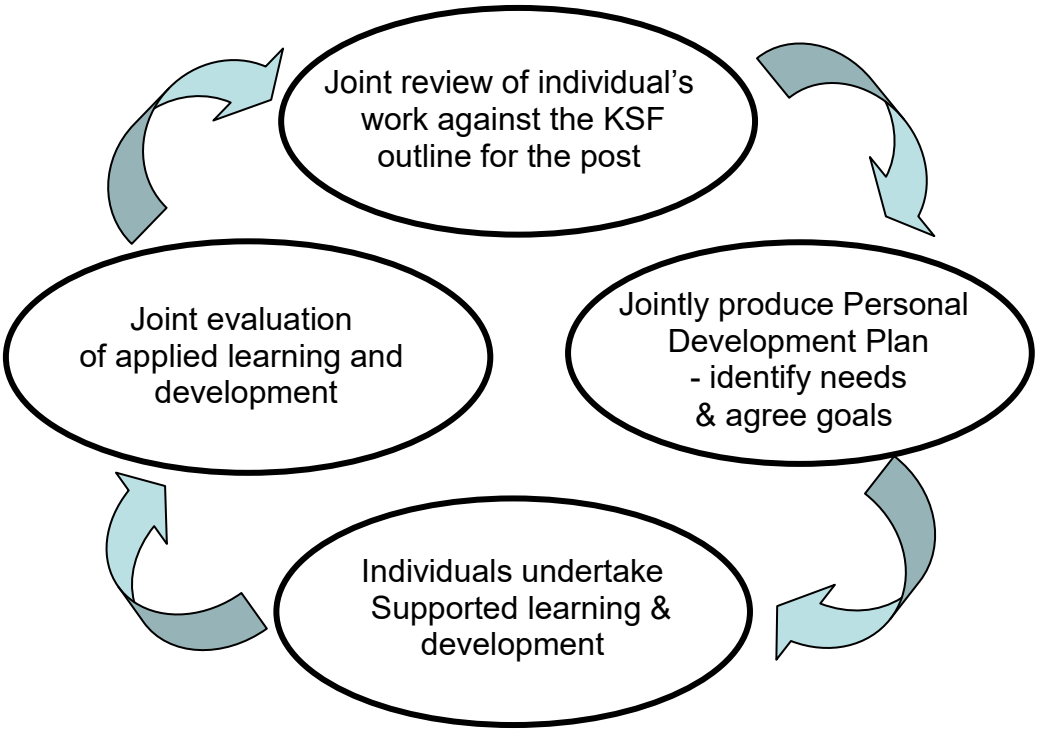
- learning and development undertaken by the individual, supported by their reviewer
- an evaluation of the learning and development that has taken place and how it has been applied by the individual in their work.

Evaluation of the learning and development undertaken is an important aspect of KSF as it will ensure that learning and development undertaken has been effective and applied to the workplace where benefits can be seen and potentially shared with other teams or team members. It will also ensure that learning and development undertaken has been beneficial and cost effective.

Please see the diagram below which illustrates the cycle.



The process of review begins with a focus on the review of an individual's work in relation to individual, service and organisational objectives. This provides an opportunity for individual staff members to receive feedback from the line manager on how they are working towards meeting the KSF post outline and roles and responsibilities of their post. In addition, objectives of a job role for the incoming period can be linked to KSF dimensions. However it should be noted that the KSF Outline looks at the knowledge and skills required to carry out the roles and responsibilities of the post, but the objectives are the key goals to be aimed for in order to achieve set targets. Therefore ways in which performance can be sustained or improved, can be laid out in the form of agreed individual/team/Trust objectives. There is a separate section on the PDR form for recording these objectives.

The PDR meeting will focus on helping individuals develop to meet the demands of

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the KSF outline for the post in which they are currently employed.

Discussion should be honest, open and positive. An individual's strengths, successes and contribution to the service should be recognised explicitly alongside a consideration of areas in which they might need to develop or improve. Staff and managers will be most likely to get the best out of PDR if they go into the process with an open mind and are prepared to be positive about the experience.

The KSF post outline provided in the review documentation should be jointly considered. This should structure the discussion, enabling both parties to prepare for and contribute to the process.

The review evaluates the individual's application of knowledge and skills in their work, using the KSF outline for the post as the basis for the discussion. The process will involve consideration of information relevant to the post outline on the individual's work – this can be called 'evidence for the development review'.

This evidence can take a number of different forms, which might include:-

- verbal feedback from the individual, manager or other
- written work produced by the individual
- electronic work produced by the individual
- records of work (such as minutes / notes of meetings showing the individual's contribution)
- the individual's portfolio containing such items as reflection on learning / practice that they are prepared to share.

Newly appointed or promoted staff joining a pay band under the new system will serve an initial foundation period of up to 12 months. This includes newly appointed or promoted staff joining a payband and also those moving posts within the payband, particularly where this cuts across job families eg from Admin to Social Care.

Discussion and decisions made at the PDR meetings should be clearly recorded using the mandatory forms (see Appendix 1). Section three Personal Development Plan (PDP) forwarded to KSF Department after each review meeting.

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4. Personal Development Plan (PDP)

The outcome of the PDR meeting should be recorded and a plan of action drawn up using the Personal Development Plan (PDP). This identifies the areas an individual needs to demonstrate more fully and the help they need to develop in order to achieve the required level for their post. This will include a discussion about the method of delivery for the learning and how the application of learning will be evaluated. The manager and employee are jointly responsible for doing this and both must then confirm they agree with the plan. Once completed a copy of the PDP should be forwarded to **KSF Department, Hill Building, St Luke's Site, Loughgall Road, Armagh. BT61 7NQ.**

The PDP will focus initially upon enabling an individual to meet the demands of their current post as described in the KSF outline. Once this has been achieved a PDP should enable an individual to maintain their knowledge and skills; developing them to meet any changing requirements, and facilitate an individual's further development within or beyond their current post, considering both individual and organisation needs and aspirations.

When thinking about learning and development needs the following three steps can be followed:-

CAN DO = the knowledge and skills that an individual already has and that seem to match the KSF job outline

WILL DO = the skills and knowledge that individuals think they ought to develop further because they haven't already achieved them or because they want to make them stronger

HOW TO = the learning opportunities or other activities that are likely to help individuals develop these skills and knowledge, or the people and agencies that can direct them towards their goals.

Remember that this should be done with the KSF post outline in mind.
Learning and development needs can arise for the following reasons, such as:-

- to meet an identified personal learning and development need to help an employee to meet the requirements of their post;
- to develop a skill identified as part of a job description; and
- to meet an organisational aim arising from the Trust's operational plans.

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Managers must not rely on sending an employee on a course to meet all development needs. They should look at all possible methods of developing skills and widening the employee's experience. These might include some of the following options:

- Conferences
- Reading journals and research papers
- Carrying out a literature search
- Attending relevant meetings
- Attending relevant in-service lectures/ presentations
- Membership of relevant Professional Groups/Body
- Reflection on day to day practice with colleagues
- Visits to centres of excellence
- Work Shadowing
- Business in Community Initiatives
- Courses
- Learning from an experienced colleague
- Membership of a Special Interest Group
- Giving lectures/updates
- Appropriate job rotation/ opportunities in own work setting
- Participation in relevant multi-professional work group
- Self directed study/open learning
- Participation in project work
- Secondment within/outside Trust
- Mentoring
- Action learning

5. KSF Links with Pay (Gateways)

Staff will progress through the paypoints on their payband by applying the necessary knowledge and skills to the demands of their post. Although, at two defined points in a pay band – known as gateways – decisions are made about pay progression as well as development. There are two gateways in each pay band:

1. Foundation gateway – this takes place no later than 12 months after an individual is appointed to a pay band, regardless of the pay point to which the individual is appointed. During this initial period all staff will have at least two discussions with their manager (or the person acting as their reviewer) to review progress, guided by the KSF foundation outline for the post. The first of these discussions should normally be during the induction period. The aim of these discussions and any resulting support and development will be to help staff make a success of the new job and confirm as quickly as possible that they are applying the basic knowledge and skills needed for the job and can pass through the foundation gateway and commence progression up their pay band.

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2. Second gateway – this is set at a fixed point towards the top of a pay band. The purpose of the second gateway is to confirm that individuals are applying their knowledge and skills to consistently meet the full demands of their post.

Position of Gateways

Pay Band	Position Of Gateway
	Before final point
	Before 1st of last 2 points
	Before 1st of last 3 points
	Before final point
	Before final point

The whole system is based on the principle of NO SURPRISES – if there are problems with individuals developing towards the full KSF outline for the post, or there are disciplinary issues, these must have been addressed separately by reviewers before the gateway reviews. This mirrors good management practice and should be no different from good appraisal practice. Therefore deferral of pay progression should be the exception rather than the rule.

There is an expectation that individuals will progress through the paypoints on a payband by applying the necessary knowledge and skills to the demands of the post. It is only at gateways, or if concerns have been raised about significant weaknesses in undertaking the current role, that the outcome of a review might lead to deferment of pay progression. In between gateways staff progress up the pay increments within their pay band on a yearly basis as they continue to learn and develop with the support of their manager through the participation in PDR meetings.

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New Members of Staff who commence at the 2nd Gateway Point

In some instances a new member of staff may commence with the Trust and have sufficient length of service with another Trust that will mean they will commence at an increment which equates with their second gateway review. In this instance, during the Local Induction, the Line Manager should ensure that a one-to-one meeting takes place in which they explain the KSF Post Outline, discuss any transferred PDR information from their previous post and develops and together agree a PDP and Action Plan for the incoming Probationary Period of 6 months. The individual will automatically progress through their gateway and they will be reviewed at the end of the 6 month probationary period.

Preceptorship

Staff joining pay band 5 as new entrants on or after 1st October 2004, will have accelerated progression through the first two points (spine points 17 and 18) in six monthly steps (that is they will move up one pay point after six months and a further point after 12 months) providing those responsible for the relevant standards in the organisation are satisfied with their standard of practice. This twelve month period will be referred to as 'Preceptorship'.

Within the first 12 months of employment the individual will have two development reviews. The first review after 6 months will seek to establish whether the individual is on track in their development towards the foundation gateway, and if this is the case, they should receive an incremental point.

After 12 months, the second development review will focus on the KSF foundation outline for the post and this will form the foundation gateway. When the individual passes through this foundation gateway, they will move up to the next point on the pay band. Like all other staff they will only have one foundation gateway and only one foundation gateway review.

Accelerated Progression

Accelerated Progression relates to staff eligible under Agenda for Change Circular HSS (AFC)(12) 2008 ie there are groups of staff (such as midwives) who tend to move quickly to operate in roles that demand a level of autonomous decision making in the overall delivery of care that exceeds that normally associated with jobs allocated to pay band 5. Typically these roles operate without the influence of other professional groups. Where supervision operates, it is generally management supervision and does not normally impinge upon clinical practice. In such circumstances job size

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should be reviewed no earlier than one year and no later than two years from the date of qualification, using the NHS Job Evaluation scheme. If the evaluation demonstrates that the post holder's job weight is of sufficient size to move to the next pay band (Pay Band 6) this should be affected without the need for application for a post at a higher level.

It is not expected that the review will be widespread practice as the majority of staff will work in circumstances in which there is regular clinical supervision and the delivery of care and treatment is subject to control or influence from other health care professionals There is no facility for this provision to operate in any other part of the pay structure. (Annex T, Terms and Conditions Handbook).

The process for handling such posts should be as follows:

- The post holder obtains a post with an agreed new entrant job description and person specification, which matches the band 5 profile
- 6 months post appointment, a first review will help to assess progress towards achieving what is required at the foundation gateway review for Band 5
- 12 months after appointment the foundation gateway review will take place. If the individual has achieved the necessary skills and competences for a band 5 they will then be awarded an increment.
- 12 months after appointment, an assessment should be made against the band 6 job description and person specification. If it can be demonstrated that the post holder has achieved the required standard, s/he is deemed ready to assume the responsibility and thereby work to the band 6 job at the level expected of a new recruit to that band.
- If this is agreed, the appropriate head of service is informed of the outcome. They will then authorise the progression to Band 6.

In the event where a practitioner is unable to attain the required level of knowledge and skill, this should be reassessed on a three monthly basis for a further 12 months.

If, following a further 12 month period (24 months post qualification) an individual is still unable to work at a level of a Band 6 post, the organisation concerned may wish to refer to its local capability procedures.

6. Dealing with Problems at Gateway Reviews

There may be times when staff are unable to achieve their full KSF outline and therefore not progress through the relevant gateway. Some examples of this may be:-

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(a) KSF Outline not achieved due to organisational issues

If the employee is unable to demonstrate the application of the necessary skills and knowledge due to organisational issues such as:

- inadequate managerial support,
- not being released from the workplace due to staffing levels,
- financial constraints, etc – for example, continuation of pandemic for prolonged period.

In these cases the employee will progress through the gateway with an agreed action plan in place. Note that this list is not exhaustive.

(b) KSF Outline not achieved due to non-achievement of training and/or development agreements

In some instances staff may not have followed up or attended the necessary development opportunities as agreed with their manager through no fault of the Trust. In these circumstances staff will not progress to the next incremental point on their pay band until such times as they can demonstrate achievement of their KSF Outline. Pay progression cannot be deferred unless there has been prior discussion between the individual and the person undertaking their review, which should be recorded, about the knowledge and skills that the individual needs to develop and apply and that the member of staff has been given the opportunity to achieve the necessary development.

In the above circumstances a short term action plan should be agreed and put in place by both parties. The action plan should clearly outline:-

- the reason/s for deferment
- the KSF dimensions and levels which are still to be achieved,
- identified training and development opportunities
- an agreed review date (within 3 months of the previous review).

(c) KSF Outline not achieved as the Reviewee is unable / unwilling to apply their learning and development

On rare occasions the reviewee may be unable to apply their learning and development in order to achieve their KSF Outline. Good management practice and effective use of the annual review process will ensure that the staff member is aware of the issues as they arise. Problems with roles and responsibilities should be dealt with well in advance of the gateway reviews therefore allowing the individual adequate opportunity to work toward the standard required. If

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issues still remain it may be necessary to refer to the Trust's Capability Procedure in the future. In these circumstances pay progression to the next incremental point on the pay scale will be deferred at the appropriate Gateway and this deferral will last until issues are resolved. The application of knowledge and skills cannot be backdated therefore the increment is not backdated.

7. Disagreements Regarding Gateway Decisions

If the member of staff and the reviewer fail to reach agreements regarding gateway decisions both parties can seek advise/support on an informal local basis from the Human Resources Department and Trade Union Side. If the informal process does not provide consensus, the member of staff can take their issue in writing to the Reviewer's Line Manager. The right to be accompanied by an employee representative will apply throughout the process.

Issues of disagreement should be the exception rather than the rule as one of the principles of the system is that it is based on "no surprises".

8. Extenuating Circumstances

8.1 Planned Long Term Sick Leave:

If a member of staff is on planned long-term sickness absence when an annual development review is due to take place, the reviewer and member of staff should agree when the review is to be scheduled. The review can take place either prior to the commencement of leave or within 3 months of returning to work or at a date that affords an equivalent timescale to the period missed prior to the review due date eg review due 10th August and sick leave commenced on 6th April the time period missed is 18 weeks. Therefore the annual review would be planned for 18 weeks following return to work.

8.2 Unplanned Long Term Sick Leave:

(a) If a member of staff is on unplanned long term sick leave absence when an annual development review is due to take place, the reviewer and member of staff should agree when the review is to be scheduled. The review can take place within 3 months of returning to work or at a date that affords an equivalent timescale to the period missed prior to the review due date eg review due 10th August and sick leave commenced on 6th April the time period missed is 18 weeks. Therefore the annual review would be planned

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for 18 weeks following return to work.

If a gateway review is to take place and there has not previously been any significant weakness in performance or a skill gap identified, the member of staff will progress through the gateway while on sick leave. The reviewer must complete the first page of the PDR form and forward to the Trust's Payroll Department. It is important to note that where this form is not completed and sent to Payroll in time the individual will not receive their entitled increment.

In the event that Occupational Health guidance indicates that the member of staff is not able to undertake the full range of duties immediately on return to work, the foundation subset or full post outline requirements for second gateway may be modified for a period of time, if appropriate.

(b) If a significant weakness in performance or a skill gap has been previously identified, discussed and documented and has yet to be resolved, the member of staff will not progress through the gateway while on leave. The reviewer should meet with the member of staff on return to work to revisit the development action plan previously put in place. The gateway review should then take place at the earliest possible date, but no later than 3 months from the date the member of staff returned to work or an equivalent timescale to the period missed prior to the review due date eg review due 10th August and sick leave commenced on 6th April the time period missed is 18 weeks. Therefore the annual review would be planned for 18 weeks following return to work.

Once there is agreement that the individual meets the KSF post outline appropriate to the particular gateway then pay progression resumes from that date. The application of knowledge and skills cannot be backdated therefore the increment is not backdated.

8.3 <u>Maternity Leave / Adoption Leave</u>

(a) If a member of staff is on maternity leave/adoption leave when an annual development review is due to take place, he/she and the reviewer must agree that the review is to take place prior to the commencement of leave.

Where a gateway review is to take place and there has not previously been any significant weakness in performance or a skill gap identified, the member of staff will progress through the gateway while on leave. The

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reviewer must complete the first page of the PDR form and forward to the Trust's Payroll Department. It is important to note that where this form is not completed and sent to Payroll in time the individual will not receive their entitled increment.

(b) If a significant weakness in performance or a skill gap has been previously identified, discussed and documented and has yet to be resolved, the member of staff will not progress through the gateway while on leave. The reviewer should meet with the member of staff on return to work to revisit the development action plan previously put in place. The gateway review should then take place at the earliest possible date, but no later than 3 months from the date the member of staff returned to work or an equivalent timescale to the period missed prior to the review due date eg review due 10th August and sick leave commenced on 6th April the time period missed is 18 weeks. Therefore the annual review would be planned for 18 weeks following return to work.

Once there is agreement that the member of staff can meet the KSF post outline appropriate to the particular gateway then pay progression resumes from that date. The application of knowledge and skills cannot be backdated therefore the increment is not backdated.

8.4 Unexpected long term leave / absence of reviewer

If the reviewer is on relatively short unplanned leave of any kind and this coincides with the date of a development or gateway development review, the date should be re-scheduled. Where the reviewer is likely to be absent on a long term basis and particularly where gateway progression will be affected by their absence, the review must be undertaken by an appropriate nominated reviewer in his/her absence who must be aware of any issues that have been highlighted at the previous development review or meetings that have taken place during the year.

8.5 Career Break

If a member of staff has opted to take a career break, incremental rises will be frozen until their return to work. On returning to work the member of staff and manager must have a meeting to discuss the KSF post outline, bearing in mind that the member of staff may have been on a career break for a number of years or may have returned to a different post; Map the current level of knowledge and skills against the outline and agree an initial Personal Development Plan.

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The manager should meet with the member of staff on at least two occasions during the first 12 months of returning to work to ensure an appropriate level of support is provided.

8.6 Acting Up

Periods of acting up should not normally last any longer than 6 months except in instances of maternity leave or long-term sick leave where a longer period may be known at the outset. For development purposes, the member of staff and his/her manager should meet at the commencement of the period of acting up to discuss the KSF outline associated with the acting post.

If a gateway review associated with the member of staff's substantive post would have otherwise taken place except for the fact that he/she was acting up, on return to their substantive post the member of staff will be allocated the pay point that would have been awarded on successful gateway review except where there was a previously identified skill gap etc. The reviewer and member of staff should arrange to meet following his/her return to the substantive post to ensure that he/she has settled back into the job and to carry out the gateway review.

8.7 Movement to another post within the same pay band

If a member of staff moves to another post on the same payband after having passed through a foundation or final gateway then he/she will be expected to apply the necessary knowledge and skills described in the KSF outline. A foundation gateway will not apply for pay purposes if the individual has previously successfully passed through the gateway. However, the member of staff will still be reviewed against the KSF post outline subset and have a Personal Development Plan developed to meet the necessary knowledge and skills for the new post as described in the NHS KSF post outline. The reviewer and member of staff should meet at least twice during the first twelve months to ensure that the member of staff is adequately supported in their post.

If a member of staff moves to another post on the same payband when he/she has already passed through the second gateway, the final gateway will not apply for pay purposes. However, the member of staff will be reviewed against the full KSF outline and have a Personal Development Plan developed in order to meet the necessary knowledge and skills for the new post. The reviewer and member of staff need to decide and agree a realistic target within the first 12

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months and ascertain when the full KSF post outline will be attained. Their Personal Development Plan will need to prioritise areas of development for the current post over any career progression.

In cases where a person moves to another post on the same payband but different job family eg from Admin to Social Care whilst their knowledge and skills may be transferable in relation to for example some of the Core Dimensions, they may not be for example the Health & Well Being Dimensions because they may not have been part of the person's previous Post Outline and therefore they will not have had the opportunity to demonstrate their application. These circumstances will be considered on an individual basis as part of the appointment process.

8.8 Temporary Staff

In accordance with employment law, temporary staff should be treated in the same way as permanent staff members.

Where an individual is employed on a temporary contract for a very short period of time, the manager and individual will agree the training needs as part of the induction. If the period of employment is for more than 6 months or the original temporary employment is extended to exceed 6 months it is expected that a Personal Development Plan will be developed for the member of staff based on the KSF outline.

8.9 Part-Time Working

Irrespective of the number of hours worked staff are required to have gateway reviews in order to pass through the paypoints. Personal Development Plan's and subset outlines should be realistic for the hours worked.

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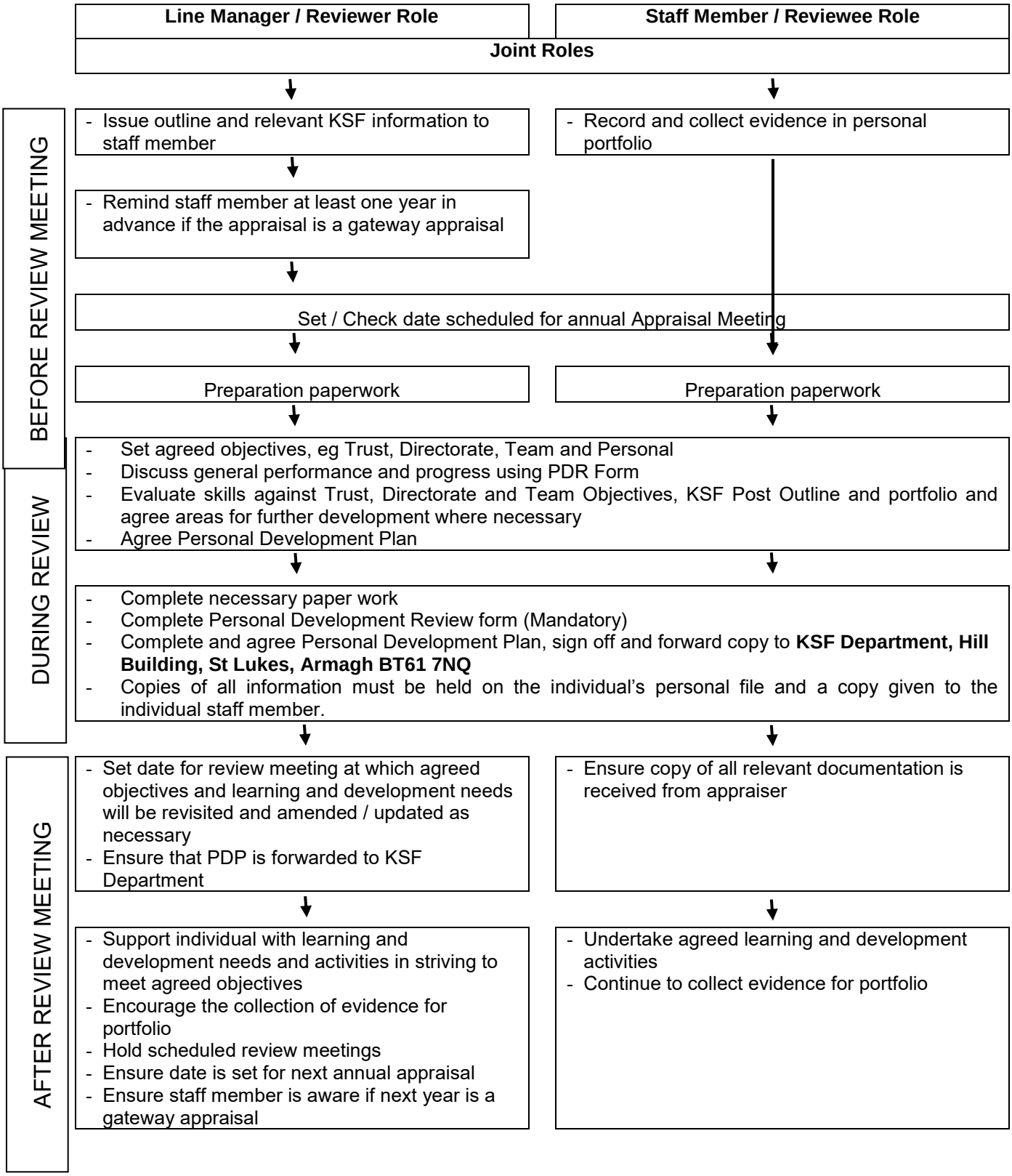
9. Flowchart for Personal Development Review



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Contents

***** The new Band 7 HR Team Manager profile has a different level in respect of factor 2, therefore, sites are immediately required to revisit existing matches and non-matches to HR/Personnel Services Manager profile in line with the agreed procedure for matching to reviewed profiles.

** new in September 2005

Note:
Following the review of the profiles, the following profiles have been withdrawn.

Profile Title	AfC Banding	Date of Publication
HR/Personnel Assistant (Recruitment)	**2**	**Sept 03**
Administrative Officer Personnel/Personnel Assistant Higher Level	3	**Nov 03**
HR/Personnel Services Officer	**6**	**Feb 04**
HR/Personnel Services Manager	**7**	**Apr 04**

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Profile Label: **HR Assistant**

Job Statement:

1. Compiles HR information on e.g. recruitment, workforce, absence.
2. Enters employee data to HR systems.
3. Responds to routine enquires.
4. Types/processes standard documents

Factor	Relevant Job Information	JE level
1. Communication & Relationship Skills	**Provide and receive routine information, to inform work colleagues, patients, clients.** Communicates information to staff and members of the public on standard HR information	2
2. Knowledge, Training & Experience	**Range of routine work procedures requiring job training.** Knowledge of standard HR procedures, IT skills to RSA/NVQ level 2 or equivalent experience	2
3. Analytical & Judgemental Skills	**Judgements involving straightforward facts or situations.** Responds to routine enquiries to staff and applicants	1
4. Planning & Organisational Skills	**Plan and organise straightforward activities, some ongoing.** Plans and schedules interviews	2
5. Physical Skills	**Physical skills obtained through practice/Developed physical skills: advanced keyboard use.** Dexterity, coordination for keyboard skills; advanced keyboard skills for data input	2-3a
6. Responsibility for Patient/Client Care	**Assist patients/clients during incidental contacts.** Contact with patients is incidental	1
7. Responsibility for Policy/Service Development	**Follow policies in own role, may be required to comment.** May comment on procedures	1
8. Responsibility for Financial & Physical Resources	**Maintain stock control.** Orders stationery, supplies	2c
9. Responsibility for Human Resources	**Demonstrate own activities to new or less experienced employees.** Demonstrates activities in own work area to new employees	1
10. Responsibility for Information Resources	**Data entry, text processing, storage of data/Take, transcribe formal minutes.** Enters data into HR systems/ Takes minutes of absence, grievance hearings etc	2a-3a
11. Responsibility for Research & Development	**Undertake surveys or audits, as necessary to own work.** Completes e.g. staff surveys	1
12. Freedom to Act	**Standard operating procedures, someone available for reference.** Complies with standard HR operating procedures, supervisor available	2
13. Physical Effort	**Frequent sitting or standing in a restricted position; Frequent light effort for several short periods.** Sits in constrained position for data processing; filing and storing activities.	2ab
14. Mental Effort	**Frequent concentration; work pattern predictable** Daily concentration on data handling, answering queries	2a
15. Emotional Effort	**Exposure to distressing or emotional circumstances is rare; occasional indirect distressing or emotional circumstances/Occasional distressing or emotional circumstances.** Little exposure; types minutes of disciplinary meetings/deals with calls from distressed members of staff	1ab-2a
16. Working Conditions	**Use VDU equipment more or less continuously.** Uses keyboard continuously for substantial proportion of the day.	2e
JE Score/Band	**JE Score 162 187**	**Band 2**

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Profile Label: **HR Assistant Higher Level**

Job Statement:

1. Provides administrative HR support to staff.
2. Advises on queries arising from staffs terms and conditions/recruitment issues.
3. Maintains HR records and databases.

Factor	Relevant Job Information	JE level
1. Communication & Relationship Skills	**Provide and receive routine information requiring tact or persuasive skills; Provide and receive complex or sensitive information.** Tact required when dealing with, e.g. sickness and compassionate leave requests; communicates information to staff regarding their pay, terms and conditions, deals with recruitment information with applicants	3ab
2. Knowledge, Training & Experience	**Range of work procedures and practices; base level of theoretical knowledge** Knowledge of HR systems and procedures, e.g. recruitment, terms and conditions, absence control, acquired through NVQ level 3 or equivalent experience	3
3. Analytical & Judgemental Skills	**Judgements involving facts or situations, some requiring analysis.** Resolves queries regarding leave entitlements, sickness and vacancies	2
4. Planning & Organisational Skills	**Plan and organise straightforward activities, some ongoing.** Arranges meetings, including liaising with other departments, arranges job interviews, panel hearings	2
5. Physical Skills	**Developed physical skills: advanced keyboard use** Dexterity, coordination for keyboard skills; advanced skills for data input	3a
6. Responsibility for Patient/Client Care	**Assist patients/clients during incidental contacts.** Contact with patients is incidental	1
7. Responsibility for Policy/Service Development	**Follow policies in own role, may be required to comment.** May comment on procedures	1
8. Responsibility for Financial & Physical Resources	**Maintain stock control.** Orders stationery, supplies	2c
9. Responsibility for Human Resources	**Provide basic HR advice.** Provision of advice on e.g. staff pay, terms and conditions queries, recruitment procedures	2d
10. Responsibility for Information Resources	**Data entry, text processing, storage of data/Take, transcribe formal minutes.** Enters data into HR systems/ Takes minutes of absence, grievance hearings etc	2a-3a
11. Responsibility for Research & Development	**Undertake surveys or audits, as necessary to own work.** Completes, e.g. staff surveys	1
12. Freedom to Act	**Standard operating procedures, someone available for reference.** Complies with standard HR operating procedures, supervisor available	2
13. Physical Effort	**Frequent sitting or standing in a restricted position; Frequent light effort for several short periods.** Sits in constrained position for data processing; filing and storing activities	2ab
14. Mental Effort	**Frequent concentration; work pattern predictable.** Daily concentration on data handling, answering queries	2a
15. Emotional Effort	**Exposure to distressing or emotional circumstances is rare; occasional indirect distressing or emotional circumstances/Occasional distressing or emotional circumstances.** Little exposure; types minutes of disciplinary meetings/deals with calls from distressed members of staff	1ab-2a
16. Working Conditions	**Use VDU equipment more or less continuously.** Uses keyboard continuously for substantial proportion of the day	2e
JE Score/Band	**JE Score 223 236**	**Band 3**

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WIT-90488

Profile Label: **HR Administrator**

Job Statement:

1. Provides administrative service to the HR Department.
2. May supervise a team of administrative staff and HR.
3. Responsible for HR administrative systems.
4. Deals with a range of queries arising from staff terms and conditions, HR Policies etc.

Factor	Relevant Job Information	JE level
1. Communication & Relationship Skills	**Provide and receive routine information requiring tact or persuasive skills; Provide and receive complex or sensitive information/Provide and receive complex, sensitive information; barriers to understanding.** Tact required when dealing with, e.g. sickness and compassionate leave requests; communicates information to staff regarding their pay, terms and conditions, deals with recruitment information with applicants/Communicates complex/sensitive information, e.g. redeployment, grading appeals, disciplinary matters	3ab-4a
2. Knowledge, Training & Experience	**Range of work procedures and practices, majority non-routine; intermediate level theoretical knowledge.** Knowledge of a range of administrative and HR procedures, acquired through relevant training and experience to diploma, CPP equivalent level	4
3. Analytical & Judgemental Skills	**Judgements involving facts or situations, some requiring analysis.** Resolves queries regarding leave entitlements, sickness and vacancies	2
4. Planning & Organisational Skills	**Plan and organise complex activities or programmes, requiring formulation, adjustment.** Coordinates activities which include multi-disciplinary meetings, disciplinary hearings, training programmes, workforce planning	3
5. Physical Skills	**Physical skills obtained through practice/Developed physical skills; advanced keyboard use.** Dexterity, coordination for keyboard skills	2-3a
6. Responsibility for Patient/Client Care	**Assist patients/clients during incidental contacts.** Contact with patients is incidental	1
7. Responsibility for Policy/Service Development	**Follow policies in own role, may be required to comment/Implement policies and propose changes to practices, procedures for own area.** May comment on procedures/implements administrative policies in own area	1-2
8. Responsibility for Financial & Physical Resources	**Safe use of equipment other than equipment used personally; authorised signatory, small payments/authorised signatory** Responsible for office equipment, e.g. photocopier; authorises temporary staff timesheets/overtime payments	2bd-3a
9. Responsibility for Human Resources	**Deliver core HR advice, range of subjects** Provides advice on a range of HR policies and procedures, e.g. equal opportunities, workforce, terms and conditions	3d
10. Responsibility for Information Resources	**Take, transcribe formal minutes/Responsible for maintaining one or more information systems, significant job responsibility.** Takes minutes of absence, grievance hearings, etc/Maintains HR records system(s)	3a-3c
11. Responsibility for Research & Development	**Undertake surveys or audits, as necessary to own work.** Completes, e.g. staff surveys	1
12. Freedom to Act	**Clearly defined occupational policies, work is managed, rather than supervised.** Works within HR policies and procedures; operates on own initiative, takes advice from manager if required	3
13. Physical Effort	**Frequent light effort for several short periods.** Filing and storing activities	2b
14. Mental Effort	**Occasional concentration; work pattern unpredictable.** Concentration required for answering enquiries	2b
15. Emotional Effort	**Exposure to distressing or emotional circumstances is rare; Occasional indirect distressing or emotional circumstances/Occasional distressing or emotional circumstances.** Little exposure; types minutes of disciplinary meetings/deals with calls from distressed members of staff	1ab-2a
16. Working Conditions	**Exposure to unpleasant conditions is rare/Use VDU equipment more or less continuously.** Little exposure/uses keyboard for substantial proportion of the day	1-2e
JE Score/Band	**JE Score 272 321**	**Band 4**

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Profile Label: **HR Adviser**

Job Statement:

1. Provides advice and support to line managers and employees across a range of HR services e.g. recruitment, employee relations, workforce planning or advice in a specific area
2. Delivers HR training and staff development courses
3. May manage a team of HR staff which may be within a discrete section, e.g. medical personnel, workforce planning, recruitment

Factor	Relevant Job Information	JE level
1. Communication & Relationship Skills	**Provide and receive complex information; persuasive, motivational, negotiating, training skills are required.** Communicates complex/sensitive information, e.g. redeployment, grading appeals, disciplinary matters	4a
2. Knowledge, Training & Experience	**Expertise within specialism, underpinned by theory.** Understanding or relevant legislation, e.g. employment law, data protection plus HR knowledge acquired through relevant training and experience to degree equivalent level	5
3. Analytical & Judgemental Skills	**Range of facts or situations requiring analysis.** Makes judgements on a range of HR issues, e.g. absence, special leave entitlement, redeployment, IWL or judgements in a specific area of HR	3
4. Planning & Organisational Skills	**Plan and organise complex activities or programmes, requiring formulation, adjustment.** Coordinates activities which include multi-disciplinary meetings, disciplinary hearings, training programmes, workforce planning, medical staffing	3
5. Physical Skills	**Physical skills obtained through practice.** Standard keyboard skills	2
6. Responsibility for Patient/Client Care	**Assist patients/clients during incidental contacts.** Contact with patients is incidental	1
7. Responsibility for Policy/Service Development	**Implement policies and propose changes to practices, procedures for own area/Propose policy or service changes, impact beyond own area.** Implements HR policies in own area/makes recommendations on changes to HR policies and procedures	2-3
8. Responsibility for Financial & Physical Resources	**Authorised signatory, small payments/Authorised signatory** Authorises payments for HR materials and publications/staff overtime payments	2d-3a
9. Responsibility for Human Resources	**Teach, devise training and development programmes, major job responsibility; Deliver comprehensive range of HR services.** Provides and delivers training on HR policies and procedures; responsible for the delivery of range of HR services, e.g. staff development and training, equal opportunities, terms and conditions, recruitment, employee relations, medical staffing	4bc
10. Responsibility for Information Resources	**Occasional/Regular requirement to develop or create reports, documents, drawings; Responsible for maintaining one or more information systems, significant job responsibility.** Occasionally/regularly develops e.g. workforce planning, staff development spreadsheets/maintains HR records system(s)	2b-3bc
11. Responsibility for Research & Development	**Undertake surveys or audits, as necessary to own work** Undertakes staff surveys on HR issues	1
12. Freedom to Act	**Clearly defined occupational policies, work is managed, rather than supervised.** Works within HR policies and procedures; operates on own initiative, takes advice from manager if required	3
13. Physical Effort	**Combination of sitting, standing, walking.** Light physical effort	1
14. Mental Effort	**Frequent concentration; work pattern predictable.** Concentration required for answering enquiries	2a
15. Emotional Effort	**Occasional/Frequent distressing or emotional circumstances.** Deals with welfare issues, long term sickness, redeployment & redundancy, grievance and discipline	2a – 3a
16. Working Conditions	**Exposure to unpleasant conditions is rare.** Office conditions	1
JE Score/Band	**JE Score 340 372**	**Band 5**

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Profile Label: **HR Adviser Specialist**

Job Statement:

1. Provides a range of HR advice e.g. recruitment & selection, employee relations, workforce planning, equality and diversity, change management or specialist advice in a specific area
2. May design and deliver staff development and training courses
3. May manage a section of the HR directorate
4. May implement all or part of a specific HR strategy, e.g. learning and development, OD strategy

Factor	Relevant Job Information	JE level
1. Communication & Relationship Skills	**Provide and receive complex/highly complex, sensitive or contentious information, agreement or co-operation required; Presents complex, sensitive or contentious information to large groups.** Communicates complex/highly complex information e.g. redeployment issues, absence management, workforce development strategies, grading appeals, welfare issues; gives evidence at disciplinary and tribunal hearings, delivers specialist training courses	4a - 5ab
2. Knowledge, Training & Experience	**Specialist knowledge across work procedures, underpinned by theory** Knowledge of specialist HR topics to postgraduate diploma level acquired through degree and professional HR qualification or equivalent level of training experience	6
3. Analytical & Judgemental Skills	**Complex facts or situations requiring analysis, interpretation, comparison of a range of options** Analyses complex HR issues and makes decisions in relation to e.g. disciplinary action, grievance hearings, sickness counselling, interpretation of HR policies, workforce strategies	4
4. Planning & Organisational Skills	**Plan and organise complex activities or programmes, requiring formulation, adjustment** Plans e.g. recruitment drives, workforce planning, organisational development	3
5. Physical Skills	**Physical skills obtained through practice** Standard keyboard skills	2
6. Responsibility for Patient/Client Care	**Assist patients/ clients during incidental contacts** Provides assistance to patients/clients when necessary	1
7. Responsibility for Policy/Service Development	**Propose policy or service changes, impact beyond are** Makes proposals on range of personnel policies which impact on other departments. May implement a specific HR strategy.	3
8. Responsibility for Financial & Physical Resources	**Authorised signatory for small payments/Authorised signatory** Authorises payments for HR materials and publications/staff overtime payments	2d-3a
9. Responsibility for Human Resources	**Teach, devise training and development programmes, major job requirement; deliver comprehensive range of HR services** Develops training/staff development courses; Responsible for delivery of some or all of range of HR services e.g. recruitment & selection, sickness management	4bc
10. Responsibility for Information Resources	**Occasional requirement to develop or create reports, documents, drawings/ Responsible for maintaining one or more information systems, significant job responsibility.** Occasionally develops e.g. workforce planning, staff development spreadsheets/maintains HR records system(s)	2b–3c
11. Responsibility for Research & Development	**Undertake surveys or audits as necessary to own work / regularly undertakes R&D activities** Undertakes staff surveys on HR issues	1-2a
12. Freedom to Act	**Broad occupational policies** Works autonomously; provides HR services to managers, lead specialist in own field	4
13. Physical Effort	**Combination of sitting, standing walking** Office based	1
14. Mental Effort	**Frequent concentration; work pattern unpredictable** Concentration for complaints, report writing, giving advice, frequent interruptions for advice, queries	3a
15. Emotional Effort	**Occasional/frequent distressing or emotional circumstances** Deals with welfare issues, long term sickness, redeployment and redundancy, grievance and discipline	2a-3a
16. Working Conditions	**Exposure to unpleasant working conditions is rare** Office conditions	1
JE Score/Band	**JE Score 416 459**	**Band 6**

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Profile Label: **HR Team Manager**
Job Statement:
1. Manages the performance of a discrete section of an HR department
2. Provides highly specialist advice, HR/ OD consultancy services to the organisation

Factor	Relevant Job Information	JE level
1. Communication & Relationship Skills	**Provide and receive highly complex, sensitive or contentious information, agreement or co-operation required; presents complex, sensitive or contentious information to large groups** Communicates highly complex/sensitive information e.g. redeployment issues, workforce development strategies, employee relations, gives evidence at disciplinary and tribunal hearings/ run specialist training courses, give presentations on complex HR issues	5(a), (b)
2. Knowledge, Training & Experience	**Highly developed specialist knowledge across work procedures, underpinned by theory and experience** Highly specialist knowledge of one or more HR topics to masters level equivalent acquired through degree and professional HR qualification plus additional training or equivalent experience	7
3. Analytical & Judgemental Skills	**Complex facts or situations requiring analysis, interpretation, comparison of a range of options** Assesses and recommends courses of action on complex, specialist HR issues	4
4. Planning & Organisational Skills	**Plan and organise broad range of complex activities; formulates, adjusts plans and strategies** Plans implementation of HR strategies, change management programmes across service	4
5. Physical Skills	**Physical skills obtained through practice** Standard keyboard skills	2
6. Responsibility for Patient/Client Care	**Assist patients/ clients during incidental contacts** Provides assistance to patients /clients when necessary	1
7. Responsibility for Policy/Service Development	**Propose policy or service changes, impact beyond own area** Makes proposals on range of HR policies which impact on other departments	3
8. Responsibility for Financial & Physical Resources	**Authorised signatory; hold delegated budget** Authorises costs e.g. recruitment; manages delegated budget	3(a), (d)
9. Responsibility for Human Resources	**Line manager for single function or department; deliver comprehensive range of HR services/ Manage significant part of HR function across organisation** Manage an HR section, including appraisal, discipline, personal development; Responsible for provision of an advisory service to managers on all aspects of e.g. employee relations / Manages a specialist area e.g. equal opportunities, employee relations, workforce planning, medical staffing	4(a), (c)-5(c)
10. Responsibility for Information Resources	**Occasional requirement to develop or create reports, documents, drawings/ Responsible for maintaining one or more information systems, significant job responsibility.** Occasionally develops e.g. workforce planning, staff development spreadsheets/maintains HR records system(s)	2(b)-3(c)
11. Responsibility for Research & Development	**Undertakes surveys or audits as necessary to own work** Undertakes staff surveys on HR issues	1
12. Freedom to Act	**Broad occupational policies/ General policies, needs to establish interpretation** Works autonomously, provides HR services to managers/ Interprets employment legislation and case law, provides authoritative advice on specialist HR issues	4-5
13. Physical Effort	**Combination of sitting, standing walking** Light physical effort	1
14. Mental Effort	**Frequent requirement for concentration; unpredictable** Concentration for complaints, report writing, frequent interruptions for advice, queries	3(a)
15. Emotional Effort	**Occasional/ frequent distressing or emotional circumstances** Deals with welfare issues, long term sickness, redeployment and redundancy, grievance and discipline	2(a)-3(a)
16. Working Conditions	**Exposure to unpleasant working conditions is rare** Office conditions	1
JE Score/Band	**JE Score 493 533**	**Band 7**

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Profile Label: **HR Adviser Advanced**
Job Statement:
1. Provides highly specialist advice, HR/OD consultancy services to the organisation
2. May design and deliver specialist staff development and training courses

Factor	Relevant Job Information	JE level
1. Communication & Relationship Skills	**Provide and receive highly complex, sensitive or contentious information, agreement or co-operation required; Presents complex, sensitive or contentious information to large groups.** Communicates highly complex/sensitive information e.g. redeployment issues, workforce development strategies, employee relations, gives evidence at disciplinary and tribunal hearings; run specialist training courses, give presentations on complex HR issues.	5ab
2. Knowledge, Training & Experience	**Highly developed specialist knowledge across work procedures, underpinned by theory and experience** Highly specialist knowledge of one or more HR topics to masters level equivalent acquired through degree and professional HR qualification plus additional training or equivalent experience	7
3. Analytical & Judgemental Skills	**Complex facts or situations requiring analysis, interpretation, comparison of a range of options** Analyses complex HR issues and makes decisions in relation to e.g. disciplinary action, grievance hearings, interpretation of HR policies, workforce strategies	4
4. Planning & Organisational Skills	**Plan and organise complex activities or programmes, requiring formulation, adjustment/Plan and organise broad range of complex activities; formulates, adjusts plans and strategies** Plans e.g. recruitment drives, workforce planning, organisational development programmes/Plans implementation of HR strategies, change management programmes across service	3-4
5. Physical Skills	**Physical skills obtained through practice** Standard keyboard skills	2
6. Responsibility for Patient/Client Care	**Assist patients/clients during incidental contacts** Provides assistance to patients/clients when necessary	1
7. Responsibility for Policy/Service Development	**Propose policy or service changes, impact beyond are** Makes proposals on range of personnel policies, which impact on other departments. May implement a specific HR strategy.	3
8. Responsibility for Financial & Physical Resources	**Authorised signatory for small payments/Authorised signatory** Authorises payments for HR materials and publications/staff overtime payments, sign payroll authorisations	2d-3a
9. Responsibility for Human Resources	**Teach, devise training and development programmes, major job requirement; deliver comprehensive range of HR services** Develops training/staff development courses; provides highly specialist advice, OD, training, consultancy services	4bc
10. Responsibility for Information Resources	**Occasional requirement to develop or create reports, documents, drawings/ Responsible for maintaining one or more information systems, significant job responsibility.** Occasionally develops e.g. workforce planning, staff development spreadsheets/maintains HR records system(s)	2b–3c
11. Responsibility for Research & Development	**Undertake surveys or audits as necessary to own work / regularly undertakes R&D activities** Undertakes staff surveys on HR issues	1-2a
12. Freedom to Act	**Broad occupational policies** Works autonomously; provides HR services to managers, lead specialist in own field	4
13. Physical Effort	**Combination of sitting, standing walking** Office based	1
14. Mental Effort	**Frequent concentration; work pattern unpredictable** Concentration for complaints, report writing, giving advice, frequent interruptions for advice, queries	3a
15. Emotional Effort	**Occasional/frequent distressing or emotional circumstances** Deals with welfare issues, long term sickness, redeployment and redundancy, grievance and discipline	2a-3a
16. Working Conditions	**Exposure to unpleasant working conditions is rare** Office conditions	1
JE Score/Band	**JE Score 469 514**	**Band 7**

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Profile Label: **HR Manager Principal (Assistant Director)**

Job Statement:
1. Manages the performance and direction of part of a large HR function or all of a smaller function
2. Investigates and advises on very complex issues and leads on strategic HR development
3. Advises on very complex employment issues

Factor	Relevant Job Information	JE level
1. Communication & Relationship Skills	**Provide and receive highly complex, sensitive or contentious information, agreement or co-operation required; present complex, sensitive or contentious information to large groups** Communicates very complex/sensitive information e.g. redeployment issues, workforce development strategies, employee relations, gives evidence at disciplinary and tribunal hearings/ run specialist training courses, give presentations on complex HR issues	5(a), (b)
2. Knowledge, Training & Experience	**Highly developed specialist knowledge across work procedures, underpinned by theory and experience** Highly specialist knowledge of one or more HR topics acquired through degree and professional HR qualification plus additional training or equivalent experience to masters level or equivalent	7
3. Analytical & Judgemental Skills	**Complex facts or situations requiring analysis, interpretation comparison of a range of options / Highly complex facts or situations requiring analysis, interpretation, comparison of a range of options** Assesses and recommends courses of action on complex, specialist HR issues / analyses a range of very complex employment situations which require deciding on the way forward where no precedent exists or options conflict	4 -5
4. Planning & Organisational Skills	**Plan and organise broad range of complex activities; formulates, adjusts plans and strategies/ Formulate long term strategic plans, involving uncertainty, may impact on the whole of the organisation** Plans implementation of HR strategies, change management programmes across service / Develops and takes the lead in advising on long term strategic HR, business planning for the whole organisation	4-5
5. Physical Skills	**Physical skills obtained through practice** Standard keyboard skills	2
6. Responsibility for Patient/Client Care	**Assist patients/ clients during incidental contacts** Provides assistance to patients /clients when necessary	1
7. Responsibility for Policy/Service Development	**Responsible for policy implementation and development for a service/ responsible for policy implementation for a Directorate or equivalent** Responsibility for developing policy and procedures for a section of the HR function which impact across the organisation/develops HR policies for the organisation, working jointly with other organisations to create a consistent approach; implements national policies and practices.	4-5
8. Responsibility for Financial & Physical Resources	**Budget holder for department/service** Manages HR budget	4(a)
9. Responsibility for Human Resources	**Manage teaching/training function/Manage significant part of HR function across organisation** Manages training department; manages a discreet area of the HR function e.g. organisational development, employee relations	5(b), (c)
10. Responsibility for Information Resources	**Responsible for the operation of one or more information systems for department/service, major job responsible** Manages the operation of e.g. recruitment, training, equal opportunities, job evaluation information systems	4(b)
11. Responsibility for Research & Development	**Undertake surveys and audits as necessary to own work** Researches HR topics e.g. employment law, equal opportunities	1
12. Freedom to Act	**Broad occupational policies/ General policies, needs to establish interpretation** Works autonomously, provides HR services to managers/ Interprets employment legislation and case law, provides authoritative advice on specialist HR issues	4-5
13. Physical Effort	**Combination of sitting, standing walking** Desk based, required to visit staff throughout organisation	1
14. Mental Effort	**Frequent requirement for concentration; unpredictable** Concentration for complaints, report writing; frequent interruptions for advice, queries	3(a)
15. Emotional Effort	**Frequent distressing or emotional circumstances** Deals with welfare issues, long term sickness, redeployment and redundancy, grievance and discipline, tribunal and court hearings	3(a)

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

16. Working Conditions	**Exposure to unpleasant working conditions is rare** Office conditions	1
JE Score/Band	**JE Score 550 612**	**Band 8ab**

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Profile Label: **HR Head of Service**

Job Statement:

1. Manages the performance and direction of the whole HR function
2. Ensures all HR systems and policies are in place to comply with employment law and governance requirements
3. Investigates and advises on very complex employment and organisational development issues
4. May have corporate responsibility for organisation policy

Factor	Relevant Job Information	JE level
1. Communication & Relationship Skills	**Provide and receive highly complex, sensitive or contentious information, agreement or co-operation required; presents complex, sensitive or contentious information to large groups/Provides and receives highly complex, sensitive or contentious information; significant barriers to acceptance; hostile, antagonistic or highly emotive atmosphere** Communicates very complex/sensitive information e.g. redeployment issues, workforce development strategies, employee relations. Gives evidence at disciplinary and tribunal hearings; Runs specialist training courses, give presentations on complex HR issues/Communicates issues e.g. mergers where barriers to acceptance may cause a hostile and emotive atmosphere	5ab-6
2. Knowledge, Training & Experience	**Highly developed specialist knowledge across work procedures, underpinned by theory and experience** Highly specialist knowledge of one or more HR topics acquired through degree and professional HR qualification plus additional training or equivalent experience to masters level or equivalent	7
3. Analytical & Judgemental Skills	**Highly complex facts or situations requiring analysis, interpretation, comparison of a range of options** Analyses a range of very complex employment situations which require deciding on the way forward where no precedent exist or options conflict	5
4. Planning & Organisational Skills	**Formulate long term strategic plans, involving uncertainty, may impact on the whole of the organisation** Develops and takes the lead in advising on long term strategic HR, business planning for the whole organisation	5
5. Physical Skills	**Physical skills obtained through practice** Standard keyboard skills	2
6. Responsibility for Patient/Client Care	**Assist patients/ clients during incidental contacts** Provides assistance to patients /clients when necessary	1
7. Responsibility for Policy/Service Development	**Responsible for policy implementation and development for a directorate or equivalent/corporate responsibility for major policy implementation, impacts across or beyond the organisation** Develops HR policies for the organisation, working jointly with other organisations to create a consistent approach; implements national policies and practices/Corporate responsibility for all the organisation's HR policy development and implementation and provides HR input to all the organisations policies and strategies.	5-6
8. Responsibility for Financial & Physical Resources	**Budget holder for department/service/Responsible for the budget for several services** Holds budget for HR function/HR and other service budget e.g. OD	4a-5a
9. Responsibility for Human Resources	**Corporate responsibility for the HR function** Responsible for interpreting legislation and policy and developing organisation wide HR strategy	6
10. Responsibility for Information Resources	**Responsible for the operation of one or more information systems for department/service, major job responsible** Manages the operation of e.g. recruitment, training, equal opportunities monitoring, job evaluation information systems	4b
11. Responsibility for Research & Development	**Undertake audits and surveys as necessary to own work** Completes e.g. staff surveys	1
12. Freedom to Act	**General policies, need to establish interpretation/Required to interpret overall health service policy and strategy** Interprets employment legislation and case law, provides authoritative advice on specialist HR issues	5
13. Physical Effort	**Combination of sitting, standing walking** Desk based, required to visit staff throughout organisation	1
14. Mental Effort	**Frequent requirement for concentration; unpredictable/occasional intense concentration** Concentration for complaints, report writing; frequent interruptions for advice, queries/intense concentration e.g. giving evidence, board meetings, pay negotiations	3a – 4b
15. Emotional Effort	**Frequent distressing or emotional circumstances; Occasional highly distressing or**	3ab

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	emotional circumstances Deals with welfare issues, long term sickness, redeployment and redundancy, grievance and discipline, tribunal and court hearings; hostile public meetings,	
16. Working Conditions	**Exposure to unpleasant working conditions is rare** Office conditions	1
JE Score/Band	**JE Score 627 676**	**Band 8bcd**

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

March 31, 2010

Postoutline: ST272 Head of Service (Generic) Band 8a

Created On: 31/03/2010

Created By: Anne Forsythe

Originating Organisation: Southern Health & Social Care Trust

Post Outline is Approved

Purpose: :

Pay Band: Band 8a

Reporting To: Line Manager

KSF Dimensions, Levels And Indicators

Dimension Type	Dimension Number	Dimension Name	Second Gateway (Full Outline)		Foundation Gateway (Subset Outline)	
			Level	Indicator	Level	Indicator
Core	C1	COMMUNICATION	4	A,B,C,D,E,F	4	A,B,C,D,E,F
Core	C2	PERSONAL AND PEOPLE DEVELOPMENT	4	A,B,C,D,E,F,G,H	4	A,B,C,D,E,F,G,H
Core	C3	HEALTH, SAFETY AND SECURITY	3	A,B,C,D,E	3	A,B,C,D,E
Core	C4	SERVICE IMPROVEMENT	3	A,B,C,D,E,F,G	3	A,B,C,D,E,F,G
Core	C5	QUALITY	4	A,B,C,D,E,F,G	4	A,B,C,D,E,F,G
Core	C6	EQUALITY AND DIVERSITY	2	A,B,C,D	2	A,B,C,D
Specific	HWB3	PROTECTION OF HEALTH AND WELLBEING	4	A,B,C,D,E,F,G,H,I	4	A,B,C,D,E,F,G,H,I
Specific	G4	FINANCIAL MANAGEMENT	3	A,B,C,D,E,F,G,H	3	A,B,C,D,E,F,G,H
Specific	G5	SERVICES AND PROJECT MANAGEMENT	4	A,B,C,D,E,F	4	A,B,C,D,E,F
Specific	G6	PEOPLE MANAGEMENT	3	A,B,C,D,E,F,G,H	3	A,B,C,D,E,F,G,H

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Second Gateway (Full Outline)

COMMUNICATION - Level: 4

Level Indicators:

a) identifies:
- the range of people involved in the communication
- potential communication differences
- relevant contextual factors
- broader situational factors, issues and risks

b) communicates with people in a form and manner which:
- is consistent with their level of understanding, culture, background and preferred ways of communicating
- is appropriate to the purpose of the communication and its longer term importance
- is appropriate to the complexity of the context
- encourages effective communication between all involved
- enables a constructive outcome to be achieved

c) anticipates barriers to communication and takes action to improve communication

d) is proactive in seeking out different styles and methods of communicating to assist longer term needs and aims

e) takes a proactive role in producing accurate and complete records of the communication consistent with legislation, policies and procedures

f) communicates in a manner that is consistent with legislation, policies and procedures.

Examples Of Application: Lead uni & multi disciplinary teams/agencies and other colleagues, statutory/voluntary agencies. Be aware of and respond with differing methods of communication in light of target audience/complexity of issues. Support AD to implement commissioning priorities/targets. Contribute to local/regional services planning. Take action re complex staffing issues eg disciplinary panels. Regular advice/reporting on discharge of statutory functions. Adhere to, actively promote and ensure implementation of legislation/Trust Policies & Procedures across service area.

Foundation Gateway (Subset Outline)

COMMUNICATION - Level: 4

Level Indicators:

a) identifies:
- the range of people involved in the communication
- potential communication differences
- relevant contextual factors
- broader situational factors, issues and risks

b) communicates with people in a form and manner which:
- is consistent with their level of understanding, culture, background and preferred ways of communicating
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f) communicates in a manner that is consistent with legislation, policies and procedures.

Examples of Application: Lead uni & multi disciplinary teams/agencies and other colleagues, statutory/voluntary agencies. Be aware of and respond with differing methods of communication in light of target audience/complexity of issues. Support AD to implement commissioning priorities/targets. Contribute to local/regional services planning. Take action re complex staffing issues eg disciplinary panels. Regular advice/reporting on discharge of statutory functions. Adhere to, actively promote and ensure implementation of legislation/Trust Policies & Procedures across service area.

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Second Gateway (Full Outline)

PERSONAL AND PEOPLE DEVELOPMENT - Level: 4

Level Indicators:

a) evaluates the currency and sufficiency of own knowledge and practice against the KSF outline for the post and identifies own development needs and interests
b) develops and agrees own personal development plan with feedback from others
c) generates and uses appropriate learning opportunities and applies own learning to the future development of practice
d) encourages others to make realistic self assessments of their application of knowledge and skills challenging complacency and actions which are not in the interest of the public and/or users of services
e) enables others to develop and apply their knowledge and skills

f) actively promotes the workplace as a learning environment encouraging everyone to learn from each other and from external good practice
g) alerts managers to resource issues which affect learning, development and performance
h) develops others in a manner that is consistent with legislation, policies and procedures.

Examples Of Application: Evaluates performance against KSF outlines/Supervision, identifying and agreeing PDP's (self/others) including challenging complacency and/or inappropriate actions. Assist and support staff to recognise training needs and to undertake appropriate learning activities. Ensure evaluation and application of new knowledge and skills (self/others) including sharing of knowledge. Provide clear leadership to staff and ensure all facilities/teams have a highly skilled, flexible and motivated workforce, ensuring adherence to legislation/professional standards/policies and procedures. Manage implications for service delivery whilst ensuring staff are appropriately skilled eg raise governance issues.

Foundation Gateway (Subset Outline)

PERSONAL AND PEOPLE DEVELOPMENT - Level: 4

Level Indicators:

a) evaluates the currency and sufficiency of own knowledge and practice against the KSF outline for the post and identifies own development needs and interests
b) develops and agrees own personal development plan with feedback from others
c) generates and uses appropriate learning opportunities and applies own learning to the future development of practice
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Second Gateway (Full Outline)

HEALTH, SAFETY AND SECURITY - Level: 3

Level Indicators:

a) identifies:
- the risks involved in work activities and processes
- how to manage the risks
- how to help others manage risk

b) undertakes work activities consistent with:
- legislation, policies and procedures
- the assessment and management of risk

c) monitors work areas and practices and ensures they:
- are safe and free from hazards
- conform to health, safety and security legislation, policies, procedures and guidelines

d) takes the necessary action in relation to risks

e) identifies how health, safety and security can be improved and takes action to put this into effect.

Examples Of Application: Use of Supervision/KSF PDR to monitor safe practice. Ensure robust arrangements are in place to meet controls assurance standards, the assessment and management of risk and the implementation of relevant DHSSPS guidance eg Safety First framework. Ensure that facilities/services/projects and practices conform to health, safety and security legislation, policies, procedures and guidelines. Ensure that staff adhere to Infection Control policies eg hand hygiene. Ensure accident/incident/near misses are analysed/reported on at service level and appropriately acted upon. Challenging staff who put themselves or others at risk and promote awareness of, and adherence to, safe working practices eg Lone Worker Policy. Contributing to maintaining and improving organisational policy and procedure eg re safe working practices.

Foundation Gateway (Subset Outline)

HEALTH, SAFETY AND SECURITY - Level: 3

Level Indicators:

a) identifies:
- the risks involved in work activities and processes
- how to manage the risks
- how to help others manage risk

b) undertakes work activities consistent with:
- legislation, policies and procedures
- the assessment and management of risk

c) monitors work areas and practices and ensures they:
- are safe and free from hazards
- conform to health, safety and security legislation, policies, procedures and guidelines

d) takes the necessary action in relation to risks

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Examples of Application: Use of Supervision/KSF PDR to monitor safe practice. Ensure robust arrangements are in place to meet controls assurance standards, the assessment and management of risk and the implementation of relevant DHSSPS guidance eg Safety First framework. Ensure that facilities/services/projects and practices conform to health, safety and security legislation, policies, procedures and guidelines. Ensure that staff adhere to Infection Control policies eg hand hygiene. Ensure accident/incident/near misses are analysed/reported on at service level and appropriately acted upon. Challenging staff who put themselves or others at risk and promote awareness of, and adherence to, safe working practices eg Lone Worker Policy. Contributing to maintaining and improving organisational policy and procedure eg re safe working practices.

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Second Gateway (Full Outline)

SERVICE IMPROVEMENT - Level: 3

Level Indicators:

a) identifies and evaluates areas for potential service improvement

b) discusses and agrees with others:
- how services should be improved as a result of suggestions, recommendations and directives
- how to balance and prioritise competing interests
- how improvements will be taken forward and implemented

c) constructively undertakes own role in improving services as agreed and to time, supporting others effectively during times of change and working with others to overcome problems and tensions as they arise

d) maintains and sustains direction, policies and strategies until they are firmly embedded in the culture inspiring others with values and a vision of the future whilst acknowledging traditions and background

e) enables and encourages others to:
- understand and appreciate the influences on services and the reasons why improvements are being made
- offer suggestions, ideas and views for improving services and developing direction, policies and strategies
- alter their practice in line with agreed improvements
- share achievements
- challenge tradition

f) evaluates with others the effectiveness of service improvements and agrees that further action is required to take them forward

g) appraises draft policies and strategies for their effect on users and the public and makes recommendations for improvement

Foundation Gateway (Subset Outline)

SERVICE IMPROVEMENT - Level: 3

Level Indicators:

a) identifies and evaluates areas for potential service improvement

b) discusses and agrees with others:
- how services should be improved as a result of suggestions, recommendations and directives
- how to balance and prioritise competing interests
- how improvements will be taken forward and implemented

c) constructively undertakes own role in improving services as agreed and to time, supporting others effectively during times of change and working with others to overcome problems and tensions as they arise

d) maintains and sustains direction, policies and strategies until they are firmly embedded in the culture inspiring others with values and a vision of the future whilst acknowledging traditions and background

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- understand and appreciate the influences on services and the reasons why improvements are being made
- offer suggestions, ideas and views for improving services and developing direction, policies and strategies
- alter their practice in line with agreed improvements
- share achievements
- challenge tradition

f) evaluates with others the effectiveness of service improvements and agrees that further action is required to take them forward

g) appraises draft policies and strategies for their effect on users and the public and makes recommendations for improvement

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Examples Of Application:
Identifies and encourages others to identify areas for improvement eg ensure active engagement with service users. Ensure clear pathways are developed and implemented for service users/projects. Support AD to implement and actively promote the divisional Health & Wellbeing Improvement Plan. Support AD to implement quality initiatives. Contribute to local/regional services planning including policy development. Promote innovation and change to underpin modernisation of services and challenge traditional ways of working. Ensure direction, policies and strategies and reasons for same are cascaded and embedded within service area. Evaluate effectiveness of service improvements and further modify or roll out improvements as appropriate. Demonstrate an understanding of Personal and Public Involvement (PPI), Community Development (CD) and Health Improvement (HI) and implement PPI/CD/HI in own service; acts consistently with legislation, policies, procedures in relation to PPI/CD/HI and promotes the value of PPI/CD/HI approaches to others; evaluates the quality of own and others' work in relation to PPI/CD/HI and raises issues and related risks with the relevant people; supports the introduction and maintenance of systems and processes to embed PPI/CD/HI in own service area.

Examples of Application:
Identifies and encourages others to identify areas for improvement eg ensure active engagement with service users. Ensure clear pathways are developed and implemented for service users/projects. Support AD to implement and actively promote the divisional Health & Wellbeing Improvement Plan. Support AD to implement quality initiatives. Contribute to local/regional services planning including policy development. Promote innovation and change to underpin modernisation of services and challenge traditional ways of working. Ensure direction, policies and strategies and reasons for same are cascaded and embedded within service area. Evaluate effectiveness of service improvements and further modify or roll out improvements as appropriate. Demonstrate an understanding of Personal and Public Involvement (PPI), Community Development (CD) and Health Improvement (HI) and implement PPI/CD/HI in own service; acts consistently with legislation, policies, procedures in relation to PPI/CD/HI and promotes the value of PPI/CD/HI approaches to others; evaluates the quality of own and others' work in relation to PPI/CD/HI and raises issues and related risks with the relevant people; supports the introduction and maintenance of systems and processes to embed PPI/CD/HI in own service area.

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Second Gateway (Full Outline)

QUALITY - Level: 4

Level Indicators:

a) acts consistently with legislation, policies, procedures and other quality approaches and alerts others to the need for improvements to quality
b) works effectively in own team and as part of the whole organisation

c) prioritises, organises and carries out own work effectively

d) enables others to understand, and address risks to quality

e) actively promotes quality in all areas of work

f) initiates and takes forward the introduction and maintenance of quality and governance systems and processes across the organisation and its activities
g) continuously monitors quality and takes effective action to address quality issues and promote quality.

Examples Of Application: Adhere to legislation, delegated statutory functions, profession, DHSSPS guidelines, standards, policies and procedures (self/others) and a high quality standard is maintained, eg the 5 standards of improving the patient & client experience (respect, attitude, behaviour, communication, privacy & dignity). Being an effective team member as well as leader. Liaise closely with the Division's Governance Lead and/or Director/AD re the need for improvements in quality eg analysis of legislation, auditing, benchmarking, investigation of accidents/incidents/near misses. Ensure robust arrangements are in place to meet controls assurance standards, the assessment and management of risk. Ensure all recommendations from RQIA and/or other regulatory bodies are implemented within timescales. Support AD with effective performance management arrangements, including defining and monitoring performance standards in contracts/SLA's or against delivery of project objectives. Promote a culture of continuous improvement and actively address identified deficits in quality.

Foundation Gateway (Subset Outline)

QUALITY - Level: 4

Level Indicators:

a) acts consistently with legislation, policies, procedures and other quality approaches and alerts others to the need for improvements to quality
b) works effectively in own team and as part of the whole organisation

c) prioritises, organises and carries out own work effectively

d) enables others to understand, and address risks to quality

e) actively promotes quality in all areas of work

f) initiates and takes forward the introduction and maintenance of quality and governance systems and processes across the organisation and its activities
g) continuously monitors quality and takes effective action to address quality issues and promote quality.

Examples of Application: Adhere to legislation, delegated statutory functions, profession, DHSSPS guidelines, standards, policies and procedures (self/others) and a high quality standard is maintained, eg the 5 standards of improving the patient & client experience (respect, attitude, behaviour, communication, privacy & dignity). Being an effective team member as well as leader. Liaise closely with the Division's Governance Lead and/or Director/AD re the need for improvements in quality eg analysis of legislation, auditing, benchmarking, investigation of accidents/incidents/near misses. Ensure robust arrangements are in place to meet controls assurance standards, the assessment and management of risk. Ensure all recommendations from RQIA and/or other regulatory bodies are implemented within timescales. Support AD with effective performance management arrangements, including defining and monitoring performance standards in contracts/SLA's or against delivery of project objectives. Promote a culture of continuous improvement and actively address identified deficits in quality.

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Second Gateway (Full Outline)

EQUALITY AND DIVERSITY - Level: 2

Level Indicators:

a) recognises the importance of people's rights and acts in accordance with legislation, policies and procedures
b) acts in ways that:
- acknowledge and recognise people's expressed beliefs, preferences and choices
- respect diversity
- value people as individuals
c) takes account of own behaviour and its effect on others

d) identifies and takes action when own or others' behaviour undermines equality and diversity.

Examples Of Application: Promote the Trust's policy on equality of opportunity through his/her own actions and ensure that this policy is adhered to by staff for whom he/she has responsibility eg the 5 standards of improving the patient & client experience (respect, attitude, behaviour, communication, privacy & dignity), age, religion, gender, etc. Participate as required in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust. Ensure that caring service is delivered and people are treated in a courteous and respectful manner, recognising and valuing their expressed beliefs, preferences and choices. Identify and seek to address areas of service improvement required to ensure equality of opportunity eg translation services. Comply with HPSS and/or professional codes of conduct.

Foundation Gateway (Subset Outline)

EQUALITY AND DIVERSITY - Level: 2

Level Indicators:

a) recognises the importance of people's rights and acts in accordance with legislation, policies and procedures
b) acts in ways that:
- acknowledge and recognise people's expressed beliefs, preferences and choices
- respect diversity
- value people as individuals
c) takes account of own behaviour and its effect on others

d) identifies and takes action when own or others' behaviour undermines equality and diversity.

Examples of Application:
Promote the Trust's policy on equality of opportunity through his/her own actions and ensure that this policy is adhered to by staff for whom he/she has responsibility eg the 5 standards of improving the patient & client experience (respect, attitude, behaviour, communication, privacy & dignity), age, religion, gender, etc. Participate as required in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust. Ensure that caring service is delivered and people are treated in a courteous and respectful manner, recognising and valuing their expressed beliefs, preferences and choices. Identify and seek to address areas of service improvement required to ensure equality of opportunity eg translation services. Comply with HPSS and/or professional codes of conduct.

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Second Gateway (Full Outline)

PROTECTION OF HEALTH AND WELLBEING - Level: 4

Level Indicators:

a) works in partnership with others to identify and assess
- the nature, location and seriousness of risks
- the problems that need to be addressed
- the factors that might be causing the problems
- priorities
- legislative, policy and procedural requirements

b) identifies and agrees with others a range of options for addressing agreed priorities and selects those that have the best chance of success

c) develops with the help of others an overall protection plan

d) considers each specific case in the context of the overall protection plan and decides with others how to proceed

e) identifies and agrees in partnership with others
- who will be involved in the management of specific risks
- how the risks can best be managed
- who needs to be kept informed

f) coordinates across the different people involved to effectively manage risks facilitating swift and effective communication and support

g) undertakes any protective interventions that are necessary for the management of risks, their complexity and for which s/he holds responsibility

h) maintains an ongoing accurate record of risks, the actions taken and other investigations that have been put into effect

i) reviews with others the effectiveness of protection plans, any issues with their implementation, and makes the necessary changes as a result.

Foundation Gateway (Subset Outline)

PROTECTION OF HEALTH AND WELLBEING - Level: 4

Level Indicators:

a) works in partnership with others to identify and assess
- the nature, location and seriousness of risks
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i) reviews with others the effectiveness of protection plans, any issues with their implementation, and makes the necessary changes as a result.

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Examples Of Application: This will not be included in the HOS in Finance & Procurement, Performance & Reform and Human Resources & Organisational Development. Lead uni and multidisciplinary teams and oversee the co-ordination of all processes to ensure the delivery of high quality services. Liaise closely with the division's social care governance lead to ensure robust arrangements are in place for the assessment and management of risk. Ensure that services comply with all professional regulatory and requisite standards and the discharge of statutory functions. Ensure all recommendations from the RQIA and other regulatory bodies are implemented within requisite timescales. Work closely with senior colleagues and other statutory and voluntary agencies to secure an appropriate balance between child protection, safeguarding and family support services. Ensure clear pathways are developed and implemented for service users referred to and/from other divisions/directorates. Ensure systems and procedures for the management and storage of information in each facility/team meet internal and external reporting requirements eg Good Records, Good Management, Data Protection Act.

Examples of Application:
This will not be included in the HOS in Finance & Procurement, Performance & Reform and Human Resources & Organisational Development. Lead uni and multidisciplinary teams and oversee the co-ordination of all processes to ensure the delivery of high quality services. Liaise closely with the division's social care governance lead to ensure robust arrangements are in place for the assessment and management of risk. Ensure that services comply with all professional regulatory and requisite standards and the discharge of statutory functions. Ensure all recommendations from the RQIA and other regulatory bodies are implemented within requisite timescales. Work closely with senior colleagues and other statutory and voluntary agencies to secure an appropriate balance between child protection, safeguarding and family support services. Ensure clear pathways are developed and implemented for service users referred to and/from other divisions/directorates. Ensure systems and procedures for the management and storage of information in each facility/team meet internal and external reporting requirements eg Good Records, Good Management, Data Protection Act.

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Second Gateway (Full Outline)

FINANCIAL MANAGEMENT - Level: 3

Level Indicators:

a) gives relevant people opportunities to provide information on the use of financial resources
b) presents recommendations and requests to the relevant people regarding financial resource use which:
- take account of relevant past experience
- take account of trends and developments
- are consistent with organisational objectives and policies
- are realistic, justifiable and of clear benefit
- are sufficient to support the activities within his/her control

c) negotiates and agrees the allocation of financial resources

d) supports and encourages budget holders to make efficient and effective use of financial resources
e) plans, schedules, controls and monitors the use of financial resources against agreed budgets
f) identifies any actual or potential deviations from budgets and works with the budget holder to find effective ways of handling it
g) reviews the allocation and use of financial resources and agrees appropriate improvements
h) provides appropriate support to others to improve their knowledge and understanding of financial resource management.

Examples Of Application: Responsible for the management of relevant expenditure/budgets/SLA's and the meeting of all financial targets by each team/service area (self/others). Ensure the effective implementation of all Trust financial policies and procedures in each facility/team to include ensuring the safe custody of clients' property and accounts and the use of endowments and gifts. Ensure the effective management, use and maintenance of all physical assets in each facility/team ensure that management structures and practices within each of the facilities/teams support efficient use of resources.

Foundation Gateway (Subset Outline)

FINANCIAL MANAGEMENT - Level: 3

Level Indicators:

a) gives relevant people opportunities to provide information on the use of financial resources
b) presents recommendations and requests to the relevant people regarding financial resource use which:
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Second Gateway (Full Outline)

SERVICES AND PROJECT MANAGEMENT - Level: 4

Level Indicators:

a) works with others to identify and produce plans that contain all the necessary detail for managing and delivering services and/or projects and that are:
- consistent with legislation, policies and procedures
- supportive of the organisation's / partnership's direction, strategy and objectives

b) negotiates and agrees with others how to put in place sufficient supporting mechanisms to ensure that services and/or projects are managed and delivered effectively

c) works with others to put in place methods, processes and systems for implementing service / project plans

d) monitors the delivery and management of services and/or projects in order to:
- evaluate performance against plans
- identify issues
- predict future needs and shortfalls
- identify trends and developments
- assess capacity to meet future needs

e) reviews plans, methods, processes and systems for managing services and/or projects and modifies them to improve effectiveness

f) provides appropriate support to others to improve their knowledge and understanding of service and/or project management.

Foundation Gateway (Subset Outline)

SERVICES AND PROJECT MANAGEMENT - Level: 4

Level Indicators:

a) works with others to identify and produce plans that contain all the necessary detail for managing and delivering services and/or projects and that are:
- consistent with legislation, policies and procedures
- supportive of the organisation's / partnership's direction, strategy and objectives

b) negotiates and agrees with others how to put in place sufficient supporting mechanisms to ensure that services and/or projects are managed and delivered effectively

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- evaluate performance against plans
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- predict future needs and shortfalls
- identify trends and developments
- assess capacity to meet future needs

e) reviews plans, methods, processes and systems for managing services and/or projects and modifies them to improve effectiveness

f) provides appropriate support to others to improve their knowledge and understanding of service and/or project management.

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Examples Of Application: Support the AD with service planning/development initiatives, promoting innovation/change, liaising closely with senior planning/performance staff in order to implement the objectives of the Trust's Delivery Plan and local commissioning priorities. Ensure the Trust's and division's objectives and decisions are effectively communicated and staff supported through change. Contribute to services planning locally and regionally, working closely with commissioners and relevant stakeholders in the statutory and voluntary sectors to support the planning and delivery of high quality care/projects/services. Act as a member of the division's senior management team and contribute to its policy development processes. Represent the division and/or directorate in Trust project teams and/or regional planning teams as appropriate. Ensure robust arrangements are in place to assess and manage risk ensuring that services comply with all professional regulatory and requisite standards and/or the discharge of statutory functions.

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Second Gateway (Full Outline)

PEOPLE MANAGEMENT - Level: 3

Level Indicators:

a) suggests workforce requirements to meet team and organisational objectives
b) selects individuals for posts using agreed methods and based on objective assessments against agreed criteria
c) gives team members clear information on, and opportunities to influence, work objectives, planning and organisation, in a way which inspires commitment and enthusiasm
d) plans and coordinates work:
- prioritising and reprioritising activities to respond to changing circumstances
- managing multiple processes simultaneously whilst enabling teams and individuals to focus on their own specific objectives
e) delegates authority to people and monitors them against the required outcomes, agreeing with them:
- clear, explicit and achievable targets and timescales
- ways in which their development will be supported
- how progress and performance will be monitored and reviewed
f) allocates and provides sufficient resources and support for delegated work and reviews progress and outcomes with people as agreed
g) gives people support and opportunities to meet their personal development objectives
h) agrees with people appropriate courses of action to address any issues with their work

Foundation Gateway (Subset Outline)

PEOPLE MANAGEMENT - Level: 3

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a) suggests workforce requirements to meet team and organisational objectives
b) selects individuals for posts using agreed methods and based on objective assessments against agreed criteria
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g) gives people support and opportunities to meet their personal development objectives
h) agrees with people appropriate courses of action to address any issues with their work

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Examples Of Application: Provide clear leadership to staff and ensure all facilities/teams have a highly skilled, flexible and motivated workforce. Ensure that systems and processes are in place to ensure the professional leadership and supervision of staff including KSF PDR's and their effective personal development. Work closely with senior human resources staff to take forward the development and implementation of workforce planning and modernisation initiatives eg skill mix initiatives. Ensure that management structures and practices within each of the facilities/teams support a culture of effective team working, continuous improvement and innovation. Ensure that systems and processes are in place to identify, and address difficulties/conflicts which may impact upon effective team working. Ensure the effective implementation of all Trust people management policies in each facility/team and the achievement of all relevant targets such as those relating to staff performance and development reviews, the management of sickness and absenteeism, turnover, etc. Ensure the effective management of staff health and safety and support in each facility/team. Delegate responsibility and authority to staff within his/her control consistent with effective decision making whilst retaining responsibility and accountability for results. Participate as required in the selection and appointment of staff in accordance with procedures laid down by the Trust. Take such action as may be necessary in accordance with procedures laid down by the Trust eg disciplinary matters.

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Document has ended

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Parks, Zoe

From: Boyd, Kathryn <[redacted]>
Sent: 21 April 2020 11:57
To: Parks, Zoe
Subject: RE: From your Medical HR Team - NEW MEDICAL HR HUB *PLEASE READ*

Zoe, congratulations on the production of this excellent resource. So comprehensive and easily accessed.

Kathryn

From: Parks, Zoe
Sent: 21 April 2020 10:46
To: Acheson, Janet; Adams, Dr Beverley; Aljarad, Bassam; Green, Andrea; Arava, Shiva; Armstrong, Matt; Bennett, Tim; Best, Stephen; Boggs, Edgar; Boyd, Kathryn; Bradford, Christina; Bradley, Una; Brady, Aidan; Brown, Jeffrey; Brown, Martin; Brown, Robin; Browne, Gail; Bunn, Jonathon; Bunting, Helen; Campbell, Clarke; Campbell, John; Campbell, PatriciaM; Carson, Anne; Cassidy, Lisheen; Chada, Neta; Clarke, Chris; Clarke, Rosemary; Conlan, Enda; Convery, Rory; Cosgrove, Jenny; Cotter, Paul; Coulter, Paul, G; Craig, David; Cullen, Aidan; Cunningham, Marietta; Curran, Judy; Currie, Aoife; Daly, Cathy; Damani, Nizam; DeCourcyWheeler, Richard; Donnelly, Brian; Doyle, Timothy; East, Adrian; Eedy, David J; Epanomeritakis, Manos; Ervine, Aaron; Farnan, Turlough; Fawzy, Mohamed; Flannery, Daniel; Forbes, Raeburn; Foy, Allister; Gilpin, David; Glackin, Anthony; Gormley, Damian; Gorski, Michal; Gracey, David; Graham, David; Gray, Alastair; Grier, David; Gupta, Nidhi; Hamilton, Beverley; Hampton, Gareth; Hanna, Heather; Harty, John; Haynes, Mark; Henderson, Jonathan; Hewitt, Gareth; Hillemand, Christophe; Hussain, Mumtaz; Lewis, JulieZ; charlie mcallister; McCauley, Chris; McCormick, Eleanor; McCutcheon, Fiona; McIntyre, Gemma; McKeating, Cara; McKeown, Ciara; McKillop, Derek; McLoughlin, Laura; Millar, Sarinda; Ahmed, Gamal; Chinnadurai, Anitha; Goddard, Karen; Henry, Rebecca M; Holmes, Erskine; Hughes, James; James, Barry; Jamison, Michael; John, Alexander; Johnston, Dr Linda; Jones, Michael; Kamath, Meeta; kearney, Angela; Khan, Ahmed; Khan, Sana; King, Eimear; Knox, Andrew; Korda, Marian; Kumar, Devendra; Lewis, Alastair; Leyden, Peter; Lichnovsky, Erik; Liggett, Nathaniel; Loane, Katharine; Lowry, Darrell; Mackle, Eamon; Maiden, Nicola; Martin, Laure; Mathers, Helen; Mathers, Rachel; McArdle, Gerarde; McCaffrey, Patricia; McCaul, David; McClean, Gareth; McClelland, Anthony; McConaghy, Paul; McConnell, Mae; McConville, Richard; McCormick, Tim; McCracken, Geoff; McEneaney, David; McGalie, Clare; McGarry, Paul; McGleenon, Bronagh; McGovern, Anna; McGrath, Conor; McGucken, Paul; McKay, Damian; McKee, Raymond; McKenna, Michael; McKeown, Ronan; McKinney, Karen; McKnight, Karen; McLoughlin, Caroline; McMahon, Dr; McMurray, David; McNaboe, Ted; Menown, Ian; Merjavy, Peter; Milligan, Aaron; Mills, Heather; Minay, Joanne; Mkandawire, Mercy; Mlodzianowski, Artur; Moan, Shane (Michael-John); Morgan, Neal; Morrow, Michael; Mulroe, Teresa; Murphy, Seamus; Nicholson, Gail; OHagan, Art; Morris, Osmond; Patton, David; Southwell, Chris; Yousuf, Imran
Cc: Clegg, Malcolm; OHanlon, Niambh; McNeice, Andrea; OKane, Maria; Diamond, Aisling
Subject: From your Medical HR Team - NEW MEDICAL HR HUB *PLEASE READ*

New HR Information and Guidance for Clinical Managers

All Consultants,

Please check out the new Medical HR HUB: [redacted]. ***Password:*** [redacted]

The password is needed as this HUB will be accessible from your mobile device, home computer and tablet. You may need to save this link to 'your favourites'* for ease of access in the future. You can however get the link at any time from the Medical HR Share-point Page under useful links.
[redacted]

We recognise this is a difficult and demanding time for clinical leaders, so the information and resources contained within this Hub have been designed to support and guide you as best as possible. I have also attached a new document – **Covid19 Frequently Asked Questions for Medics** which has been agreed

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regionally and with the BMA for your reference. (This document is also available from the Medical HR Hub.)

Please also be aware that if you would like us to help you record medical staff on HR/Payroll systems who are absent e.g. due to self-isolating or Covid19, then please forward the details; name, staff number, reason, start date and expected end date to Personal Information redacted by the USI. It is important this information is captured on the first day of absence to facilitate accurate reporting to the Minister of Health. Staff members who may be symptomatic should contact Occupational Health as soon as possible (within the first few days) to ensure testing can be considered.

Thank you for all that you do. Please feel free to contact the Medical HR team who are here to help you with whatever you need.

Personal Information redacted by the USI

Zoë Parks
Head of Medical HR
Southern Health & Social Care Trust
Tel: Personal Information redacted by the USI
Mob: Personal Information redacted by the USI

Working together Excellence Openness & Honesty Compassion
HSC Values

*** How to save to Favourites:**

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Southern Health and Social Care Trust

Quality Care - for you, with you

SHSCT - VULNERABLE ROTAS January 2018

The Medical Staffing Department manage: 35 separate working patterns. • **23 rotas for Craigavon** • **12 rotas for Daisy Hill** ***The following 13 rotas have been classified as Vulnerable/At Risk by Medical Staffing***	**OUR CLASSIFICATION OF RISK** **1: Above Funded Band & Non EWTD compliant & Reliance on Locums / Safety** **2: Two or more of the above (but less than all)** **3: One or more of the above but less than all)**

Location/site	Specialty/ Tier	Comments	Suggested Actions	RISK
Craigavon	General surgery 2nd tier registrars	• 4 training posts funded at 50% 1A Band • 1:6 rota Band 3 since 2013 • Rota includes a Specialty Doctor (14.5PA's) and relies on a sixth Agency Locum.	• Appoint Consultant Lead to document plan for sustainable and safe long term rota • Document our concerns to the region to ensure remains on the agenda to look for regional solutions to safeguard safety of doctors and the patients.	1
Daisy Hill	General surgery 2nd tier registrars	• 3 training posts funded at 50% 1A Band • Long term chronic underfill of posts • 1:6 Full Shift Rota with 2 SAS doctors band 2A • Reliance on Agency locums	• As above	1
Craigavon	Urology	• 2 Urology training posts. • 1 in 6 partial shift rota, (no nights) Work up to 11pm. • Rota reliant on agency Locums • Vulnerable band 3 outcome - Rest issues and excessive hours. • Funded 2B (50%) AMD wants to move to 2A (80%)	• Need an Agreed Rota and agreement on pay banding • AMD and Clinical Lead to review rota and explore possible change required. • Details on rota compliance included on AMD and CD's role reviews?	1
Craigavon	Trauma	• 2 training posts at FY2 level in T&O	*As before with Gen Surgery: 1st Tier*	1

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Location/site	Specialty/ Tier	Comments	Suggested Actions	RISK
	& Orthopaedics 1st and 2nd tier	• Funded at 50% for banding. • Work a 1 in 6 on-call rota, reliance on agency locums to fill rota slots. • Monitored band 3 - rest issues overnight when on-call. • 3 training posts at registrar level -These posts are funded at 50% for banding; Work alongside SAS doctors. • 2nd Tier 1:8 on-call rota (filling 1 slot with locum)	• *Need to move to Full Shift rota with T&C and General Surgery.* • *Appoint a Consultant Lead to drive this project through.* 2nd Tier – fairly stable for now.	
Daisy Hill	General Medicine 2nd tier	• 1 post at registrar level (doesn't work nights) • Works alongside SAS 1:7 cover until 9.30pm • Ongoing reliance on agency locums to provide overnight cover at middle grade level in Daisy Hill (Mon-Sun). • SAS doctors don't currently work overnight: only until 9.30. Consultants are Category A on-call as opposed to Category B historically due to no middle grade cover? • ***HUGE locum costs*** *associated with SHSCT Medical Team being asked to book full shift resident locum cover at registrar level 7 days per week.*	• URGENT need to appoint Lead consultant to address unsustainable requirement for locum doctors. • Total reliance on unknown external locum doctors to provide resident cover from 8.30pm – 9am 7 days per week. • Need to review activity overnight; alternative means to cover and a more sustainable and affordable but primarily safe solution long term.	**1***
Daisy Hill	General surgery	• 4 ST posts. Funded at 1A 50%.	*As before with Gen Surgery: 1st Tier*	**1**

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Location/site	Specialty/ Tier	Comments	Suggested Actions	RISK
	1st tier	• Rota has changed to 1 in 6 so evening and night cover every night. • Band increased from 1A 50% to 2A 80%. • Rota is reliant on locum cover to fill the 4th and 5th slots.	• *Need to move to Full Shift rota with T&C and General Surgery.* • *Appoint a Consultant Lead to drive this project through.*	
Craigavon	Surgery/Medicine FY1	• 23 FY1's in Craigavon • Lowest Number in Northern Ireland • Funded for 1A (50%) • Currently paying doctors band 2A (80%) • High Risk for band 3 due to intensity of rota	• Documented case to DHSSPS/NIMDTA re our overall numbers? • Consultant Lead to take forward Action plan for non-EWTD compliance and intense working patterns to drive forward necessary change and review of solutions. (i.e. PA support, HAN etc.) • Nominated lead for liaison and to monitor/control breaks taken	**2**
Craigavon	ENT 1st tier	• 3 core trainees & 1 ST3 work 1:5 non-resident on-call rota. Funded (band 1A-50%) but recently monitored Band 3. • Consistency monitoring Non-Compliant – but have continued to pay 50% to date. • Not achieving Rest requirements.	• Need to move to Full Shift rota with T&O and General Surgery. • Appoint a Consultant Lead to drive this project through.	**2**

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Location/site	Specialty/ Tier	Comments	Suggested Actions	RISK
Craigavon	General Medicine 1st tier	• 21 training posts. Due to gaps only 19 in post • Rota collapsed and higher banding paid. • Funded Band 1B (40%). Had to increase banding to 1A (50%) due to gaps on rota.	• No priority action required at present.	3
Daisy Hill	Emergency Medicine	• 6 training posts in ED in Daisy Hill. • 1 in 8 full shift rota. • Reliant on agency locums to fill rota slots.	• Monitor agency locum usage • Aim to transfer locums from agency to HSC E Locums.	3
Daisy Hill	Medicine/ surgery FY1	• 11 FY1's from Aug 2017. Band 1A • Industrial Tribunal Claim submitted from FY1 doctors August 2016 – Aug 17. • Surgery Fy1 don't work nights. Issue re compliance with breaks/lunchtime teaching	• Appoint Lead on DHH site to monitor ability of doctors to take Breaks for FY1 doctors.	3
Daisy Hill	General Medicine 1st tier	• 1:16 full shift rota (some trust funded posts) • Aug 16 rota redesigned to provide additional cover to 9pm • Funded 1B (40%) • Banding increased to Band 1A (50%)	• Fairly Stable for Now. • Monitor with Medical Locum team to ensure locum costs reduce.	3

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Southern Health and Social Care Trust

Quality Care - for you, with you

SHSCT - VULNERABLE ROTAS January 2018

The Medical Staffing Department manage: 35 separate working patterns. • **23 rotas for Craigavon** • **12 rotas for Daisy Hill** ***The following 13 rotas have been classified as Vulnerable/At Risk by Medical Staffing***	**OUR CLASSIFICATION OF RISK** **1: Above Funded Band & Non EWTD compliant & Reliance on Locums / Safety** **2: Two or more of the above (but less than all)** **3: One or more of the above but less than all)**

Location/site	Specialty/ Tier	Comments	Suggested Actions	RISK
Craigavon	Emergency Medicine All tiers	• Historically 10 SHO level posts and 2 registrar posts in ED; however reported by trainees as being one of the worst rotas in NI. Trust has agreed to fund 5 additional ST4 training posts & 1 Trauma Fellow over the past couple of years. (Total 18 NIMDTA posts) • August 2016 introduced 3 separate rotas – 1st tier (SHO) rota (1 in 12), Intermediate rota (1 in 6) and registrar rota (1 in 6). However we don't have 24 trainees • Rotas are reliant on **6 Agency Locums at Locum Rates** to fill rota slots. • Banding 1A (50%) for the Trust employed posts • SAS Rota also reliant on Agency locums	• Consultant lead to review rotas to reduce reliance on Agency Locums & ensure we are making best use of rota design with doctor numbers and other skill mix • Trial of electronic solution for rostering in ED? • Ask the doctors to pitch ideas on how to plan for a sustainable solution – pitch their ideas? • Documented Plan towards sustainable solution.	**3**
Daisy Hill	Obs & Gynae 1st tier	• 1:6 full shift • 6 training posts - Long history of training posts not being filled • Huge reliance on agency locums to cover vacant rota slots.	• Document correspondence to NIMDTA on chronic under fill of training posts • This needs to be reviewed given recent RCOG/NIMDTA visit reports	**3**

- ** Some other reason has necessitated priority 1 classification: - entire rota middle tier dependant on locums*

Circulated to Dr Wright MD, S Gibson AD, V Toal DirHR. MD to share with all AMD's and CD's for action

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SHSCT - VULNERABLE ROTAS August 2021

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Location/site	Specialty/ Tier	Current status/Comments	Suggested Actions	RISK
Craigavon	General surgery 2nd tier registrars	• The Trust has 4 training posts funded at 50% (band 1A) • rota is 1:6 **Band 3** (100% supplement) – has been since 2013 • This rota relies on all 4 training posts being filled by NIMDTA each year, however even if all the posts are filled, this still places a reliance on locums. In the last few years the Trust has been fortunate to secure research registrars (ADEPT Fellows) in posts 5 and 6 to provide on call cover at nights and weekends. There is otherwise a reliance on agency locums for these 2 posts.	• Pending the outcome of the planned reconfiguration plan for surgery early next year and the proposed Assessment Ambulatory Area, a Consultant Lead should be appointed to develop a plan for a sustainable and safe long term rota. Special consideration should be given to safety and training needs and service demands • Document our concerns to the Department to ensure these remain on the agenda for regional solutions to safeguard the safety of doctors and the patients. In a recent College review, it was noted this rota was band 3. • Make representations to NIMDTA and the DoH via the AMD for Medical Education for additional registrar posts in surgery • Consultant Lead to give consideration to the appointment of MTI doctors or possible research role	1

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Location/site	Specialty/ Tier	Current status/Comments	Suggested Actions	RISK
Daisy Hill	General surgery 2nd tier registrars	• 3 training posts funded at 50% (band 1A) • rota has been comprised of 3 trainees and 3 SAS doctors for some time • rota template band is 2B (50%), however trainees are being pay protected at band 2A (80%). This was agreed some years ago in an attempt to make the Daisy Hill rota attractive • it is very rare for all 3 DHH training posts to be filled by NIMDTA, hence there is an ongoing reliance on locums • Following August 2021 changeover, the Trust has ended up with 1 trainee plus 2 SAS doctors in post, therefore half the rota is dependent on agency locums (3 doctors)	• There is an urgent requirement for more substantive consultants in DHH. Posts advertised recently with sub specialty interest were not approved by the Specialty Advisor • Pending the outcome of the planned reconfiguration plan in surgery early next year, decide if registrar cover is required on both sites. Appoint a Consultant Lead to review this. Special consideration should be given to safety and training needs and service demands • Consultant Lead to give consideration to appointment of SAS and MTI doctors	1
Daisy Hill	General surgery 1st tier Junior rota	• The Trust has 4 training posts at this level in Daisy Hill surgery. Funded at 50% (band 1A). • Rota was changed to 1 in 6 Full shift a few years ago to provide evening and overnight cover every night. • As a result of this, the band increased from 1A (50%) to 2A (80%).	• Pending the outcome of the planned reconfiguration plan early next year, appoint a Consultant Lead to develop a plan for a sustainable and safe long term rota. • Divisional Medical Director for surgery should consider moving to a surgical	1

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Location/site	Specialty/ Tier	Current status/Comments	Suggested Actions	RISK
		• Rota is reliant on locum cover to fill the 5th and 6th slots. • Following August 2021 changeover, 3 out of the 4 training posts were filled, therefore half the rota is dependent on agency locums (3 doctors)	specialties Full Shift rota at FY2/core level to include core trainees from General surgery, T&O and ENT. He/she should also consider the potential for rotation between sites • Appoint a Consultant Lead to drive this project through • Make representations to NIMDTA and the DoH via the AMD for Medical Education for additional core level training posts in surgery	
Craigavon	Urology	• Trust has 3 approved training posts in Urology. • Rota is 1 in 6 partial shift, (no nights) Trainees cover up to 11pm on weeknights and 9pm at weekends. • Rota is band 2B, and reliant on agency Locums • Vulnerable to band 3 outcome – difficulties with achieving required rest during out of hours periods and average weekly hours fall outside EWTD requirements. • August 2021 – 2 Clinical Fellows appointed along with 2 NIMDTA trainees and 2 ADEPT Fellows (who cover OOH periods only)	• Divisional Medical Director for surgery has begun to review this rota to explore moving to a full shift pattern (no nights). This would remove the rest issues associated with the Partial shift. • Divisional Medical Director for surgery should consider appointment of SAS and MTI doctors. SAS doctors could be offered sub-specialty interest • Trainees have already raised concerns with management re limited training	1

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Location/site	Specialty/ Tier	Current status/Comments	Suggested Actions	RISK
			opportunities due to elective lists being cancelled, limited theatres etc	
Craigavon	Trauma & Orthopaedics 1st tier Junior rota	• There is only 1 training post at FY2 level in T&O • Funded for 50% banding. • Rota is 1 in 6 on call, so there is an ongoing reliance on agency locums to fill 5 rota slots. • Monitored band 3 - rest issues overnight when on-call. • 4 LAS appointments were made prior to Aug 2021 (however 1 has resigned), so 2 agency locums required	As above with Gen Surgery: 1st Tier • Divisional Medical Director for surgery should consider moving to a surgical specialties Full Shift rota at FY2/core level with General Surgery and ENT. • Appoint a Consultant Lead to drive this project through. • Make representations to NIMDTA and the DoH via the AMD for Medical Education for additional core level training posts in these specialties, • GP trainees in Ortho geriatrics??	**1**
Craigavon	Surgery/Medicine FY1	• 23 FY1's in Craigavon • SHSCT has lowest Number of FY1s (per Trust) in Northern Ireland • Funded for 1A (50%) • Currently paying doctors band 2A (80%), so rota is non-compliant with EWTD	• Urgent need to appoint FY1 Lead Consultant specifically for liaison with FY1s re rota issues, breaks etc • Document case to DHSSPS/NIMDTA re our overall FY1 numbers compared to other Trusts • Lead Consultant to bring forward	**2**

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Location/site	Specialty/ Tier	Current status/Comments	Suggested Actions	RISK
			Action plan to develop solutions for non-EWTD compliance and intense working patterns and to review impact and best use of support grades e.g. Physician Associates, Medical Assistants, Clinical Coordinators, nursing staff etc to drive forward necessary change	
Craigavon	General Medicine 1st tier	• 20 approved training posts. There had been 21, but 1 FY2 post was removed following an overall reduction in FY1 numbers by DoH a few years ago. • 1 trainee is allocated to Lurgan and 1 to South Tyrone during day time hours • Rota collapsed and higher banding paid. Funded Band 1B (40%), however had to increase banding to 1A (50%) because of reduced training numbers and additional weekend cover required. • Additional Clinical Fellow rota (12 slots) operates alongside the Junior trainee rota. This has been introduced to provide additional support with ongoing pressures, cover medical outliers etc	• Make representations to NIMDTA and the DoH via the AMD for Medical Education for additional core training posts/ GP trainee posts in Medicine • 1 trainee is allocated to Lurgan and South Tyrone every day. Could this cover be provided by other grades (e.g. non-medical) or perhaps by the ACAH service?	**2**

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Location/site	Specialty/ Tier	Current status/Comments	Suggested Actions	RISK
		• Extra locums being sourced every night – either 2 SHOs or 1 SHO and 1 registrar		
Daisy Hill	General Medicine 1st tier	• 1:17 full shift rota • In Aug 2016 DHH Medicine had 14 approved SHO level training posts. There are now 17 approved posts (3 x FY2s, 5 GP trainees and 9 CT/IMTs) • In Aug 2016 the rota was redesigned to provide additional cover to 9pm and more recently additional weekend cover has been introduced • Funded 1B (40%), however banding increased to Band 1A (50%) because of this additional cover • Approval has been granted for 2 additional locums (9-5) to help with ongoing day time pressures. •	• Develop matrix of minimum numbers required during the week (24/7) to identify pressure points. • Review best use of medical staff and support grades to alleviate pressures e.g. SAS doctors, Physician Associates, Medical Assistants, Clinical Coordinators, nursing staff etc	2
Craigavon	General surgery 1st (Junior) tier	• Trust has 7 approved training posts • Rota is 1:7 Full shift, band 2A (80%). We are funded for 50%	• Pending the outcome of the planned reconfiguration plan early next year, make representations to NIMDTA and the DoH via the AMD for Medical Education for additional training posts in core surgery • Divisional Medical Director for surgery	2

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Location/site	Specialty/ Tier	Current status/Comments	Suggested Actions	RISK
			should consider moving to a surgical specialties Full Shift rota at FY2/core level with ENT and T&O. He should also consider the potential for rotation between sites	
Craigavon	ENT 1st (Junior) tier	• 3 core trainees & 1 ST3 work alongside 3 SAS doctors in 1:7 non-resident on-call rota. • The 3 core training posts are not always filled by NIMDTA • Funded for band 1A - 50%, but vulnerable to Band 3 outcome. • Difficulty achieving rest requirements when on call. Compromise reached – band 2A (80%) currently being paid	• Divisional Medical Director for surgery should consider moving to a surgical specialties Full Shift rota at FY2/core level with General Surgery and T&O. • Appoint a Consultant Lead to drive this project through. • Make representations to NIMDTA and the DoH via the AMD for Medical Education for additional core level training posts in ENT	**2**
Daisy Hill	Obs & Gynae 1st tier	• 1:6 full shift • There are only 4 approved training posts (includes 2 FY2s) in DHH O&G, so there is a continued reliance on locums to fill 5th and 6th slots • Long history of training posts not all being filled by NIMDTA	• Review previous NIMDTA/RCOG visits or training surveys to establish why DHH O&G is unattractive to trainees and take steps to correct this • Document correspondence to NIMDTA on the regular under fill of training posts • CAH numbers have increased in recent years with additional GP	**2**

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Location/site	Specialty/ Tier	Current status/Comments	Suggested Actions	RISK
			trainees having been allocated. Consider re-distribution of some of these additional CAH posts to Daisy Hill	
Craigavon	Trauma & Orthopaedics 2nd tier registrars	• 1:8 on call rota. • 3 NIMDTA trainees work alongside SAS doctors • Rota funded at 50% • Rota is fairly stable, but can be vulnerable to non-compliance because of a failure to achieve adequate rest when on call, or maximum duty length being exceeded on the day following on call	• Para 22 of the medical T&Cs should be applied i.e. equivalent time off built in to the rota where adequate rest has not been achieved at weekends. This must be taken within 8 days. • Make representations to NIMDTA and the DoH via the AMD for Medical Education for additional registrar level training posts i	**3**
Craigavon	General medicine 2nd tier	• 1:14 Full shift • Funded at 50% - band 1A • 13 training posts in General Medicine (CAH) plus 1 locum	• Make application to NIMDTA and the DoH via the AMD for Medical Education for additional training posts at registrar level • Consider appointment of Clinical Fellows or MTIs • Reduce rota to 1:13	**3**

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Location/site	Specialty/ Tier	Current status/Comments	Suggested Actions	RISK
Craigavon	MAU rota	• Rota is 1:6 Full shift (no nights) • 2 NIMDTA trainees plus SAS doctors • The position at August 2021 is 2 trainees, 3 SAS doctors and 1 locum. There is a reliance on locum doctors to support the rota	• There are only 2 registrar level training posts in Acute Medicine. Representations should be made to NIMDTA and the DoH via the AMD for Medical Education for additional training posts in Acute Medicine • Consider appointment of Clinical Fellows or MTIs	3
Daisy Hill	General Medicine 2nd tier	• 1:8 Full shift • 3 NIMDTA trainees work alongside MTIs and Clinical Fellows • Aug 2021 – 2.6 NIMDTA trainees, 2 MTIs and 3 Clinical Fellows • SAS doctors do not provide overnight cover • Locum costs previously associated with the need for 7 day registrar cover have significantly diminished following the appointment of MTIs and Clinical Fellows	• The Senior rota is in a much more favourable position than it has been for some time, however there is a need to continue to monitor this, as Clinical Fellows and MTIs are not a long term, sustainable solution • Advertise for longer term Clinical Fellows e.g. 4 years • Possible representations to NIMDTA and the DoH via the AMD for Medical Education for further registrar level training posts in Medicine	3
Daisy Hill	Emergency Medicine	• Rota has now increased to 1 in 12 full shift • There are 8 approved training posts in Daisy Hill ED, so the rota is reliant on 4 locums to fill vacant slots	• Make representations to NIMDTA and the DoH via the AMD for Medical Education for additional training posts (e.g. GP trainees)	3

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Location/site	Specialty/ Tier	Current status/Comments	Suggested Actions	RISK
			• Appoint Junior Clinical Fellows • Aim to transfer locums from agency to HSC E Locums	
Craigavon	Emergency Medicine All tiers <u>3 ROTAS</u>	• Junior rota is 1:14; however the position at Aug 2021 is 9 trainees, 2 supernumery trainees plus 3 agency locums. • Historically 10 SHO level posts and 2 registrar posts in ED; however reported by trainees as being one of the worst rotas in NI. Trust agreed to fund 5 additional ST4 training posts & 1 Trauma Fellow over the past number of years. • In August 2016 the Emergency Department in CAH introduced 3 separate rotas – 1st tier (SHO) rota (1 in 12), Intermediate rota (1 in 6) and registrar rota (1 in 6). However we don't have 24 trainees • Rotas are reliant on **<u>Agency Locums</u> who are paid Locum Rates** or the appointment of Clinical Fellows to fill rota slots. • SAS Rota also reliant on Agency locums	• Consultant lead to review rotas to reduce reliance on Agency Locums & ensure we are making best use of rota design with doctor numbers and other skill mix • Make representations to NIMDTA and the DoH via the AMD for Medical Education for additional training posts in ED • Trial of electronic solution for rostering in ED? • Ask the doctors to pitch ideas on how to plan for a sustainable solution? • Consider use of Physician Associates/ENPs to support junior rota	**3**
Craigavon	Obs & Gynae 1st tier	• 1:10 Full shift • Funded at 50% • Unlikely for all 10 posts to be filled + high recurrence of LTFT trainees, resulting in	• Review rota numbers each year. In the event that all posts not filled, revert to 1:9 rota	**3**

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Location/site	Specialty/ Tier	Current status/Comments	Suggested Actions	RISK
		reliance on locums		
Craigavon	Obs & Gynae 2nd tier	• 1:8 Full shift • Trust has 7 training posts funded at 50% • There is a reliance on locum cover to fill the 8th slot	• Consider applying for MTIs or Clinical Fellows and further recruitment of SAS doctors. Promote Trust support for CESR applications • Make representations to NIMDTA and the DoH via the AMD for Medical Education for additional training posts	3
Craigavon	Paediatrics 1st tier	• 1:9 Full shift • High ratio of LTFT trainees in Paediatrics, resulting in continued reliance on locums • MTI doctor appointed Aug 2021	• Consider the expansion of the extended/ advanced role of nurse practitioners to support the junior tier • Aim to transfer locums from agency to HSC E Locums	3
Craigavon	Paediatrics 2nd tier	• 1:8 Full shift • Trust has 7 training posts funded at 50% band 1A, so there is continued reliance on locums to fill the 8th slot • High ratio of LTFT trainees in Paediatrics, resulting in continued reliance on locums	• Continue to pursue MTI doctors and SAS doctors • Aim to transfer locums from agency to HSC E Locums	3
Daisy Hill	Paediatrics 1st (junior) tier	• 1:8 Full shift • Trust has 6 training posts funded at 50%, band 1A, so there is continued reliance on locums to	• Consider the expansion of the extended/ advanced role of nurse practitioners to support the junior tier	3

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Location/site	Specialty/ Tier	Current status/Comments	Suggested Actions	RISK
		fill vacant slots • MTI doctor appointed Aug 2021 • Aug 2021 – 6 trainees, 1 MTI, 1 locum	• Make representations to NIMDTA and the DoH via the AMD for Medical Education for additional training posts • Aim to transfer locums from agency to HSC E Locums	
Craigavon	Radiology rota	• 1:6 Full shift (no nights) • Funded at 50% - band 1A • It is very rare that all 6 posts are filled by NIMDTA • 1 vacant post – filled by locum + 1 LTFT trainee • When CAH is allocated a trainee at ST1 level, they do not participate in rota	• Make application to NIMDTA and the DoH via the AMD for Medical Education for additional training posts in Radiology • Aim to transfer locums from agency to HSC E Locums	**3**
Daisy Hill	Obs & Gynae 2nd tier	• 1:7 Full shift • 1 training registrar + SAS doctors • Funded at 50% - band 1A • Rota is reliant on locum cover for weekend days	• Continue to pursue MTI doctors and SAS doctors. Could promote support for CESR and sub-specialty interest (if available) • Aim to transfer locums from agency to HSC E Locums	**3**
Craigavon	Anaesthetics 1st tier	• 1:7 Full shift • Funded at 50% - band 1A	• Rota is stable at present	**Low risk**
Craigavon	Anaesthetics 2nd tier	• 1:7 Full shift • Funded at 50% - band 1A	• Rota is stable at present	**Low risk**
Craigavon	ICU	• 1:8 Full shift	• Rota is stable at present	**Low**

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Location/site	Specialty/ Tier	Current status/Comments	Suggested Actions	RISK
		• Funded at 50% - band 1A		**risk**
Craigavon	ENT 2nd on call	• 1:5 non-resident on call • Funded at 50% - band 1A	• Rota is stable at present with some locum usage	**Low risk**
Craigavon	Psychiatry 1st on call	• 1:20 Partial shift (24 hour) • Funded at 50% - band 1A, although rota is band 1B (40%) • Trainee numbers fluctuate each year	• Rota is stable at present • Low risk of monitoring breaches e.g. maximum duty length exceeded or rest not achieved	**Low risk**
Craigavon	Psychiatry 2nd on call	• 1:9 non-resident on call • Rota covers SHSCT and SET – normally 1:7 or 1:8 • Funded at 40% - band 1B	• Rota is stable at present	**Low risk**
Daisy Hill	Surgery/ Medicine FY1	• 11 training posts • Funded at 50% - band 1A	• Review impact and best use of support grades e.g. Physician Associates, Medical Assistants, Clinical Coordinators, nursing staff etc to assist FY1s and drive forward necessary change • Appoint a Lead Consultant specifically to liaise with FY1s re rota issues	**Low risk**

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Southern Health and Social Care Trust

Consultant Job Planning Steering Group Meeting

Meeting of the Steering Group held Wednesday 11 June @ 5pm in the Boardroom, Trust Headquarters

Present: CHAIR – Mrs M McAlinden, Chief Executive
Mr K Donaghy, Director HR & Organisational Development
Dr J Simpson, Medical Director
Mrs D Burns, Interim Director of Acute Services
Mr R Carroll, AD, Cancer & Clinical Services
Mr S Hall, CD Surgery & Elective Care
Dr P McCaffrey, CD Geriatric Medicine
Dr C McAllister, AMD Anaesthetics, Theatres & ICU
Dr G McCusker, CD, Laboratory
Dr N Chada, AMD, Mental Health
Dr S O"Reilly, AMD, Emergency Medicine
Dr S Mone, CD, Medicine DHH
Dr D Sim, CD, Maternity & Women"s Health
Dr P Murphy, AMD Medicine & Unscheduled Care (Joined late)
Mrs Z Parks, Medical Staffing Manager
Mr M Clegg, Assistant Medical Staffing Manager

1. Welcome and note of any apologies

Apologies which were indicated in advance and noted as follows:
Dr J McGuinness, CD Mental Health
Dr P McMahon, CD Mental Health
Dr S Hall, AMD, CCS
Dr D Scullion, CD Anaesthetics
Dr A Khan, AMD Paediatrics
Dr J Hughes, CD Paediatrics DHH
Dr M Fawzy, CD Radiology CCS

Mairead welcomed everyone and stated that the purpose of the meeting was to „stock take" the job planning process and identify any barriers to progress.

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2. Summary of Job planning trends across the Trust (paper tabled)

Average PA's

Mrs Parks circulated a report summarising the e-job planning progress as at 11 June 2014. This paper provided an overview of the average PA"s paid. This illustrated that the average Trust PA"s are 11.42PA"s. Given one of the principles discussed when this group was first established was to bring total PA"s closer to 12, Mrs McAlinden acknowledged the work of AMD"s and CD"s.

Progress with Job planning

It was reported that the vast majority (94%) of consultants now have a job plan on the Zircadian system. However it was noted that many still remain in "Discussion" stage (44%).

ACTION: Associate Medical Directors were asked to ensure job plans are reviewed and moved through the approval pathways as a priority.

Supporting Professional Activities

The circulated paper provided a table summarizing the average SPA"s paid across the Trust. This highlighted the average SPA"s were currently 1.73PA"s.

ACTION: Attendees wanted a more detailed table of the breakdown of the SPA activities. It was agreed a table giving additional info by specialty would be circulated to illustrate the breakdown and how it had been recorded in the electronic job planning system.

The paper highlighted the PA"s allocated for Additional HPSS Responsibilities , External Duties and Patient Administration by Directorate.

3. HOT TOPICS

- **Travelling Time in Consultant Job Plans for weekend working**

It was agreed that where a consultant is undertaking routine work (i.e. not classed as a HPSS Emergency) then travel time from home to hospital should not be included in job plans. It was agreed that Emergencies refer to unplanned and unpredicted call ins (i.e. recall to hospital to operate on an emergency basis, not to planned out of office hours work at weekends/evenings such as lists, sessions or ward rounds.

ACTION: AMD"s to review job plans in their area and where travel time has been included for non-emergency work (as set out above) they should move to give 3 months" notice that this position will be corrected to ensure consistency and fairness is applied across the Trust.

- **Clarification on use of Term Professional Leave**

It was agreed that Professional Leave is not a term endorsed by the Trust. Entitlement to time off must fall under the Study Leave policy - there are not two separate entitlements. If the activity falls under the definition of study leave (i.e. the individual claims CPD points) then the time must be taken from the entitlement for 30 days over 3 years.

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If the activity is work for a Royal College, NIMDTA, or other body associated with the NHS, then this would fall under the definition of Additional HPSS responsibilities or External Duties. This therefore needs the prior approval of the Trust and therefore consultants should complete the relevant application form and if agreed annualize this activity in their online job plans.

Where the Trust asks a consultant to attend a regional meeting on behalf of the Trust, then this would be managed by the AMD/Service Director on a day to day basis through appropriate displacement of work – without the need for any redelivery of work.

4. Update from Associate Medical Directors

Mr O'Reilly: Emergency Medicine
Job Plans still to be entered and signed online. Intend to focus on this within the next few weeks, with the support of Medical Staffing. Hope to have them all signed off by the end of the summer.

Mr Hall: ENT, T&O, Surgery
All job plans have been agreed in ENT, with the exception of one.
There are ongoing challenges in Trauma & Orthopaedics – one consultant signed off, subject to the agreement of others. There are ongoing difficulties with the application of annual leave in the specialty.

Dr P McCaffery: Geriatrics
Progress has not been good. Process has been started with the specialty doctors. Consultant job plans have been delayed as a new rota is planned for September. Want to ensure prospective job plans reflect this new rota.

Dr N Chada: Mental Health
Online job planning has been technically challenging. All paper job plans have been completed but need to transfer this onto Zircadian. Plan to send the paper job plans to Medical Staffing for assistance in transferring them online.

Dr G McCusker: Pathology
Job planning has been slow and there is a need for this to be progressed more proactively. Haematology are undertaking an on-call diary to reassess their out of hours commitment so this will inform their job plans. A review of all job plans has been considered to see if PA"s can be given up to support additional roles if appropriate. However there is reluctance from consultants to reduce below 11PA"s as this renders them ineligible for WLI work.

Mr D Sim: Obstetrics & Gynaecology
There is a general unwillingness to engage with online job planning within O&G mainly due to the IT computer requirements. Agreed that HR can provide a crash course and support if necessary for the consultants.

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Dr C McAllister: ATICS

Job planning process within Anaesthetics and ICU has been completed which involved some challenging discussions. In line with previous agreements from Job planning Steering Group – all job plans were managed below 12PA"s. Maintaining this will be difficult if other specialties are delaying moving towards this target as there need to be consistent approach across the Trust.

DISCUSSION

It was recognised that whilst the Trust average is 11.42PA"s, there are consultants in various specialties who are paid more than this.

The rationale for suggesting the 12PA"s target was linked to a safety and quality principle for safe working hours. It was noted however that there are some specialties where there is a recognised shortage of consultants and additional PA"s may have been agreed as a result of this. Therefore the Trust would have to continue to address some of these wider workforce planning issues. The Trust is committed to a 12 PA limit while accepting that there are times that this will be a challenge to maintain due to operational necessity.

The Medical Director stressed the importance of thorough and detailed job planning as a means to match the service demand with the available consultants – and once this was fully utilised, this would provide the evidence to support a case for extra posts if necessary. Whilst some clinical managers expressed a concern about the time required for job planning, it was stressed that this is a priority for the Trust and a core responsibility of management posts. Therefore if any Clinical Directors or Associate Medical directors needed more time, they should raise this with their Service Director to see if some “time out” can be given to ensure completion.

ACTION: As there is a requirement to have prospective job plans agreed every year, AMD"s/CD"s must ensure job plans are agreed and progressed from the discussion stage through the online system as a matter of priority.

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JOB PLAN SIGN OFF - PROGRESS REPORT- Oct 2017

Directorate	Discussion stage	Awaiting 1st sign off	Awaiting 2nd sign-off	Awaiting 3rd sign-off	Fully signed off	Total job plans	% completed
Anaesthetics/ICU	3	3		1	30	37	81%
Pathology	4	1		3	4	12	33%
Radiology	11	7			4	29	24%
Emergency Medicine	5	1			4	10	40%
Geriatrics	1	2	1	2	3	9	33%
Obsetrics & Gynaecology	4	5	3	3	5	20	25%
Medicine & sub specialties	12	6	5	2	15	40	37%
ENT	1	3			3	7	42%
Gen surgery	3	2			11	16	68%
T&O	2	1			7	10	70%
Urology	4				2	6	33%
CAMHS		1			5	6	83%
CYPS	5	1	1		9	17	53%
Mental Health	2	3	8		9	22	40%
				Total	**111**	**241**	46%

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Parks, Zoe

From: Parks, Zoe <[redacted]>
Sent: 13 October 2017 13:12
To: Gibson, Simon
Cc: Clegg, Malcolm; Wright, Richard
Subject: JP update 131017.xlsx
Attachments: JP update 131017.xlsx

Importance: High

Simon,

Update on Job planning for the AMD Forum as requested

Zoë

Zoe Parks
Head of Medical Staffing HRODSouthern Health & Social Care Trust
[redacted]
My working days are Tuesday-Friday

☎ [redacted] (Internal: [redacted] – prefix by [redacted] if dialling from legacy telephone)

You can follow us on:

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Progress Report

			Surname	First Name	GMC Number	Role	Full/Part Time	Contract	Last Logged In	Activities	Job Plan Start Date	Job Plan End Date	Draft	Discussion	Facilitation	Appeal	Awaiting 1st Sign Off By Consultant	Awaiting 1st Sign Off By Manager	Awaiting 2nd Sign Off	Awaiting 3rd Sign Off	Signed Off
Acute Directorate	Surgery & Elective Care	ENT	Personal Information redacted by the USI			Consultant	Full time	New	09 May 14	30	1 Apr 2014			X							
						Consultant	Full time	New	17 Jul 14	41	1 Jan 2013									X	
						Consultant	Full time	New	22 Dec 13	24	1 Apr 2013										X
						SAS Doctor	Full time	New	14 Nov 13	14	22 Feb 2013										X
						Consultant	Full time	New	04 Apr 13	24	1 Apr 2013						X				
						Consultant	Full time	New		16	15 May 2014			X							
						Consultant	Full time	New	27 Sep 13	23	1 Apr 2013										X
						Consultant	Full time	New	26 Feb 14	23	1 Sep 2013										X
													0	**2**	**0**	**0**	**1**	**0**	**0**	**1**	**4**
		General Surgery				Consultant	Full time	New	08 Jun 14	34	1 May 2014			X							
						SAS Doctor	Full time	New	29 Apr 13	18	1 Apr 2013										X
						Consultant	Full time	New	21 Jan 14	0	1 Apr 2013			X							
						Consultant	Full time	New	06 Mar 14	38	1 Apr 2013										X
						Consultant	Full time	New	09 Jul 14	40	1 Apr 2013							X			
						Consultant	Full time	New	04 Jul 14	20	17 Mar 2014										X
						SAS Doctor	Full time	New	06 May 14	22	1 Apr 2013								X		
						SAS Doctor	Part time	New	03 Sep 13	6	1 Aug 2013								X		
						SAS Doctor	Full time	New	09 Nov 13	13	15 Sep 2013										X
						Consultant	Full time	New	16 Jun 14	32	1 Apr 2013										X
						Consultant	Full time	New	16 Apr 14	27	1 Mar 2013								X		
													0	**2**	**0**	**0**	**0**	**1**	**3**	**0**	**5**
		General Surgery				Consultant	Full time	New	13 Jul 14	28	1 Apr 2013							X			
						Consultant	Full time	New	11 Jul 14	36	1 Apr 2013			X							
						SAS Doctor	Full time	New	10 Jul 14	12	1 Apr 2014								X		
						SAS Doctor	Full time	New	21 Jun 14	16	13 Feb 2014			X							
						SAS Doctor	Full time	New	11 Jun 14	15	1 Apr 2013								X		
						Consultant	Full time	New	11 Jul 14	52	25 Mar 2012			X							
						Consultant	Full time	New	30 May 14	37	1 Apr 2013								X		
													0	**3**	**0**	**0**	**0**	**1**	**3**	**0**	**0**
		Orthodontics				Consultant	Full time	Old	11 Mar 14	15	1 Nov 2013										X
													0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
		Trauma and Orthopaedics				Consultant	Full time	New	15 Jan 13	56	1 Apr 2013						X				
						SAS Doctor	Full time	New	17 Jul 14	17	1 Apr 2014								X		
						Consultant	Full time	New	04 Jun 14	36	1 Apr 2013			X							
						Consultant	Full time	New	26 Jun 13	43	25 Apr 2013			X							
						Consultant	Full time	New	16 Jun 14	48	1 Apr 2013			X							
						Consultant	Full time	New	08 Jan 14	50	1 Jan 2013			X							
						SAS Doctor	Full time	New	03 Mar 14	14	1 Apr 2013			X							
						Consultant	Full time	New	14 Jun 13	40	1 Jan 2013						X				
			SubTotal										**0**	**5**	**0**	**0**	**2**	**0**	**1**	**0**	**0**
		Urology	Glackin	Anthony Jude	4652061	Consultant	Full time	New	15 Mar 13	41	5 Feb 2013			X							
			O'Brien	Aidan	1394911	Consultant	Full time	New	23 Jan 14	38	1 Apr 2013			X							
			Suresh	Kothandaraman	4579997	Consultant	Full time	New	20 May 14	2	11 Dec 2013			X							
			Young	Michael	2846385	Consultant	Full time	New	24 Jan 13	46	1 Apr 2013			X							
			SubTotal										**0**	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
		SubTotal											**0**	**16**	**0**	**0**	**3**	**2**	**7**	**1**	**10**
	SubTotal												**0**	**16**	**0**	**0**	**3**	**2**	**7**	**1**	**10**
Total													**0 (0%)**	**16 (41%)**	**0 (0%)**	**0 (0%)**	**3 (8%)**	**2 (5%)**	**7 (18%)**	**1 (3%)**	**10 (26%)**

Total job plans : 39
Total job plans with at least 1 activity entered : 38
Total consultants : 39
Total consultants who have not logged in once : 1

Parks, Zoe

From: Parks, Zoe <[redacted]>
Sent: 18 July 2014 11:33
To: Brennan, Anne
Subject: URGENT ProgressReport(1).xls
Attachments: ProgressReport(1).xls; image001.jpg; image002.jpg; image003.png

Anne,

I am so sorry for the delay – please see attached Progress Report for General Surgery as of today – which gives you the % of all the job plans online and what stage they are at. Ideally we would be looking to see that they all have a Signed off Job plan.

Mrs Zoe Parks
Medical Staffing Manager
* Southern Health & Social Care Trust
([redacted]
Mobile: [redacted]
Fax: [redacted]
8 [redacted]
Follow the SHSCT:

Click here for the Medical Staffing Sharepoint site

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Medical Staff Management Task and Finish Group

Action notes – 23rd August

Present
Simon Gibson, Malcolm Clegg, Dr Chada, Dr Murphy, Dr Khan, Richard Wright, Esther Gishkori, Bryce McMurray, Vivienne Toal, Geraldine Maguire

Apologies
Zoe Parks, Paul Morgan, Dr Hogan

Minutes of last meeting
These were agreed.

Updated position as at August 2017
Following the baseline position of 28%, it was noted that the position in August had moved to 44%, which was recognised as a positive improvement, with the detail noted as:

Specialty	Signed off	Total	% completed
Anaesthetics	30	37	81%
T&O	7	10	70%
CAMHS	4	6	67%
Urology	3	5	60%
ENT	4	7	57%
General Surgery	8	15	53%
Pathology	4	10	40%
Mental Health	9	23	39%
CYP	6	17	35%
Medicine	11	33	33%
Geriatrics	2	8	25%
O&G	4	18	22%
Radiology	2	16	13%
Emergency Department	1	10	10%
Total	**95**	**215**	**44%**

Following discussion, the following actions were agreed:

"Rollovers and long-tails"
Medical staffing to provide to AMDs/CDs a list of those consultants who had:

1. Been on the same job plan for a number of years and needed to be met with to review and sign off the plan,
2. A job plan with no adjustment to make, but was just rolling over.

Medical staffing would also write to this group of consultants to encourage them to sign off their job plan by September 30th.
Action: Medical staffing, and AMD's/CD's

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Plotting first, second and third sign off
Data would be provided to plot out the sign off process to identify if any opportunities existed to shorten the timescales for completion by Directorates.
Action: Medical staffing

Zircadian Alert flag
It was agreed to enquire from Zircadian whether they had within their software an option to provide an "Alert" to medical staff when their job plan was coming up for renewal.
Action: Medical staffing

Link in with appraisal
It was agreed to adjust the wording within Factor 2 of 4 within the appraisal documentation to make it obligatory that appraisal could **only** be completed with a current, signed off job plan, which would be attached to the appraisal documentation.
Action: Simon Gibson

Focus on specialties under 40%
It was agreed that AMDs/CDs and Assistant Directors would pay particular attention to those specialties who were showing under 40% completion of job plans.
Action: AMDs/CDs and Assistant Directors

Regular reporting
It was agreed to provide quarterly reporting on completed job plans to all Directorates
Action: Medical staffing

There was also discussion relating to other job plan issues raised during the meeting:

SPA's at home
Given options for SPAs offered in neighbouring Trusts, it was agreed that Dr Chada and Dr Khan would create some potential parameters for offering SPAs at home, such as:

- Only available if job plan is fully signed off
- Agreement to be available for emergencies
- Agreement to be available on site to cover for annual leave of colleagues
- At the discretion of the AMD
- For a temporary period only

Action: Dr Khan/Dr Chada

Travel
Whilst there was a need for travel to be included accurately, there was also a need that agreements on travel were consistent with other staff groups, particularly in relation to travel at the start of the day.
Action: Medical staffing

Date of next meeting
Given the above actions required, it is proposed to cancel the meeting scheduled for 13th September and hold the next meeting on Wednesday 25th October 2017 at 4.30pm
Action: Simon Gibson

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Southern Health and Social Care Trust

Quality Care - for you, with you

Consultant Job Planning UPDATE

The Headlines

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

1 April 2019: JOB PLAN PROGRESS - Grouped by Associate Medical Director

Dr Damian Scullion – AMD Anaes/ICU (32 Consultants) (56% Signed off)

Anaes

- 18 Signed off
- 10 Awaiting 1st Sign Off
- 1 in Discussion

ICU

- 1 in Discussion
- 2 Awaiting 3rd Sign off

Dr Tariq – Cancer & Clinical Services (33 Consultants) (24% Signed off)

Pathology

- 6 Signed off
- 2 Awaiting 3rd Sign off
- 2 Awaiting 1 sign off
- 4 in Discussion

Radiology

- 2 Signed off
- 2 Awaiting 1st Sign off/Mgr
- 1 Awaiting 1st Sign off/Cons
- 14 in Discussion

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Dr P Murphy – Medicine/Unscheduled Care and ED (62 Consultants) (24% Signed off)

Emergency Dept

- 1 Signed off
- 9 awaiting 1st Sign off/Cons
- 1 Signed off

Geriatrics

- 2 Signed off
- 1 Awaiting 1 sign off
- 3 in Discussion

Acute

- 2 Signed off

Cardiology

- 3 Signed off
- 1 Awaiting 1st Sign off
- 3 in Discussion

Dermatology

- 1 Signed off
- 1 Awaiting sign off/cons
- 2 in Discussion

Diabetes/Endo

- 2 Signed off
- 1 in Discussion

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Gastro

- 6 in Discussion

Nephrology

- 3 in Discussion

Neurology

- 2 Awaiting 1 sign off/mgr
- 1 in Discussion

OrthoGeriatrics

- 1 Signed off

Pall Medicine

- 3 in Discussion

Respiratory Medicine

- 2 Signed off
- 2 Awaiting 2 sign off/mgs
- 3 in Discussion

Rheumatology

- 1 Signed off
- 1 Awaiting 1st Sign off/Mgr
- 2 in Discussion

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Dr M Hogan – Maternity/Women's Health (21 Consultants) (28% Signed off)

Obstetrics/Gynae CAH

- 4 Signed off
- 1 Awaiting 2nmd Sign off
- 1 Awaiting sign off/Mgr
- 6 in Discussion

Obstetrics/Gynae DHH

- 2 Signed off
- 7 in Discussion

Mr M Haynes – Surgery/Elective Care (44 Consultants) (6.3% Signed off)

ENT

- 1 Signed off
- 1 Awaiting 1 sign off/con
- 1 Awaiting 2 sign off
- 4 in Discussion

Surgery CAH

- 2 Signed off
- 1 Awaiting 2nd Sign off
- 1 Awaiting 1st Sign off
- 8 in Discussion

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Surgery DHH

- 4 Awaiting 2 Sign off
- 1 in Discussion

Orthodontics

- 1 in Discussion

T&O

- 1 Awaiting 1 Sign off/mgr
- 10 in Discussion

Urology

- 1 Awaiting 2nd Sign off
- 2 Awaiting 1st Sign off/cons
- 3 in Discussion

Mr A Khan – Children/Young People (23 Consultants) (65% Signed off)

CAMHS

- 2 Signed off
- 1 Awaiting 3rd sign off
- 1 Awaiting 2 sign off
- 1 Awaiting 1 sign off

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Community Peads

- 2 Signed off
- 1 Awaiting 1 Sign off/mgr

Paeds DHH

- 6 Signed off
- 1 in Discussion

Paeds CAH

- 5 Signed off
- 3 in Discussion

Mr P McMahon – Mental Health (19 Consultants) (10% Signed off)

- 2 Signed off
- 2 Awaiting 2 Sign off
- 1 Awaiting 1 Sign off
- 14 in Discussion

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Progress with Online Job planning May 2019

Southern Health and Social Care Trust.

Date of report: 19 May 2019

Consultants

Total number of consultants	246	
Job plans signed off within the last 12 months	71	28.9%
Job plans not signed-off or not updated		
Never logged in	5	2%
In draft stage	0	0%
In discussion stage	109	44.3%
In facilitation	0	0%
In appeal	0	0%
Awaiting 1st sign off	42	17.1%
Awaiting 2nd sign off	15	6.1%
Awaiting 3rd sign off	5	2%
Signed off longer than 12 months ago	4	1.6%

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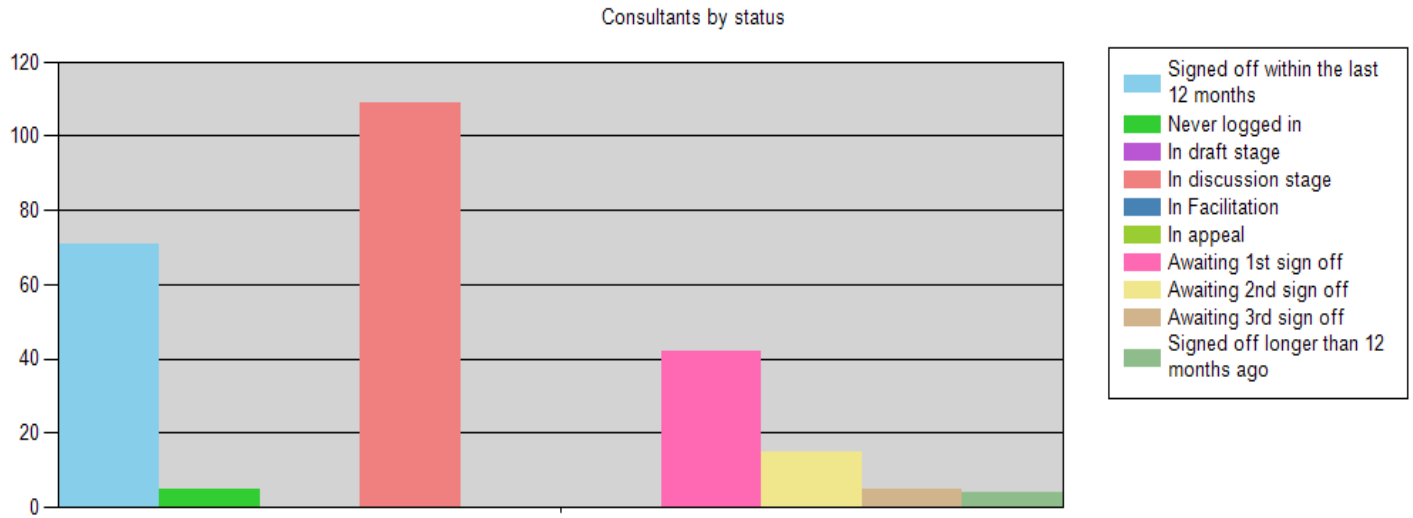

Acute Directorate

	Total	Signed off within the last 12 months	Never logged in	Draft	Discussion	Facilitation	Appeal	Awaiting 1st sign off	Awaiting 2nd sign off	Awaiting 3rd sign off	Signed off longer than 12 months ago
Consultants	201	53	5	0	90	0	0	37	12	5	4

Children and Young People Directorate

	Total	Signed off within the last 12 months	Never logged in	Draft	Discussion	Facilitation	Appeal	Awaiting 1st sign off	Awaiting 2nd sign off	Awaiting 3rd sign off	Signed off longer than 12 months ago
Consultants	23	16	0	0	4	0	0	2	1	0	0

Mental Health and Disability Directorate

	Total	Signed off within the last 12 months	Never logged in	Draft	Discussion	Facilitation	Appeal	Awaiting 1st sign off	Awaiting 2nd sign off	Awaiting 3rd sign off	Signed off longer than 12 months ago
Consultants	22	2	0	0	15	0	0	3	2	0	0

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