Parks, Zoe

From: Montgomery, Ruth <[redacted]>
Sent: 30 April 2018 12:58
To: Carroll, Ronan; Clegg, Malcolm; Gibson, Simon; Gishkori, Esther; Haynes, Mark; Hogan, Martina; Khan, Ahmed; McMahon, Dr; McMurray, Bryce; McVey, Anne; Morgan, Paul; Murphy, Philip; Parks, Zoe; Scullion, Damian; Tariq, S; Toal, Vivienne; Trouton, Heather; Wright, Richard
Cc: Alexander, Ruth; Beattie, Pauline; Conlon, Noeleen; Goodman, Maria; Griffin, Tracy; Mallagh-Cassells, Heather; McAlinden, Matthew; Stinson, Emma M; White, Laura; White, Sarah; Woods, Maria
Subject: Medical Staff Job Planning Task and Finish Group - 02/05/2018
Attachments: 02.05.2018 Agenda Task Finish Group.doc; Job Planning Guidance for Medical Managers MARCH 2018.pdf; Final Report Management of Medical Staff 17-18.pdf

Dear All,

Please see attached Agenda and papers for the Medical Staff Job Planning Task and Finish Group Meeting which is scheduled to take place on:

Date: Wednesday 2nd May
Time: 4.30pm-6pm
Venue: Meeting Room, THQ - VC to Tutorial Room, DHH

*As a reminder, please see below - dates for meetings for the remainder of the year : (times all remain the same 4.30pm – 6pm)

13th June 2018
Meeting Room, THQ with VC to Tutorial Room, DHH

25th July 2018
Meeting Room, THQ with VC to Tutorial Room, DHH

5th September 2018
Meeting Room, THQ with VC to Tutorial Room, DHH

24th October 2018
Meeting Room, THQ with VC to Tutorial Room, DHH

5th December 2018
Meeting Room, THQ with VC to Tutorial Room, DHH

Kind Regards,

Ruth

Ruth Montgomery
Administrative Officer – Medical Director's Office,
Southern Health & Social Care Trust
1st Floor, Trust Headquarters, CAH

My hours of work are : 8.30am – 4.30pm, Monday, Wednesday, Thursday & Friday
8.30am – 3pm Tuesday

☎ Please note my new contact number – External - Personal Information redacted by the USI / Internal ext: Personal Information redacted by the USI

Personal Information redacted by the USI

Southern Health and Social Care Trust

Workforce Planning Steering Group (Initial Focus Job Planning)

Southern Health and Social Care Trust
1.0

Workforce Planning Steering Group – Terms of Reference

Southern Health and Social Care Trust

1.0 Introduction

The key purpose of the Workforce Steering Group will initially focus on supporting the Chief Executive and the Medical Director to improve the completion of consultant job planning in all specialties across the Southern Trust for 2009/10.

There is a need for the Trust to have detailed and transparent job plans for all consultants which match consultant time to best meet the identified needs and demands of the service. The group will also be responsible for maintaining a strategic overview of the consultant job planning progress.

2.0 Remit

The remit of the group will be:

- Oversee the completion of 2010 prospective job plans for all consultants in the Southern Trust.
- Act as the decision/approval body for the consultant job planning process so a Trust view is taken on issues raised.
- Act as an approval body on a bi-monthly basis so Associate Medical Directors jointly report to the Steering Committee on job planning progress within their specialty. AMD's will be required to report on allocations for SPA, External Duty, Additional HPSS Responsibilities and bring to the attention of the Steering Group any proposed job plan which exceeds 12 programmed activities for authorization.
- Ensure that service requirements and clinical demands have been met where possible through consultant job planning.
- To take action to support the Job Planning working team to unblock barriers and champion the agreed approaches.
- To support the delivery and dissemination of Job Planning good practice through the use of personal and professional networks.
- To provide expert and professional advice as appropriate.

- Relaying relevant concerns from the service to the Department of Health and/or other bodies/Trusts as appropriate.
- Consider the impact of consultant Job planning upon other initiatives connected with the medical workforce as appropriate, e.g. service redesign and reconfiguration, reduction of junior doctor availability and the use of new roles/new ways of working.

3.0 Membership

PROJECT STEERING GROUP
This group will be chaired by: Mrs M McAlinden, Acting Chief Executive

Suggested Steering Group members:

- Dr P Loughran, Medical Director
- Mr Kieran Donaghy, Director of Human Resources & Organisational Development
- Mrs J Youart, Director of Acute Services or Assistant Directors where appropriate.
- Mr Stephen McNally, Acting Director of Finance
- Mrs P Clarke, Acting Director of Performance and Reform
- Dr G Rankin, Director of Older People & Primary Care
- Mr F Rice, Director Mental Health & Disability
- Mr B Dornan, Director Children & Young People

- Associate Medical Directors

4.0 Meetings

- The Steering group will meet on a monthly basis between now and August 2010
- The Chair/or deputy chair and a quorum of 3 members must be present for the meeting to take place
- Members may be asked to lead on working groups to undertake specific work for a time limited period.
- Minutes of the Steering Group meeting will be taken by …

5.0 Project "Working" Group

This group will represent the support team for Associate Medical Directors / Clinical Directors for consultant job planning. There should be a dedicated team of people for each specialty/Programme of Care. The "core team" will include the following:

- Representative from Medical Director's office (Mrs Teresa Cunningham)
- Human Resources Representative (Mrs Zoe Parks)
- Finance Representative (Ms Sinead O'Kane)
- Relevant Representative from Performance & Reform (Debbie Burns & Jacqueline Morton/Lynn Lappin)

For each specialty:

- Relevant Service Manager / Representative from relevant POC
- Relevant Associate Medical Director / Clinical Manager (The job planner)

These teams should meet at least monthly (more frequently as required) to support the AMD/CD to ensure job planning driven forward in accordance with the “Local Trust Framework on Job Planning for Medical Managers”.

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

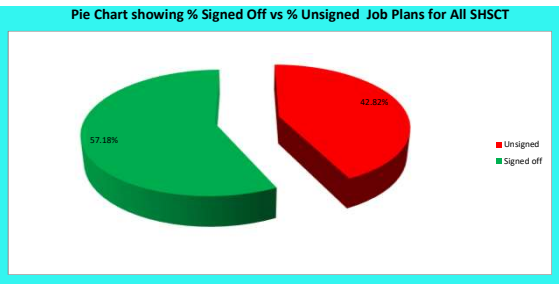
Job Planning Dashboard

Job Planning Tracking Summary

Row Labels	Discussion Stage	Consultant Sign Off	1st Sign Off Manager	2nd Sign Off Level	3rd Sign Off Level	Signed Off Complete
Anaesthetics	35	31	31	30	30	30
0						
Personal Information redacted by the USI						
Grand Total	35	31	31	30	30	30

Dept
Anaesthetics
CAMHS
Child and Ad...
Community P...
Disability
Emergency M...
ENT
Family Planning
General Medi...
General Surg...
General Surg...
Genitourinar...
Geriatric Med...
Geriatrics
ICU Anaesthe...
Mental Health
Obstetrics an...
Obstetrics an...
Oncology
Orthodontics
Paediatrics D...
Paediatrics, C...
Pathology
Radiology
Trauma and ...
Urology

Pie Chart showing % Signed Off vs % Unsigned Job Plans for All SHSCT

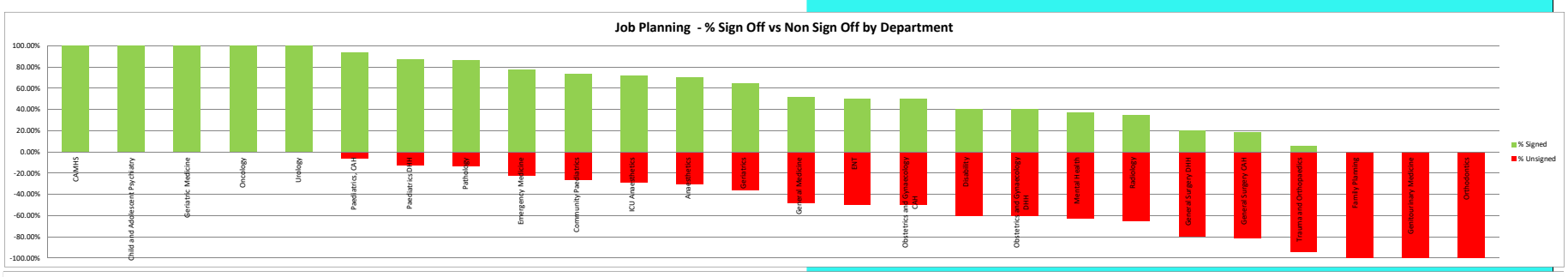


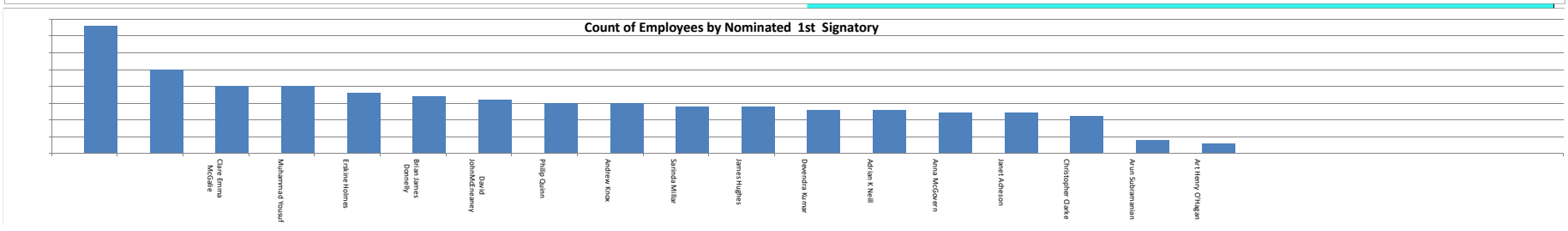
Welcome to the SHSCT Job Planning Dashboard

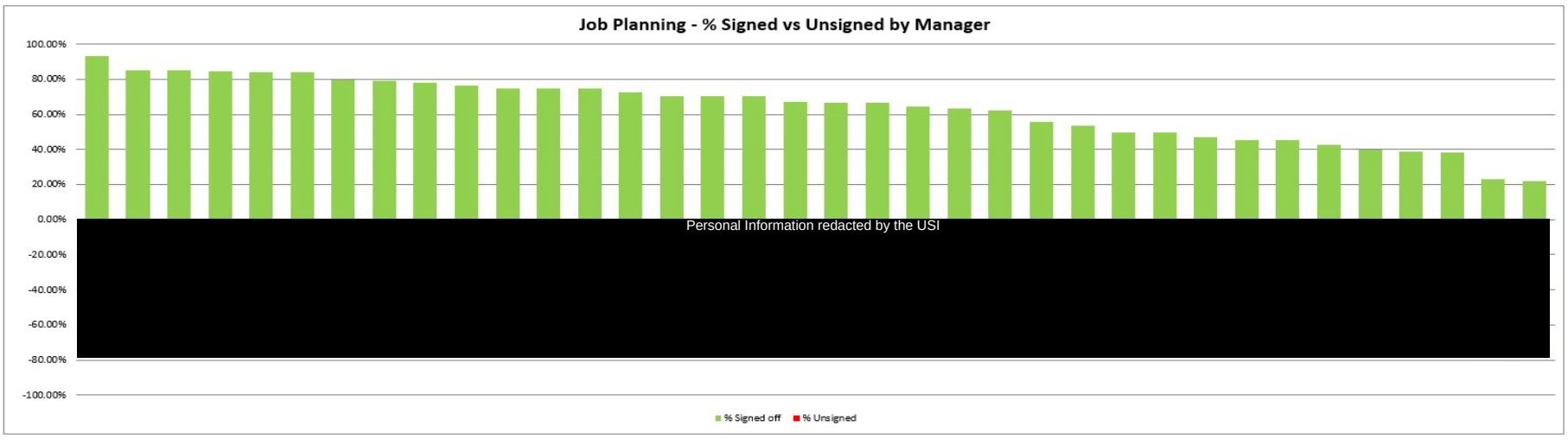
The aim is to provide an overview of the current status of each consultant and doctor's job plan. This is only current as of 21 September 2022. It is nOT linked to liove ssystem. Also it summarises by department and manager the % that are both signed off and that remain unsigned.

Table Showing Count of Sign Offs by Manager and % Completed

Signatory Name	Count - 1st sign off	Count - 2nd sign off	Count - 3rd sign off	Total - To be signed off	Count - 1st sign off - Complt	Count - 2nd sign off - Complete	Count - 3rd sign off - Complete	Total Signed Off	Count - 1st sign off - Incomplete	Count - 2nd sign off - Incompl	Count - 3rd sign off - Incompl ete	Total Unsigned	% Signed off	%Unsigned
Personal Information redacted by the USI	0	1	0	1	0	1	0	1	0	0	0	0	100.00%	0.00%
	15	0	0	15	14	0	0	14	1	0	0	1	93.33%	6.67%
	27	0	0	27	23	0	0	23	4	0	0	4	85.19%	14.81%
	20	0	0	20	17	0	0	17	3	0	0	3	85.00%	15.00%
	13	0	0	13	11	0	0	11	2	0	0	2	84.62%	15.38%
	12	45	0	57	12	36	0	48	0	9	0	9	84.21%	15.79%
	0	12	44	56	0	12	35	47	0	0	9	9	83.93%	16.07%
	15	0	0	15	12	0	0	12	3	0	0	3	80.00%	20.00%
	3	26	0	29	3	20	0	23	0	6	0	6	79.31%	20.69%
	37	0	0	37	29	0	0	29	8	0	0	8	78.38%	21.62%
	17	0	0	17	13	0	0	13	4	0	0	4	76.47%	23.53%
	16	0	0	16	12	0	0	12	0	0	4	4	75.00%	25.00%
	12	0	0	12	9	0	0	9	3	0	0	3	75.00%	25.00%
	5	39	0	44	4	29	0	33	1	10	0	11	75.00%	25.00%
	11	0	0	11	8	0	0	8	3	0	0	3	72.73%	27.27%
	6	38	0	44	6	25	0	31	0	13	0	13	70.45%	29.55%
	0	6	38	44	0	6	25	31	0	0	13	13	70.45%	29.55%
	1	3	33	37	1	2	23	26	0	1	10	11	70.27%	29.73%
	8	102	0	110	5	69	0	74	3	33	0	36	67.27%	32.73%
	3	0	0	3	2	0	0	2	1	0	0	1	66.67%	33.33%
	12	0	0	12	8	0	0	8	4	0	0	4	66.67%	33.33%
	2	9	3	14	2	5	2	9	0	4	1	5	64.29%	35.71%
	2	8	96	106	1	5	61	67	1	3	35	39	63.21%	36.79%
	16	0	0	16	10	0	0	10	6	0	0	6	62.50%	37.50%
	25	0	0	25	14	0	0	14	11	0	0	11	56.00%	44.00%
	15	0	0	15	8	0	0	8	7	0	0	7	53.33%	46.67%
	4	0	0	4	2	0	0	2	2	0	0	2	50.00%	50.00%
	18	0	0	18	9	0	0	9	9	0	0	9	50.00%	50.00%
	1	14	85	100	1	8	38	47	0	6	47	53	47.00%	53.00%
	0	4	27	31	0	1	13	14	0	3	14	17	45.16%	54.84%
	4	27	0	31	1	13	0	14	3	14	0	17	45.16%	54.84%
	1	13	0	14	1	5	0	6	0	8	0	8	42.86%	57.14%
	0	1	4	5	0	0	2	2	0	1	2	3	40.00%	60.00%
	2	29	0	31	0	12	0	12	2	17	0	19	38.71%	61.29%
	1	1	24	26	0	0	10	10	1	1	14	16	38.46%	61.54%
	24	32	0	56	10	3	0	13	14	29	0	43	23.21%	76.79%
	18	0	0	18	4	0	0	4	14	0	0	14	22.22%	77.78%
	15	0	0	15	3	0	0	3	12	0	0	12	20.00%	80.00%
	15	0	0	15	3	0	0	3	12	0	0	12	20.00%	80.00%
	396	410	354	1160	258	252	209	719	134	158	149	441		







Progress Report

				Surname	First Name	Full/Part Time	Last sign-off date	Last Logged In	Job Plan Start Date	Discussion	Awaiting 1st Sign Off By Consultant	Awaiting 1st Sign Off By Manager	Awaiting 2nd Sign Off	Awaiting 3rd Sign Off	Signed Off
Acute Directorate	Anaesthetics Theatres & Intensive Care	Anaesthetics		Personal Information redacted by the USI		Full time	11 Mar 19	09 Apr 19	1 Apr 2019						X
						Full time	11 May 19	04 Apr 19	1 Apr 2019						X
						Full time	11 Mar 19	09 Apr 19	1 Jan 2019						X
						Full time	11 May 19	13 Apr 19	1 Apr 2019						X
						Full time	11 May 19	22 May 19	1 Apr 2019						X
						Full time	11 May 19	26 Apr 19	1 Apr 2019						X
						Full time	11 Mar 19	13 Apr 19	1 Apr 2019						X
						Full time	11 May 19	28 Mar 19	1 Apr 2019						X
						Part time	24 Sep 18	19 Feb 19	1 Apr 2019		X				
						Full time	24 Sep 18	13 May 19	1 Apr 2019					X	
						Full time	11 May 19	01 Apr 19	1 Apr 2019						X
						Full time	11 Mar 19	19 May 19	1 Apr 2019						X
						Full time	11 May 19	21 Mar 19	2 Apr 2019						X
						Full time	11 Mar 19	30 Apr 19	1 Apr 2019						X
						Full time	24 Sep 18	08 Mar 19	1 Apr 2019		X				
						Full time	11 Mar 19	10 Mar 19	1 Jan 2019						X
						Full time	23 Oct 18	21 May 19	1 Apr 2019		X				
						Full time	11 May 19	16 May 19	1 Apr 2019						X
						Full time	24 Sep 18	14 Mar 19	1 Feb 2019		X				
						Full time	11 May 19	21 Mar 19	2 Apr 2019						X
						Full time	18 Jul 18	18 Dec 18	1 Apr 2019		X				
						Full time	23 Oct 18	26 Apr 19	1 Apr 2019		X				
						Full time	24 Sep 18	23 May 19	1 Apr 2019		X				
						Full time	11 May 19	15 Mar 19	1 Apr 2019						X
						Full time	18 Jul 18	14 Sep 18	1 Apr 2019		X				
						Full time	02 Nov 18	20 Feb 19	1 Apr 2019		X				
						Full time	11 May 19	24 May 19	1 Apr 2019						X
						Full time	29 Oct 18	20 May 19	1 Apr 2019				X		
						Full time	11 May 19	13 May 19	1 Apr 2019						X
						Full time		28 Nov 18	1 Apr 2019	X					
						Full time	02 Aug 18	21 May 19	1 Apr 2019					X	
						Full time	23 Oct 18	12 Mar 19	1 Apr 2019		X				
			SubTotal					32 of 32 (100%)		1	10	0	1	2	18
		ICU Anaesthetics				Full time	24 Oct 17	12 Apr 19	1 Apr 2019					X	
						Full time			13 May 2019	X					
						Full time	26 Sep 18	03 May 19	1 Apr 2019	X					
						Full time	05 Apr 18	23 May 19	1 Apr 2019					X	
						Full time	24 Oct 18	01 Apr 19	1 Apr 2019					X	
								4 of 5 (80%)		2	0	0	0	3	0
			SubTotal					4 of 5 (80%)		2	0	0	0	3	0
		SubTotal						36 of 37 (97%)		3	10	0	1	5	18
	Services	thology	Chemical Path			Full time	13 Jun 18	22 May 19	1 Apr 2019					X	
			SubTotal					1 of 1 (100%)		0	0	0	0	1	0

Progress Report

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				Full/Part Time	Last sign-off date	Last Logged In	Job Plan Start Date	Discussion	Awaiting 1st Sign Off By Consultant	Awaiting 1st Sign Off By Manager	Awaiting 2nd Sign Off	Awaiting 3rd Sign Off	Signed Off
	Cancer and Clinical S	Pa	Haematology	Full time	03 Jan 19	10 May 19	28 Jan 2019			X			
				Full time	25 Feb 19	18 May 19	1 Apr 2019	X					
				Part time		17 Apr 19	28 Jan 2019	X					
						3 of 3 (100%)		**2**	**0**	**1**	**0**	**0**	**0**
			Histo Cyto	Full time	13 May 19	03 Apr 19	1 Apr 2019						X
				Part time	13 May 19	06 Mar 19	1 Apr 2019						X
				Full time	16 Jan 19	22 Mar 19	1 Apr 2019						X
				Full time	20 Nov 18	29 Apr 19	1 Apr 2019					X	
				Full time	05 Jul 18	07 May 19	7 May 2019			X			
				Part time	16 Jan 19	30 Apr 19	1 Jan 2019						X
				Part time		10 Apr 19	1 Mar 2019	X					
				Full time	13 May 19	16 May 19	1 Apr 2019						X
						8 of 8 (100%)		**1**	**0**	**1**	**0**	**1**	**5**
			Microbiology	Full time	05 Jul 18	01 Mar 19	1 Apr 2019	X					
				Full time	01 Mar 19	15 Feb 19	15 Feb 2019						X
						2 of 2 (100%)		**1**	**0**	**0**	**0**	**0**	**1**
			SubTotal			14 of 14 (100%)		**4**	**0**	**2**	**0**	**2**	**6**
		Radiology	Radiology	Full time	07 Nov 18	30 Apr 19	3 Jun 2019			X			
				Full time	05 Jul 18	19 Sep 18	1 Apr 2019	X					
				Full time	27 Feb 15	22 May 19	1 Apr 2019	X					
				Full time	21 Nov 18	14 May 19	1 Apr 2019		X				
				Full time	20 Nov 18	22 May 19	1 Apr 2019	X					
				Full time	05 Jul 18	02 Jul 18	1 Apr 2019	X					
				Full time	07 Nov 18	02 Oct 18	1 Apr 2019	X					
				Part time	07 Nov 18	21 Feb 19	1 Apr 2019	X					
				Full time	16 Jan 19	15 Jan 19	10 Jan 2019						X
				Full time	20 Nov 18	22 Jan 19	1 Jan 2019	X					
				Full time	06 Mar 18	10 Apr 18	1 Apr 2019	X					
				Full time		21 Nov 18	1 Mar 2018	X					
				Full time	20 Nov 18	11 Mar 19	1 Apr 2019	X					
				Full time	07 Nov 18	25 Mar 19	1 Apr 2019	X					
				Full time		12 Feb 19	1 Feb 2019	X					
				Full time	05 Jul 18	30 Jun 18	1 Apr 2019	X					
				Full time	05 Jul 18	11 Mar 19	15 Apr 2019			X			
				Full time	29 Jan 19	07 Feb 19	1 Jan 2019						X
				Part time		04 Dec 18	1 Apr 2019	X					
						19 of 19 (100%)		**14**	**1**	**2**	**0**	**0**	**2**
			SubTotal			19 of 19 (100%)		**14**	**1**	**2**	**0**	**0**	**2**
		SubTotal				33 of 33 (100%)		**18**	**1**	**4**	**0**	**2**	**8**
	Emergency Medicine	Emergency Medicine		Full time	22 Jan 19	18 Dec 18	1 Nov 2018						X
				Full time	06 Sep 18	06 Dec 18	1 Apr 2019		X				
				Full time	19 Dec 18	10 Apr 19	1 Apr 2019		X				
				Full time	31 May 18	04 Jun 18	1 Apr 2019		X				
				Full time	11 Apr 18	04 Apr 18	1 Apr 2019		X				
				Full time	11 Apr 18	22 May 19	1 Apr 2019		X				
				Full time	28 Apr 17	25 Apr 19	1 Apr 2019	X					
				Full time	21 May 18	15 Oct 18	1 Apr 2019		X				

Progress Report

				Personal Information redacted by the USI	Full/Part Time	Last sign-off date	Last Logged In	Job Plan Start Date	Discussion	Awaiting 1st Sign Off By Consultant	Awaiting 1st Sign Off By Manager	Awaiting 2nd Sign Off	Awaiting 3rd Sign Off	Signed Off
					Full time	06 Sep 18	29 Jun 18	1 Apr 2019		X				
					Full time	11 Apr 18	09 Apr 19	1 Apr 2019		X				
					Full time	20 Mar 18	24 Apr 19	1 Apr 2019		X				
					Part time	08 Feb 16	21 Dec 18	1 Apr 2019	X					
							12 of 12 (100%)		**2**	**9**	**0**	**0**	**0**	**1**
			SubTotal				12 of 12 (100%)		**2**	**9**	**0**	**0**	**0**	**1**
		SubTotal					12 of 12 (100%)		**2**	**9**	**0**	**0**	**0**	**1**
	Geriatrics/Medicine and Unscheduled Care	Geriatric Medicine			Full time	22 Apr 19	27 Mar 19	1 Dec 2018						X
							1 of 1 (100%)		**0**	**0**	**0**	**0**	**0**	**1**
			SubTotal				1 of 1 (100%)		**0**	**0**	**0**	**0**	**0**	**1**
		Geriatrics			Full time	01 Nov 17	25 Jun 18	1 Apr 2019	X					
					Part time	21 May 18	01 Apr 19	25 Feb 2019		X				
					Full time	23 May 19	13 May 19	1 Apr 2019						X
					Full time	01 Nov 17	24 Oct 17	1 Apr 2019	X					
					Part time	22 Mar 19	20 Mar 19	1 Apr 2019						X
					Full time	21 May 18	30 Apr 19	1 Apr 2019	X					
							6 of 6 (100%)		**3**	**1**	**0**	**0**	**0**	**2**
			SubTotal				6 of 6 (100%)		**3**	**1**	**0**	**0**	**0**	**2**
		SubTotal					7 of 7 (100%)		**3**	**1**	**0**	**0**	**0**	**3**
	Maternity & Womens Health	Obstetrics and Gynaecology CAH			Part time	25 Feb 19	29 Apr 19	1 Apr 2019						X
					Full time	20 Aug 18	28 Jun 18	1 Apr 2019	X					
					Full time	30 Jan 19	18 Dec 18	1 Nov 2018						X
					Full time	17 Apr 19	19 Mar 19	24 Dec 2018						X
					Full time	31 May 18	11 Jun 18	1 Apr 2019	X					
					Full time	15 Nov 18	17 May 19	1 Apr 2019	X					
					Full time	12 May 17	18 Apr 19	1 Apr 2019	X					
					Full time	17 Apr 19	17 May 19	1 Apr 2019						X
					Full time	25 Oct 17	30 Apr 19	1 Apr 2019				X		
					Full time	31 May 18	11 Jan 19	1 Apr 2019	X					
					Part time	31 May 18	15 Apr 19	1 Jun 2019			X			
					Full time	27 Sep 17	23 Jan 18	1 Apr 2019	X					
							12 of 12 (100%)		**6**	**0**	**1**	**1**	**0**	**4**
			SubTotal				12 of 12 (100%)		**6**	**0**	**1**	**1**	**0**	**4**
		Obstetrics and Gynaecology DHH			Part time	15 Nov 18	07 Nov 18	1 Apr 2019	X					
					Full time	10 Jan 19	29 Apr 19	1 Nov 2018						X
					Full time	09 Nov 18	28 Feb 19	1 Apr 2019	X					
					Full time			1 Apr 2019	X					
					Full time	22 Jan 19	01 May 19	1 Apr 2019	X					
					Full time	09 Nov 18	01 Nov 18	1 Apr 2019	X					
					Full time	29 Apr 19	12 May 19	1 Mar 2017						X
					Full time	17 Oct 18	17 Oct 18	1 Apr 2019	X					
					Full time	09 Nov 18	11 Feb 19	1 Nov 2018	X					
							8 of 9 (89%)		**7**	**0**	**0**	**0**	**0**	**2**
			SubTotal				8 of 9 (89%)		**7**	**0**	**0**	**0**	**0**	**2**
		SubTotal					20 of 21 (95%)		**13**	**0**	**1**	**1**	**0**	**6**
	are	cine	Acute Medicine		Full time	22 Apr 19	29 Jan 19	1 Apr 2019						X

Progress Report

				Personal Information redacted by the USI	Full/Part Time	Last sign-off date	Last Logged In	Job Plan Start Date	Discussion	Awaiting 1st Sign Off By Consultant	Awaiting 1st Sign Off By Manager	Awaiting 2nd Sign Off	Awaiting 3rd Sign Off	Signed Off
	Medicine & Unscheduled C	General Medic			Full time	22 Apr 19	18 Apr 19	2 Apr 2019						X
							2 of 2 (100%)		0	0	0	0	0	2
			Cardiology		Full time	07 Mar 19	20 Dec 18	1 Dec 2018						X
					Full time	28 Feb 19	01 May 19	30 Nov 2018						X
					Full time	17 Feb 17	06 Jul 18	1 Apr 2018	X					
					Full time	18 Jun 18	02 May 19	1 Nov 2018	X					
					Full time	01 Nov 17	13 Aug 18	1 Apr 2018	X					
					Full time	15 Dec 16	08 May 19	3 Sep 2018			X			
					Full time	11 Dec 18	12 Mar 19	1 Nov 2018						X
							7 of 7 (100%)		3	0	1	0	0	3
			Dermatology		Full time	07 Feb 18	02 Feb 18	1 Apr 2019		X				
					Full time	13 Mar 19	20 Feb 19	2 Sep 2018						X
					Full time	12 Feb 18	02 Feb 18	1 Apr 2019	X					
					Full time	20 Feb 17	11 Apr 19	1 Apr 2019	X					
							4 of 4 (100%)		2	1	0	0	0	1
			Diabetes and Endocrinology		Full time	07 May 19	08 May 19	1 Apr 2019						X
					Full time		05 Mar 19	5 Mar 2019	X					
					Full time	22 Apr 19	15 Apr 19	1 Oct 2018						X
							3 of 3 (100%)		1	0	0	0	0	2
			Gastroenterology		Full time	26 Sep 18	24 Sep 18	1 Apr 2019	X					
					Full time	27 Sep 17	30 Apr 19	1 Apr 2019	X					
					Full time	22 Aug 17	26 Apr 19	1 Apr 2019	X					
					Full time	28 Jun 18	12 Oct 18	29 Jun 2018	X					
					Full time	19 Mar 19	23 May 19	1 Apr 2019	X					
					Full time	19 Oct 18	11 Mar 19	1 Apr 2019	X					
							6 of 6 (100%)		6	0	0	0	0	0
			Nephrology		Full time	06 Sep 18	04 Mar 19	1 Apr 2019	X					
					Full time		13 May 19	11 Mar 2019	X					
					Full time	27 Sep 17	31 May 18	1 Apr 2019	X					
							3 of 3 (100%)		3	0	0	0	0	0
			Neurology		Full time	07 Feb 18	07 May 19	4 Mar 2019			X			
					Full time	26 Sep 18	11 May 19	1 Apr 2019	X					
					Full time	11 Dec 18	30 Apr 19	1 Apr 2019			X			
							3 of 3 (100%)		1	0	2	0	0	0
			Orthogeriatrics		Full time	06 Feb 19	21 May 19	1 Dec 2017						X
							1 of 1 (100%)		0	0	0	0	0	1
			Palliative Medicine		Full time			1 Feb 2020	X					
					Part time	05 Jul 18	15 May 19	1 Apr 2019	X					
					Full time		11 Oct 18	1 Apr 2019	X					
							2 of 3 (67%)		3	0	0	0	0	0
			Respiratory		Full time	22 Aug 17	15 May 19	1 Apr 2019			X			
					Full time		21 May 19	25 Feb 2019	X					
					Full time	31 May 18	16 Apr 18	1 Apr 2019	X					
					Full time	06 Feb 19	21 May 19	1 May 2019			X			
					Full time	22 Apr 19	19 Apr 19	2 Apr 2019						X

Progress Report

Personal Information redacted by the USI

				Full/Part Time	Last sign-off date	Last Logged In	Job Plan Start Date	Discussion	Awaiting 1st Sign Off By Consultant	Awaiting 1st Sign Off By Manager	Awaiting 2nd Sign Off	Awaiting 3rd Sign Off	Signed Off
				Full time	06 Feb 19	21 Jan 19	1 Jan 2019						X
				Full time	01 Nov 17	17 May 19	1 Apr 2019	X					
						7 of 7 (100%)		**3**	**0**	**2**	**0**	**0**	**2**
			Rhuematology	Full time	18 Jun 18	05 Sep 18	1 Apr 2019	X					
				Part time	25 Apr 19	19 Apr 19	2 Apr 2019						X
				Full time	21 Jan 18	24 Apr 19	1 Apr 2019	X					
				Part time	06 Feb 19	29 Apr 19	1 May 2019			X			
			SubTotal			43 of 45 (96%)		**24**	**1**	**6**	**0**	**0**	**12**
		SubTotal				43 of 45 (96%)		**24**	**1**	**6**	**0**	**0**	**12**
	Surgery & Elective Care			Full time	24 Sep 18	03 May 19	1 Apr 2019				X		
				Full time	24 Oct 18	23 Sep 18	1 Apr 2019		X				
				Full time	24 Oct 18	15 May 19	1 Apr 2019	X					
				Full time		24 Oct 16	1 Apr 2019	X					
				Full time	24 Oct 18	24 Oct 18	1 Apr 2019	X					
				Full time	18 Jan 17	06 May 19	1 Apr 2019	X					
				Full time	11 May 19	05 Dec 18	1 Apr 2019						X
						7 of 7 (100%)		**4**	**1**	**0**	**1**	**0**	**1**
			SubTotal			7 of 7 (100%)		**4**	**1**	**0**	**1**	**0**	**1**
				Full time	11 May 19	03 May 19	1 Apr 2019						X
				Full time	28 Aug 18	20 Aug 18	1 Apr 2019		X				
				Full time	27 Sep 16	18 Mar 19	1 Apr 2019	X					
				Full time	18 Jan 17	04 Nov 17	1 Apr 2019	X					
				Full time	05 Jul 16	07 Sep 18	1 Apr 2019	X					
				Full time	24 Sep 18	23 May 19	1 Apr 2019	X					
				Full time	18 Jan 17	02 May 19	1 Jun 2019				X		
				Full time	18 Jan 17	26 Oct 16	1 Apr 2019	X					
				Full time		06 Feb 19	1 Apr 2019	X					
				Full time	13 May 19	21 May 19	1 Apr 2019						X
				Full time	18 Jan 17	24 May 19	1 Apr 2018	X					
				Full time	10 Mar 17	12 Nov 18	1 Apr 2018	X					
						12 of 12 (100%)		**8**	**1**	**0**	**1**	**0**	**2**
			SubTotal			12 of 12 (100%)		**8**	**1**	**0**	**1**	**0**	**2**
				Part time	17 Aug 18	29 Mar 19	1 Apr 2019				X		
				Full time	17 Aug 18	24 May 19	2 Jan 2019	X					
				Full time	05 Jul 16	15 Apr 19	1 Apr 2019				X		
				Full time	05 Jul 16	15 Mar 19	1 Apr 2019				X		
				Full time	17 Aug 18	14 Mar 19	1 Feb 2019				X		
			SubTotal			5 of 5 (100%)		**1**	**0**	**0**	**4**	**0**	**0**
				Full time		15 May 19	7 May 2019	X					
			SubTotal			1 of 1 (100%)		**1**	**0**	**0**	**0**	**0**	**0**
				Full time	28 Jun 17	03 Dec 18	1 Apr 2019		X				
				Full time	18 Jan 17	12 Nov 18	1 Apr 2019	X					
				Full time		20 Dec 18	1 Apr 2019	X					

Progress Report

				Surname	First Name	Full/Part Time	Last sign-off date	Last Logged In	Job Plan Start Date	Discussion	Awaiting 1st Sign Off By Consultant	Awaiting 1st Sign Off By Manager	Awaiting 2nd Sign Off	Awaiting 3rd Sign Off	Signed Off
		Trauma and O		Personal Information redacted by the USI		Full time		21 May 19	1 Apr 2019	X					
						Full time		01 May 19	1 Apr 2019	X					
						Full time	28 Jun 17	15 Feb 17	1 Apr 2019	X					
						Full time	18 Jan 17	14 May 19	1 Apr 2019	X					
						Full time	18 Jan 17	08 Apr 19	1 Apr 2019	X					
						Full time	20 Jul 18	01 Jun 18	1 Apr 2019	X					
						Full time	20 Jul 18	15 Nov 18	1 Apr 2019	X					
						Full time	28 Jun 17	14 Jul 18	1 Apr 2019	X					
				SubTotal				11 of 11 (100%)		**10**	**1**	**0**	**0**	**0**	**0**
			SubTotal					11 of 11 (100%)		**10**	**1**	**0**	**0**	**0**	**0**
		Urology		Glackin	Anthony Jude	Full time	27 Sep 16	16 Apr 19	1 Feb 2019	X					
				Haynes	Mark Dean	Full time	22 Aug 17	24 May 19	1 Oct 2017	X					
				O'Donoghue	John Paul	Full time	18 Jan 17	15 May 19	1 Apr 2018				X		
				O'Brien	Aidan	Full time		29 Nov 18	1 Apr 2018		X				
				Tyson	Matthew	Full time		12 Feb 19	25 Feb 2019		X				
				Young	Michael	Full time		16 May 18	1 Apr 2018	X					
				SubTotal				6 of 6 (100%)		**3**	**2**	**0**	**1**	**0**	**0**
			SubTotal					6 of 6 (100%)		**3**	**2**	**0**	**1**	**0**	**0**
		SubTotal						42 of 42 (100%)		**27**	**5**	**0**	**7**	**0**	**3**
	SubTotal							193 of 197 (98%)		**90**	**27**	**11**	**9**	**7**	**51**
Children and Young People Directorate	Children and Young People	CAMHS		Personal Information redacted by the USI		Full time	15 Jun 17	03 May 19	1 Apr 2019				X		
						Part time	04 Apr 19	25 Apr 19	1 Apr 2019						X
						Full time	30 Oct 18	21 May 19	1 Jun 2019					X	
						Part time	23 Jul 18	20 May 19	1 Apr 2019			X			
								4 of 4 (100%)		**0**	**0**	**1**	**1**	**1**	**1**
			SubTotal					4 of 4 (100%)		**0**	**0**	**1**	**1**	**1**	**1**
		Child and Adolescent Psychiatry				Full time	19 Apr 19	22 Apr 19	1 Apr 2019						X
								1 of 1 (100%)		**0**	**0**	**0**	**0**	**0**	**1**
			SubTotal					1 of 1 (100%)		**0**	**0**	**0**	**0**	**0**	**1**
		Community Paediatrics				Full time	30 Oct 18	14 Apr 19	1 Apr 2019			X			
						Part time	19 Apr 19	24 May 19	1 Apr 2019						X
						Full time	04 Apr 19	13 Mar 19	1 Apr 2019						X
								3 of 3 (100%)		**0**	**0**	**1**	**0**	**0**	**2**
			SubTotal					3 of 3 (100%)		**0**	**0**	**1**	**0**	**0**	**2**
		Paediatrics DHH				Full time	04 Apr 19	09 May 19	1 Apr 2019						X
						Full time	04 Apr 19	15 Apr 19	1 Apr 2019						X
						Full time	19 Dec 18	14 May 19	1 Jan 2019						X
						Full time	02 Aug 18	01 Apr 19	1 Jan 2019	X					
						Part time	19 Apr 19	05 Apr 19	1 Apr 2019						X
						Part time	04 Apr 19	11 Mar 19	1 Apr 2019						X
						Full time	19 Apr 19	02 Apr 19	1 Apr 2019						X
								7 of 7 (100%)		**1**	**0**	**0**	**0**	**0**	**6**
			SubTotal					7 of 7 (100%)		**1**	**0**	**0**	**0**	**0**	**6**
		Paediatrics, CAH				Full time	04 Apr 19	09 Apr 19	1 Apr 2019						X
						Full time	04 Apr 19	01 Apr 19	1 Apr 2019						X
						Full time	05 Jul 18	03 Apr 19	1 Apr 2019	X					
						Full time	04 Jun 18	30 Apr 19	1 Apr 2019	X					
						Full time	04 Apr 19	01 May 19	1 Apr 2019						X

Progress Report

				Personal Information redacted by the USI	Full/Part Time	Last sign-off date	Last Logged In	Job Plan Start Date	Discussion	Awaiting 1st Sign Off By Consultant	Awaiting 1st Sign Off By Manager	Awaiting 2nd Sign Off	Awaiting 3rd Sign Off	Signed Off
					Full time	19 Apr 19	26 Apr 19	1 Apr 2019						X
					Full time	04 Apr 19	16 Apr 19	1 Apr 2019						X
					Full time		05 Mar 19	4 Mar 2019	X					
							8 of 8 (100%)		**3**	**0**	**0**	**0**	**0**	**5**
			SubTotal				8 of 8 (100%)		**3**	**0**	**0**	**0**	**0**	**5**
		SubTotal					23 of 23 (100%)		**4**	**0**	**2**	**1**	**1**	**15**
	SubTotal						23 of 23 (100%)		**4**	**0**	**2**	**1**	**1**	**15**
Mental Health and Disability Directorate	Mental Health and Disability	Disability	Psychiatry Learning Disability		Full time	25 Jul 18	18 Jun 18	1 Apr 2019	X					
					Full time		22 Feb 19	6 Feb 2019			X			
					Full time	25 Jul 18	04 May 19	1 Apr 2019	X					
							3 of 3 (100%)		**2**	**0**	**1**	**0**	**0**	**0**
			SubTotal				3 of 3 (100%)		**2**	**0**	**1**	**0**	**0**	**0**
		Mental Health	Mental Illness		Full time	06 Sep 17	09 May 19	1 Apr 2019			X			
							1 of 1 (100%)		**0**	**0**	**1**	**0**	**0**	**0**
			Psychiatry		Full time	09 Jan 19	25 Mar 19	1 Apr 2019						X
					Full time	28 Aug 18	01 May 19	1 Apr 2019	X					
					Full time	28 Aug 18	23 Aug 18	1 Apr 2019	X					
					Full time	09 Jan 19	15 May 19	1 Apr 2019						X
					Full time	28 Aug 18	24 Jul 18	1 Apr 2019	X					
					Full time	08 Oct 18	08 Apr 19	18 Mar 2019	X					
					Full time			15 Jan 2019	X					
					Full time	23 Jul 18	22 Jan 18	1 Apr 2019	X					
					Part time	28 Aug 18	13 May 19	1 Apr 2019	X					
					Full time	25 Jul 18	03 Jan 19	1 Apr 2019				X		
					Part time	09 Jan 19	10 Dec 18	1 Apr 2019	X					
					Full time		08 May 19	1 Apr 2019	X					
					Full time	05 Nov 18	08 Oct 18	1 Apr 2019	X					
					Full time	28 Aug 18	20 Aug 18	1 Apr 2019	X					
					Full time	10 Jan 17	30 Apr 18	1 Apr 2019	X					
					Full time	08 Oct 18	13 May 19	1 Apr 2019	X					
					Part time	09 Nov 17	08 May 19	1 Apr 2019			X			
					Full time	08 Oct 18	25 Apr 19	17 Dec 2018				X		
					Full time		02 Jan 19	1 Apr 2019	X					
				SubTotal			18 of 19 (95%)		**14**	**0**	**1**	**2**	**0**	**2**
			SubTotal				19 of 20 (95%)		**14**	**0**	**2**	**2**	**0**	**2**
		SubTotal					22 of 23 (96%)		**16**	**0**	**3**	**2**	**0**	**2**
	SubTotal						22 of 23 (96%)		**16**	**0**	**3**	**2**	**0**	**2**
Total							238 of 243 (98%)		**110 (45%)**	**27 (11%)**	**16 (7%)**	**12 (5%)**	**8 (3%)**	**68 (28%)**

Total job plans	243
Total job plans with at least 1	238
Total users	243
Total users who have not	5
Total users who do not	0

CONSULTANT JOB PLAN SIGN OFF - PROGRESS REPORT- 30 April 2018								
Directorate	**Discussion stage**	**Awaiting 1st sign off**	**Awaiting 2nd sign-off**	**Awaiting 3rd sign-off**	**Appeal**	**Fully signed off**	**Total job plans**	**% completed**
Anaesthetics/ICU	20	6	1	2	5	3	37	8%
Pathology	8	1	1	1	0	2	13	15%
Radiology	13	2	0	0	0	2	17	12%
Emergency Medicine	6	0	0	1	0	4	11	36%
Geriatrics	3	1	1	0	0	3	8	38%
Obsetrics & Gynaecology	12	2	0	1	0	5	20	25%
Medicine & sub specialties	14	6	2	0	0	14	36	39%
Palliative medicine	3	0	0	0	0	0	3	0%
ENT	5	0	2	0	0	0	7	0%
Gen surgery + Orthodontics	15	2	0	0	0	0	17	0%
T&O	10	1	1	0	0	0	12	0%
Urology	5	0	0	0	0	0	5	0%
CAMHS	3	1	1	0	0	1	6	17%
CYPS	11	2	4	0	0	1	18	6%
Mental Health& Disability	7	6	4	0	0	6	23	26%
				Total		**41**	**233**	18%

45% of job plans fully signed-off for CAH

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

DRAFT

Regional Influence to Allocation to Trainees

DAISY HILL HOSPITAL
Pathfinder Group

Workforce Development Sub Group

Zoe Parks
Head of Medical HR

Gail Browne
Director Medical Education

BACKGROUND

At a meeting of the DHH Pathfinder Workforce Development Group on 5th October 2018 it was agreed that a number of work streams should be established to deliver on the Group's Terms of Reference.

One of these sub groups was to focus on **Rotational Doctors in Training Allocations**. The need for equity/fair allocation of trainees has been identified as a priority. The specific aim of this group is to look at rotas across NI and to ensure that NIMDTA & DOH are informed about SHSCT requirements. The outcome of this work-stream would be escalated to the Department of Health through a Chief Executive meeting/letter and DHH Pathfinder monthly progress updates to Dep PS/CMO.

Current Position

There are currently 1608 Rotational Doctors in Training within a hospital setting across Northern Ireland. The table below (provided by NIMDTA) shows the current split of rotational doctors across Trusts. Whilst there are 1608 rotational doctors in hospital – the total number listed above will be higher since this will include doctors on Out of Programmes, Adept Fellows or GP trainees in Primary Care).

Some significant highlights:

- ***Southern Trust has the lowest number of overall Training Posts (243)***

	Posts
Belfast Trust	811
SE Trust	260
Southern Trust	243
Northern Trust	260
Western Trust	247
	1821

- ***Southern Trust has the lowest number of Foundation Year 1 posts (34)***

	FY1 Posts
Belfast Trust	99
SE Trust	39
Southern Trust	34
Northern Trust	38
Western Trust	42

	Belfast Trust	South Eastern Trust	Southern Trust	Northern Trust	Western Trust	Overall
Specialties	**Overall Posts**	**Overall Posts**	**Overall Posts**	**Overall Posts**	**Overall Posts**	**Overall Total Posts**
Foundation Year 1	99	39	**34**	38	42	252
Foundation Year 2 (incl. GP, Academic & PHA)	97	39	**32**	42	42	252
GP Training	29	33	**33**	32	26	153
Anaesthetics	70	20	**19**	14	16	139
ICM		2				2
Emergency Medicine	24	13	**14**	18	8	77
Obstetrics & Gynaecology	30	10	**16**	17	17	90
Paediatrics	55	9	**12**	18	18	112
Radiology	29	7	**5**	4	5	50
Histopathology	19					19
Medical Microbiology	9					9
Chemical Pathology	3					3
Public Health	11					11
Core Medical Training (CT1/2)	52	29	**24**	23	12	140
General Medicine / Acute Medicine (ST3+/SpR)	4	4	**1**	6	1	16
Cardiology (ST3+/SpR)	14	2	**3**	1	2	22
Clinical Genetics (ST3+/SpR)	2					2
Clinical Oncology (ST3+/SpR)	12				3	15
Clinical Neurophysiology (ST3+/SpR)	1					1
Dermatology (ST3+/SpR)	8	1				9
Endocrinology (ST3+/SpR)	6	2	**2**		1	11
Gastroenterology (ST3+/SpR)	7	2	**2**	3	2	16
Geriatric Medicine (ST3+/SpR)	6	3	**3**	2	2	16

	Belfast Trust	South Eastern Trust	Southern Trust	Northern Trust	Western Trust	Overall
Genitourinary Medicine (ST3+/SpR)	2					2
Haematology (ST3+/SpR)	15					15
Immunology (ST3+/SpR)	3					3
Infectious Diseases (ST3+/SpR)	1					1
Medicine ICM (ST3+/SpR)	1	2				3
Medical Oncology (ST3+/SpR)	9				1	10
Neurology (ST3+/SpR)	8	1	**1**		1	11
Occupational Medicine (ST3+/SpR)	1					1
Paediatric Cardiology (ST3+/SpR)	1					1
Palliative Medicine (ST3+/SpR)	6					6
Rehabilitation Medicine (ST3+/SpR)	2					2
Renal Medicine (ST3+/SpR)	4	1		1	1	7
(Use posts in GIM) Respiratory Medicine (ST3+/SpR)	9	2	**1**	2	1	15
Rheumatology (ST3+/SpR)	5	1	**1**	1	1	9
Stroke Medicine (ST3+/SpR)	1					
Core Psychiatry Training (CT1 - CT3)	16	6	**10**	12	7	15
Psychiatry of Old Age (ST4+)	2	1				3
General Adult Psychiatry (ST4+)	12	2	**3**	5	3	25
Psychiatry of Learning Disability (ST4+)	4					4
Forensic Psychiatry (ST4+)	4					4

	Belfast Trust	**South Eastern Trust**	**Southern Trust**	**Northern Trust**	**Western Trust**	**Overall**
Child & Adolescent Psychiatry (ST4+)	4	1	**3**	1		9
Psychotherapy (ST4+)	1					1
Core Surgical Training (CT1/2)	36	11	**10**	13	18	88
General Surgery (ST3/SpR)	15	5	**7**	5	3	35
Trauma & Orthopaedic Surgery (ST3+/SpR)	19	3	**3**		6	31
Cardiothoracic Surgery (ST3+/SpR)	8					8
Neurosurgery (ST3+/SpR)	5					5
Paediatric Surgery (ST3+/SpR)	3					3
Otolaryngology (ST3+/SpR)	5		**2**	1	2	10
Urology (ST3+/SpR)	4		**2**		2	8
Ophthalmology	14				4	18
Plastic Surgery		10				10
Vascular Surgery (ST3+/SpR)	4					4
	811	**261**	**243**	**259**	**247**	

Information provided by NIMDTA February 2019

FOCUS ON GENERAL MEDICINE

We decided to focus in on **General Medicine**; since this is an area experiencing a large number of gaps; locum expenditure and work intensity. We sought some further information form the other Trusts to detail the working practices.

Medicine Rotas:

Foundation Year1:

Trust	Grade	Location	Shift Type	No Posts	Total Posts	Banding	Additional Info
SHSCT	FY1	CAH	F/S 1:11	11	19	1A -50%	
		DHH	F/S 1:11	8		1A – 50%	Medicine(8) Surgery Rota (4)
SE Trust	FY1	Lagan Valley	F/S 1:8	8	27	1A – 50%	
		Ulster/Downe	F/S 1:29	19		1B – 40%	4 Downe. 15 Ulster Medical specialties
Western	FY1	ALT	F/S	14	23	1A – 50%	Medical
		SWAH		9			Medical specialties
Northern	FY1	Antrim	F/s 1:14	14	24	1A – 50%	Medical specialties
		Antrim	F/S 1	1		1A – 50%	Standalone Cardiology
		Causeway	F/S 1:13	9		1A* - 50%	9 in Medicine
Belfast	FY1	RVH - Mixed	F/S 1:27	27	56 – *may inc. some in surgery*	1B	General Medicine /geriatrics/cardiology
		MIH - Mixed	F/S 1:15	15		1A	General Medicine/Surgery
		BCH - Mixed	F/S 1:17	14		1A	3 gaps - General medicine / geriatrics / Haematology /Nephrology / cardiology

Junior CT/ST1-2 & FY2 Tier

Trust	Grade	Location	Shift Type	No Posts	Total Posts	Banding	Additional Info
SHSCT	ST1-2/ F2	CAH	F/S 1:20	20*	36	1A – 50%	Collapsed 1:18 due to gaps
	ST 1-2/ F2	DHH	F/S 1:16	16		1A - 50%	
SE Trust	ST 1-2/F2	ULSTER	F/S 1:22	22	44	1B – 40%	
	ST 1-2/F2	Ulster MAU	F/S 1:5	5		1B – 40$	
	ST 1-2/F2	Ulster Renal	F/S	1		1B – 40%	
	ST 1-2/F2	Downe	F/S 1:8	8		2B – 50%	
	ST 1-2/F2	Lagan Valley	F/S 1:8	8		2B – 50%	
Western	ST 1-2/F2	Altnagelvin	F/S 1:24	24	41	2B – 50%	
	ST 1-2/F2	SWAH	F/S 1:17	17		1A – 50%	
Northern	F2	Antrim	F/S 1:10	10	50	1A – 50%	
	CT 1-2	Antrim	F/S 1:14	14		2A – 80%	
	ST/CT	Antrim	F/S 1:9	9			
	F2	Causeway	F/s 1:9	9		1A – 50%	
	CT 1-2	Causeway	F/S 1:8	8		1A – 50%	
Belfast	F2	RVH (AMU)	F/S 1:7	7	64	1B	
	ST1-2/CT/F2	MIH	F/S 1:13	13		1B	
	ST1-2/CT/F2	RVH	F/S 1:24	24		1A	
	ST1-2/CT/F2	BCH - Mixed	F/S 1:24	20		1A	4 gaps – General / Geriatric Medicine / Cardiology

Senior SpR Tier

Trust	Grade	Location	Shift Type	No Posts	Total	Banding	Additional Info
SHSCT	SpR	CAH	F/S 1:11	11	12	1A – 50%	
	SPR	DHH	F/S 1:8	1		1A – 50%	Locums employed to make up rota
SE Trust	ST3/SpR	Ulster	F/S 1:13	13	19	1B – 40$	
	ST3/SpR	Ulster	O/C 1:5	5		3 – 100%*	Non-resident on-call
	ST3/SpR	Ulster - Renal	O/C	1		2B – 50%	Non-resident on-call
Western	SpR	Altnagelvin	F/S 1:13	13	17	2B – 50%	
	SpR	Altnagelvin		4			4 trainees on separate oncology rota
	SpR	SWAH Has ICU support	0	0			No SpR/ST3's in SWAH. SAS/Consultants provide out of hours cover. 2 Perm SAS; 1 Temp & 6 Agency.
Northern	SpR	Antrim		13	16		13 NIMDTA posts (11in post)
	SpR	Causeway		3			2 vacant: 1 P/T
Belfast	ST3+	MIH	F/S 1:8	8	32	1A	
	ST3+	BCH	F/S 1:12	11		1A	
	ST3+	RVH	F/S 1:13	13		1A	

KEY FINDINGS FROM FOCUS ON MEDICINE

- The Southern Trust would appear to have the least number of NIMDTA Training posts in comparison to all other Trusts at all grades in General Medicine.

NIMDTA response to Allocation of Training Post

The Trust recently received some correspondence from NIMDTA which set out their position on the allocation of training posts throughout Northern Ireland. Their position is highlighted below:

"The distribution of posts has been largely based on historical patterns which NIMDTA did not control – they have grown up over years – some funded by DoH and some funded by Trusts. The DoH has commissioned new posts in recent years in a number of specialties and these have been distributed among the different Trusts. Some Trusts have also approached NIMDTA with the proposal that they will fund new training posts – when they receive these applications, they evaluate the educational merits of the post and if educationally sound approach HSCB and PHA for their views. If there is support from HSCB and PHA, then the application is forwarded to DoH for their consideration as they have the oversight of the medical workforce planning for NI. NIMDTA does not have funding which is not already committed to a training post somewhere. NIMDTA currently is not in a position to either create new training posts or redistribute existing training posts.

If there is felt to be a need to create additional training posts within the SHSCT, this should be discussed with the senior leadership within the Trust as there is a need to identify a funding stream for the new training post and associated training costs before there can be any consideration of seeking educational approval, service approval or workforce planning approval from the DoH. NIMDTA also pointed out that there is not a limitless supply of doctors who want to apply for such posts and the danger of increasing the number of training posts without addressing the supply from medical school or increasing the attractiveness of posts can just result in an increase in the number of vacant training posts without increasing the number of trainees. Trusts therefore do need to consider alternative solutions to managing the service pressures they are under rather than relying on an ever increasing number of trainee doctors". (Position from NIMDTA April 2018

GENERAL MEDICINE ROTAS

FY1 – 1:11 Rota – CAH

Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun
1	C	+++, C	+++, C	+++, C	+++		
2	A	B	A		A	D	D
3	A	A	B	A	A		
4	B	A	A	B	A		
5	A	B	A	A	B		
6	A	A	B	A		B	B
7	A	A	A	A	A		
8	B	A	A		C	+++, C	+++, C
9	+++		A	A	A		
10	A	A		A	B	B	B
11			A	B	A		

Duty details:

Duty	Name	Work Pattern	Start	Finish	Duration
A	NWD	NWD	9:00	17:00	8:00
B	Late	Full Shift	9:00	21:00	12:00
C	Night	Full Shift	20:30	9:00	12:30
D	Weekend	Full Shift	13:00	21:00	8:00

New Deal Rules	Rota	Maximum
Duty hours	48:15 (47:14)	56:00
Actual hours	48:15 (47:14)	56:00
Max consecutive days	8	13
Max continuous duty length	12:30	14:00 / 14:00

SHO Collasped Rota 1:18 CAH

Rota timetable:

Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun
1	D	D		D	L	L	L
2		D	D	D	D		
3	L	D	D	L	D		
4	C	D	D	D	N	+++, N	+++, N
5	+++		D	D	D		
6	D	D	D	D	D		
7	D	D	L	C	D		
8	N	+++, N	+++, N	+++, N	+++		
9	D	L	C	D	D		
10	D	D	D	D	D		
11	D	D	D	D	D		
12	L	C	D		N	+++, N	+++, N
13	+++		D	D	D		
14	N	+++, N	+++, N	+++, N	+++		
15	D	L	D	L			
16	D	D		D	L	L	L
17			L	D	D		
18	D	D	D	D	C	E	E

Duty details:

Duty	Name	Work Pattern	Start	Finish	Duration
D	NWD	NWD	9:00	17:00	8:00
L	Long Shift	Full Shift	9:00	21:00	12:00
N	Night	Full Shift	20:30	9:30	13:00

SpR Rota 1:11 – CAH

Rota timetable:

Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun
1	N	+++, N	+++, N	+++, N	+++		
2	L	D	D	D	D		
3	D	D	D	D	L	L	L
4		D	D	D	D		
5	D	L	D	L	D		
6	D	D	D	D	N	+++, N	+++, N
7	+++		D	D	D		
8	D	D	L		D	W	W
9	D	D	D	D			
10	D	D	D	D	D		
11	D	D	D	D	D		

Duty details:

Duty	Name	Work Pattern	Start	Finish	Duration
D	NWD	NWD	9:00	17:00	8:00
L	Late	Full Shift	9:00	21:00	12:00
N	Night	Full Shift	20:30	9:30	13:00
W	Weekend day	NWD	9:00	17:00	8:00

COMPARISON WITH NORTHERN TRUST

We have obtained a copy of a few of the working rota patterns from the Northern Trust to give a visual comparison against our own working patterns. These are set out below for information.

ALTNAGELVIN SHO ROTA

CURRENT SHO GENERAL MEDICINE - FULL SHIFT ROTA (24 DOCTORS) - AS AT 1 AUGUST 2018

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total Hours
Doctor 1	DAY	DAY	OFF	DAY	DAY	OFF	OFF	32
Doctor 2	NIGHT (ON CALL)	NIGHT (ON CALL)	NIGHT (ON CALL)	NIGHT (ON CALL)	OFF	OFF	OFF	50
Doctor 3	DAY	DAY	DAY	DAY	DAY	OFF	OFF	40
Doctor 4	DAY	DAY	DAY	OFF	ADMISSIONS	ADMISSIONS	ADMISSIONS	63
Doctor 5	DAY	DAY	DAY	DAY	DAY	OFF	OFF	40
Doctor 6	DAY	DAY (ON CALL)	DAY	DAY (ON CALL)	DAY	OFF	OFF	50
Doctor 7	DAY	DAY	DAY	DAY	NIGHT (ON CALL)	NIGHT (ON CALL)	NIGHT (ON CALL)	69.5
Doctor 8	OFF	OFF	DAY	DAY	DAY	OFF	OFF	24
Doctor 9	DAY (ON CALL)	DAY	DAY (ON CALL)	DAY	DAY	OFF	OFF	50
Doctor 10	DAY	DAY	DAY	DAY	DAY	PTWR	PTWR	56
Doctor 11	DAY	DAY	OFF	DAY	DAY	OFF	OFF	32
Doctor 12	DAY	ADMISSIONS	DAY	ADMISSIONS	DAY	OFF	OFF	50
Doctor 13	WATERSIDE	WATERSIDE	WATERSIDE	WATERSIDE	WATERSIDE	OFF	OFF	40
Doctor 14	DAY	DAY	DAY	OFF	DAY (ON CALL)	DAY (ON CALL)	DAY (ON CALL)	63
Doctor 15	DAY	DAY	DAY	DAY	DAY	OFF	OFF	40
Doctor 16	NIGHT (ADMISSION)	NIGHT (ADMISSION)	NIGHT (ADMISSION)	NIGHT (ADMISSION)	OFF	OFF	OFF	50
Doctor 17	DAY	DAY	DAY	DAY	DAY	OFF	OFF	40
Doctor 18	DAY	DAY	DAY	DAY	LATE	LATE	LATE	62
Doctor 19	OFF	DAY	DAY	DAY	DAY	OFF	OFF	32
Doctor 20	ADMISSIONS	DAY	ADMISSIONS	DAY	DAY	OFF	OFF	50
Doctor 21	DAY	DAY	DAY	DAY	NIGHT (ADMISSION)	NIGHT (ADMISSION)	NIGHT (ADMISSION)	69.5

Doctor 22	OFF	OFF	DAY	DAY	DAY	OFF	OFF	24
Doctor 23	LATE	LATE	LATE	LATE	OFF	OFF	OFF	40
Doctor 24	CLINIC	CLINIC	CLINIC	CLINIC	CLINIC	REVIEWS /TAKE	REVIEWS / TAKE	66
Total Hours								**1133**
Unsocial Hours	31	31	31	31	36	82	77	319/1133 = 28%
Ward Cover (Day)	18.5	19.5	19.5	19.5	18.5			

Normal Day = 9.00 a.m. – 5.00 p.m. (8hrs)

Clinic = 9.00 a.m. – 5.00 p.m. (8 hrs)

Day/On -Call = 9.00 a.m. – 10.00 p.m. (13 hrs)

Admissions = 9.00 a.m. – 10.00 p.m. (13 hrs)

Late = 2.00 p.m. - 12 Midnight (10 hrs)

Night On-Call = 9.00 p.m. – 09.30 a.m. (12.5hrs)

Night Admissions = 9.00 p.m. – 09.30 a.m. (12.5hrs)

Post Take Ward Round = 08.30 a.m. – 16.30 p.m. (8 hrs)

Reviews / Take = 09.00 a.m. – 22.00 p.m. (13 hrs)

TOTAL HOURS =

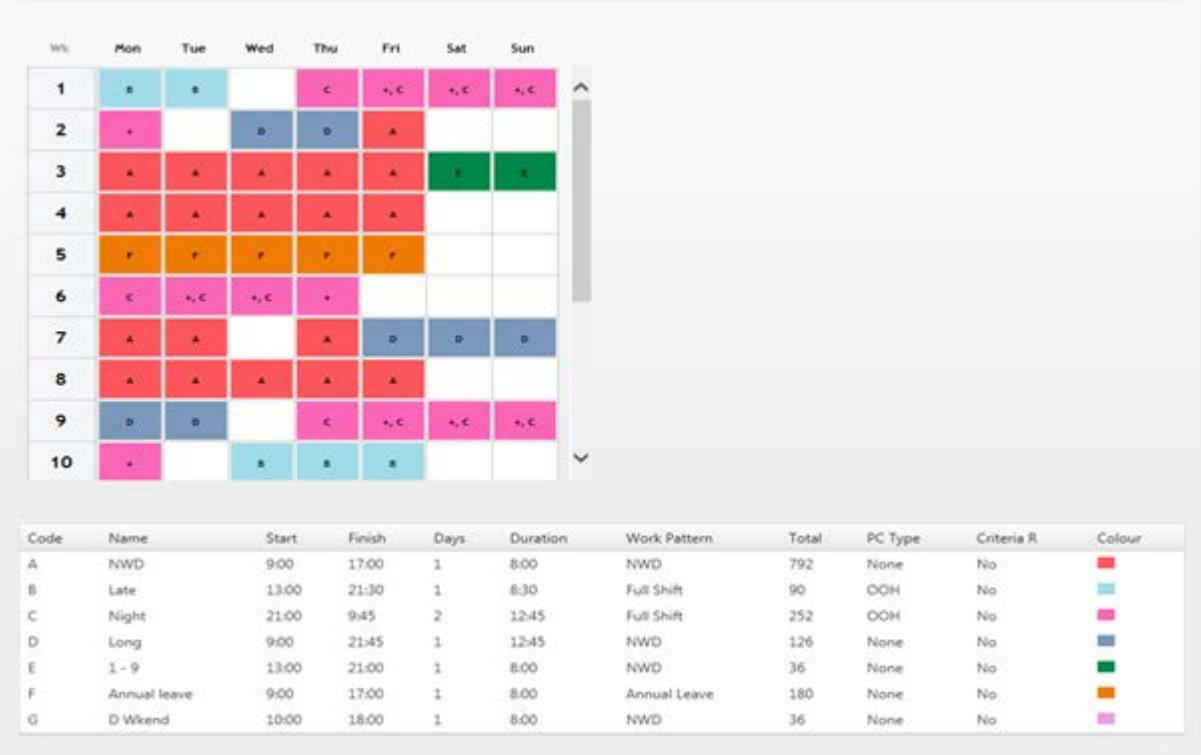
Actual Hours of Work = 1133 – 212.4 / 18.69 = 49.2 Hours

Unsocial Hours = 319/1133 = 28%

Weekends = 7 /24 = 29%

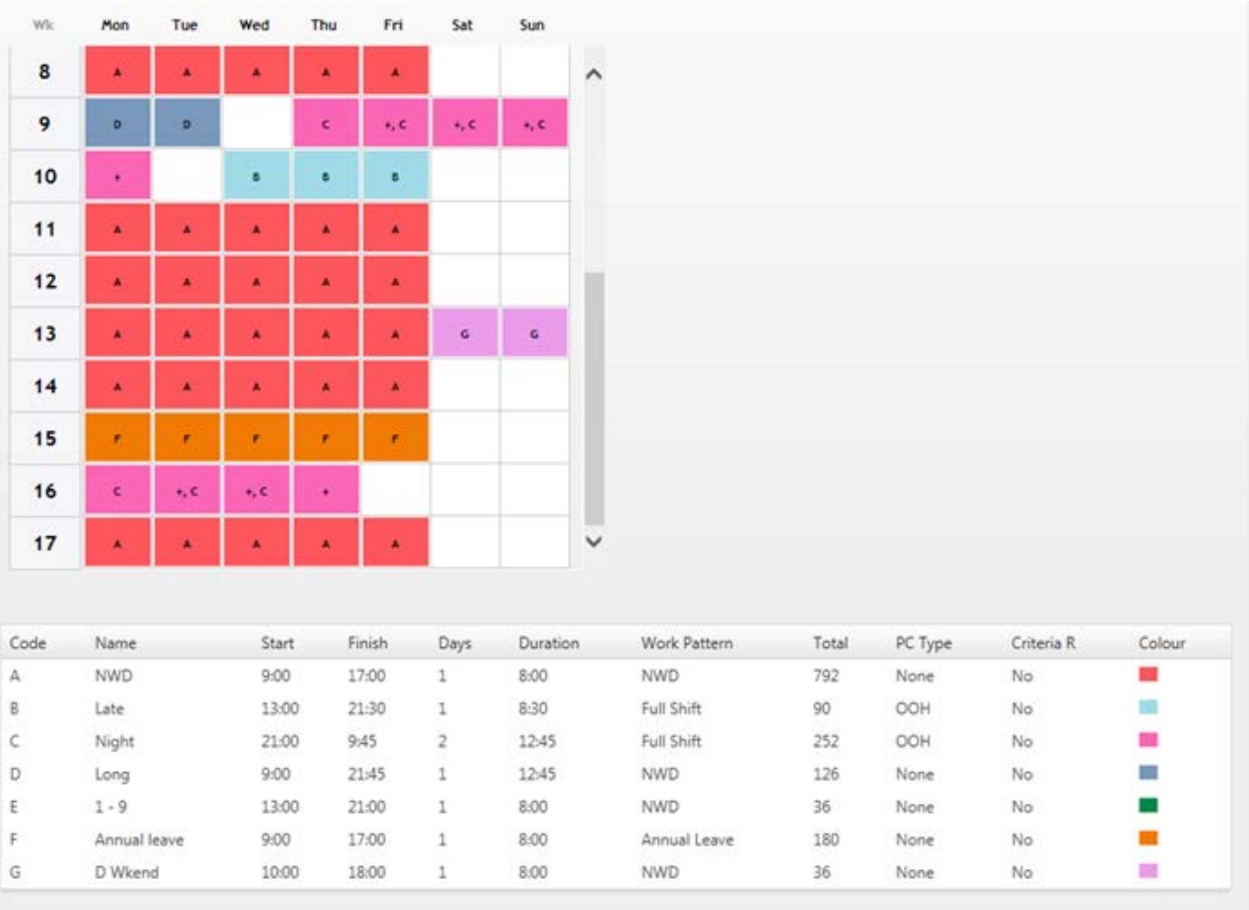
Band 2B

SWAH SHO 1:17 ROTA



Wk	Mon	Tue	Wed	Thu	Fri	Sat	Sun
1	B	B		C	+, C	+, C	+, C
2	+		D	D	A		
3	A	A	A	A	A	E	E
4	A	A	A	A	A		
5	F	F	F	F	F		
6	C	+, C	+, C	+			
7	A	A		A	D	D	D
8	A	A	A	A	A		
9	D	D		C	+, C	+, C	+, C
10	+		B	B	B		

Code	Name	Start	Finish	Days	Duration	Work Pattern	Total	PC Type	Criteria R	Colour
A	NWD	9:00	17:00	1	8:00	NWD	792	None	No	
B	Late	13:00	21:30	1	8:30	Full Shift	90	OOH	No	
C	Night	21:00	9:45	2	12:45	Full Shift	252	OOH	No	
D	Long	9:00	21:45	1	12:45	NWD	126	None	No	
E	1 - 9	13:00	21:00	1	8:00	NWD	36	None	No	
F	Annual leave	9:00	17:00	1	8:00	Annual Leave	180	None	No	
G	D Wkend	10:00	18:00	1	8:00	NWD	36	None	No	



Wk	Mon	Tue	Wed	Thu	Fri	Sat	Sun
8	A	A	A	A	A		
9	D	D		C	+, C	+, C	+, C
10	+		B	B	B		
11	A	A	A	A	A		
12	A	A	A	A	A		
13	A	A	A	A	A	G	G
14	A	A	A	A	A		
15	F	F	F	F	F		
16	C	+, C	+, C	+			
17	A	A	A	A	A		

Code	Name	Start	Finish	Days	Duration	Work Pattern	Total	PC Type	Criteria R	Colour
A	NWD	9:00	17:00	1	8:00	NWD	792	None	No	
B	Late	13:00	21:30	1	8:30	Full Shift	90	OOH	No	
C	Night	21:00	9:45	2	12:45	Full Shift	252	OOH	No	
D	Long	9:00	21:45	1	12:45	NWD	126	None	No	
E	1 - 9	13:00	21:00	1	8:00	NWD	36	None	No	
F	Annual leave	9:00	17:00	1	8:00	Annual Leave	180	None	No	
G	D Wkend	10:00	18:00	1	8:00	NWD	36	None	No	

NIMDTA FILL RATES

In August 2017, the Medical Foundation Programme achieved a fill rate of 96% and Medical Specialty Training a fill rate of 83%. At August 2017, there were a total of 185 training posts that were unfilled with the highest vacancy rate within **Core Medical Training**, Obstetrics and Gynaecology and Paediatrics. The number of vacancies increased to 201 by February 2018 due to resignations, maternity leave, sick leave, completion of training and out of programme training.

In 2015-16 the Minister for Health announced an increase of 20 posts in General Practice, in addition to the 65 posts that had been previously recruited to training on an annual basis. A subsequent announcement stated there would be expansion to this figure by a further twelve training posts to start in August 2017, and as a result 97 posts were recruited to. In 2017-18 the Minister has announced a further increase of 14 posts in General Practice resulting in 111 available places. NIMDTA has been involved in planning for this expansion in cooperation with HSC Trusts and GP practices. From August 2017, the following hospital specialties expanded their training programmes: Core Medical Training (1), Radiology (4), Emergency Medicine (7) and Ophthalmology (1). It is anticipated that the Clinical Radiology training programme will further expand in August 2018 in addition to Anaesthetics, Urology and Neurology.

NIMDTA competition ratios for 2017 for specialty training recruitment for General Medicine CT1/2 posts indicated a fill rate of 62%.

RECOGNISING TREND FOR AGENCY WORKING

It is undisputed that many doctors are choosing not to re-enter the training scheme often at the point they complete FY2 training, but instead choose to take a number of years out - often to work via external private locum agencies. This has undoubtedly contributed to numerous gaps throughout our junior doctor workforce and most notably in Medicine where NIMDTA have been unable to fill all our core medical training posts. The percentage of FY2 doctors in particular choosing not to re-enter a training post has been increasing year on year.

We know these doctors receive lots of flexibility, choice on where they can work and a significant enhancement of pay when working directly for the locum agencies. We believe it would be helpful to consider this very real issue in light of our workforce planning considerations to ensure our systems are not actually making this the most attractive option for doctors. We know for instance that currently there is no detriment to a doctor choosing to work for this NHS in this manner. When they return to a training post – they are successfully seeking for the time spent with the private locum agency to be counted when determining their point on the incremental scale. We believe there is an opportunity for this position to be reviewed. There may also be opportunities to consider if further action is necessary to consider how this locum service is considered in other aspects also when a doctor chooses to re-enter training. It would be helpful if a collaborative approach was considered to see how we can ensure we offer a positive and attractive proposal within

the NHS to doctors which successfully reduces the current attractiveness of agency working.

REGIONAL MEDICAL WORKFORCE WORK

The DHSSPS is responsible for medical workforce planning, and the DHSSPS regional workforce planning group oversees the preparation of workforce plans for Health and Social Care. The Director of Public Health/Medical Director of PHA chairs a medical workforce subgroup which reports to the DHSSPS regional workforce planning group. This subgroup has been tasked with the development of a suite of medical workforce plans for primary and secondary care for the five-year period 2013/14 to 2018/19. These will cover all specialities and will be developed incrementally to enable the methodology to be tested and refined. The methodology engages stakeholders throughout the project to refine the modelling and outputs.

Each speciality plan is required to take account of key national and regional drivers such as Quality 2020, a strategic move to seven-day services, and a shift from secondary to primary care as outlined in Transforming Your Care, General Medical Council (GMC) requirements, and NICE guidance. The Report that was completed by this Group for Medical Specialites is appended at the end of this report.

The Public Health Agency issued their final report to Andrew Dawson in the DOH in April 2018.

ACTIVITY DATA FOR COMPARISON

Table 24: Specialty 300 - Inpatient and Day Case Activity Data by Hospital/HSC Trust for General Medicine, 2017/18

Hospital/ HSC Trust	Non Elective Inpatients General Medicine	Non Elective Inpatients Gastroenterology	Non Elective Inpatients Respiratory	Non Elective Inpatients Cardiology	Non Elective Inpatients Geriatric Medicine	Total
Belfast City	60	296	1,278	564	2,644	4,842
Mater Infirmorum	1,051	976	1,767	956	741	5,491
Royal Victoria	3,935	1,789	2,224	3,873	1,208	13,029
Belfast HSCT	**5,046**	**3,061**	**5,272**	**5,558**	**5,002**	**23,939**
Antrim	7,884	1,925	3,187	0	1,658	14,654
Causeway	4,574	75	89	828	347	5,913
Mid Ulster	0	0		0		0
Whiteabbey	0	0		0	547	547
Northern HSCT	**12,458**	**2,000**	**3,276**	**828**	**2,552**	**21,114**
Ards	1			0	349	350
Downe	2,336			0	37	2,373
Lagan Valley	3,023			87	470	3,580
Ulster	12,394			1,942	2,397	16,733
South Eastern HSCT	**17,754**			**2,029**	**3,253**	**23,036**
Craigavon Area	9,256	6		1,642	1,903	12,807
Daisy Hill	6,152	1		99	377	6,629
South Tyrone	0			0	525	525

Lurgan	0			0	850	850	
Southern HSCT	**15,408**	7		**1,741**	**3,655**	**20,811**	
Altnagelvin Area	5,678			1,929	1,191	8,798	
South West Acute	4,236			586	1,452	6,274	
Omagh	0			3,778	0	3,778	
Waterside					569	569	
Western HSCT	**9,914**			**6,293**	**3,212**	19,419	
	19,828			6,293	6,424	**32,545**	
NI Total	**60,580**						
Source: Hospital Inpatient System & KH03a							

Information provided by Dr D Gormley Consultant SHSCT

LOCAL SHORT TERM WORKFORCE ACTIONS TAKEN

1. Medical Training initiative Model

There is a need for additional Doctors for General Medicine and Renal in DHH but there is a deficit of Doctors across the region of all specialties. This proposal is to source **Medical Training Initiative (MTI) Doctors for Daisy Hill Hospital** by investing in the creation of a number of International Training Fellowships in Medical Specialties (ST3 level) to join the existing complement of trainees, consultant and non-consultant career grades. These posts will provide excellent training and service opportunities for doctors with varying career aspirations. Successful MTI applicants will be provided an opportunity to experience specialty training and development in the UK's National Health Service (NHS) before returning home to implement their new skills and experience. They will receive training at Specialty Training Year 3 level or above, supervised by a qualified NHS consultant. The training plan is usually tailored to suit the trainee's educational objectives and the work they wish to undertake on returning home. The aim of these posts is to provide development opportunity for the post-holders, building on their existing basic and specialty training while supporting our key service areas in relation to the provision of in and out of hours clinical care by a trained doctor workforce. Trainees can therefore expect in addition to gaining specialty ward-based and clinic/procedural experience and development to contribute to the Trust's middle grade medical receiving rotas. The trainee will not take part in on call duties until a period of induction and close supervision has been undertaken and both they and the Supervising consultant are satisfied that they are competent and ready. The trainee will always have access to Consultant or senior Registrar support during on call periods.

NIMDTA were consulted and have given written confirmation that these MTI posts in Daisy Hill (See Appendix) would hev sufficient training content and would enhance supervision of the Core Medical Trainees.

Funding has just been approved by our IPT Committee to proceed with the Royal College to attempt recruitment to these 2 year posts.

2. Clinical Fellow Model

The Southern Trust designed and implemeneted a Clinical Fellow/self rostering model in Emergency Medicine from August 2018. There are plans in place to review how this could work in General Medicine with the hope that this can be piloted from August 2019.

3. Physician Associate Model

The Southern Trust has recently appointed 3 Physician Associates to work across the Trust from the end of March 2019 – following the first tranch of qualified professionals from University of Ulster. This is a new model of care across Northern Ireland. These associates will be based in Haematology./Care of Eldery in CAH and 2 in Emergency Medicine /Medicine in Daisy Hill Hospital. There is scope if this model is successful to advertise to see if we can attract qualified PA's (from the UK) in advance of the new bunch of qualified PA's coming out of our local univerisity in March 2020.

REQUESTED ACTIONS

The Southern Trust would ask that urgent attention and consideration is given to the following:

- A thorough and robust regional review of all rotational doctors in training across Northern Ireland with a view to reconsidering allocations to ensure a fair and equitable distribution of trainees across NI, taking into account service need as well as training opportunities.
- Communicating a regional strategic position on the growing problem of rotational doctors leaving the NI Training scheme and choosing to work via external locum agencies. Historically this has been tackled by attempting to make training schemes more attractive to encourage retention however we feel this should also include some additional approaches on a regional level.
    - HR Representatives have documented a proposal to the Department of Health which if endorsed and communicated would faciliate a consistent approach around the recognition of locum medical service on return to training posts in respect of incremental pay. Currently this is not consistent with some Truists continuing to increase pay increments by recognising locum medical service. We are awaiitng a response from the Department of Health on this issue.
    - We believe there is also an urgent need to review how locum medical service is considered for shortlisting purposes on application for higher training posts. Again there does not appear to be any disincentive for doctors to choose Locum positions for obtaining competecies as arguably it will be accepted as equivalent service to those who have completed service within normal training positions.
- The regional workforce paper completed by the PHA for Medical Specialties highlighted in their conclusions that It would be prudent to review these specialty workforce plans in 2019 prior to decisions on the intake of new ST3 doctors in 2020. We would like to seek an update on what action has been taken by the Department following this detailed analysis and how this has fed back into the workforce planning projections for our junior doctor workforce.

APPENDIX

Northern Ireland
mdta
Medical & Dental Training Agency

Beechill House
42 Beechill Road
Belfast
BT8 7RL

Tel: Personal Information redacted by the USI
Fax:
Web:
Email: Personal Information redacted by the USI

Our Ref: mgt/trust/pd

12 November 2018

Dr Ahmed Khan
Medical Director (Interim)
Southern Health & Social Care Trust

Via Email Only: Personal Information redacted by the USI (PA to Medical Director)

Dear Dr Khan

Re: MTI Doctors (ST3+ Level in Medicine – Daisy Hill Hospital)

Thank you for your recent letter from 29 October 2018 regarding the Trust proposal to appoint MTI doctors at ST3+ level in Medicine in Daisy Hill Hospital.

Dr Steele, Director of Hospital Specialty Training, has consulted with the NIMDTA Head and Deputy Head of School of Medicine and the conclusion was that having MTI doctors at this level would enhance the support and supervision for Core Medical Trainees. Therefore this proposal can be supported from the training perspective, however, there may be Deanery costs associated with including the MTI doctors in training processes, which would be deducted from the Trust RRL.

Yours sincerely

Personal Information redacted by the USI

Professor Keith Gardiner
Chief Executive/Postgraduate Medical Dean

cc. Dr I Steele (Director for Hospital Specialty Training/ Professional Development, NIMDTA)
Ms D Hughes (Education Manager, NIMDTA)
Ms P Black (Business Manager, NIMDTA)

APPENDIX

NIMDTA Process – February 2018

Process for Approval and Allocation of a New Training Post

NIMDTA approval relates only to the suitability of a post for training and education. Requests for NIMDTA to provide educational approval for new training posts can originate from DoH, HSCB/PHA, or a Local Educational Provider (LEP).

A trainee cannot be allocated to a new training post until a recurrent funding stream has been identified which in addition to the basic salary and employer's costs includes the NIMDTA expenses associated with:

- Recruitment
- Induction events to their Foundation/Specialty Programme
- Supervision (PAs for named clinical and educational supervisors; NIMDTA events targeted at Recognised Trainers)
- Annual Review
- Study leave
- Generic and Professional Training (iQuest Programme)
- Formal Specialty-specific Education events organised by the Specialty Programme
- Excess travel allowance
- Quality Management of the training post (survey, visits, report review)

These costs are based on the mid-point dependant on the level of training – Foundation Year 2, Core Training (CT1-2 level) or Run-Through Specialty Training (ST1-8 level).

Funding is not available from NIMDTA to facilitate an increase in the number of training posts on a training programme.

NIMDTA will require written confirmation from the funding body (DoH, PHA/HSCB, or LEP) that they will meet the full costs of the new training post over the entire duration of the training programme before NIMDTA will initiate a recruitment process. Costs associated with the banding of this post are in addition to the costs described above and need to be agreed with the HSCB. NIMDTA does not manage the banding costs associated with training posts. The approval process to be followed depends on the source identified for funding of the new training post. Where funding has been provided by the DoH or PHA/HSCB the process outlined in Section 1 will be followed. This process will also be followed where post approval is required due to the need to relocate an existing training post to another hospital site or LEP. Where funding for a new training post is being provided by a LEP, the process outlined in Section 2 will be followed.

Section 1: New funding identified from Department of Health or HSCB/PHA or Decision to relocate a Training Post

The requirements of a training post are based on the standards set by the GMC relating to the delivery of high quality education and training in an LEP. Where there is more than one possible location for a training post to be sited, the following criteria will be used by NIMDTA to inform in the decision making process regarding the site of the new post

Consideration will be given to the evidence of the quality of training and education experienced by trainees who have been allocated to that training unit and LEP previously and the potential impact of a new post on the training and experience of existing trainees in that unit. Information available from NIMDTA visits, GMC visits, the GMC National Training Survey and other sources will be utilised. The ability of a site to meet training requirements which are currently not available/not sufficiently available for trainees in the programme will also be considered.
Any LEP which wishes to be considered for recognition of a new training post and allocation of an additional trainee will be asked to submit an application to be considered by Hospital Specialty Trainee Committee (HSTC) **(Appendix 1).**
Section 1 to section 4 of this application will consider the areas outlined below:

a) To demonstrate Board level engagement in education and training the LEP must:
   - meet the required standards for a learning environment for the delivery of postgraduate education and training, set by the regulator
   - provide evidence that they produce an annual education and training plan for their workforce
   - demonstrate there is a named individual on the Board with responsibility for postgraduate education and training and that Board engagement is active in relation to education and training
   - give assurance that there are adequate levels of supervision for trainees
   - demonstrate an ability to respond to feedback on the quality of the training and a desire to improve performance where required

b) To meet requirements for Clinical Leadership and Trainee Engagement the LEP must:
   - demonstrate they have achieved effective clinical engagement at all levels of the organisation
   - demonstrate effective leadership of medical education through robust educational governance.
   - provide a mechanism for trainees to meet with senior Trust staff (Education and Management) such as a Trainee Forum
   - have in place Local Faculty Group arrangements to review training provision in association with trainee representatives

c) To demonstrate provision of safe trainee supervision the LEP must:
   - give assurance to NIMDTA that there are adequate levels of supervision including induction, handover, appropriate access to senior support and graded experience

- demonstrate there is adequate time for trainers to meet the education and training requirements
- ensure that all relevant consultant work time is job planned including SPA time for educational and clinical supervision
- have named educational and clinical supervisors appropriately selected and approved for the roles
- have mechanisms in place to identify and assist trainees requiring support in conjunction with NIMDTA
- have sufficient consultants in the specialty to provide ongoing supervision to trainees

d) To demonstrate capacity for training the LEP must:
- demonstrate for existing trainees the ability to comply with the national or regional quality indicators for that specialty where defined
- demonstrate that current trainees have adequate exposure to training opportunities
- demonstrate the training opportunities available by mapping them to the curriculum
- consider the possible impact of an increase in training numbers on existing trainees
- have in place appropriate training infrastructure including local faculty groups to review the quality of the training
- have adequate infrastructure including IT and library facilities
- be able to meet trainee requirements for study leave and annual leave

e) To demonstrate previous training quality the LEP must have:
- satisfactory feedback from the GMC National Training Survey
- information relating to previous trainees' ability to achieve satisfactory outcomes at ARCP and in professional exams
- review of feedback from previous trainees
- previous trainees' ability to obtain a level of competence appropriate for their level
- engagement of the training unit in delivery of Workplace Based Assessments
- the unit should not be under Enhanced Monitoring

Following application from LEPs the evidence submitted will be reviewed by the relevant Lead Educators, School Board and/or Specialty Training Committee and recommendation will be made to HSTC.

Consideration will be given to the experience of other trainees in that unit in the LEP and the potential impact of a new training post on existing trainees in that unit. Information available from NIMDTA visits, GMC visits, the GMC National Training Survey and other sources will be utilised. The ability of sites to meet any training requirements not already available in the region for trainees will also be considered.

Any new training post is subject to review after one year. If the timing when funding is approved is too close to allocation to allow the full assessment of the relative merits of applications from different training sites to be completed, then an interim

decision without prejudice to place the training post in a Trust for the next training year may be made until that assessment is concluded.

Level of support and development of trainees, as defined in Domains 1 and 6 of *The Trainee Doctor*

Level	Evidence	Allocation Decision
Level 0 – unit which is under GMC Enhanced Monitoring. The unit is at risk of not meeting the GMC's minimum requirements for supervision set out in Domains 1 and 6 of *The Trainee Doctor.*	NIMDTA informed by the GMC that this unit is under Enhanced Monitoring	Not suitable for placement of a new trainee.
Level 1 – unit which is considered unsatisfactory.	Unit is graded as Unsatisfactory by NIMDTA QMG following Deanery visit or serious concerns raised by other sources of information which require a NIMDTA triggered visit	Not suitable for placement of a new trainee.
Level 2 – The unit is considered borderline.	Unit is graded as Borderline by NIMDTA QMG following Deanery visit or has multiple below (red) outliers on the NTS +/- the National Survey of Trainers for supervision at LEP level	Decision required by NIMDTA HSTC regarding suitability of placement.
Level 3 - The unit is considered satisfactory (with or without conditions).	There are no areas of significant concern identified by NIMDTA QMG about the quality of the training	Unit suitable for placement of a new trainee.
Level 4 - The unit is considered good LEP has demonstrated that quality control and quality improvement measures are in place which meet the GMC's minimum requirements for training.	There are no areas of concern, significant concern or areas for improvement identified by NIMDTA QMG about the quality of the training.	Unit suitable for placement of a new trainee.
Level 5 - The unit is considered excellent LEP has demonstrated that quality control and quality improvement measures are in place which exceed the GMC's minimum requirements for training.	There are no areas of concern, significant concern or areas for improvement identified by NIMDTA QMG about the quality of the training. The LEP has demonstrated one or more areas of good practice	Unit suitable for placement of a new trainee.

Chart 1: Allocating a new training post funded by DoH or HSCB/PHA (or relocation of an existing training post).

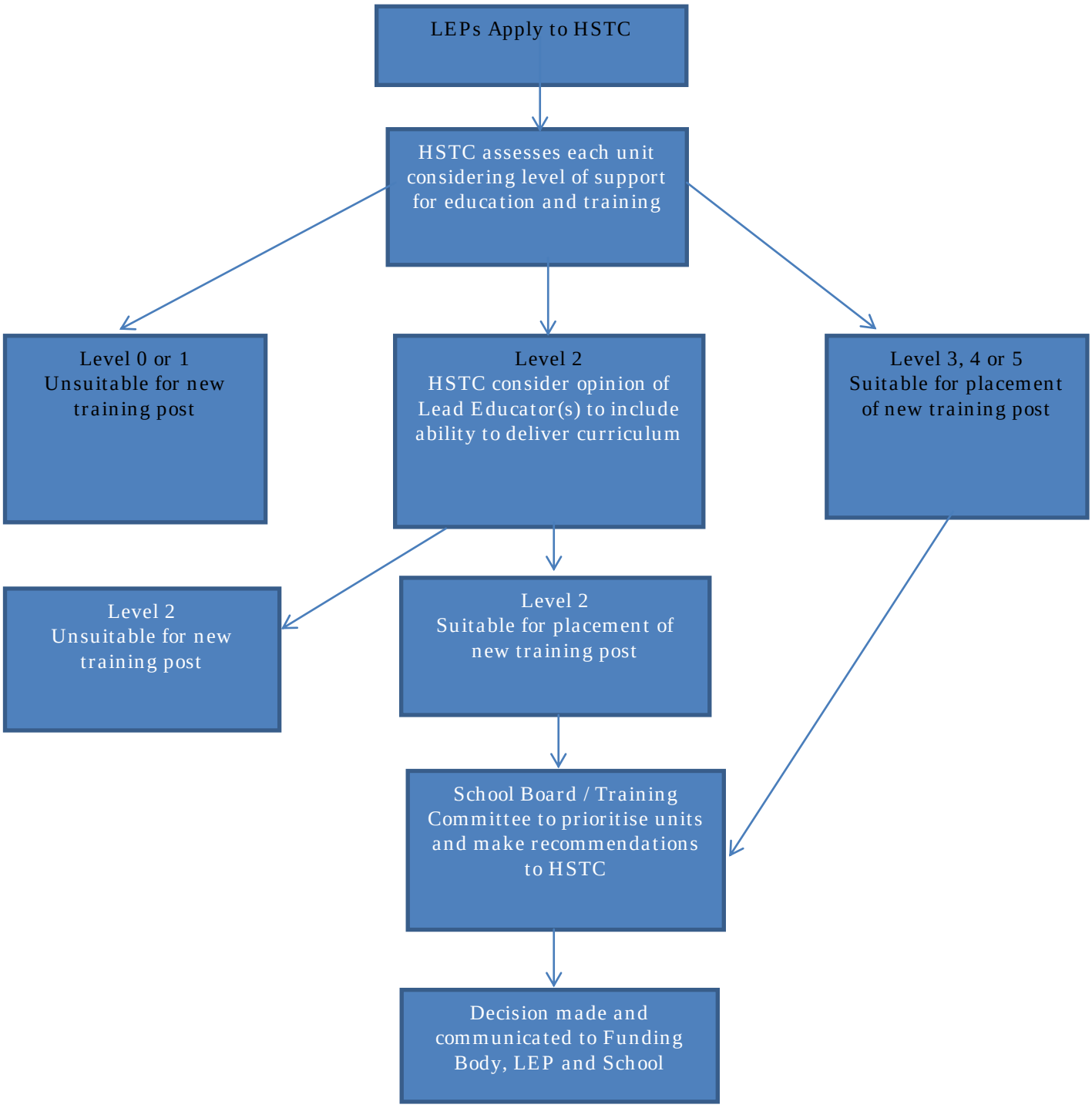


Table 1 - New Training Post Costing

	Basic Salary	Employer costs*	Recruitment	Supervision	Study leave	Excess Travel	Trainee Support	School costs (PA & admin)	TOTAL
F2 Training Post	£29,912	£7,065	£1,000	£5,076	£750	£1,000	£1,000	£6,489	**£52,292**
Core Training Post (CT1– CT2)	£34,402	£8,264	£1,000	£5,076	£750	£1,000	£1,000	£6,489	**£61,302**
Specialty Training Post (ST1 – ST8)	£37,822	£9,177	£1,000	£5,076	£750	£1,000	£1,000	£6,489	**£66,088**

**includes 3% increase pension contribution.*

The out of hours supplement is normally funded by HSCB.

Section 2: Request from LEP for approval of a new training post.

NIMDTA is not in a position to provide funding for new training posts from within its current training budget. For an LEP to be considered for a new training post they must be in a position to provide recurrent funding for the post for the entire duration of the training programme as detailed in the Specialty Training Post Costings (Table 1).
NIMDTA will recharge the Trust for expenses in addition to basic salary and employer costs (Table 2).

Table 2 - New Trust Funded training Post Costing (Expenses in addition to basic salary and employer costs

	Recruitment	Supervision	Study leave	Excess Travel	Trainee Support	School costs (PA & admin)	TOTAL
F2 Training Post	£1,000	£5,076	£750	£1,000	£1,000	£6,489	**£15,315**
Core Training Post (CT1– CT2)	£1,000	£5,076	£750	£1,000	£1,000	£6,489	**£15,315**
Specialty Training Post (ST1 – ST8)	£1,000	£5,076	£750	£1,000	£1,000	£6,489	**£15,315**

The requirements of a training post are based on the standards set by the GMC relating to the delivery of high quality postgraduate medical education and training in an LEP.
Any LEP which wishes to be considered for an additional trainee will be asked to submit an application form **(Appendix 1)** to be considered by HSTC. Support is

required from both the LEP (Clinical Director, Finance Director and Director of Medical Education) and Specialty School (Head of School and Training Programme Director) in advance of submission to HSTC for approval. HSTC will consider the quality of the training provided already in the unit when deciding whether to approve a new training post. The HSTC decision process will be informed by the findings from a number of sources which includes NIMDTA visits, surveys (including GMC National Training Survey), ARCP outcomes, trainee feedback from attendance at formal education events and educational supervisors' reports. The ability of sites to meet any training requirements not already available in the region for trainees will also be taken into consideration.

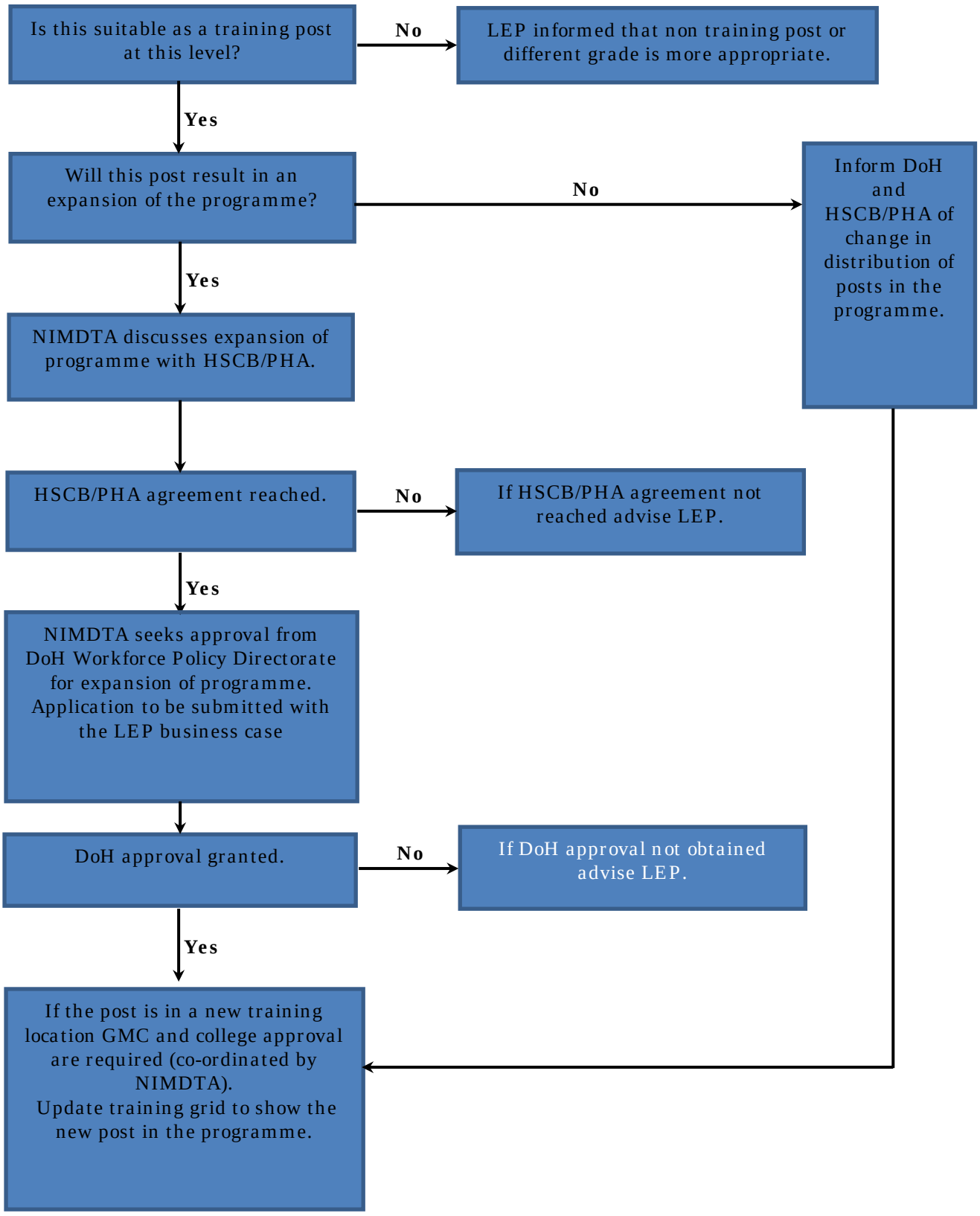
HSTC approval relates only to the suitability of a post for training. A trainee cannot be allocated to a new training post until a recurrent funding stream has been identified and confirmed in writing. **Please note funding is not available from NIMDTA to increase the number of training posts on a training programme.**

Approval of a new training post is subject to final approval from the Health and Social Care Board/Public Health Agency and the DoH to ensure the workforce planning needs have been considered. New training locations are also subject to GMC Approval. Further information is available at www.gmc-uk.org/education/approval_post_and_programme.asp

Where an application is made without funding, NIMDTA may be able to provide educational approval but the LEP will need to submit a business case to the HSCB/PHA for the process to progress.

Any new training post is subject to review after one year. The proforma in **Appendix 2** will be requested from the Director of Medical Education.

Chart 2: Process for approval of a new training post funded by LEP



Appendix 1

REQUEST FOR APPROVAL OF A NEW TRAINING POST

Requests for new foundation training posts will be considered by Foundation School Board (FSB) and requests for new specialty training posts will be considered by the NIMDTA Hospital Specialty Training Committee (HSTC). Support is required from both the Trust (Clinical Director, Finance Director and Director of Medical Education) and School (Head of School and Training Programme Director or Foundation Programme Director) **in advance** of submission to NIMDTA for approval.

Please complete the sections below to request approval for new training posts and email to [redacted] or [redacted]

FSB/HSTC will consider the quality of the training provided already in the unit when deciding whether to approve a new training post. The decision process will be informed by the findings from a number of sources which may include NIMDTA visits, surveys (including GMC National Training Survey), ARCP outcomes, trainee feedback from attendance at formal education events and educational supervisors' reports.

Approval relates only to the suitability of a post for training. A trainee cannot be allocated to a new training post until a recurrent funding stream has been identified. This funding must include salary costs, banding supplement, employer contribution, excess travel, supervision, educational, recruitment, trainee support and administrative costs. **Please note funding is not available from NIMDTA to expand positions on a training programme.**

Approval of a new training post is subject to final approval from the Health and Social Care Board/Public Health Agency and the Department of Health to ensure the workforce planning needs have been considered. This may require the LEP to submit a business case to the HSCB/PHA for the process to progress.

New training locations are also subject to GMC Approval. Further information is available at http://www.gmc-uk.org/education/programme_approval.asp. Any new post is subject to review after one year.

Trust Name:	
Hospital Site(s):	
Specialty:	
Grade of New Post:	

Section 1	Suitability of Training Post
1.1	Please clarify why a training post rather than a service post is required.
1.2	Please provide evidence of how this post maps to the relevant curriculum.
1.3	Please indicate how the LEP demonstrates Board level engagement in education and training.
1.4	Please provide evidence of Clinical Leadership and Trainee Engagement.
1.5	Please provide assurance of safe trainee supervision in this post.
1.6	Please provide evidence of high quality training within this LEP.

Section 2	Practical Experience and Training Opportunities

2.1	Please attach a short description of the post including the educational opportunities available.

2.2	What impact will this post have on training for other trainees in the unit? There must be sufficient training opportunities to facilitate an additional trainee.

2.3	Practical Experience		
Ward rounds per week:		OP clinics per week:	
Operating lists per week:		Other:	

2.4 **<u>Foundation Posts only</u>: What support services are available?** Eg: phlebotomy services, physician's assistant, clinical support staff.

2.5	What formal education or study sessions will be provided by the hospital for this post? Please enclose programmes or other supporting evidence and profile of weekly activities.

2.6 **Please state the staffing numbers for the <u>specialty</u> at the hospital where this post is based** (including this post)

Consultants:		**Higher Trainees:**	
Core Trainees:		**F2:**	
F1:		**Specialty doctors/Assoc Specialists:**	

Section 3	Supervision Arrangements

The Trust will be required to identify any additional funding, if necessary, to support Programmed Activities for recognised trainers.
3.1 To which clinical team is this post attached to?
3.2 Name of Recognised Educational Supervisor
3.3 Name of Recognised Clinical Supervisor
3.2 Name of other Supervising Consultants (please list)

Section 4 Rota Arrangements	
4.1 Please indicate the shift practice for this post: **Full Shift** ☐ **Partial Shift** ☐ **On-call Rota** ☐ **Other** (please state)_____	
4.2 Is this arrangement EWTR compliant?	YES ☐ NO ☐
4.2.1 If No, would this post make it compliant	
4.3 <u>Foundation Posts only</u>: What arrangements are in place for on-site cover Out of Hours? *'Foundation doctors must always have direct access to a senior colleague who can advise them in any clinical situation. Foundation doctors must never be left in a situation where their only help is outside the hospital or the place where they work. (GMC's 'The Trainee Doctor'; Page 15 Para 1.11)*	

Section 5 Funding

5.1	**Please specify how this post will be funded.** Funding must include salary costs, banding supplement), employer contribution, excess travel, supervision, educational, recruitment, trainee support and administrative costs.
5.2	**Has funding been secured? If not, what process is being followed to achieve this? <u>Please note funding is not available from NIMDTA to expand positions on a training programme.</u>**

Section 6	**Stakeholder Engagement**	
6.1	**Has this post been discussed with any of the following:**	
DoH	YES ☐ NO ☐	
HSCB / PHA	YES ☐ NO ☐	
BLG	YES ☐ NO ☐	
If Yes to any or all of the above (6.1), please provide further details of the discussions.		
6.2	**How does this post fit with workforce planning within the specialty?**	

Section 7	**Other Supporting Information**
This section provides the opportunity to highlight any facets of the post or training, which do not readily emerge using the above format. This may include a fuller description of the potential new trainee's role within the training programme and/or department.	

Section 8	Trust Approval (Director of Medical Education)	
8.1	I support this post from an educational perspective	YES ☐ NO ☐
8.2	The Trust has the necessary training resources in place to support this post (educational and clinical supervision)	YES ☐ NO ☐
8.3	The Trust has identified the full salary costs which include banding for this post	YES ☐ NO ☐
Title:	Director of Medical Education	
Signature:		
Date:		

Section 9	School Approval
Title:	Foundation / Training Programme Director
Signature:	
Date:	
Additional Comments:	
Title:	Head of School / Foundation School Director
Signature:	
Date:	
Additional Comments:	

Section 10	Hospital Specialty Training Committee / Foundation School Board Review			
GMC Programme Approval Code				
Locations Currently Approved				
Date of QMG Meeting				
Outcome	Approved ☐ Not Approved ☐			
Level of Suitability (if applicable)	Level 0 ☐ Level 1 ☐	Level 2 ☐ Level 3 ☐	Level 4 ☐ Level 5 ☐	
Additional Comments				
Title:	**Associate Dean**			
Signature:				
Date:				

Appendix 2

REVIEW OF IMPLEMENTATION OF NEW TRAINING POST

Northern Ireland mdta Medical & Dental Training Agency

NIMDTA approval relates only to the suitability of a post for training and education. All new training posts are subject to review after one year.

Please complete the sections below to provide assurance to the Hospital Specialty Training Committee that the new training post has contributed to improvements to training within the unit.

Trust Name:	
Hospital Site(s):	
Specialty:	
Grade of New Post:	
How has this new training post improved Practical Experience and Training Opportunities for other trainees in the unit? (include details of access to ward rounds, operating lists, OP Clinics, etc)	
How has this new training post impacted upon workload intensity in the unit?	
How has this new training post impacted upon supervision in the unit?	
How has this new training post improved rota compliance within the unit?	
How has this new training post improved training for other trainees in the unit?	

How has this new training post improved access to formal education or study sessions?
Additional Comments: **(i.e. details of further improvements/positive impact)**

Completed by:	
Title:	
Signature:	
Date:	

Hospital Specialty Training Committee / Foundation School Board Review	
GMC Programme Approval Code	
Areas for Improvement: **(if required, list all suggested further improvements, with an update via the LEP Quality Report)**	
Final Comments: **(if required, list monitoring arrangements, e.g. update via the LEP Quality Report)**	
Title:	
Signature:	
Date:	

APPENDIX

Medical Workforce Planning in Northern Ireland for the acute medical specialties of:

acute internal medicine, endocrinology, gastroenterology, geriatric medicine, respiratory medicine, and rheumatology

PHA April 2018

Addendum to Acute Medical Specialities Consultant Workforce Report

The Report of the Workforce Plan for the Acute Medical Specialties is the most complex done to date. In the majority of Trusts, sites which accept unscheduled medical admissions have close interdependencies between Acute Internal Medicine (AIM), Gastroenterology, Respiratory Medicine, Endocrinology, Rheumatology and Care of the Elderly (CoE), therefore a single report covering all 6 medical subspecialties was deemed appropriate. As with other workforce reports, advice was sought from a group of senior clinicians and managers from each Trust during its development. A draft of the report was shared with all Trusts seeking their views on its content.

The report recommendations are largely based on the Royal College of Physicians' recommendations, which were linked to population size and addressed both elective and non-elective work. There are three exceptions. One is the on-site consultant presence required for each site accepting emergency medical admissions. The calculations are based on the assumption that all sites currently delivering acute inpatient medical care will still be doing so in 2024. If this was not to be the case, certain sites would no longer need this input, while others would have an increase in workload which would require additional posts. This possibility is therefore thought unlikely to materially affect the total numbers of CCT-holders required. The second exception is that additional CoE posts were included to acknowledge the evolving role of CoE consultants in Acute Care at Home and Frailty assessment models. Lastly, an adjustment has been made to acknowledge the higher proportion of part-time consultants in the relatively small subspecialty of rheumatology.

Unlike previous reports there is not complete consensus from clinicians or Trusts on the conclusions of this report. Although there has been general agreement with the methodology and calculations used, and that the predicted need to increase consultant numbers is justified, there are concerns that the conclusions would require a significant shift in the proportions of physicians in each subspecialty as well as changes in

current individuals' roles. These issues need therefore to be considered by the Department of Health (DoH) to provide direction.

Historically in NI many consultants who trained in respiratory medicine, gastroenterology, endocrinology and CoE were appointed to posts which required them to deliver up to 50% of their time to general medicine. This was particularly the case outside Belfast Trust. The working group heard that this pattern of service delivery results in clinicians having difficulty maintaining their subspecialty skills. Their preference is therefore to move to job plans which reduce their acute general medicine duties, which is also in keeping with the RCP recommended job plans. For this to happen NI would need more consultants trained in AIM to take up the general medical duties their subspecialty colleagues would no longer deliver. In addition, given the high proportion of elderly patients with comorbidities seen in a medical inpatient 'take', and the need to expand Acute Care at Home models for the elderly, there is a need for more CoE-trained consultant input to unscheduled care services who would work alongside their AIM/general medicine colleagues. For Trusts outside Belfast this would be an extension of existing practice for CoE consultants. However within Belfast Trust this level of input to unscheduled care from CoE is not the norm. Concerns have therefore been expressed that this change in roles and workplans would be difficult to implement, particularly in Belfast Trust.

Lastly, concerns have also been expressed that the report would result in a reduction in medical trainees overall which would have service implications. One example put forward by Belfast Trust is that rheumatology trainees currently provide substantial service input. Although service modernisation and skill mix developments should in theory mitigate the impact of fewer trainees, there is uncertainty that the funding needed to develop these new roles will be available in the timescale to ensure new models of service would be in place alongside the proposed trainee reduction.

The report has highlighted that implementing this change in the proportion of general medicine done by subspecialty consultants would need regional coordination and agreement. If Trusts chose to recruit to posts in a way which did not follow the RCP model, or sufficient trainees with dual accreditation chose to take a job in one subspecialty rather

than another, then it could cause mismatches in supply and demand in certain subspecialties or locations. However to suggest central control of consultant recruitment would be a very radical step in the NI context.

The report authors carefully considered the responses received to the draft report. We acknowledge that this would be a significant change to be implemented in a relatively short period. In addition, the models of care which require input from physicians in the acute medical specialities are changing rapidly in NI, with much greater emphasis on ambulatory care, direct advice to GPs and one-stop investigation and diagnostic services. These roles were not being done at scale in the UK when the RCP workforce guidance was published. It is impossible to be certain how much of these new ways of working will be replacements for traditional outpatient or ward duties and how much will be entirely new work, but it may not be resource neutral in terms of consultant time.

In summary, having considered the comments outlined above from Trusts and clinicians, we have decided to share the original report which indicates the trainee numbers needed to achieve a consultant workforce which should, based on extant national guidance, be sufficient to meet need in NI by 2024. However there are many uncertainties, and full implementation of the net reduction in training numbers in such a short timescale might result in imbalances in subspecialty consultant numbers. If the DoH also accepts that these changes are too difficult to implement within a 5 year timescale, it may be that a pragmatic compromise could be considered. AIM and CoE training numbers do need to increase. The proposed reduction in the other subspecialty training places could be scaled back but not to the full extent proposed, with a planned review of the position in early 2020.

Dr Gillian Rankin & Dr Diane Corrigan

April 2018

CONTENTS

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 to take forward medical workforce planning for Northern Ireland for the period until 2019, under the auspices of the DoH Regional Workforce Planning Group. Workforce plans for specialties are being developed speciality by specialty, under the direction of Dr Gillian Rankin. This range of acute medical specialties was identified as a priority for workforce planning in order to assess the workforce requirements to provide a consultant delivered 7 day service for acute medical inpatients. The proposed integrated approach across these six specialties which are involved in shared rotas for acute medical in-patients, will support the focus of 7 day working to provide the necessary consultant cover in order to meet the clinical standards for acute medical inpatient care.

A clinical and senior manager engagement group was established for the purpose of developing the workforce plan and this consisted of a senior physician and senior manager representation from each Trust, NIMDTA representatives and PHA staff. Dr Diane Corrigan, Consultant in Public Health Medicine, PHA chaired the workforce group. The group membership is set out in Appendix A.

A review of the workforce requirements for these six acute medical specialties for 2016 -2022 in Northern Ireland commenced in February 2016. This work included:

- A stocktake of the current medical workforce across these six specialties at all grades working in Northern Ireland
- The identification of a set of principles and standards in relation to the admission and treatment of acute medical inpatients; and in relation to elective care in each separate specialty
- The determination of the medical workforce required to deliver the service in line with the agreed principles
- 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

- Integration of the early workforce planning for geriatric medicine/Care of the Elderly (CoE) within this workforce planning process

In view of the lead time to deliver a change in output of training programmes, and that adjustment in training programmes would not happen until 2018, the group included estimates of consultant need and trainee supply to 2023/24.

2 Summary of the Acute Medical Specialties workforce review

- At April 2017 there were 237.5WTE funded posts in these six specialties across Trusts in NI. 209 posts were filled permanently and 7 were filled with locums. There were 21.5 posts vacant.
- In order to meet the Royal College of Physicians' requirements in each specialty for the projected population for NI in 2024 and to meet the standards for consultant presence in Medical Assessment Units, the number of consultants should rise to 267WTE (Table 14).
- The total number of training places currently funded across these six specialties is sufficient to meet the requirements for this increase in consultants, assuming that the new trainees from August 2017, August 2018 and August 2019 are included in the projected workforce calculations.
- The balance of training places needs to change across the six specialties with an increase of 3 places in Acute Internal Medicine and an increase of 13 places in Care of the Elderly (Table 17).
- The numbers of funded training places in the other four specialties could decrease (Table 17) for the training years commencing in August 2018 and August 2019. The position regarding endocrinology, gastroenterology, respiratory medicine and rheumatology must be reviewed in 2019 to determine the requirements for the August 2020 ST3 specialty intake.

This workforce plan is the most complex done to date, with multiple interdependencies between subspecialties. If accepted, work will need to be done to ensure the planning assumptions remain valid and that recruitment plans by Trusts are in keeping with the agreed direction of travel to meet RCP recommendations. **The total amount of subspecialty time proposed in this report is sufficient to meet NI population need. It will not work if individual Trusts choose to operate models of service which would require a very different balance of AIM and subspecialty roles.** Further work will be required to align the commissioning of additional consultant posts within Trusts with the needs of the population served.

It is important to note that the estimates above rely on a significant contribution to the acute medical take from CoE consultants, which is not currently the case in all units. In the light of demographic change, which requires the significant increase in CoE consultant numbers proposed in this report, this model is logical. That does not mean it will be easy to implement.

It is understandable that individual Trusts plan recruitment based on their aspirations for separate subspecialty, service or site rotas or their balance between AMU and base ward bed capacity. **However this plan requires a regional forum to coordinate progress and to ensure individual Trust plans are considered against the likely output from the training programme. If this is not done, there is a risk of destabilising the regional workforce planning process.**

3 Medical Staffing in Acute Internal Medicine (AIM), endocrine, gastroenterology, geriatric medicine, respiratory medicine and rheumatology

Table 1.1 Consultants in the 6 specialities by Trust as at April 2017

Posts /Trust	Total funded posts	Permanent consultants by headcount	Number of locums in permanently funded posts	Number of vacant permanently funded posts	Specialty of vacant permanently funded posts
Belfast	86	80		6	1 AIM, 1 endocrine, 3 CoE in recruitment, 1 resp
Northern	44	35	-	9	2 AIM,1 endocrine,3 CoE, 2 resp, 1 rheum
South Eastern	40	40	-	-	
Southern	33	29	2	2	2 CoE
Western	34.5	25	5 (2 AIM,1 endocrine, 2 CoE)	4.5	2.5 AIM,1 gastro,1 endocrine
Total	**237.5**	**209**	**7**	**21.5**	**21.5**

Table 1.1 identifies that there are 237.5 permanently funded consultant posts in the 6 specialties with 209 permanent consultants in post, 21.5 posts currently vacant, and 7 posts currently filled with locum staff.

Table 1.2 Consultants in permanently funded posts by speciality and Trust

Trust/ Speciality	Belfast	Northern	South Eastern	Southern	Western	Total
AIM	10	6	6	2	4	**28**

Endocrine	8	3	6	4	3	**24**
Gastroenterology	13	9	6	6	5	**39**
Geriatric medicine	22	7	12	8	6	**55**
Respiratory medicine	20	7	7	5	4	**44**
Rheumatology	7	3	3	4	3	**20***
Total	**80**	**35**	**40**	**29**	**25**	**209**

*this group of 20 consultants contains many working part-time

Table 1.3 Permanently funded vacant consultant posts (V) and locums (L)

Trust/ Speciality	Belfast L V	Northern L V	South Eastern L V	Southern L V	Western L V	Total L V total
AIM	1	2		2	2 2.5	**4 + 5.5 = 9.5**
Endocrine	1	1			1 1	**1 + 3 = 4**
Gastroenterology					1	**1 = 1**
Geriatric medicine	3	3		2	2	**2 + 8 = 10**
Respiratory medicine	1	2				**3 = 3**
Rheumatology		1				**1 = 1**
Total	**6**	**9**	**0**	**2 2**	**5 4.5**	**7 + 21.5 =28.5**

The total consultant posts in these six specialties in NI is 237.5. Of these 237.5 posts there are 209 posts permanently filled, 21.5 posts vacant and 7 posts filled by a locum.

The Western Trust has the largest number of locum consultants in post (5) and the Northern Trust has the largest number of vacancies(9).

The specialties with the largest number of vacancies are Acute Internal Medicine (5.5) and Geriatric Medicine (8). These two specialties also have the largest number of locum consultants in post (6).

Table 2 Number of consultants by hospital and specialty, locums and vacant permanently funded posts at March 2017.

The lead specialty is indicated where more than or equal to 50% clinical time is spent in that specialty.

Table 2.1 Belfast Trust

Specialty	Total number of consultants in permanent posts	Number of permanent consultants by hospital	Dual specialty	Number of locums in permanently funded posts	Number of vacant permanently funded posts
Acute medicine	10	RVH 5 RVH/BCH 4 MIH 1	3 emergency medicine 1 joint appointment 3 endocrine 1 gastroenterology		RVH 1

Endocrinology	8	RVH 5 BCH 1 MIH 2	- 2 general medicine	-	RVH 1 due to retirement (interviews April 2017)
Gastroenterology	13	RVH/BCH 10 MIH/RVH/ BCH 1 MIH 2	1 joint appointment - - 2 general medicine	-	-
Geriatric medicine	22	RVH 5 BCH 7 MPH 4 MIH 1 RVH/BCH 1 BCH/MPH 1 MPH/comm 2 RVH/MIH 1	-	-	3 CoE community posts in recruitment
Respiratory medicine	20	RVH 8 BCH 8 MIH 4	3 joint appointments 1 joint appointment 4 general medicine		BCH 1
Rheumatology	7	RVH/MPH 3 BCH/MPH/ SET 1 BCH/MPH 3	-	-	-
Total	**80**	**80**		**0**	**6**

The Belfast Trust has 80 consultants in post, with 6 vacant posts in 4 specialties including 1 AIM and 3 CoE posts.

Table 2.2 Northern Trust

Specialty	**Total number of consultants in permanent posts**	**Number of consultants in permanent posts by hospital**	**Dual specialty**	**Number of locums in permanently funded posts**	**Number of vacant permanently funded posts (with dual speciality)**
Acute medicine	6	Antrim 5 C'way 1	3 nephrology, 1 endo, 1 Direct assess unit 1 resp med	-	2
Endocrinology	3	Antrim 3 C'way -	2 AIM -	-	- 1 (AIM)
Gastroenterology	9	Antrim 7 C'way 2	7 AIM 2 AIM	-	
Geriatric medicine	7	Antrim 6 C'way 1	- 1 AIM	-	2 1(AIM)
Respiratory medicine	7	Antrim 6 C'way 1	6 acute medicine 1 acute medicine	-	1 1 (AIM)
Rheumatology	3	Antrim 3	-	-	1
Total	**35**	**35**		**0**	**9**

The Northern Trust has 35 consultants in post and 9 vacancies (6 in Antrim and 3 in Causeway) across 5 specialties.

Table 2.3 South Eastern Trust

Specialty	**Total number of consultants in permanent posts**	**Number of consultants in permanent posts by hospital**	**Dual specialty**	**Number of locums in permanently funded posts**	**Number of vacant permanently funded posts(with dual**

					specialty)
Acute medicine	6	UHD …….6	3 endocrine	-	
Endocrinology	6	UHD 4 LVH 1 Downe 1	1 laboratory medicine	-	-
Gastro enterology	6	UHD 3 UHD/LVH 1 UHD/Downe 1 LVH 1	-	-	-
Geriatric medicine	12	UHD 8 LVH 2 Downe 2	-	-	
Respiratory medicine	7	UHD 5 UHD/Downe 1 LVH 1	-	-	-
Rheumatology	3	UHD 2 UHD/Downe 1	1 general medicine	-	-
Total	**40**	**40**		**0**	**0**

The South Eastern Trust has 40 consultants in post and no vacant consultant posts.

Table 2.4 Southern Trust

Specialty	Numbers of consultants in permanent posts	Numbers of consultants in permanent posts by hospital	Dual specialty	Number of locums in permanently funded posts	Number of vacant permanently funded posts (with dual speciality)
Acute medicine	2	CAH 2 -	1 geriatrics, 1 rheum -	2	-
Endocrinology	4	CAH 2 DHH 2	2 AIM 2 AIM	-	-
Gastro enterology	6	CAH 4 DHH 2	4 AIM 2 AIM	-	-
Geriatric medicine	8	CAH 7 DHH 1	1 orthogeriatrics, all non-acute hospitals -	-	2
Respiratory medicine	5	CAH 3 DHH 2	3 AIM 2 AIM	-	-
Rheumatology	4	CAH 4	1 AIM	-	-
Total	**29**	**29**		**2**	**2**

NB in addition 1 consultant (cardiology) in DHH contributes 33% clinical time into acute medicine

The Southern Trust has 29 consultants in post, 2 locum consultants in post in AIM and 2 vacant CoE posts.

Table 2.5 Western Trust

Specialty	Numbers of consultants in permanent posts	Numbers of consultants in permanent posts by hospital	Dual specialty	Number of locums in permanently funded posts	Number of vacant permanently funded posts (with dual speciality)
Acute medicine	4	Alt 3 SWAH 1	2 other -	2 -	2 0.5
Endocrinology	2	Alt 2 SWAH 1	2 AIM	- 1	- 1

Gastro enterology	5	Alt 3 SWAH 2	3 AIM 2 AIM	-	1 -
Geriatric medicine	6	Alt …….. 3 SWAH 3	- 3 acute medicine	2 -	-
Respiratory medicine	5	Alt …….. 3 SWAH 1	- 1 acute medicine	-	-
Rheumatology	3	Alt …….. 3 SWAH -	2 acute medicine -	-	-
Total	**25**	**25**		**5**	**4.5**

The Western Trust has 25 consultants in post, 5 locums in post (4 Altnagelvin and 1 SWAH) and 4.5 vacancies (Altnagelvin 3 and SWAH 1.5).

Table 3 Number of Non-consultant non-trainee doctors (middle grades) by Trust, permanent staff, locums and vacant funded posts at March 2017

Trust	**Total funded posts**	**Middle grades in permanent posts by headcount**	**Number of locums in permanently funded posts**	**Number of vacant permanently funded posts**	**Hospital and specialty of vacant permanently funded posts**
Belfast	14	13	1	-	RVH-acute medicine
Northern	23	15	-	8	Antrim-3 CoE/acute med, 1 endo,1 stroke C'way-2 acute med, 1 gastro, 1 respiratory
South Eastern	16	14	-	2	UHD -1 gastro,1 endocrine
Southern	26	26	-	-	-
Western	14	5	4	5	Altnagelvin-1 AIM SWAH-3 AIM
Total	**93**	**73**	**5**	**15**	

Table 3 identifies that there are 93 funded posts, with 73 doctors permanently in post, 5 locums and 15 vacant posts.

The highest number of vacant posts is in the Northern Trust (8), with the largest number of locums (4) and vacancies(5) combined in the Western Trust.

The specialty with the highest number of vacancies and locums is AIM.

Table 4 Number of Non-consultant non-trainee doctors (middle grades) by hospital, specialty, permanent, locums and vacant permanently funded posts at March 2017.

Table 4.1 Belfast Trust

Specialty	Number of middle grade doctors in permanent posts	Number of middle grades by hospital in permanent posts	Dual specialty	Number of locums in permanently funded posts	Number of vacant permanently funded posts (with dual specialty)
Acute medicine	1	RVH……1	-	1	-
Endocrinology	-				
Gastroenterology	2		-	-	
Geriatric medicine	-				
Respiratory medicine	4		-		
Rheumatology	6		-		
Total	**13**			**1**	**-**

There are 13 middle grade doctors permanently in post and 1 locum in AIM.

Table 4.2 Northern Trust

Speciality	Number of middle grade doctors in permanent posts	Number of doctors by hospital in permanent posts	Dual speciality	Number of locums in permanently funded posts	Numbers of vacant permanently funded posts (with dual specialty)
Acute medicine	6	Antrim 3 C'way 3	3 geriatric med 1 endocrine,1 resp	-	2 geriatric med 1 AIM
Endocrinology	3	Antrim …….3	2 AIM, 1 gastro	-	1
Gastroenterology	2	Antrim 2	2 AIM	-	1 AIM 1 AIM
Geriatric medicine	3	Antrim……..2 C'way …….1	- -	-	1 stroke 1 CoE (Whiteabbey)
Respiratory medicine	-	- -	-	-	-
Rheumatology	1	Antrim……..1	-	-	-
Total	**15**	**15**			**8**

There are 15 middle grade doctors in post in the Northern Trust with 8 vacant posts all within AIM and CoE.

Table 4.3 South Eastern Trust

Specialty	Number of middle grade doctors in permanent posts	Number of doctors by hospital in permanent posts	Dual specialty	Numbers of locums in permanently funded posts	Numbers of vacant permanently funded posts (with dual specialty)
Acute medicine	2	UHD 2	-	-	-
Endocrinology	-	-	-	-	1 (new post)

Gastroenterology	-	-	-	-	1 (vacant)
Geriatric medicine	5	UHD 5	-	-	-
Respiratory medicine	2	UHD 2	-	-	-
Rheumatology					
General medicine	5	LVH 3 Downe 2	-	-	-
Total	**14**	**14**			**2**

The South Eastern Trust has 14 middle grade doctors in post and 2 vacancies.

Table 4.4 Southern Trust

Specialty	Number of middle grade doctors in permanent posts	Number of doctors by hospital in permanent posts	Dual specialty	Number of locums in permanently funded posts	Number of vacant permanently funded posts(with dual specialty)
Acute medicine	5	CAH……3 DHH……2	1 geriatric med, 2 other 1 resp	-	-
Endocrinology	1	CAH DHH……1	- 1AIM /other	-	-
Gastro enterology	2	CAH ……1 DHH……1	1 AIM 1 AIM	-	-
Geriatric medicine	14	CAH……12 DHH……..2	9 rehab geriatric, 1 orthogeriatrics	-	-
Respiratory medicine	2	CAH……..1 DHH……..1	1 AIM 1 AIM	-	-
Rheumatology	2	CAH …….2	-	-	-
Total	**26**	**26**			-

The Southern Trust has 26 middle grade doctors in post with no vacancies.

Table 4.5 Western Trust

Specialty	Number of doctors in permanent posts	Number of doctors by hospital in permanent posts	Dual specialty	Number of locums in permanently funded posts	Number of vacant permanently funded posts(with dual specialty)
Acute medicine	2	Alt…….. 1 SWAH…….1	- -	1 2	1 3
Endocrinology	-				
Gastroenterology	-				
Geriatric medicine	1	Alt 1		1 1	-
Respiratory medicine	1	Alt…… 1	-		
Rheumatology	1	Alt……1	-		
Total	**5**	**5**		**5**	**4**

The Western Trust has 5 middle grade doctors permanently in post, 5 locums in AIM and geriatric medicine, and 4 vacancies in AIM.

4 Trainees in AIM, endocrinology, gastroenterology, geriatric medicine, respiratory medicine and rheumatology

Table 5 Trainee numbers in NI dual training with GIM* from 2011 to 2015

Year of entry into specialist training	2011	2012	2013	2014	2015	2016
Total training places	78 posts (incl 3 S/N) 82 NTNs	80 posts (incl 3 S/N) 80 NTNs	78 posts (incl 2 S/N) 79 NTNs & LATs	80 posts (incl 4 S/N) 82 NTNs & LATs	80 posts (incl 2 S/N) 79 NTNs & LATs	85 posts (incl 3 S/N) 94 NTNs & LATs
Total trainees in post	76 (incl 2 slotshares)	83 (incl 3 slotshares)	80 (incl 3 slotshares)	73	73	82 (incl 1 slotshare)

*AIM, Endocrinology, GI, Respiratory, Geriatric Medicine, and Rheumatology
(S/N = supernumerary posts)

Table 6 Trainee numbers* by hospital in NI at August 2016

Trust	Hospital	ST3 CT3	ST4	ST5	ST6	ST7	LAT	Vacant	Total
Belfast Trust	BCH	2	3	1	3	0	2	0	**11**
	RVH	3	2	3	4	0	0	0	**12**
	MIH	0	2	1	2	0	1	0	**6**
	MPH	1	0	1	0	1	0	0	**3**
	RVH/ BCH/ MPH	2	2	0	0	3	0	0	**7**
Northern Trust	AAH	2	3	2	1	2	1	0	**11**
	CWAY	0	0	0	0	0	0	2	**2**
SE Trust	UHD	3	4	4	1	1	0	0	**13**
	LVH/ Downe	0	0	0	0	0	0	2	**2**
Southern Trust	CAH	1	2	4	0	2	1	0	**10**
	DHH	0	0	0	0	0	1	0	**1**
Western Trust	Alt	0	4	1	1	1	1	0	**8**
	SWAH	0	0	0	0	0	0	0	**0**
Total in post		14	22	17	12	10	7	3	**85**
OOP/mat leave		0	0	4	3	2	0	0	**9**
Total		**14**	**22**	**21**	**15**	**12**	**7**	**3**	**94**

*AIM, Endocrinology, GI, Respiratory, Geriatric Medicine, and Rheumatology

Table 7 Award of CCT by year and speciality

Year	2011	2012	2013	2014	2015	2016
Number of new CCT holders AIM	0	2	1	2	3	1
Number of new CCT holders GIM/ Endocrinology	2	3	3	4	2	2
Number of new CCT holders GIM/ Gastroenterology	5	4	3	0	4	3
Number of new CCT holders GIM/Geriatrics	4	4	3	6	0	1
Number of new CCT holders GIM/Rheumatology*	0	4	5	0	1	3
Numbers of new CCT holders GIM/ Respiratory Medicine	3	1	4	3	4	3

*Historically rheumatology trainees may have accredited in Rheumatology alone but now all are enrolled for dual CCT with General Internal Medicine (GIM).

Table 8 Predicted additional CCT holders by year by specialty accreditation

The new ST3 trainees for August 2017 have been added to all tables in this section to provide the most up to date information on projected new CCT holders

Table 8.1 all specialties

Year/grade	2016	2017	2018	2019	2020	2021	2022
ST3	25	10					
ST4	20	25	10				
ST5	17	20	25	10			
ST6	17	17	20	25	10		
ST7	11	17	17	20	25	10	
Predicted new CCT holders	4	11	17	17	20	25	10
Sum of total predicted new CCT holders	4*	15	**32**	**49**	**69**	**94**	104

*2 of this cohort of new CCT holders have already taken up consultant posts in rheumatology and therefore the total new CCT predicted and available for consultant posts is 102.

Table 8.2 AIM

Year/grade	2016	2017	2018	2019	2020	2021	2022
ST3	1	2					
ST4	2	1	2				
ST5	2	2	1	2			
ST6	2	2	2	1	2		
ST7	2	2	2	2	1	2	
Predicted new CCT holders		2	2	2	2	1	2

Sum of total predicted new CCT holders			**4**	**6**	**8**	**9**	**11**

Table 8.3 Endocrinology

Year/grade	2016	2017	2018	2019	2020	2021	2022
ST3	2	2					
ST4	2	2	2				
ST5	2	2	2	2			
ST6	4	2	2	2	2		
ST7	0	4	2	2	2	2	
Predicted new CCT holders		0	4	2	2	2	2
Sum of total predicted new CCT holders			**4**	**6**	**8**	**10**	**12**

Table 8.4 Gastroenterology

Year/grade	2016	2017	2018	2019	2020	2021	2022
ST3	2	0					
ST4	4	2	0				
ST5	5	7	3	0			
ST6	3	3	6	3	0		
ST7	3	2	3	6	3	0	
Predicted new CCT holders		3	2	3	6	3	0
Sum of total predicted new CCT holders			**5**	**8**	**14**	**17**	**17***

*there are 2 additional trainees on maternity leave and 3 trainees Out of Programme; and 1 trainee has left this specialty training

The number of potential new CCT holders in gastroenterology is therefore 21.

Table 8.5 Geriatrics

Year/grade	2016	2017	2018	2019	2020	2021	2022
ST3	6	2					
ST4	6	6	2				
ST5	4	6	6	2			
ST6	1	5	6	6	2		
ST7	4	0	5	6	6	2	
Predicted new CCT holders		4	0	5	6	6	2
Sum of total predicted new CCT holders			**4**	**9**	**15**	**21**	**23***

* there is 1 trainee on maternity leave and 1 trainee Out of Programme.

The total new predicted CCT holders in geriatric medicine is 25.

Table 8.6 Respiratory

Year/grade	2016	2017	2018	2019	2020	2021	2022
ST3	3	2					
ST4	7	3	2				
ST5	3	8	3	2			
ST6	4	2	8	3	2		
ST7	2	4	2	8	3	2	
Predicted new CCT holders		2	4	2	8	3	2
Sum of total predicted new CCT holders			**6**	**8**	**16**	**19**	**21***

*there are 2 trainees Out of Programme .

The predicted new CCT holders in respiratory medicine is therefore 23.

Table 8.7 Rheumatology

Year/grade	2016	2017	2018	2019	2020	2021	2022
ST3	1	2					
ST4	1	1	2				
ST5	4	2	1	2			
ST6	2	5	2	2	2		
ST7	2	0	5	1	2	3	
Predicted new CCT holders		2*	0	5	1	1	3
Sum of total predicted new CCT holders			**2**	**7**	**8**	**9**	**12**

The 2 new CCT holders in 2017 have already taken up consultant posts and therefore the predicted number of new CCT holders is 10.

Table 9 Number of trainees leaving the training programme by specialty without CCT

Year	2011	2012	2013	2014	2015	2016	Total by speciality
AIM						1	**1**
GIM/ Endocrinology				1			**1**
GIM/ Gastroenterology						1	**1**
GIM/Geriatrics	1			1	1		**3**
GIM/Rheumatology							**-**
GIM/ Respiratory Medicine					1		**1**
Total number of trainees leaving programme without CCT	**1**	**0**	**0**	**2**	**2**	**2**	**7**

5 Principles and standards for acute medical inpatient care

The key documents which set out the principles to be addressed in acute medical inpatient care are:

- *''Acute Care Toolkit 4, Delivering a 12-hour, 7-day consultant presence on the acute medical unit,*'' Royal College of Physicians, October 2012
- ''*Consultant physicians working with patients*,'' RCP, 2013
- *''Improving Patient Flow in HSC Services*,'' DHSSPS, October 2014

The principles relevant to this workforce plan are set out in Table 10.

Table 10 Principles from key national and regional documents

Principle	Key documents
Consultant presence in AMU/MAU The consultant physician on call should be on site for at least 12 hours per day, 7 days a week, and should have no other duties scheduled during this time	Acute Care Toolkit 4, RCP, October 2012 Consultant Physicians working with Patients, RCP, 2013 Improving Patient Flow in HSC Services, DHSSPS, October 2014
Patient review in AMU/MAU The consultant on call should review patients as soon as possible after their formal assessment has been completed. During the working day this review should take place within 6-8 hours of the patient's admission to AMU. Patients admitted overnight should have a consultant review within 14 hours.	Acute Care Toolkit 4, RCP, October 2012 Consultant Physicians working with Patients, RCP, 2013
Patient review in specialty wards Hospital inpatients should be reviewed by an on-site consultant at least once every 24 hours, seven days per week, unless it has been determined that this would not affect the patient's pathway. Admit direct to the specialty ward from ED……and their (consultants) job plans should enable them to see their inpatients typically twice daily (7 days per week), or as soon as possible after the next stage in care…	Improving Patient Flow in HSC Services, DHSSPS, October 2014
Ambulatory care Specialty consultants and acute physicians	Improving Patient Flow in HSC Services, DHSSPS, October 2014

would be available in the Clinical Assessment Area (CAA) (Ambulatory care) on a consultant of the week type arrangement, to discuss patients with GPs.	

The RCP *''Consultants working with Patients 2013''*, provides guidance on the WTE requirements by speciality for the population. The relevant guidance for specialties is set out in Table 11.

Table 11 RCP Guidance on consultant WTE by specialty for population

Specialty	RCP Guidance or HSCB/PHA recommendation on consultant WTEs
AIM	12 hour presence for 365 days assuming 32 admissions in 24 hours*
Endocrinology	4 per 250,000 popn
GI	6.9 per 250,000 popn
Respiratory	7 per 250,000 popn
Rheumatology	2.9 per 250,000 popn
Geriatrics/CoE	1 per 4000 > 75 years
Stroke	20 DCCs per 500 strokes or 300,000 popn
Orthogeriatrics	No RCP recommendation
Acute Care at Home inc ambulatory assessment	HSCB/PHA 4 per Trust ie.20WTE.

* RCP suggest 4WTE per site. On larger sites this will deliver 12 hour on-site cover for AMU/MAU component. It is assumed 1WTE can provide 307.5 DCCs per annum.

6 Consultant workforce WTE requirements

Using the RCP guidance set out in Table 11 and the projected population for 2024, the methodology to identify the consultant requirement in each specialty was discussed and agreed by the Clinical Engagement Group. The method assumes that there are 11 sites in NI accepting undifferentiated acute medical inpatients i.e. the current position.

Table 12 shows the WTE consultant numbers for each of the subspecialties other than acute internal medicine (AIM), CoE and stroke. RCP guidance envisages that all consultants will have an ongoing contribution to acute care. The balance of individual job plans will vary depending on the stage of a consultant's career and the subspecialty requirements to maintain minimum caseload volumes of certain specialist skills such as endoscopy. For planning

purposes it is assumed that there will be some subspecialty post-holders who have only 1PA per week for care of the acute medical take while others appointed to AMU posts may work more.

Table 12 WTE requirement for subspecialty requirements by 2024
Assumes a NI population of 1.939m including 0.172m over-75s

Specialty	WTE	Annual DCCs* to acute general take/ambulatory care
Endocrinology	31.0	1271
Gastroenterology	53.5	2194
Respiratory	54.4	2230
Rheumatology	22.5	923
Total	**161.4**	**6617**

*Direct Clinical Care PAs

Care of the Elderly, Stroke, Orthogeriatrics and Acute Care at Home

- RCP guidance indicates that the NI population would require 43.3 WTE CoE consultants. Additional posts are also required for stroke medicine (17.3). Although there is no formal guidance on numbers of orthogeriatricians, who support pre-and post-operative care for elderly patients with fractures, the consensus was that the latter required 10WTE, i.e 70.6WTE in total
- A secondary care-led model for Acute Care at Home has been proposed by commissioners as requiring 4WTE per Trust/LCG. However there is some overlap between the latter role and the input needed from CoE as a whole. The group consensus was that 9WTE of the 20 required would come from the larger CoE complement. It follows that the net number of CoE trained consultants needed to support groups of elderly patients including stroke is 81.6WTE
- In light of the changing age structure of the population, resulting in higher proportions of acute medical patients who are elderly and have comorbidities, it was agreed in discussion with clinical representatives to assume input to the acute take from Care of the Elderly (CoE) consultants. It is assumed therefore that CoE consultants, other than those working in stroke, orthogeriatrics or primarily in acute community care of the elderly (81.6 WTE minus 17.3,10 and 20 respectively = 34.3 WTE), are assumed to provide an average of 2.5 Direct Clinical Care

(DCCs) per week to acute roles as per the sample RCP job plan (34.3 x 2.5 x 41 = 3516 DCCs). In practice this commitment may be spread across some of the other CoE posts

- For planning purposes it is also assumed that ambulatory care for the frail elderly will be addressed within the 20 WTE posts to support the acute care at home mode

Sessional commitment required to cover AMU/MAU and acute ambulatory care models.

The AIM CCT has been introduced only recently. Unlike other specialties, RCP guidance is per site rather than for a population, reflecting the need to have senior medical input on all acute receiving sites for 12 hours per day. With 11 such sites in NI the minimum number of AIM-CCT holders advised by the RCP would be 44WTE. Currently there are 37 posts, but only 9 are occupied by AIM-CCT holders. It follows that many individuals currently delivering consultant input to AMUs in NI do not have an AIM CCT.

There have been several reports in NI indicating that there should be a change in acute hospital configuration (such as *DBS, TYC, Donaldson, Bengoa).* It was beyond the remit of this project to predict how and when any reduction in acute medical receiving sites will take place. If some sites cease to accept undifferentiated acute medical admissions patient flow would increase to other sites, potentially requiring those to have more than 4WTE consultants. It follows that it would be premature to aim to have 44WTE AIM-CCT holders by 2024; nor would that scale of expansion of the training numbers be possible in any event. In the interim there remains a need to increase the proportion of AMU posts occupied by AIM-CCT holders from its existing very low base. Existing training numbers could provide for 24 AIM CCT-holders in post by 2024 and this was taken forward as a reasonable planning assumption in the calculations below. This should be kept under review as the DoH-led Transformation Implementation Group (TIG) makes decisions on service configuration.

It is assumed that each acute receiving site requires 12 hours per day on-site presence for 251 weekdays and 114 weekend days and statutory days per annum. Allowing for premium time, this requires 1,230 DCCs per site per annum.

1,230 DCCs per acute receiving site* x 11 = **13,530 DCCs** for NI

*BCH Direct is not included as it is not assumed to be staffed as an AMU taking undifferentiated medical take

Added to this are 3,650 DCCs to provide 2PAs per day of consultant input, 365 days per year, to support ambulatory care models on 5 larger sites bringing the total requirement to **17,180 DCCs.** On smaller sites the ambulatory care roles will be accommodated within the earlier referenced site DCC complement of 1,230 DCCs.

Table 13 below illustrates one scenario in which the expected number of AIM CCT-holders, combined with RCP-recommended WTEs in CoE and non-AIM medical subspecialties, should be sufficient to deliver the required 17,180 DCCs for AMU/MAU/Ambulatory are.

Table 13 Combined DCCs service provision to AMU/MAU on all 11 sites plus additional ambulatory care on larger sites from a mix of AIM, CoE and non-AIM CCT holders

Consultant CCT holders	**AMU DCCs**	**Additional Ambulatory care on larger sites DCCs**
AIM CCT -holders 24WTE x 5DCC x 41 weeks	4920 +	2460
CoE CCT-holders 32.7WTE x 2.5DCC x 41 wks	3516	
Other non-AIM CCT 161.4WTE x 1 x 41 weeks	6617	
Total	**15,053**	**2460**

Combined total requirements is 15,053 + 2460 = 17,513 DCCs

Table 14 below summarises the subspecialty distribution of consultants in NI by 2024.

Table 14 WTE requirement for AIM, subspecialty and CoE requirements by expected 2024 NI population of 1.939m (including an over-75 population of 0.173m)

Specialty	**Consultant WTE requirement to meet population requirements and AMU contribution**
AIM	**24.0**
Endocrinology	**31.0**

Gastroenterology	**53.5**
Geriatric medicine	**81.6**
Respiratory medicine	**54.4**
Rheumatology	**22.5**
Total	**267.0**

It is important to note that the estimates above rely on a significant contribution to the acute medical take from CoE consultants, which is not currently the case in all units. In the light of demographic change, which required the significant increase in CoE consultant numbers proposed in this report, this model is logical. That does not mean it would be easy to implement as it would require negotiation on job plan changes.

The current distribution across NI of consultants in some subspecialties does not appear to relate directly to patient need. One example is that of CoE, where 40% of current post-holders are based in the Belfast Trust. It is understandable that individual Trusts plan recruitment based on their aspirations for separate subspecialty, service or site rotas or their balance between AMU and base ward bed capacity. However if there is no forum at which these plans are considered against the likely output from the training programme, this risks destabilising the regional workforce planning process.

This workforce plan is the most complex done to date, with multiple interdependencies between subspecialties. If accepted, work will need to be done to ensure the planning assumptions remain valid and that recruitment plans by Trusts are in keeping with the agreed direction of travel to meet RCP recommendations. **The total amount of subspecialty time proposed in this report is sufficient to meet NI population need. It will not work if individual Trusts choose to operate models of service which would require a very different balance of AIM and subspecialty roles.** Further work will be required to align the commissioning of additional consultant posts within Trusts with the needs of the population served.

It should also be noted that the non-career grade doctors provide an integral contribution to service delivery in each specialty. While the numbers of this grade of doctor currently employed by Trusts are set out within this workforce review, there is no national or College guidance on the requirements for this grade of doctor by specialty. Historically the requirements for non-career grade doctors has not been taken into account in workforce planning and therefore

there is currently no training capacity or funding identified for this group of permanently employed specialty doctors.

7 Potential consultant retirements

Table 15 Age band of consultants by specialty, with estimated potential retirement numbers

Specialty	Consultants in age band 55-59 years	Consultants in age band 60 years or over	Estimated potential retirements (all >60 years and 50%of 55-59 years)
AIM	1	0	0.5 i.e. 1
Endocrine	4	1	3.0 i.e. 3
Gastroenterology	5	0	2.5 i.e. 3
Geriatric medicine	5	5	7.5 i.e. 8
Respiratory medicine	5	0	2.5 i.e. 3
Rheumatology	3	1	2.5 i.e. 3
Total	**21**	**7**	**21**

There are 21 potential retirements during the period of this review.

8 Consultant requirements and gap across the six specialties

The consultant requirements and the gap between the current position and the requirements are set out in Table 16. The table takes account of the current number of consultants in post, the projected potential retirements and the future consultant WTE requirements to meet population need at 2024.

Table 16 Consultant requirements by headcount taking account of the current consultants in post, potential retirements and the WTE requirements to meet the population need at 2024

The gap is calculated as B – C + D = E

A	B	C	D	E
Specialty	**Requirements Table 15**	**Current permanent consultants in post with CCT in specialty**	**Retirements** **Table 16**	**Gap**
AIM	24.0	8	1	17.0 i.e. 17

Endocrin-ology	31.0	23 + 7 = 30	3	4.0 i.e. 4
Gastro enterology	53.5	39 + 1 = 40	3	16.5 i.e. 17
Geriatric /CoE	81.6	55 + 1 = 56	8	33.6*** i.e. 34
Respiratory	54.5	44 + 1 = 45	3	12.5 i.e. 13
Rheumat-ology	22.5 ****	19 + 1 = 20	3	7.5**** i.e. 8
Total	**267.1**	**188+11*=199****	**21**	**93**

*these consultants work some clinical sessions in AMU/MAUs while most of their clinical sessions are in their base specialty

**an additional 8 consultants who work sessions in AMU/MAU are not included in Table 17 above as they have other specialty CCTs for example emergency medicine and renal medicine or hold academic posts

***the gap assumes that all new CCT-holders for stroke medicine will come through the CoE specialty training programme. Doctors seeking to specialise in stroke medicine may also come through the neurology specialty training programme

****the current cohort of rheumatology consultants contain a significant number who work part time and an adjustment of 2 WTE is made to the gap in column E to take account of this position.

9 Changes in trainee requirements

It is expected that 102 doctors with CCT will be delivered through the existing training places across these 6 specialties by 2022 (Table 8.1). With the existing funded training places projected through the August 2018 and 2019 cycles, a total of 118 new CCT holders would be expected by 2024. This assumes that existing training posts are filled, there is no increased attrition, delay through maternity leave, OOPT, or delay through examination failure. It is important to note that not all specialty training posts were filled at ST3 in August 2017 (e.g.gastroenterology).

Table 17 sets out the changes in funded training places required for each specialty noting that some specialties require an increase in funded training places and some specialties could decrease the number of new ST3 trainees for a short period in the years 2018 and 2019. This position will require to be reviewed in 2019 to assess any changes in the need for trainees by specialty

prior to the 2020 intake of new specialty trainees in endocrinology, gastroenterology, respiratory medicine and rheumatology.

Table 17 Additional trainees required by specialty to meet consultant requirements

The gap in trainees is calculated as Column D + C - B = E

Specialty	Column A Current number of trainees to gain CCT by 2022 (to include August 2017 ST3 intake)- Table 8	Column B Current and projected trainees within funded training places to include ST3 intake in 2018 and 2019	Column C Number of specialty trainees leaving the programme over the past 5 years - Table 9**	Column D Projected CCT-holder require ments - Table 16	Column E Gap in trainee numbers (+ means increase required, -means decrease required)
AIM	11	11 +4 = 15	1	17	**+3**
Endocrin ology	12	12 +4 = 16	1	4	**-11**
Gastro enterology	21	21 +5 = 26	1	17	**-8**
Geriatric medicine / CoE	23*	23 +1 = 24	3	34	**+13**
Respiratory	23	23 +7 = 30	1	13	**-16**
Rheum atology	10	10 +5 = 15	-	8	**-7**
Total	**100***	**126**	**7**	**93**	**+16 -42**

***as at May 2017 there are 2 less trainees due to leaving the programme

**taken as an indicative rate of attrition projecting over the next 5 years based on the attrition rate in the last 5 years –Table 10

Table 17 illustrates that:

- there are 26 (42-16=26) more funded training posts across these 6 specialties than are required for the consultant requirements to meet the RCP standards for the projected population. It should be noted that these 26 funded places include the expected funded places for new ST3 doctors for the training years commencing in 2018 and 2019 for endocrinology, gastroenterology, respiratory medicine and rheumatology

- in the specialties of AIM and CoE an increase in trainees is required to meet the consultant requirements. The numbers of additional trainees required which NIMDTA can meet through an increase in the training capacity with Trusts, are set out in Tables 18 and 19 below

Counted within the additional CoE trainees are the trainees required for stroke medicine CCT. With the current consultation on acute stroke units in Northern Ireland it would be reasonable to identify 1 training post per year as a minimum specifically for stroke training from 2018 (from within the additional CoE trainees).

A small number of the current funded training places across these specialties are funded non-recurrently by Trusts.

Table 18 Additional AIM training places to meet consultant requirements

Year/ grade	2017	2018	2019	2020	2021	2022	2023	2024
ST3	2	2 +2	2	2				
ST4	1	2	2 +2	2	2			
ST5	2	1	2	2 +2	2	2		
ST6	2	2	1	2	2 +2	2	2	
ST7	2	2	2	1	2	2 +2	2	2
Total new CCT - holders per year	2	2	2	2	1	2	2 +2	2
Sum of predicted new CCT - holders	**2**	**4**	**6**	**8**	**9**	**11**	**13 +2 =15**	**15 +2 =17**
Current training places (9) +additional places	9	9 +2	9 +2	9 +2	9 +2	9 +2	9	9

Table 19 Additional CoE training places to meet consultant numbers

Year/ grade	2017	2018	2019	2020	2021	2022	2023	2024	2025
ST3	6	1 +5	0 +5	6 +2	4 +2				
ST4	4	6	1 +5	0 +5	6 +2	4 +2			
ST5	6	4	6	1 +5	0 +5	6 +2	4 +2		
ST6	0	6	4	6	1 +5	0 +5	6 +2	4 +2	

ST7	1	0	6	4	6	1 +5	0 +5	6 +2	4 +2
Predicted new CCT holders per year	2	0	1	5	5	6	1 +5	0 +5	4 +2
Sum of predicted new CCT holders	**2**	**2**	**3**	**8**	**13**	**19**	**20 +5 =25**	**20 +5+5 =30**	**24 +5+5+2 =36**
Total raining places (17) and additional places (+)	17	17 +5 =22	17 +10 =27	17 +12 =29	17 +14 =31	17 +14 =31	17 +9 =26	17 +4 =21	17 +2 =19

Conclusion

This complex workforce report covering six medical specialties has used the RCP workforce guidance published in 2013 which identifies the consultant WTE for the population. As demography changes and population needs change, these ratios may be adjusted by the Royal College of Physicians in the future.

It would be prudent to review these specialty workforce plans in 2019 prior to decisions on the intake of new ST3 doctors in 2020. At this stage the implications of Shape of Training will be clearer and the impact of the new approach to training doctors on their availability for consultant posts will be available for the next period of workforce planning.

Appendix A

Membership of the Clinical Engagement Group

- Belfast Trust – Dr Neil McDougall, Dr Eoghan Ferrie, Dr Brian Armstrong
- Northern Trust – Dr Wendy Anderson, Linda Linford/Audrey Harris
- South Eastern Trust – Dr Darren McLaughlin, Karen McIlveen
- Southern Trust – Dr Philip Murphy, Anne McVey
- Western Trust – Dr Ying Kuan, Mark Gillespie
- NIMDTA – Dr Michael Trimble/ Dr Jackie Rendall, Dr Mark Roberts
- PHA – Dr Diane Corrigan (Chair), Dr Gillian Rankin

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Prepared by: Medical Locums Team

Prepared for: Shane Devlin, Chief Executive

Ref: Q_008

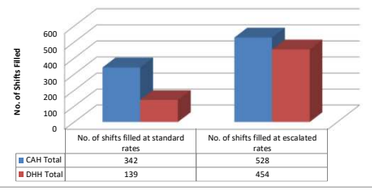
Date: 08 May 2019

Section 1 - Cover Required	CAH			DHH		
Ad Hoc	**Total**	**WTE**	**%**	**Total**	**WTE**	**%**
No. of shifts received by MLT	1007		60.66%	653		39.34%
No. of hours received by MLT	9120.85	989.61	58.11%	6574	713.28	41.18%

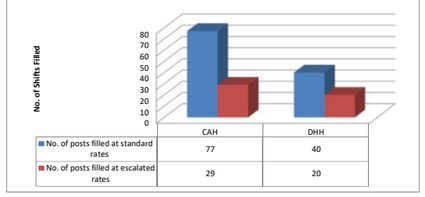
Section 2 - Cover Required	CAH			DHH		
Ad Hoc	**Total**	**WTE**	**%**	**Total**	**WTE**	**%**
No. of shifts filled						
HSC eLocums	592		68.05%	325		54.81%
Contracted Agency	267		30.69%	229		38.62%
Non-Contracted Agency	11		1.26%	39		6.58%
No. of hours filled						
HSC eLocums	5375.75	583.27	68.21%	3395	368.36	56.68%
Contracted Agency	2416.75	262.22	30.66%	2219	240.76	37.05%
Non-Contracted Agency	89.6	9.72	1.14%	376	40.80	6.28%
Cost of Filled Shifts						
HSC eLocums	£294,019.00		60.26%	£198,590.99		48.58%
Contracted Agency	£187,184.00		38.36%	£177,029.99		43.31%
Non-Contracted Agency	£6,712.36		1.38%	£33,163.78		8.11%
No. of shifts filled at standard rates	342		39.31%	139		23.44%
No. of shifts filled at escalated rates	528		60.69%	454		76.56%
Average Time taken to fill shifts (calendar days)	85		85.00%	25		25.00%

Section 3 - Breakdown of Long Term	CAH		DHH		Total	
Long Term	**Total**	**%**	**Total**	**%**	**Total**	**%**
No. of Long Term Locum Bookings						
HSC eLocums	22	20.75%	9	15.00%	31	18.67%
Contracted Agency	72	67.92%	34	56.67%	106	63.86%
Non-Contracted Agency	12	11.32%	17	28.33%	29	17.47%
No. of posts filled at standard rates	77	72.64%	40	66.67%	117	70.48%
No. of posts filled at escalated rates	29	27.36%	20	33.33%	49	29.52%

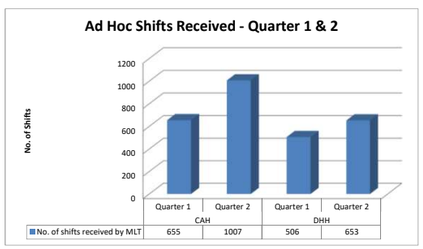
Ad Hoc Shifts filled at Standard & Escalated Rates - Quarter 2



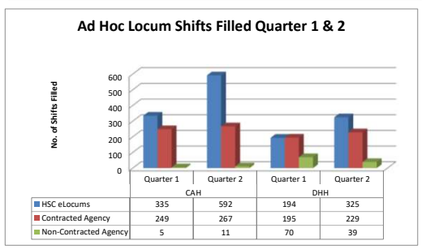
Long Term Locums Filled at Standard & Enhance Rates - Quarter 2



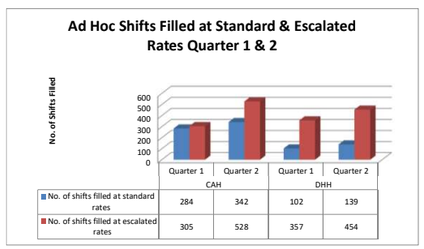
Ad Hoc Shifts Received - Quarter 1 & 2



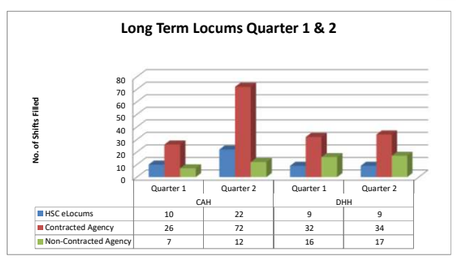
Ad Hoc Locum Shifts Filled Quarter 1 & 2



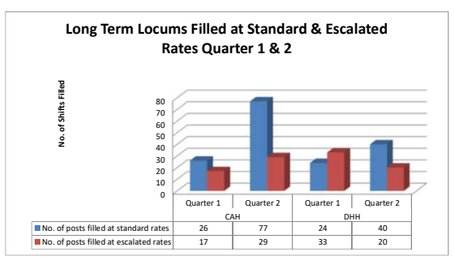
Ad Hoc Shifts Filled at Standard & Escalated Rates Quarter 1 & 2



Long Term Locums Quarter 1 & 2



Long Term Locums Filled at Standard & Escalated Rates Quarter 1 & 2



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Prepared for: Shane Devlin, Chief Executive

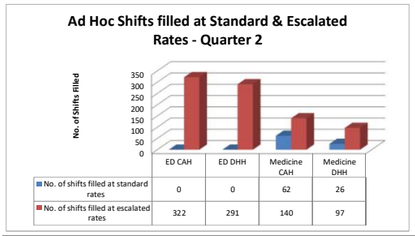
Ref: Q_008

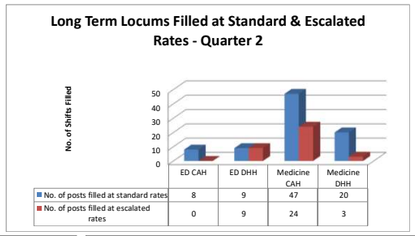
Date: 08 May 2019

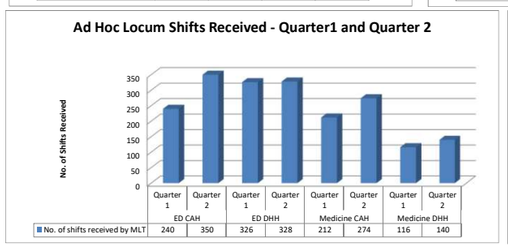
Section 1 - Cover Required	ED CAH			ED DHH			Medicine CAH			Medicine DHH			Total	
Ad Hoc	Total	WTE	%	Total	WTE	%	Total	WTE	%	Total	WTE	%	Overall WTE	Overall Total
No. of shifts received by MLT	350		32.05%	328		30.04%	274		25.09%	140		12.82%		1092
No. of hours received by MLT	3036.25	329.43	29.57%	2895	314.11	28.19%	2688	291.65	26.18%	1648.85	178.90	16.06%	1114.09	10268.10

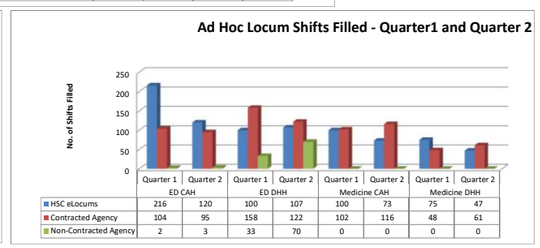
Section 2 - Cover Required	ED CAH			ED DHH			Medicine CAH			Medicine DHH			Total		
Ad Hoc	Total	WTE	%	Total	WTE	%	Total	WTE	%	Total	WTE	%	Overall WTE	Total	Overall %
No. of shifts filled															
HSC eLocums	216		67.08%	100		34.36%	100		49.50%	75		60.98%		491	52.56%
Contracted Agency	104		32.30%	158		54.30%	102		50.50%	48		39.02%		412	43.71%
Non-Contracted Agency	2		0.62%	33		11.34%	0		0.00%	0		0.00%		35	3.73%
No. of hours filled															
HSC eLocums	1863	202.14	66.74%	856	92.88	33.45%	964	104.59	50.10%	894.5	97.05	60.75%	496.66	4577.5	56.41%
Contracted Agency	916	99.39	32.82%	1400	151.90	54.71%	960	104.16	49.90%	578	62.71	39.25%	418.16	3854	43.04%
Non-Contracted Agency	12.25	1.33	0.44%	303	32.88	11.84%	0	0.00	0.00%	0	0.00	0.00%	34.20	315.25	0.56%
Cost of Filled Shifts															
HSC eLocums	£114,483.20		58.46%	£56,460.53		27.74%	£49,386.53		40.67%	£57,202.86		56.16%		£277,533.12	44.65%
Contracted Agency	£80,550.23		41.13%	£118,051.50		58.00%	£72,038.44		59.33%	£44,654.47		43.84%		£315,294.64	50.72%
Non-Contracted Agency	£791.11		0.40%	£29,042.11		14.27%	£0.00		0.00%	£0.00		0.00%		£29,833.22	4.80%
No. of shifts filled at standard rates	0		0.00%	0		0.00%	62		30.69%	26		21.14%		88	9.38%
No. of shifts filled at escalated rates	322		100.00%	291		100.00%	140		69.31%	97		78.86%		850	90.62%
Average Time taken to fill shifts (calendar days)	9		18.71%	9		17.95%	16		34.34%	14		29.00%		48	

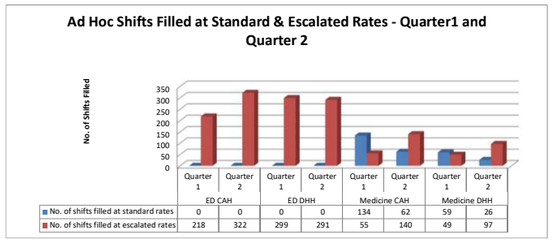
Section 3 - Breakdown of Long Term	ED CAH		ED DHH		Medicine CAH		Medicine DHH		Total	
Long Term	Total	%	Total	%	Total	%	Total	%	Total	Overall %
No. of Long Term Locum Bookings										
HSC eLocums	5	62.50%	2	11.11%	13	18.31%	5	21.74%	25	20.83%
Contracted Agency	3	37.50%	8	44.44%	48	67.61%	16	69.57%	75	62.50%
Non-Contracted Agency	0	0.00%	8	44.44%	10	14.08%	2	8.70%	20	16.67%
No. of posts filled at standard rates	8	100.00%	9	50.00%	47	66.20%	20	86.96%	84	70.00%
No. of posts filled at escalated rates	0	0.00%	9	50.00%	24	33.80%	3	13.04%	36	30.00%

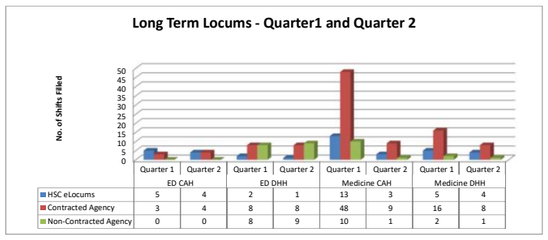


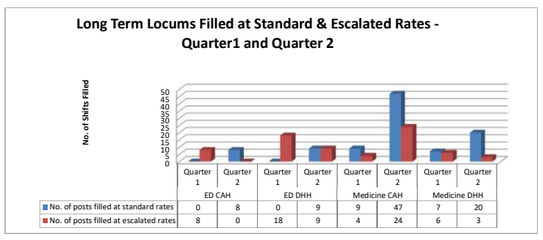












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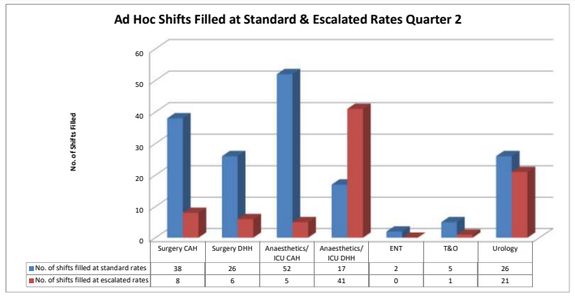
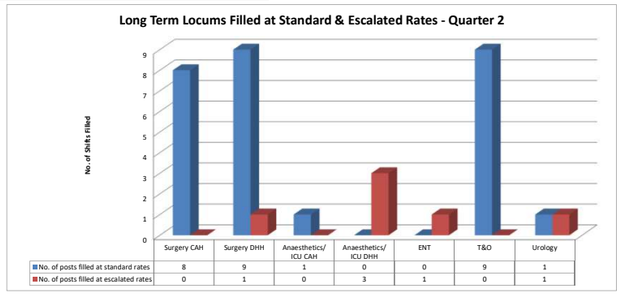
Date: 08 May 2019

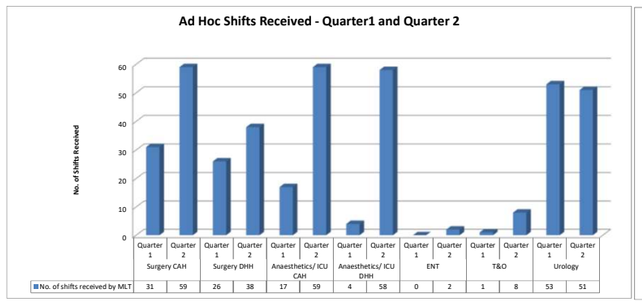
Section 1 - Cover Required	Surgery CAH			Surgery DHH			Anaesthetics/ ICU CAH			Anaesthetics/ ICU DHH			ENT			T&O			Urology			Total	
Ad Hoc	**Total**	**WTE**	**%**	**Total**	**WTE**	**%**	**Total**	**WTE**	**%**	**Total**	**WTE**	**%**	**Total**	**WTE**	**%**	**Total**	**WTE**	**%**	**Total**	**WTE**	**%**	**Overall WTE**	**Overall Total**
No. of shifts received by MLT	59		21.45%	38		13.82%	59		21.45%	58		21.09%	2		0.73%	8		2.91%	51		18.55%		275
No. of hours received by MLT	626.25	67.95	22.53%	387.5	42.04	13.94%	615.5	66.78	22.15%	627	68.03	22.56%	31	3.36	1.12%	76	8.25	2.73%	416	45.14	14.97%	301.55	2779.25

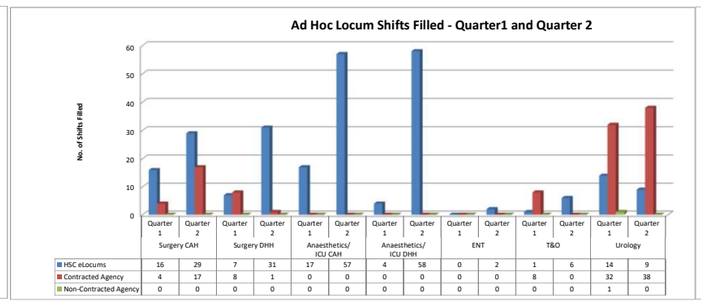
Section 2 - Cover Required	Surgery CAH			Surgery DHH			Anaesthetics/ ICU CAH			Anaesthetics/ ICU DHH			ENT			T&O			Urology			Total		
Ad Hoc	Total	WTE	%	Total	WTE	%	Total	WTE	%	Total	WTE	%	Total	WTE	%	Total	WTE	%	Total	WTE	%	Overall WTE	Total	Overall %
No. of shifts filled																								
HSC eLocums	29		63.04%	31		96.88%	57		100.00%	58		100.00%	2		100.00%	6		100.00%	9		19.15%		192	77.02%
Contracted Agency	17		36.96%	1		3.13%	0		0.00%	0		0.00%	0		0.00%	0		0.00%	38		80.85%		56	23.39%
Non-Contracted Agency	0		0.00%	0		0.00%	0		0.00%	0		0.00%	0		0.00%	0		0.00%	0		0.00%		0	0.00%
No. of hours filled																								
HSC eLocums	300.75	32.63	60.91%	303	32.88	96.04%	615.5	66.78	100.00%	627	68.03	100.00%	31	3.36	100.00%	76	8.25	100.00%	92	9.98	23.47%	221.91	2045.25	76.26%
Contracted Agency	165	17.90	33.42%	12.5	1.36	3.96%	0	0.00	0.00%	0	0.00	0.00%	0	0.00	0.00%	0	0.00	0.00%	300	32.55	76.53%	51.81	477.5	23.74%
Non-Contracted Agency	0	0.00	0.00%	0	0.00	0.00%	0	0.00	0.00%	0	0.00	0.00%	0	0.00	0.00%	0	0.00	0.00%	0	0.00	0.00%	0.00	0	0.00%
Cost of Filled Shifts																								
HSC eLocums	£14,603.17		54.82%	£12,052.83		95.15%	£40,397.77		100.00%	£35,377.42		100.00%	£1,251.63		100.00%	£2,908.49		100.00%	£5,593.54		21.50%		£112,184.85	77.23%
Contracted Agency	£9,884.60		37.11%	£614.38		4.85%	£0.00		0.00%	£0.00		0.00%	£0.00		0.00%	£0.00		0.00%	£20,422.74		78.50%		£30,921.72	21.29%
Non-Contracted Agency	£0.00		0.00%	£0.00		0.00%	£0.00		0.00%	£0.00		0.00%	£0.00		0.00%	£0.00		0.00%	£0.00		0.00%		£0.00	0.00%
No. of shifts filled at standard rates	38		82.61%	26		81.25%	52		91.23%	17		29.31%	2		100.00%	5		83.33%	26		55.32%		166	66.94%
No. of shifts filled at escalated rates	8		17.39%	6		18.75%	5		8.77%	41		70.69%	0		0.00%	1		16.67%	21		44.68%		82	33.06%
Average Time taken to fill shifts (calendar days)	9		40.91%	2		9.09%	1		4.55%	0		0.00%	0.5		2.27%	0		0.00%	10		45.45%		22	

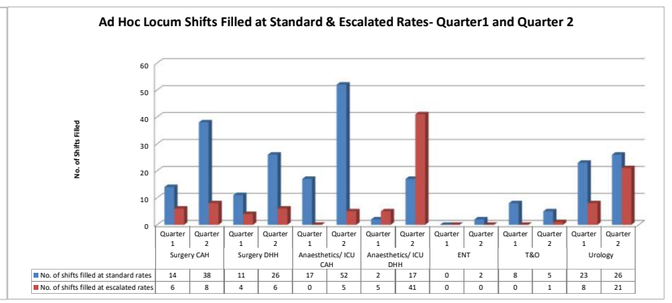
Section 3 - Breakdown of Long Term	Surgery CAH		Surgery DHH		Anaesthetics/ ICU CAH		Anaesthetics/ ICU DHH		ENT		T&O		Urology		Total	
Long Term	**Total**	**%**	**Total**	**%**	**Total**	**%**	**Total**	**%**	**Total**	**%**	**Total**	**%**	**Total**	**%**	**Total**	**Overall %**
No. of Long Term Locum Bookings																
HSC eLocums	2	25.00%	2	20.00%	0	0.00%	0	0.00%	0	0.00%	1	11.11%	0	0.00%	5	14.71%
Contracted Agency	6	75.00%	7	70.00%	1	100.00%	1	33.33%	1	100.00%	8	88.89%	2	100.00%	26	76.47%
Non-Contracted Agency	0	0.00%	1	10.00%	0	0.00%	2	66.67%	0	0.00%	0	0.00%	0	0.00%	3	8.82%
No. of posts filled at standard rates	8	100.00%	9	90.00%	1	100.00%	0	0.00%	0	0.00%	9	100.00%	1	50.00%	28	82.35%
No. of posts filled at escalated rates	0	0.00%	1	10.00%	0	0.00%	3	100.00%	1	100.00%	0	0.00%	1	50.00%	6	17.65%

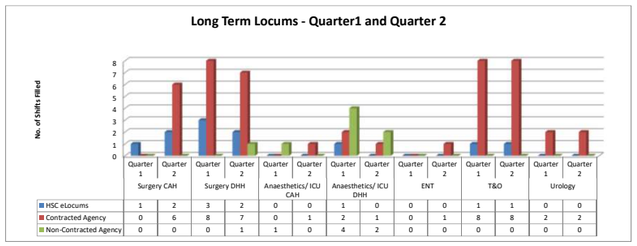


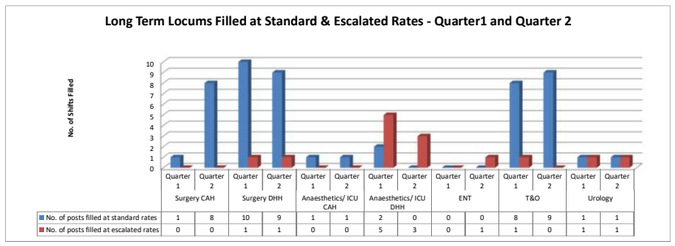












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Southern Health & Social Care Trust **CONFIDENTIAL**

Locum Usage from 1 November 2018 to 31 January 2019

Prepared by: Medical Locums Team

Prepared for: Shane Devlin, Chief Executive

Ref: Q_008

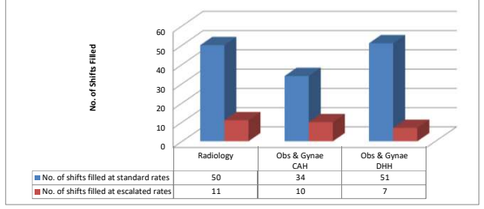
Date: 08 May 2019

Section 1 - Cover Required	Radiology			Obs & Gynae CAH			Obs & Gynae DHH			Total	
Ad Hoc	Total	WTE	%	Total	WTE	%	Total	WTE	%	Overall WTE	Total
No. of shifts received by MLT	63		36.84%	50		29.24%	58		33.92%		171
No. of hours received by MLT	387	41.99	25.86%	437.5	47.47	29.24%	671.75	72.88	44.90%	162.34	1496.25

Section 2 - Cover Required	Radiology			Obs & Gynae CAH			Obs & Gynae DHH			Total		
Ad Hoc	Total	WTE	%	Total	WTE	%	Total	WTE	%	Overall WTE	Total	Overall %
No. of shifts filled												
HSC eLocums	61		100.00%	35		79.55%	30		51.72%		126	77.30%
Contracted Agency	0		0.00%	3		6.82%	22		37.93%		25	15.34%
Non-Contracted Agency	0		0.00%	6		13.64%	6		10.34%		12	7.36%
No. of hours filled												
HSC eLocums	377	40.90	100.00%	347.5	37.70	81.48%	370.75	40.23	55.19%	118.83	1095.25	74.24%
Contracted Agency	0	0.00	0.00%	39	4.23	9.14%	228	24.74	33.94%	28.97	267	18.10%
Non-Contracted Agency	0	0.00	0.00%	40	4.34	9.38%	73	7.92	10.87%	12.26	113	7.66%
Cost of Filled Shifts												
HSC eLocums	£18,450.92		100.00%	£15,534.51		73.90%	£16,796.66		48.51%		£50,782.09	68.53%
Contracted Agency	£0.00		0.00%	£2,365.22		11.25%	£13,709.64		39.59%		£16,074.86	21.69%
Non-Contracted Agency	£0.00		0.00%	£3,120.00		14.84%	£4,121.67		11.90%		£7,241.67	9.77%
No. of shifts filled at standard rates	50		81.97%	34		77.27%	51		87.93%		135	82.82%
No. of shifts filled at escalated rates	11		18.03%	10		22.73%	7		12.07%		28	17.18%
Average Time taken to fill shifts (calendar days)	21		60.88%	13		38.05%	0		1.07%		35	

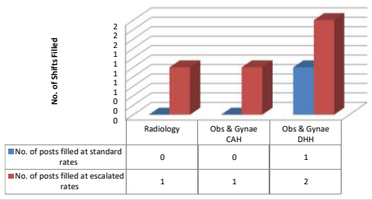
Section 3 - Breakdown of Long Term	Radiology		Obs & Gynae CAH		Obs & Gynae DHH		Total	
Long Term	Total	%	Total	%	Total	%	Total	Overall %
No. of Long Term Locum Bookings								
HSC eLocums	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Contracted Agency	0	0.00%	0	0.00%	1	33.33%	1	20.00%
Non-Contracted Agency	1	100.00%	1	100.00%	2	66.67%	4	80.00%
No. of posts filled at standard rates	0	0.00%	0	0.00%	1	33.33%	1	20.00%
No. of posts filled at escalated rates	1	100.00%	1	100.00%	2	66.67%	4	80.00%

Ad Hoc Shifts filled at standard & Escalated Rates - Quarter 2



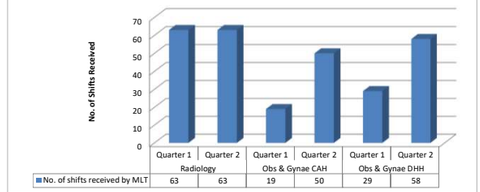
	Radiology	Obs & Gynae CAH	Obs & Gynae DHH
No. of shifts filled at standard rates	50	34	51
No. of shifts filled at escalated rates	11	10	7

Long Term Locums Filled at Standard & Ecalated Rates Quarter 2



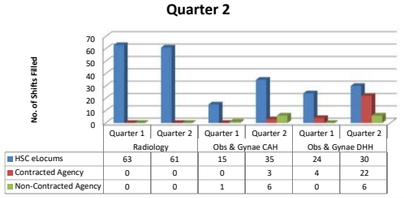
	Radiology	Obs & Gynae CAH	Obs & Gynae DHH
No. of posts filled at standard rates	0	0	1
No. of posts filled at escalated rates	1	1	2

Ad Hoc Shifts Received Filled - Quarter1 and Quarter 2



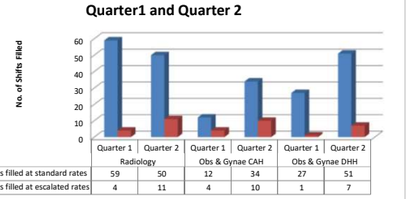
	Radiology		Obs & Gynae CAH		Obs & Gynae DHH	
	Quarter 1	Quarter 2	Quarter 1	Quarter 2	Quarter 1	Quarter 2
No. of shifts received by MLT	63	63	19	50	29	58

Ad Hoc Locum Shifts Filled Filled - Quarter1 and Quarter 2



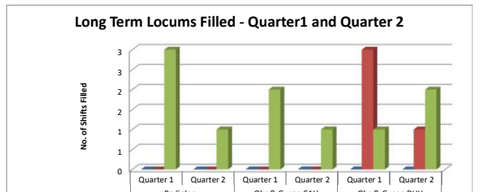
	Radiology		Obs & Gynae CAH		Obs & Gynae DHH	
	Quarter 1	Quarter 2	Quarter 1	Quarter 2	Quarter 1	Quarter 2
HSC eLocums	63	61	15	35	24	30
Contracted Agency	0	0	0	3	4	22
Non-Contracted Agency	0	0	1	6	0	6

Ad Hoc Shifts Filled at Standard & Escalated Rates Filled - Quarter1 and Quarter 2



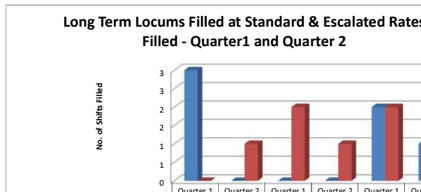
	Radiology		Obs & Gynae CAH		Obs & Gynae DHH	
	Quarter 1	Quarter 2	Quarter 1	Quarter 2	Quarter 1	Quarter 2
No. of shifts filled at standard rates	59	50	12	34	27	51
No. of shifts filled at escalated rates	4	11	4	10	1	7

Long Term Locums Filled - Quarter1 and Quarter 2



	Radiology		Obs & Gynae CAH		Obs & Gynae DHH	
	Quarter 1	Quarter 2	Quarter 1	Quarter 2	Quarter 1	Quarter 2
HSC eLocums	0	0	0	0	0	0
Contracted Agency	0	0	0	0	3	1
Non-Contracted Agency	3	1	2	1	1	2

Long Term Locums Filled at Standard & Escalated Rates Filled - Quarter1 and Quarter 2



	Radiology		Obs & Gynae CAH		Obs & Gynae DHH	
	Quarter 1	Quarter 2	Quarter 1	Quarter 2	Quarter 1	Quarter 2
No. of posts filled at standard rates	3	0	0	0	2	1
No. of posts filled at escalated rates	0	1	2	1	2	2

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Prepared for: Shane Devlin, Chief Executive

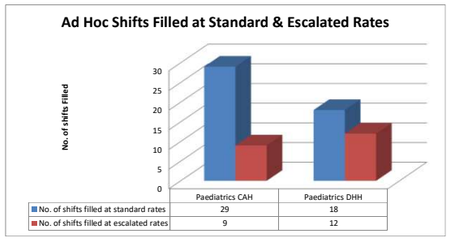
Ref: Q_008

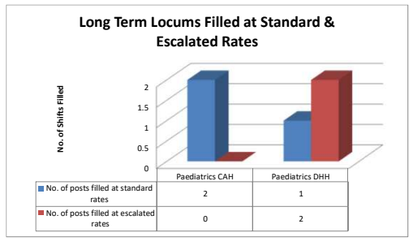
Date: 08 May 2019

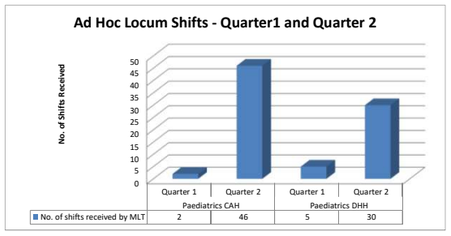
Section 1 - Cover Required	Paediatrics CAH			Paediatrics DHH			Total	
Ad Hoc	Total	WTE	%	Total	WTE	%	Overall WTE	Total
No. of shifts received by MLT	46		61%	30		39%		76
No. of hours received by MLT	391.35	42.46	54%	331.75	35.99	46%	78.46	723.1

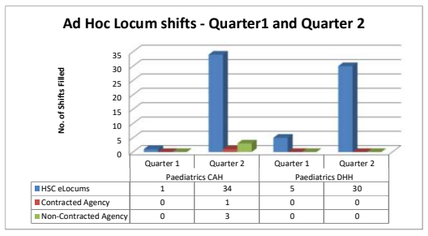
Section 2 - Cover Required	Paediatrics CAH			Paediatrics DHH			Total		
Ad Hoc	Total	WTE	%	Total	WTE	%	Overall WTE	Total	Overall %
No. of shifts filled									
HSC eLocums	34		89.47%	30		100.00%		64	94.12%
Contracted Agency	1		2.63%	0		0.00%		1	1.47%
Non-Contracted Agency	3		0.79%	0		0.00%		3	4.41%
No. of hours filled									
HSC eLocums	327	35.48	86.71%	331.75	35.99	100.00%	71.47	658.75	92.93%
Contracted Agency	12.75	1.38	3.38%	0	0.00	0.00%	1.38	12.75	1.80%
Non-Contracted Agency	37.35	4.05	9.90%	0	0.00	0.00%	4.05	37.35	5.27%
Cost of Filled Shifts									
HSC eLocums	£17,425.79		83.10%	£20,147.01		100.00%		£37,572.80	91.38%
Contracted Agency	£743.07		3.54%	£0.00		0.00%		£743.07	1.81%
Non-Contracted Agency	£2,801.25		13.36%	£0.00		0.00%		£2,801.25	6.81%
No. of shifts filled at standard rates	29		76.32%	18		60.00%		47	69.12%
No. of shifts filled at escalated rates	9		23.68%	12		40.00%		21	30.88%
Average Time taken to fill shifts (calendar days)	4		100.00%	0		0.00%		4	

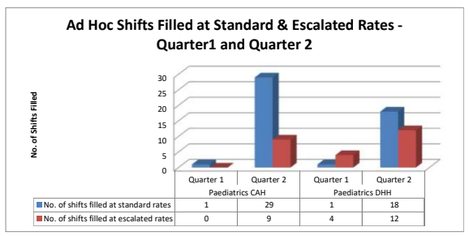
Section 3 - Breakdown of Long Term	Paediatrics CAH		Paediatrics DHH		Total	
Long Term	Total	%	Total	%	Total	Overall %
No. of Long Term Locum Bookings						
HSC eLocums	0	0.00%	0	0.00%	0	0.00%
Contracted Agency	2	100.00%	1	33.33%	3	60.00%
Non-Contracted Agency	0	0.00%	2	66.67%	2	40.00%
No. of posts filled at standard rates	2	100.00%	1	33.33%	3	60.00%
No. of posts filled at escalated rates	0	0.00%	2	66.67%	2	40.00%

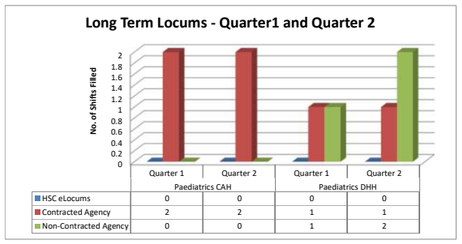


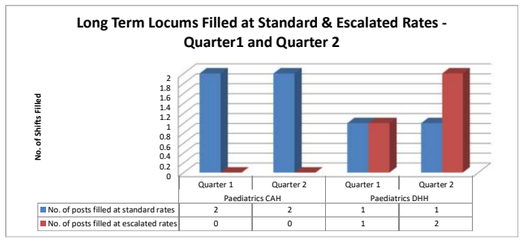












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Prepared for: Shane Devlin, Chief Executive

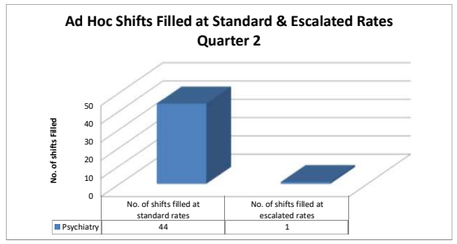
Ref: Q_008

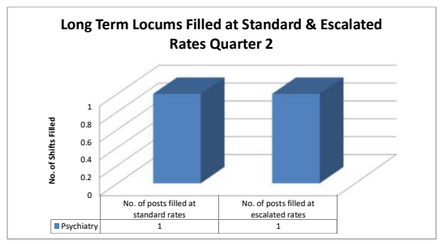
Date: 08 May 2019

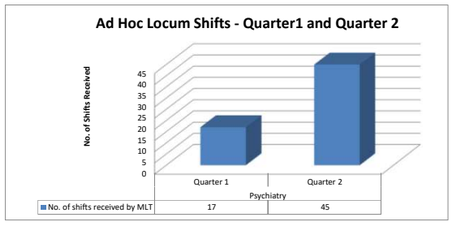
Section 1 - Cover Required	Psychiatry			Total	
No. of shifts received by MLT	45		100%		45
No. of hours received by MLT	416	45.14	100%	45.14	416

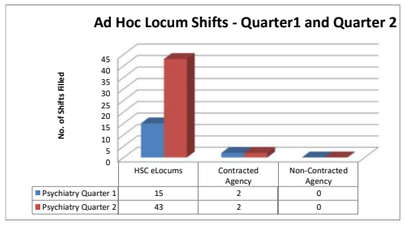
Section 2 - Cover Required	Psychiatry			Total		
Ad Hoc	Total	WTE	%	Overall WTE	Total	Overall %
No. of shifts filled						
HSC eLocums	43		96%		43	96%
Contracted Agency	2		4%		2	4%
Non-Contracted Agency	0		0%		0	0%
No. of hours filled						
HSC eLocums	392	42.53	94%	42.53	392	94%
Contracted Agency	24	2.60	6%	2.60	24	6%
Non-Contracted Agency	0	0.00	0%	0.00	0	0%
Cost of Filled Shifts						
HSC eLocums	£13,983.08		92%		£13,983.08	92%
Contracted Agency	£1,179.60		8%		£1,179.60	8%
Non-Contracted Agency	£0.00		0%		£0.00	0%
No. of shifts filled at standard rates	44		98%		44	98%
No. of shifts filled at escalated rates	1		2%		1	2%
Average Time taken to fill shifts (calendar days)	3		100%		3	

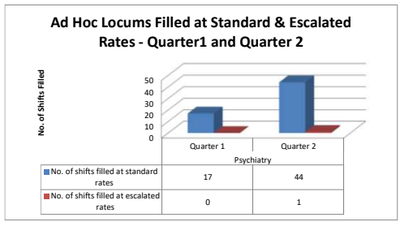
Section 3 - Breakdown of Long Term	Psychiatry		Total	
Long Term	Total	%	Total	Overall %
No. of Long Term Locum Bookings				
HSC eLocums	1	50%	1	50%
Contracted Agency	1	50%	1	50%
Non-Contracted Agency	0	0%	0	0%
No. of posts filled at standard rates	1	50%	1	50%
No. of posts filled at escalated rates	1	50%	1	50%

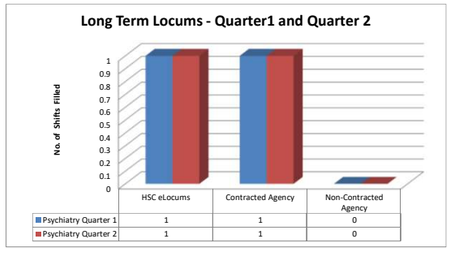


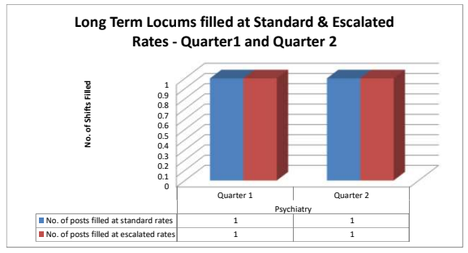












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Southern Trust Update

Author: Zoe Park -Head of Medical HR

DIFFICULTY RECRUITING PERMANENT CONSULTANTS

The difficult to fill consultant posts within the Southern Trust are: Haematology Consultants, Emergency Medicine Consultants, Diabetes & Endocrinology Physicians, Respiratory Physicians, Paediatricians, Community Paediatricians, Microbiologist and Acute Care at home Geriatricians.

- **Current Age Profile for Southern Trust Consultants across all specialties :**
  - 48.7% aged 35 - 45;
  - 38.6% aged 45 - 55;
  - 12.7% aged 55 - 65years+

  Average Consultant Retirement Age is 58.

- Current Turnover figures for our Consultants – including retirements and resignations.

Job Description	% Turnover 2014/15	% Turnover 2015/16	% Turnover 2016/17	% Turnover 2017/18	% Turnover 2018/19
Consultants	6.40%	7.48%	8.24%	7.16%	6.94%

DIFFICULTY CONVERTING VACANCIES TO PERMANENT POSTS

The Southern Trust currently engaged ***37 long term Locum Consultants*** in the following specialties:

- General Medicine and various sub specialties
- Day Admissions Unit / Acute Medical unit
- Emergency Medicine
- Care of the Elderly/Acute Care at Home/Stroke
- Haematology / Microbiology

We continue to work tirelessly to identify solutions to reduce reliance on long term locums. This has included pursuing international medical recruitment, re modelling of job plans, recent revision to our Locum consultant rate, improving uptake on internal consultant bank (to avoid agency fees/costs) and continued forward planning where possible.

See attached table in **Appendix 1** for details of these Long term Locum Consultants

- It is significant to note that **50% of these long term Locum Consultants** are **not** on the GMC Specialist Registrar for their applicable specialty. (19/38 doctors)

- The Southern Trust undertook a quick review of a small selection of our most recently appointed Consultants (10 previous appointments). ***This identified that 70% of our recently appointed consultants had worked as a ST3/Registrar in their specialty in our Hospital, prior to taking up their consultant post.*** This implies that if you have more rotational training numbers in a specialty, you are more likely to fill your consultant posts as doctors in training are familiar with the environment.

- This causes major difficulties for us in several specialties. Not least due to the fact that the Southern Trust has the ***least number of rotational training numbers in General Medicine at all grades (FY1/ST/CT/SpR) in comparison to all other Trusts in NI.*** For instance, Daisy Hill Hospital has only one General Medicine Registrar training number. This is one area where we have a large number of locum consultants in post.

GENDER ANALYSIS OF OUR MEDICAL STAFF

Staff Group	Male:Female				
	Staff in Post as at 31/03/2015	Staff in Post as at 31/03/2016	Staff in Post as at 31/03/2017	Staff in Post as at 31/03/2018	Staff in Post as at 31/3/2019
Consultants	70:30	68:32	65:35	63:37	61:39
SAS Doctors	33:67	31:69	29:71	28:72	27:73

- We are continuing to try and ensure our SAS doctors are engaged and motivated to remain in their career grade post.
- *It is difficult to attract SAS group of doctors to work overnight and at weekends regularly which would help with the service gaps left by rotational doctor vacancies.*
- Our SAS doctors are predominantly female, with many working part time and choosing this post for work/life balance reasons.
- There continues to be a challenge given the lack of career development opportunities for the SAS Grade since the closure of the AS Grade. We would welcome new/innovative opportunities to reward and/or encourage this group of staff further - particularly those who are or could contribute to the 24/7 cover throughout the hospital.

ALLOCATION OF ROTATIONAL DOCTORS ACROSS NI

- *The Southern Trust has the lowest number of total rotational Junior Doctor Training Numbers across the region.* This is considering training posts alone and not fill rate. (See attached table in **Appendix 2 for details on the distribution of rotational training number posts across NI)** Southern Trust is currently compiling some information to demonstrate the distribution of rotational trainees across the region set against service activity levels. Once this paper is complete, this will be raised with the CMO and DOH to ask for consideration for a more equitable split of rotational trainees across Trusts.

RISING GAPS WITHIN ROTATIONAL JUNIOR DOCTOR TRAINING POSTS

- In August 2018 – Southern Trust had 28 Full time Junior Doctor Gaps (12.8%)
- Additional 4.15 Gaps created from doctors working part time in full time posts
- *Total 32.15 Gaps (We have a total of 225 training doctor posts) Therefore 14% Vacancy Rate*
- Additional locum cost of approximately **£531K** for 6 month period to fill Gaps

Key issues/risks

- Rising Increases in Locum Use due to unfilled posts, Reduced cover on wards due to unpredictability of securing locums
- Rising intensity of work for doctors leading to Increases in Pay Bands in many specialties; General Surgery; FY1's, General Medicine ST/CT and SpR, Surgical specialties i.e. Urology, ENT, T&O.

RISING TREND OF DOCTORS LEAVING TRAINING & WORKING VIA EXTERNAL LOCUM AGENCY

- *Increasing Trend for Junior Doctors to leave Training Schemes to take up External Agency Locum posts.*

The Southern Trust would like to see a number of factors explored to help to tackle this ever increasing problem. For example:

- Inequity across NI Trusts on how external locum service is recognised in Pay when a doctor returns to training, which could in fact be acting as a perverse incentive. (E.g. some Trusts are rewarding doctors in

pay for their service with an external locum agency). Proposal has been tabled by HR Directors to the Department of Heath to ask that this is addressed – with a proposal that this service would not count for incremental credit in the future.

- We would ask how is locum service considered when a doctor makes an application for a higher training post via NIMDTA and the national recruitment campaigns? Is there any opportunity to look at this and identify if there is any scope to dis-incentivise external agency work.

Appendix 1: List of our Long Term Locum Consultants in Southern Trust – May 2019

LONG TERM LOCUM CONSULTANTS IN SOUTHERN TRUST

	Location	Specialty	Grade	WTE / Hours	Hours	Name of Agency	Contracted or Non Contracted	First Name of Doctor filling booking	Surname of Doctor filling booking	GMC	Specialist Reg	Start Date	Expected End Date
1	Lurgan	Acute care at home	Consultant	1	40	ID Medical	Contracted	[redacted]				29/10/2018	26/07/2019
2	CAH	AMU	Consultant	1	37.5	ID Medical	Contracted					20/05/2019	30/11/2019
3	DHH	Anaesthetics	Consultant	1	40	ID Medical	Contracted					07/05/2019	28/07/2019
4	CAH	Cardiology	Consultant	1	40	Direct	Contracted					29/01/2018	30/06/2019
5	DHH	COTE	Consultant	1	40	The Locum Specialist	Contracted					28/08/2018	30/06/2019
6	DHH	DAU DHH	Consultant	1	40	ID medical	Contracted					18/02/2019	18/08/2019
7	CAH	Diabetes & Endocrinology / General Medicine	Consultant	1	40	Direct Medics	Contracted					09/06/2014	31/07/2019
8	DHH	Emergency Medicine	Consultant	ad hoc		Locum Link	Contracted					01/02/2017	01/09/2019
9	CAH/DH H	ENT	Consultant		28	Direct Medics	Contracted					05/11/2018	30/06/2019
10	DHH	General Medicine	Consultant	1	40	NC Healthcare	Contracted					27/04/2015	30/09/2019
11	DHH	General Medicine	Consultant	1	40	ID Medical	Contracted					01/09/2015	31/07/2019
12	CAH	General Medicine	Consultant	1		Direct	Contracted					24/08/2017	31/10/2019
13	CAH	General Medicine	Consultant	1	37.5	NC Health Care	Contracted					11/12/2017	05/09/2019
14	DHH	General Surgery	Consultant	1	40	ID Medical	Contracted					07/09/2018	30/06/2019
15	DHH	Geriatrician COTE Stroke resent 30/10/18	Consultant	1	40	Direct Medics	Contracted					17/12/2018	31/08/2019

LONG TERM LOCUM CONSULTANTS IN SOUTHERN TRUST

	Location	Specialty	Grade	WTE / Hours	Hours	Name of Agency	Contracted or Non Contracted	First Name of Doctor filling booking	Surname of Doctor filling booking	GMC	Specialist Reg	Start Date	Expected End Date
16	DHH	Respriatory	Consultant	1	40	The locum specialist	Contracted	Irrelevant information redacted by the USI				07/01/2019	09/08/2019
17	DHH	Specialist interest Endocrie/diabetes	Consultant	1	40	The locum specialist	Contracted					10/12/2018	28/06/2019
18	Lurgan	Acute care at home	Consultant	1	40	TTM	Contracted					04/03/2019	31/08/2019
19	CAH	Geriatrician COTE Stroke thrombolysis	Consultant	1	40	Direct Medics	Contracted					25/02/2019	Irrelevant information redacted by the USI
20	DHH	Emergency Medicine	Consultant	2 week on 2 week	?	Surgi-Call	Non-contracted					02/02/2016	01/09/2019
21	DHH	Emergency Medicine	Consultant			Surgi-Call	Non-					20/07/2016	01/09/2019
22	DHH	Emergency Medicine	Consultant	1	40	Global Medics UK	Non-contracted						
23	CAH	Geriatrician COTE Stroke thrombolysis	Consultant	1	40	Charterhouse	Non-contracted					ASAP	31/08/2019
24	CAH	Haematology	Consultant	1	40	Empire locums	Non-contracted					05/11/2018	30/06/2019
25	CAH	Haematology	Consultant	1	40	Pathology Group	Non-contracted					19/02/2019	24/05/2019
26	CAH	Microbiology	Consultant	1	40	Surgi-call	Non-					20/05/2019	04/06/2019
27	CAH	Microbiology	Consultant	1	40	Global Medics UK	Non-contracted					26/06/2019	31/08/2019

LONG TERM LOCUM CONSULTANTS IN SOUTHERN TRUST

	Location	Specialty	Grade	WTE / Hours	Hours	Name of Agency	Contracted or Non Contracted	First Name of Doctor filling booking	Surname of Doctor filling booking	GMC	Specialist Reg	Start Date	Expected End Date
28	CAH	Microbiology	Consultant	1	40	Surgi-call	Non-	Irrelevant information redacted by the USI				04/09/2019	30/09/2019
29	DHH	Paeds	Consultant	1	40	4 recruitment	Non-contracted					18/02/2019	18/05/2019
30	CAH	AMU	Consultant	1	40	TTM	Contracted					19/02/2019	30/06/2019
31	DHH	General Medicine	Consultant	1	40	Direct	Contracted					24/08/2018	Irrelevant information redacted by the USI
32	DHH	General Surgery	Consultant	1	37.5/40 hrs	ID Medical	Contracted					02/01/2018	30/06/2019
33	CAH	Mental Health	Consultant	1	40	ID Medical	Contracted					09/10/2017	31/07/2019
34	CAH	Winter ward/Outliers	Consultant	1	40	NC Healtcare	Contracted					07/01/2019	31/05/2019
35	CAH	Winter ward/Outliers	Consultant	1	40	Direct	Contracted					03/12/2018	31/05/2019
36	DHH	Emergency Medicine	Consultant	1	40	Surgi-call	Non-					13/08/2018	01/09/2019
37	DHH	General Medicine	Consultant	1	40	Global Medics UK	Non-contracted					02/07/2018	30/06/2019
38	CAH	Obs & Gynae	Consultant	1	40	Pertemps	Non-					08/03/2019	01/09/2019

Appendix 2: Distribution of Rotational Trainees across Northern Ireland

	Belfast Trust	South Eastern Trust	Southern Trust	Northern Trust	Western Trust	Overall
Specialties	**Overall Posts**	**Overall Posts**	**Overall Posts**	**Overall Posts**	**Overall Posts**	**Overall Total Posts**
Foundation Year 1	99	39	**34**	38	42	252
Foundation Year 2 (incl. GP, Academic & PHA)	97	39	**32**	42	42	252
GP Training	29	33	**33**	32	26	153
Anaesthetics	70	20	**19**	14	16	139
ICM		2				2
Emergency Medicine	24	13	**14**	18	8	77
Obstetrics & Gynaecology	30	10	**16**	17	17	90
Paediatrics	55	9	**12**	18	18	112
Radiology	29	7	**5**	4	5	50
Histopathology	19					19
Medical Microbiology	9					9
Chemical Pathology	3					3
Public Health	11					11
Core Medical Training (CT1/2)	52	29	**24**	23	12	140
General Medicine / Acute Medicine (ST3+/SpR)	4	4	**1**	6	1	16
Cardiology (ST3+/SpR)	14	2	**3**	1	2	22
Clinical Genetics (ST3+/SpR)	2					2
Clinical Oncology (ST3+/SpR)	12				3	15
Clinical Neurophysiology (ST3+/SpR)	1					1
Dermatology (ST3+/SpR)	8	1				9
Endocrinology (ST3+/SpR)	6	2	**2**		1	11
Gastroenterology (ST3+/SpR)	7	2	**2**	3	2	16
Geriatric Medicine (ST3+/SpR)	6	3	**3**	2	2	16

	Belfast Trust	South Eastern Trust	Southern Trust	Northern Trust	Western Trust	Overall
Genitourinary Medicine (ST3+/SpR)	2					2
Haematology (ST3+/SpR)	15					15
Immunology (ST3+/SpR)	3					3
Infectious Diseases (ST3+/SpR)	1					1
Medicine ICM (ST3+/SpR)	1	2				3
Medical Oncology (ST3+/SpR)	9				1	10
Neurology (ST3+/SpR)	8	1	1		1	11
Occupational Medicine (ST3+/SpR)	1					1
Paediatric Cardiology (ST3+/SpR)	1					1
Palliative Medicine (ST3+/SpR)	6					6
Rehabilitation Medicine (ST3+/SpR)	2					2
Renal Medicine (ST3+/SpR)	4	1		1	1	7
(Use posts in GIM) Respiratory Medicine (ST3+/SpR)	9	2	1	2	1	15
Rheumatology (ST3+/SpR)	5	1	1	1	1	9
Stroke Medicine (ST3+/SpR)	1					
Core Psychiatry Training (CT1 - CT3)	16	6	10	12	7	15
Psychiatry of Old Age (ST4+)	2	1				3
General Adult Psychiatry (ST4+)	12	2	3	5	3	25
Psychiatry of Learning Disability (ST4+)	4					4
Forensic Psychiatry (ST4+)	4					4

	Belfast Trust	South Eastern Trust	Southern Trust	Northern Trust	Western Trust	Overall
Child & Adolescent Psychiatry (ST4+)	4	1	3	1		9
Psychotherapy (ST4+)	1					1
Core Surgical Training (CT1/2)	36	11	10	13	18	88
General Surgery (ST3/SpR)	15	5	7	5	3	35
Trauma & Orthopaedic Surgery (ST3+/SpR)	19	3	3		6	31
Cardiothoracic Surgery (ST3+/SpR)	8					8
Neurosurgery (ST3+/SpR)	5					5
Paediatric Surgery (ST3+/SpR)	3					3
Otolaryngology (ST3+/SpR)	5		2	1	2	10
Urology (ST3+/SpR)	4		2		2	8
Ophthalmology	14				4	18
Plastic Surgery		10				10
Vascular Surgery (ST3+/SpR)	4					4
	811	261	243	259	247	

Information provided by NIMDTA February 2019

Parks, Zoe

From: OKane, Maria <Personal Information redacted by the USI>
Sent: 10 May 2019 01:25
To: Parks, Zoe
Cc: Gibson, Simon; Wallace, Stephen
Subject: Report for Trust Board- Medical "Deep Dive"
Attachments: REPORT FOR MEDICAL DIRECTOR MAY 2019.pdf; Copy of Copy of Q_008 Trust Level Locum Usage.xlsx; Regional Influence to Allocation to Trainees May 2019.pdf; jama_blumenthal_2017_oi_170139.pdf

Importance: High

Really comprehensive – thank you Zoe . have added in the paper on impact of locums- we plan to use this as a template for the summer studentships. Simon all this can now go to trust board with jama paper as appendix – thanks maria

Dr Maria O'Kane
Medical Director
Tel: Personal Information redacted by the USI

From: Parks, Zoe
Sent: 09 May 2019 15:41
To: OKane, Maria
Subject: Draft Report as requested
Importance: High

Dr O'Kane,

I have pulled together this Draft Report for you this afternoon, for your consideration. This contains details of the long term locum consultants currently engaged in the Trust. I have also attached trust level details on locum usage as collated by our Medical HR locum Team.

- ***Update on Southern Trust***
- Trust Level details on Locum Spend within SHSCT

I have also attached the detailed report you are aware of that I have completed as part of DHH Pathfinder work re distribution of rotational trainees with a focus on Medicine in SHSCT. I understand the Chief Executive will be asked to raise this with the DOH/NIMDTA in the near future. It hasn't been shared with the CX yet.

Personal Information redacted by the USI

Zoë Parks
Head of Medical Staffing HROD
The Brackens, Craigavon Area Hospital
Tel: Personal Information redacted by the USI
Mob: Personal Information redacted by the USI

Southern Health and Social Care Trust

Quality care – for you, with you

GOVERNANCE COMMITTEE COVER SHEET

Meeting Date	8 September 2022		
Agenda item	MHPS – Open Formal Cases		
Accountable Director	Presented by: Dr D Scullion – Interim Medical Director		
Report Author	Name	Zoe Parks: Head of Medical HR	
	Email Address	Personal Information redacted by the USI	
This paper is presented for: **Information**			
Links to Trust Corporate Objectives	√	Promoting Safe, High Quality Care	
	☐	Supporting people to live long, healthy active lives	
	☐	Improving our services	
	☐	Making best use of our resources	
	☐	Being a great place to work – supporting, developing and valuing our staff	
	☐	Working in partnership	

	This report cover sheet has been prepared by the Accountable Director. *Its purpose is to provide the Trust Committee with a clear summary of the paper being presented, with the key matters for attention and the ask of the Committee.* *It details how it impacts on the people we serve.*

1. Detailed summary of paper contents:

The purpose of this paper is to provide a report to Governance Committee summarising the formal Maintaining High Professional Standards cases. (Medical & Dental staff)

- There are currently 0 exclusions in place.
- There is currently 1 formal MHPS case Irrelevant information redacted by the USI actively undergoing investigation.
- There is 1 formal MHPS case Irrelevant information redacted by the USI on hold Irrelevant information redacted by the USI Irrelevant information redacted by the USI
- There are 2 formal MHPS cases which have concluded but are currently working through actions plans to facilitate return to full practice. (detailed below)
  - Irrelevant information redacted by the USI
  - Irrelevant information redacted by the USI

2. Areas of improvement/achievement:

- All training for those currently in designated roles for active cases has been completed and is in date.

3. Areas of concern/risk/challenge:

Timescales: 4 weeks timescales as expected within MHPS for the completion of a case investigation is extremely challenging, given our investigators are also full time clinicians.

- Case Irrelevant information redacted by the USI The case investigation was delayed 3 weeks in July due to annual leave both of the consultant subject to the investigation and the case investigator. The case investigator is working to conclude witness interviews and complete the case report **by 9th September 2022**.
- Irrelevant information redacted by the USI

4. Impact: Indicate if this impacts with any of the following and how:

Corporate Risk Register	N/A
Board Assurance Framework	
Equality and Human Rights	No

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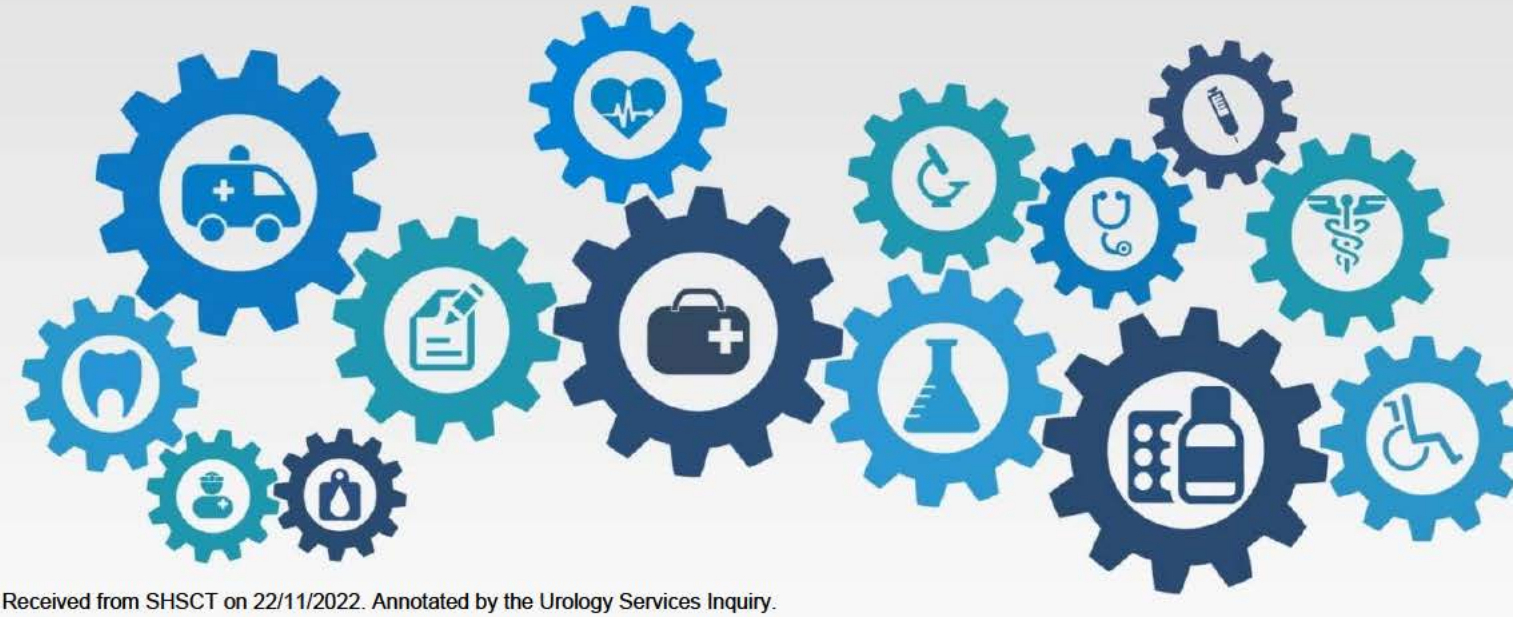
Maintaining High Professional Standard Formal Cases

September 2022



FORMAL MHPS CASES – SEPTEMBER 2022

Ref	Case Opened	Summary	Case Manager	Case Investigator	NED assigned	Any restrictions/ exclusions?	Is NHS Resolution involved?	Has GMC been informed?	Impact on Patient Care / associated SAI	Timescales
Irrelevant information redacted by the USI	20.5.22	Irrelevant information redacted by the USI	Dr G Hampton, DMD Emergency Medicine *Trained Oct 20*	Dr T Kane, Consultant Psychiatrist *Trained Jan 20*	Mrs P Leeson	No restrictions. Currently at work	Yes advice given Ref Irrelevant information redacted by the USI	Yes – the doctor has self-referred to GMC	SPPG SAI reference Irrelevant information redacted by the USI Level 3 SAI notification submitted 27/05/2022 Patient has had reversal of sterilisation	MHPS Case investigator report expected **by 9th September 2022.** Terms of Reference issued on 14th June 2022.
	24/7/20		Dr P Murphy DMD Medicine *Trained Oct 20*	Dr T Kane Consultant Psychiatrist *Trained Jan 20*	Ms E Mullan	Not currently working in SHSCT	Yes Ref Irrelevant information redacted by the USI	Yes Trust referred concerns to GMC 30.6.21 GMC is investigating	SAI in relation to clinical case. SAI **REF** Irrelevant information redacted by the USI Completed.	MHPS Determined on 26.6.21 referral Irrelevant information redacted by the USI
	23/7/20 Closed: 27.9.21 Disciplinary outcome.		Mr D Gilpin Consultant Surgeon (retired) *Trained Jan & Oct 2020*	Dr N Chada Consultant Psychiatrist (retired) *Trained Mar 17*	Mrs G Donaghy	Currently restricted to outpatients work but plan in place to phase back to full clinical duties.	Yes Ref Irrelevant information redacted by the	No	No	MHPS completed. Disciplinary Hearing concluded – formal Irrelevant information redacted by the USI
	16/3/21 Closed 22.10.21 NCAS Action Plan		Dr P Murphy DMD Medicine *Trained Oct 20*	Dr C Clarke Consultant ICU *Trained Jan 20*	Mr M McDonald	Currently under direct supervision	Yes Ref Irrelevant information redacted by the USI	Yes – GMC Conditions in place	SAI Level 1 Irrelevant information redacted by the USI ongoing	MHPS completed with formal NCAS Action Plan in place to integrate back into full role.

Southern Health and Social Care Trust

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Training Plan

Maintaining High Professional Standards (MHPS)

Lead Author & Job Title:	Zoe Parks, Head of Medical HR
Directorate responsible for document:	HROD
Issue Date:	01 September 2022
Review Date:	01 September 2024

Document Checklist

Document name:	**Training Plan – Maintaining High Professional Standards**
Lead Author & Job Title:	**Zoe Parks, Head of Medical HR**
Director responsible::	Mrs Vivienne Toal, Director of HROD
Directorate responsible:	HROD
Date approved by SMT:	Click here to enter a date.
Date approved by Trust Board:	Click here to enter a date.
Circulated to:	Eg Directors, Assistant Directors, Heads of Service for onward distribution to line managers, Global email, Staff Newsletter
Document uploaded to:	Eg SharePoint, Trust website

Version Control

Version:	**Version 0.1**		
Version History			
Version	Notes on revisions/modifications and who document was circulated or presented to	Date	Lead Policy Author

Contents

Appendix

1.0 INTRODUCTION

Maintaining High Professional Standards (MHPS), DHSSPS, November 2005, states at Section VI, paragraph 1:

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

This Training Plan therefore sets out the agreed training requirements to enable the effective implementation of MHPS in the Southern HSC Trust.

Training must be completed and in date before any member of staff can undertake a role under the MHPS Framework.

Training records will be maintained by Medical Staffing Team, HR & OD Directorate.

Staff involved in the implementation of MHPS also require equality e-learning (Corporate Mandatory Training).

2.0 SCOPE OF GUIDANCE

This guidance applies to all medical and dental staff however it is also relevant for all those who have a role in managing concerns about doctors; including non-executive directors, senior operational managers and HR Case Support staff.

3.0 TYPES OF TRAINING IN SHSCT

This Southern Trust Training Plan set out three Tiers of Training programme.

Tier 1: Non-Executive Directors/ Trust Board Training

Tier 2: Formal Case Manager & Case Investigator Training

Tier 3: Managing low-level concerns – for all Clinical/operational managers

5.0 SOURCES OF ADVICE AND FURTHER INFORMATION

This document has been developed with reference to the following, published by NHS Revalidation support team (please click for reference):

- Guidance for recruiting for the delivery of case investigator training (RST, 2014)
- Guidance for recruiting for the delivery of case manager training (RST, 2014)
- Case investigator person specification and competencies (RST, 2012)
- Case manager person specification and competencies (RST, 2012)

The links below are also useful background reading for Case Investigators and Case Managers:

- NHS England » Useful reading for case investigators and case managers
- Southern Trust Supporting Doctors in Difficulty HUB

5.0 Training Plan – Trust Board Training – MHPS

Training Name	MHPS Procedures for full Trust Board
Refresh required	Every 4 years (as per NED Term)
Externals Involved	DLS – Legal Adviser with Trust support
Duration	1 Half Day
Date and Time	This training will be arranged as required and communicated to Trust Board
Logistics Required	Online or Face to Face. Records of Training Attendance to be recorded by facilitator and returned to Medical HR
Room Arrangements	Computer and Wi-Fi access

Training Objectives: By the end of course, delegates will:
▪ Have an understanding of the Maintaining High Professional Standards Framework and the Trust Guidelines 2022
▪ Understand the Informal & Formal procedures outlined with MHPS and Trust Guidelines 2022
▪ Know how MHPS interfaces with appraisal & revalidation, NHS Resolution/PPA, Remedial Action/Back on Track
▪ Gain an overview of how risk and patient safety is managed under MHPS Framework
▪ Be clear on expectations of role and responsibilities as Chief Executive, Medical Director, Director of HR, Designated Board member and /or Panel member within MHPS
▪ Know the specific arrangements that apply when a formal exclusion is implemented
▪ Gain an overview of the legal challenges that can result from MHPS cases
▪ Be clear on MHPS reporting to governance committee

5.0 Training Plan – Case Manager (MHPS) Secondary Care

	Case Manager Training (Secondary Care). This 2 day course has been designed for anyone who undertakes the case manager role in MHPS investigations about doctors/dentists which may emerge from the processes underpinning revalidation or from concerns raised about performance. ***This training (or a recognised equivalent) is considered mandatory for Medical Director, all Divisional/Deputy Medical Directors. The Director of HR must also attend this training for awareness.**
	Trained case managers are required to attend retraining every 3 years
	NHS Resolution (or a recognised alternative)
	Min. 1 full day
	This training will be arranged annually or biannually (every 2 years) and communicated to all clinical managers
	This is Face to Face Training requiring suitable venue. Records of Training Attendance to be recorded by facilitator and returned to Medical HR
	Computer and Wi-Fi access

Training Objectives:	By the end of course, delegates will be able to:
▪	Outline the key principles and frameworks that ensure a fair, proportionate and just response to concerns raised including Maintaining High Professional Standards in the modern NHS (MHPS)
▪	Know how to source, gather and analyse data to inform decisions and recommendations
▪	Consider when an investigation is and is not appropriate and other options for resolution of performance concerns
▪	Explain the role and responsibilities of the Case Manager and how these differ to those of the Case Investigator
▪	Write a set of Terms of Reference which are robust, meaningful and effective
▪	Plan for and undertake a crucial conversation in a way that balances the protection of patient safety and the support for the practitioner and doesn't jeopardise future working relationships. Opportunity to practice skills including to practice the skills a case manager requires.
▪	Manage the investigation, identify bias and manage potential conflicts of interest
▪	Describe interventions that may be offered to resolve a performance concern
•	Formulate high quality, robust reports that can withstand scrutiny and challenge
▪	Describe the appeals process

- **Course Topics:** Introduction to case management, Understanding performance concerns, Planning for a performance conversation, Preliminary analysis, What do we mean when we say 'investigation'?, Commissioning an investigation, Terms of Reference (ToR), Roles & Responsibilities, Reviewing the case investigation report, Decision making, Writing the management case, Panel hearings, Appeals, Interventions to resolve concerns, Sources of support, Embedding the learning.

5.0 Training Plan – Case Investigator (MHPS) Secondary Care

Training Name	**Case Investigator** (Secondary Care) MHPS. This 2 day interactive course is designed for anyone who undertakes the case investigator role in investigations about doctors/dentists which may emerge from processes underpinning revalidation or from concerns raised about performance. ***This training (or a recognised equivalent) is considered mandatory for all our Clinical Directors and HR Case Support Staff**
Refresh required	Trained case Investigators are required to attend retraining every 3 years
Externals Involved	NHS Resolution (or a recognised alternative)
Duration	2 full days
Date and Time	This training will be arranged annually or biannually (every 2 years) and communicated to all consultants
Logistics Required	This is Face to Face Training requiring suitable venue Records of Training Attendance to be recorded by facilitator and returned to Medical HR
Room Arrangements	Computer and Wi-Fi access

Training Objectives:	By the end of course, delegates will be able to:
▪	explore how concerns about a practitioner's practice arise and identify the most common factors affecting performance
▪	explain why the decision to investigate is made and suggest other options to resolve performance concerns
▪	describe roles and responsibilities for those involved in investigations
▪	plan for an investigation which meets national requirements
▪	describe the principles of robust and meaningful terms of reference and know how to work within them
▪	collect, review and weight evidence
▪	conduct an investigative interview using a structured approach, including the PEACE model.
▪	recognise the key skills and attributes of a case investigator
•	recognise their own limits of competence and access sources of support and expertise
▪	reference relevant national/local standards
▪	write an investigation report with conclusions
▪	describe the potential legal challenges to an investigation

- **Course Topics:** Dealing with concerns about a practitioner's practice; investigation roles and responsibilities; starting the investigation; gathering evidence; interviewing witnesses; report writing; supporting the practitioner; responding to legal challenges; support for case investigators

5.0 Training Plan – Managing Low-Level Concerns

Training Name	Managing low-level Concerns. ***This training is considered mandatory for all our Clinical Directors, Clinical Leads and operational Assistant Directors.**
Refresh required	Every 3 years
Externals Involved	No. Trust delivered. Reference to Trust Guidance and systems for managing concerns
Duration	1 Half day
Date and Time	This training will be arranged twice yearly and offered to all Clinical Directors and operational Assistant Directors
Logistics Required	Face to Face, online or Recorded Webinar Training Records of Training Attendance to be recorded by facilitator and returned to Medical HR
Room Arrangements	Computer and Wi-Fi access

Training Objectives: By the end of course, delegates will be able to:
▪ Understand what to do when a concern first arises
▪ Know where to locate guidance and support
▪ Describe the clear practical steps to follow to ensure an effective and consistent response in line with accepted standards
▪ Know how to use risk templates to help assess and effectively identify if a concern is low-level or needs escalating
▪ Understanding of the Just Culture approach to managing concerns
▪ Clear on the importance of documentation
▪ Aware of the role of the Doctors & Dentists Oversight Group and reporting of all established concerns to Chief Executive
▪ Understand what support can be offered to practitioners

Appendix: Training Calendar 2022/23

Training Calendar for 2022/23																													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Oct 22																				*Case Investigator											
Nov 22										*Case Manager																					
Dec 22																															
Jan 23																															
Feb 23																															
Mar 23																															
Apr 23																															
May 23																															
June 23																															
July 24																															
Aug 23																															
Sept 23																															
Oct 23																															
Nov 23																															
Dec 23																															

Facilitated by NHS Resolution

Southern Health and Social Care Trust

Quality care – for you, with you

NOTIFICATION TO CHIEF EXECUTIVE

Date	20 September 2022	
Agenda item	MHPS – Open Cases	
Accountable Director	Mrs Vivienne Toal – Director of HROD & Dr D Scullion – Interim Medical Director	
Report Author	Name	Zoe Parks: Head of Medical HR
	Email Address	Personal Information redacted by the USI

This paper is presented for: **Information**

Links to Trust Corporate Objectives	√	Promoting Safe, High Quality Care
	☐	Supporting people to live long, healthy active lives
	☐	Improving our services
	☐	Making best use of our resources
	☐	Being a great place to work – supporting, developing and valuing our staff
	☐	Working in partnership

GREY SHADING DENOTES DOCTOR NO LONGER WORKING IN TRUST

1. Detailed summary of paper contents:

The purpose of this paper is to register all concerns being handled under the MHPS (Maintaining High Professional Standards Framework) with the Chief Executive (in line with para 8 Section1 MHPS).

- There are currently **0 formal or immediate** exclusions in place.
- There is currently **1 Formal MHPS** case [redacted] actively undergoing investigation.
- There is **1** formal MHPS case [redacted]
- There are **2** formal MHPS cases which have concluded but are currently working through actions plans to facilitate return to full practice. (detailed below)
  - [redacted]
  - [redacted]
- There are currently **10** screening, informal or low level concerns being handled under Maintaining High professional Standards Framework.
- There are currently additional **5 cases** being investigated by the GMC linked to the Southern Trust in addition to their knowledge of our formal MHPS cases.

2. Areas of improvement/achievement:

- All training for those currently in designated roles for active cases has been completed and is in date.
- Further NCAS training has been arranged for 24 Consultants/Managers (Case Investigator) and 24 consultants/Managers (Case Manager) to take place on 21/22 October and 10/11 November 2022.

3. Areas of concern/risk/challenge:

Timescales: 4 weeks timescales as expected within MHPS for the completion of a formal MHPS case investigation is extremely challenging, given our investigators are also full time clinicians.

- Case [redacted] The case investigation was delayed 3 weeks in July and a further 2 weeks in September due to annual leave both of the consultant subject to the investigation and the case investigator. The case investigator is working to conclude witness interviews and complete the case report **by early October 22**.
- [redacted]

GREY SHADING DENOTES DOCTOR NO LONGER WORKING IN TRUST

Southern Health and Social Care Trust

Quality Care - for you, with you

Maintaining High Professional Standard All Cases

September 2022

FORMAL MHPS CASES – SEPTEMBER 2022

Ref	Case Opened	Summary	Case Manager	Case Investigator	NED assigned	Any restrictions/ exclusions?	Is PPS involved?	Has GMC been informed?	Impact on Patient Care / associated SAI	Timescales
Irrelevant information redacted by the USI	23/7/20 **MHPS Complete** 27.9.21 Disciplinary sanction.	Irrelevant information redacted by the USI	Mr D Gilpin Consultant Surgeon (retired) *Trained Jan & Oct 2020*	Dr N Chada Consultant Psychiatrist (retired) *Trained Mar 17*	Mrs G Donaghy	Irrelevant information redacted by the USI	Yes Irrelevant information redacted by the USI	No	No	Irrelevant information redacted by the USI
Irrelevant information redacted by the USI	16/3/21 **MHPS Complete** 19.10.21		Dr P Murphy DMD Medicine *Trained Oct 20*	Dr C Clarke Consultant ICU *Trained Jan 20*	Mr M McDonald	Currently under direct supervision	Yes Irrelevant information redacted by the USI	Yes – GMC Conditions in place GMC Two year warning from Irrelevant information redacted by the USI	SAI Level 1 **REF** Irrelevant information redacted by the USI ongoing	Irrelevant information redacted by the USI
Irrelevant information redacted by the USI	24/7/20 **MHPS Paused pending PSNI**		Dr P Murphy DMD Medicine *Trained Oct 20*	Dr T Kane Consultant Psychiatrist *Trained Jan 20*	Ms E Mullan	Not currently working in SHSCT	Yes Irrelevant information redacted by the USI	Yes Trust referred concerns to GMC 30.6.21 GMC is investigating	SAI in relation to clinical case. SA Irrelevant information redacted by the USI Completed.	MHPS Determined on 26.6.21 referral to Disciplinary Hearing. Irrelevant information redacted by the USI
Irrelevant information redacted by the USI	20.5.22 **Formal MHPS Open**		Dr G Hampton, DMD Emergency Medicine *Trained Oct 20*	Dr T Kane, Consultant Psychiatrist *Trained Jan 20*	Mrs P Leeson	No restrictions. Currently at work	Yes advice given Irrelevant information redacted by the USI	Yes – the doctor has self-referred to GMC GMC Investigating	SPPG SAI reference Irrelevant information redacted by the USI Level 3 SAI notification submitted 27/05/2022 Patient Reversal of sterilisation completed	Terms of Reference issued on 14th June 2022. MHPS Case investigator report expected **by 30th September 2022.**

GREY SHADING DENOTES DOCTOR NO LONGER WORKING IN TRUST

MHPS SCREENING, INFORMAL or LOW LEVEL CONCERNS – SEPTEMBER 2022 (1)

Ref	Case Opened	Summary	Line Manager	Still employed? Any restrictions/ exclusions?	If Locum – Details of Agency and RO	Is NHS Resolution involved?	Has GMC been informed?	Timescales / Update	Are they aware discussed at Oversight?
Irrelevant information redacted by the USI	25.22.19	Irrelevant information redacted by the USI	Dr J Lewis	**Left Trust employment** Irrelevant information redacted by the USI Previously working under supervision with no out of hours	N/A	Yes from: 4.12.19 REF Irrelevant information redacted by the USI	ELA advice 14.9.22 No referral.	Doctor resigned from 31.7.22. Irrelevant information redacted by the USI	Yes
Irrelevant information redacted by the USI	3.3.20 Closed 1.5.22		Dr R McKee (previously Dr D Scullion)	Irrelevant information redacted by the USI	N/A	Yes Ref Irrelevant information redacted by the USI	No	NCAS mediation completed Irrelevant information redacted by the USI	
Irrelevant information redacted by the USI	3.3.20 Closed 1.5.22		Dr T McNaboe (previously Mr M Haynes)	Irrelevant information redacted by the USI	N/A	Yes Ref Irrelevant information redacted by the USI	No	Trust reporting will close when no further adjustments to rota.	
Irrelevant information redacted by the USI	21.2.21		Dr J Minay (previously Dr McMahon)	No restriction applies	N/A	Yes	No	Irrelevant information redacted by the USI Meetings planned in September 2022	Yes

GREY SHADING DENOTES DOCTOR NO LONGER WORKING IN TRUST

MHPS SCREENING, INFORMAL or LOW LEVEL CONCERNS – SEPTEMBER 2022 (2)

Ref	Case Opened	Summary	Line Manager	Currently at work? Any restrictions/ exclusions?	If Non Trust – Details of Agency and RO	Is NHS Resolution involved?	Has GMC been informed?	Timescales / Update	Are they aware discussed at Oversight?
Irrelevant information redacted by the USI	16.8.22	Irrelevant information redacted by the USI	Dr J Minay	IPP under consideration Irrelevant information redacted by the USI	NIMDTA RO Dr C Herron	No	Yes – via BHSCT	Irrelevant information redacted by the USI	
Irrelevant information redacted by the USI	18.2.2022		Dr R McKee	Irrelevant information redacted by the USI	N/A	Yes Irrelevant information redacted by the USI	ELA Advice 15.9.22 No referral	Preliminary screening currently being completed to Irrelevant information redacted by the USI	
Irrelevant information redacted by the USI	17.2.22		Dr B Adams	No restrictions in place Irrelevant information redacted by the USI	N/A	No	No	Informal Line management ongoing.	
Irrelevant information redacted by the USI	19.8.22		Dr G Hampton	Ongoing consultant supervision as per normal line management	RO: Dr Ian Grant PE Global non contracted agency	No	No	Informal Line management ongoing with additional training arranged	

GREY SHADING DENOTES DOCTOR NO LONGER WORKING IN TRUST

MHPS SCREENING, INFORMAL or LOW LEVEL CONCERNS – SEPTEMBER 2022 (3)

Ref	Case Opened	Summary	Line Manager	Currently at work? Any restrictions/ exclusions?	If Locum – Details of Agency and RO	Is NHS Resolution involved?	Has GMC been informed?	Timescales / Update	Are they aware discussed at Oversight?
Irrelevant information redacted by the USI	24.8.22	Irrelevant information redacted by the USI	Dr P McCaffrey	Currently at work No restriction	N/A	No	No	Screening of Concern being completed	No
Irrelevant information redacted by the USI	15.9.22	Irrelevant information redacted by the USI	Dr P McCaffrey	Irrelevant information redacted by the USI	NIMDTA Irrelevant information redacted by the USI	No	No	Screening of Concern being complete. NIMDTA are involved.	No

GREY SHADING DENOTES DOCTOR NO LONGER WORKING IN TRUST

GMC CASES OR AGENCY LOCUMS – SEPTEMBER 2022 (1)

Ref	Case Opened	Summary	Line Manager	Still employed? Any restrictions/ exclusions?	If Locum – Details of Agency and RO	Is NHS Resolution involved?	Has GMC been informed?	Timescales / Update
Irrelevant information redacted by the USI	7.5.20 GMC Open Case	Irrelevant information redacted by the USI	Dr S Murphy	**Left Trust engagement** Irrelevant information redacted by the USI Irrelevant information redacted by the USI	NC Healthcare RO Dr S Khan	No	GMC currently investigating Irrelevant information redacted by the USI	GMC Case Examiner decision – refer to MPTS - letter 27/5/22 Irrelevant information redacted by the USI
Irrelevant information redacted by the USI	01.11.20 GMC Open Case		Dr S Murphy (previously no CD)	**Left Trust engagement** Irrelevant information redacted by the USI	Locum Specialist RO Dr S Khan & Dr F Youssef	No	Yes GMC referral November 2020	GMC Info gathering in progress. Trust reporting will close when notified of GMC Outcome
Irrelevant information redacted by the USI	16.2.22 GMC Open Case		Dr U Bradley CD Medicine	**Left Trust engagement** Irrelevant information redacted by the USI	Locum Specialist RE' Dr S Khan	No	GMC Investigation not linked to SHSCT	Irrelevant information redacted by the USI Trust reporting will close following review of impact of working on 9 Sept while suspended.
Irrelevant information redacted by the USI	13.6.22		Dr S Murphy	**Left Trust Engagement** Irrelevant information redacted by the USI	RO: Dr Shahid Khan The Locum Specialist	No	Letter to RO: 21.6.22 ELA discussion 15.9.22	SHSCT currently completing a full screening of concerns for GMC Irrelevant information redacted by the USI

GREY SHADING DENOTES DOCTOR NO LONGER WORKING IN TRUST

GMC CASES OR AGENCY LOCUMS – SEPTEMBER 2022 (2)

Ref	Case Opened	Summary	Line Manager	Still employed? Any restrictions/ exclusions?	If Locum – Details of Agency and RO	Is NHS Resolution involved?	Has GMC been informed?	Timescales / Update
Irrelevant information redacted by the USI	26.7.22	Irrelevant information redacted by the USI	Dr B Adams	**Left Trust Engagement** Irrelevant information redacted by the USI	RO: Francis Kelly Locum Agency: Medi-Team	No	RO letter 1.8.22 ELA Advice 23.8.22	SHSCT currently completing detailed review of concerns for GMC

GREY SHADING DENOTES DOCTOR NO LONGER WORKING IN TRUST

Southern Health and Social Care Trust

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NOTIFICATION TO CHIEF EXECUTIVE

Date	20 October 2022	
Agenda item	MHPS – Open Cases	
Accountable Director	Dr D Scullion – Interim Medical Director	
Report Author	Name	Zoe Parks: Head of Medical HR
	Email Address	Personal Information redacted by the USI

This paper is presented for: **Information**

Links to Trust Corporate Objectives	√	Promoting Safe, High Quality Care
	☐	Supporting people to live long, healthy active lives
	☐	Improving our services
	☐	Making best use of our resources
	☐	Being a great place to work – supporting, developing and valuing our staff
	☐	Working in partnership

GREY SHADING DENOTES DOCTOR NO LONGER WORKING IN TRUST

1. Detailed summary of paper contents:

The purpose of this paper is to register all concerns being handled under the MHPS (Maintaining High Professional Standards Framework) with the Chief Executive (in line with para 8 Section1 MHPS).

- There are currently **0 formal or immediate** exclusions in place.
- There is currently **1 Formal MHPS** case [Irrelevant information redacted by the USI] which has concluded its MHPS investigation and is currently with the Case Manager for determination.
- **** There is 1 new formal case this month for which we are seeking a Case Manager and Case Investigator to be assigned.***
- There is **1** formal MHPS case [Irrelevant information redacted by the USI] on hold (pending a disciplinary hearing) on advice from DLS as we await conclusion PSNI fraud investigations. The GMC are also completing their investigation into the clinical concerns which is expected to conclude October 22.
- There are **2** formal MHPS cases which have concluded but are currently working through actions plans to facilitate return to full practice. (detailed below)
  - [Irrelevant information redacted by the USI]
  - [Irrelevant information redacted by the USI]
- There are currently **5** initial cases at screening stage, informal management or low level concerns being handled under Maintaining High Professional Standards Framework.
- There are currently additional **3 cases** being investigated by the GMC linked to the Southern Trust in addition to their knowledge of our formal MHPS cases.

2. Areas of improvement/achievement:

- NCAS training confirmed for 24 Consultants & Managers (Case Investigator) and 24 consultants and Managers (Case Manager) to take place on 21/22 October and 10/11 November 2022.

3. Areas of concern/risk/challenge:

- No further updates this month.

GREY SHADING DENOTES DOCTOR NO LONGER WORKING IN TRUST

Southern Health and Social Care Trust

Quality Care - for you, with you

Maintaining High Professional Standard All Cases

October 2022

FORMAL MHPS CASES – OCTOBER 2022

Ref	Case Opened	Summary	Case Manager	Case Investigator	NED assigned	Any restrictions/ exclusions?	Is PPS involved ?	Has GMC been informed?	Impact on Patients/ SAI	Timescales
Irrelevant information redacted by the USI	23/7/20 **MHPS Complete** 27.9.21 Disciplinary sanction.	Irrelevant information redacted by the USI	Mr D Gilpin Consultant Surgeon (retired) *Trained Jan & Oct 2020*	Dr N Chada Consultant Psychiatrist (retired) *Trained Mar 17*	Mrs G Donaghy	Irrelevant information redacted by the USI	Yes Ref Irrelevant information redacted by the	No	No	MHPS completed. Irrelevant information redacted by the USI
Irrelevant information redacted by the USI	16/3/21 **MHPS Complete** 19.10.21		Dr P Murphy DMD Medicine *Trained Oct 20*	Dr C Clarke Consultant ICU *Trained Jan 20*	Mr M McDonald	Currently under direct supervision	Yes Ref Irrelevant information redacted by the USI	GMC restrictions Stood down 21.9.22 GMC Two year warning Irrelevant information redacted by the USI	SAI Level 1 **REF** Irrelevant information redacted by the USI	Irrelevant information redacted by the USI
Irrelevant information redacted by the USI	24/7/20 **MHPS Paused pending PSNI**		Dr P Murphy DMD Medicine *Trained Oct 20*	Dr T Kane Consultant Psychiatrist *Trained Jan 20*	Ms E Mullan	Not currently working in SHSCT	Yes Ref Irrelevant information redacted by the USI	Yes Trust referred concerns to GMC 30.6.21 GMC is investigating	SAI in relation to clinical case. SAI **REF** Irrelevant information redacted by the Completed.	
Irrelevant information redacted by the USI	20.5.22 **Formal MHPS Open**		Dr G Hampton, DMD Emergency Medicine *Trained Oct 20*	Dr T Kane, Consultant Psychiatrist *Trained Jan 20*	Mrs P Leeson	No restrictions. Currently at work	Yes advice given Ref Irrelevant information redacted by the	Yes – the doctor has self-referred to GMC GMC Investigating Patient Reversal of sterilisation completed	SPPG SAI reference Irrelevant information redacted by the USI Level 3 SAI notification submitted 27/05/2022	

GREY SHADING DENOTES DOCTOR NO LONGER WORKING IN TRUST

FORMAL MHPS CASES – OCTOBER 2022

Registering **NEW FORMAL CASE to seek appointment of Case Manager, Case Investigator and NED assigned*

Ref	Case Opened	Summary	Case Manager	Case Investigator	NED assigned	Any restrictions/ exclusions?	Is PPS involved ?	Has GMC been informed?	Impact on Patients/ SAI	Timescales
Irrelevant information redacted by the USI	14.10.22	Irrelevant information redacted by the USI	*To be appointed*	*To be appointed*	*To be assigned*	DMD currently considering restrictions in consultation with NHS resolution	Yes REF Irrelevant information redacted by the USI	ELA Advice 15.9.22 No referral	N/A	Irrelevant information redacted by the USI

Irrelevant information redacted by the USI

Ref: Irrelevant information redacted by the USI	
Case Manager	
Case Investigator	
NED Assigned	

MHPS INITIAL SCREENING STAGE, INFORMAL or LOW LEVEL CONCERNS – October 2022 CHANGES

Changes from Sept Report:

**Ref Irrelevant information redacted by the USI – Removed from list. Doctor no longer employed and all necessary actions taken*

**Ref Irrelevant information redacted by the USI – Removed from list. DMD confirmed at Sept 22 Oversight Screening report completed and no further action required. Screening outcome discussed, and confirmation NHS Resolution advice sought by DMD.*

**Ref Irrelevant information redacted by the USI – Removed from list. DMD confirmed at Sept 22 Oversight managing well informally.*

**Ref Irrelevant information redacted by the USI – Removed from list. DMD confirmed at Sept 22 screening complete with no further action required for SAS doctor.*

GREY SHADING DENOTES DOCTOR NO LONGER WORKING IN TRUST

**Ref 22CW02 – This case has moved up threshold as a new Formal Case this month.*

MHPS INITIAL SCREENING STAGE, INFORMAL or LOW LEVEL CONCERNS – October 2022 (1)

Ref	Case Opened	Summary	Line Manager	Still employed? Any restrictions/ exclusions?	If Locum – Details of Agency and RO	Is NHS Resolution involved?	Has GMC been informed?	Timescales / Update	Are they aware discussed at Oversight?
Irrelevant information redacted by the USI	3.3.20 Closed 1.5.22	Irrelevant information redacted by the USI	Dr R McKee (previously Dr D Scullion)	Irrelevant information redacted by the USI	N/A	Yes Ref Irrelevant information redacted by the USI	No	Irrelevant information redacted by the USI	
Irrelevant information redacted by the USI	3.3.20 Closed 1.5.22		Dr T McNaboe (previously Mr M Haynes)	Irrelevant information redacted by the USI	N/A	Yes Ref Irrelevant information redacted by the USI	No		
Irrelevant information redacted by the USI	16.8.22		Dr J Minay	IPP under consideration Irrelevant information redacted by the USI	NIMDTA RO Dr C Herron	No	Yes – via BHSCT		
Irrelevant information redacted by the USI	17.2.22		Dr B Adams	No restrictions in place Irrelevant information redacted by the USI	N/A	No	No		

GREY SHADING DENOTES DOCTOR NO LONGER WORKING IN TRUST

MHPS SCREENING, INFORMAL or LOW LEVEL CONCERNS – OCTOBER 2022 (2)

Ref	Case Opened	Summary	Line Manager	Currently at work? Any restrictions/ exclusions?	If Locum – Details of Agency and RO	Is NHS Resolution involved?	Has GMC been informed?	Timescales / Update	Are they aware discussed at Oversight?
Irrelevant information redacted by the USI	15.9.22	Irrelevant information redacted by the USI	Dr P McCaffrey	Irrelevant information redacted by the USI	NIMDTA RO Dr C Herron	No	No	Irrelevant information redacted by the USI	No

GREY SHADING DENOTES DOCTOR NO LONGER WORKING IN TRUST

GMC CASES OR AGENCY LOCUMS – October 2022 (Changes)

*Re[Irrelevant information redacted by the USI] *Removed from list. GMC confirmed 3.10.22 they have closed case with no action.*

*Re[redacted] *Removed from list. Doctor is no longer employed. Agency/RO advised of recent actions re suspension.*

GMC CASES OR AGENCY LOCUMS – October 2022 (1)

Ref	Case Opened	Summary	Line Manager	Still employed? Any restrictions/ exclusions?	If Locum – Details of Agency and RO	Is NHS Resolution involved?	Has GMC been informed?	Timescales / Update
Irrelevant information redacted by the USI	01.11.20 GMC Open Case	Irrelevant information redacted by the USI	Dr S Murphy (previously no CD)	**Left Trust engagement** Irrelevant information redacted by the USI	Locum Specialist RO Dr S Khan & Dr F Youssef	No	Yes GMC referral November 2020	GMC Info gathering in progress. Trust reporting will close when notified of GMC Outcome
Irrelevant information redacted by the USI	13.6.22		Dr S Murphy	**Left Trust Engagement** Irrelevant information redacted by the USI	RO: Dr Shahid Khan The Locum Specialist	No	Letter to RO: 21.6.22 ELA discussion 15.9.22	SHSCT currently completing a full screening of concerns for GMC Irrelevant information redacted by the USI
Irrelevant information redacted by the USI	26.7.22		Dr B Adams	**Left Trust Engagement** Irrelevant information redacted by the	RO: Francis Kelly Locum Agency: Medi-Team	No	RO letter 1.8.22 ELA Advice 23.8.22	SHSCT currently completing detailed review of concerns for GMC Irrelevant information redacted by the USI

GREY SHADING DENOTES DOCTOR NO LONGER WORKING IN TRUST

19 August 2011

STRICTLY PRIVATE AND CONFIDENTIAL

Mr A O'Brien
Consultant Urologist
Personal information redacted by USI

Dear Mr O'Brien

RE: ISSUE OF INFORMAL WARNING

I refer to our meeting on 23 June 2011 with regard to the following concern:

1. You disposed of a large section of patient filing in a bin, which was later found and retrieved by an auxiliary on the ward. The filing consisted of fluid balance charts, mews charts, TPN prescription forms, Aminoglycosides prescription forms and prescription Kardex for an inpatient on the Ward.

I now write to confirm to you that as part of the Trust's Disciplinary Procedure, you will be issued with an informal warning in respect of this concern. This warning will remain valid for a period of six months. It is noted that during our meeting, you confirmed that you accepted your action was wrong and that it would not occur again.

You have the right to appeal this decision. Should you wish to appeal you must write to Mr E Mackle, Associate Medical Director within seven working days of receipt of this letter, stating the grounds of your appeal.

Yours sincerely

Mr R Brown
Surgical Clinical Director

Copy to: Mr E Mackle Associate Medical Director

2012

Southern Health and Social Care Trust

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Summary of Evidence gathered into concerns relating to Dr [redacted]

Personal Information redacted by the USI

This investigation was undertaken by: Mr R Brown as Case Investigator with assistance from Mrs Zoe Parks, HR Manager

Southern Health & Social Care Trust

1. Introduction

Dr [redacted] was appointed as a temporary LAT (Locum Appointment for Training) in Urology on [redacted] His contact expired on [redacted]

The Southern Trust received correspondence from the General Medical Council on 24 February 2012 which advised that as part of GMC enquiries into a complaint they asked if the Trust had any further information which may assist with their enquiries. Following clarification from the Consultant Urologists, the Trust responded to the GMC on 5 March 2012 to advise that the Trust was not aware of any problems or issues that may indicate poor clinical practice. After more detailed investigation/consultation with senior nursing staff, information and concerns came to light. The Medical Director therefore provided a supplementary response to the GMC on 30 March 2012. This indicated that there were some clinical concerns that had been raised by Senior Nursing Staff in relation to Dr [redacted] management of a number of cases which were now subject to an investigation.

2. Decision to Investigate

A number of concerns were raised formally by the lead clinician in Urology. Two consultants met with Dr [redacted] on Tuesday [redacted] and a number of restrictions on his practice were voluntarily agreed. It was determined that Dr [redacted] would no longer work any on-call duties [day or night time] and would be accompanied by the Urology SPR for Urology Ward Rounds. The GMC were advised that the Urology service were confident that these restrictions and the further support, training and mentoring would support Dr [redacted] in the development of his practice in Urology and protect our patients.

When the concerns were raised formally with the Trust, preliminary enquiries were undertaken to identify the nature of the concerns and assess the seriousness of the issues. The position was presented to a Trust Oversight Committee on 14 March and the decision to complete an investigation under "Maintaining High Professional Standards in the Modern HPSS" was endorsed. Mr R Brown was appointed as the Case Investigator

[1] Appendix 1 – Contract of Employment & Job Description

for the case. The terms of reference, set out in the Section below, encapsulate all of the concerns submitted at the outset and these formed the core of the investigation.

3. Terms of Reference

The Oversight Committee appointed the following people to complete this investigation:

Case Manager	Mr E Mackle, Associate Medical Director, Craigavon Area Hospital
Case Investigator:	*Mr R Brown, Consultant Surgeon, Daisy Hill Hospital*
HR Manager:	*Mrs Zoe Parks, Medical Staffing Manager*
Designated Board Member:	*Via Chief Executive Office (Mr R Alexander)*

The under noted terms of reference formed the basis for the investigation

14 March 2012
A preliminary investigation is commissioned into concerns relating to Dr [redacted] *LAT, Urology, Craigavon area Hospital*

Period under investigation: Concerns identified during employment with Southern Trust from [redacted] until present

Matters to be investigated:

- Statement from Sister [redacted] setting out concerns in relation to Dr [redacted] clinical ability and his ability to make decisions with regards to patient care.
- Statement from [redacted] (5 April 12) in relation to an allegation of rude attitude to patient and relative.
- Concerns from Mr A O'Brien, Consultant Urologist in relation to Dr [redacted] operative skills

Method for Investigation:
NCAS were contacted for their advice on managing this case on 30 March. NCAS correspondence is included in **Appendix 2.**

Statements to be taken from the following:
Personal Information redacted by the USI
Mr O'Brien, Consultant Urologist
Mr Young, Consultant Urologist
Mr Akhtar, Consultant Urologist
Mr KJ Ho, Locum Consultant Urologist
Dr J Keane, Specialty Registrar Urology
Personal Information redacted by the USI
Relevant Nurses in Urology

4. Method

4.1 The Case Investigator met with Dr Personal Information redacted by the USI on 28 June 2012[2] to explain the process that would be followed and to review the terms of reference for the investigation (Appendix 3). Minutes of this meeting are included in the appendix section (Appendix 7). It was also confirmed at this meeting that a further meeting would be arranged with Dr Personal Information redacted by the USI towards the end of the investigation to give him an opportunity to provide a substantive response to the reports received.

4.2 During the course of the investigation 9 witnesses were interviewed. The original witness statements are enclosed in Appendix 4. A list of the witnesses, their respective grades, locations and the dates of interview is attached in the Appendix Section (Appendix 5). At the outset of the interviews each witness was advised of the terms of reference for the investigation, and specifically those relating to their area of work. Subsequent questions to each of the witnesses were designed to elicit any direct evidence and establish whether they had been present at any incident involving Dr Personal Information redacted by the USI and if so, to state when, where and what they actually witnessed. The case investigator has endeavoured to ensure that confidentiality and integrity of the investigation process was maintained throughout, and that the investigation was carried out as expeditiously as possible.

[2] Notes of this meeting in Appendix 7

4.3 Dr [redacted] contract ended on [redacted] and he advised by email on 7 August 2012 that the case investigator should communicate with him by emails or by post as at that time he was unable to travel to Northern Ireland.

5. Allegations

5.1 The specific concerns reported included the following;

5.2 CLINICAL CONCERNS

5.2.1 Concerns around Dr [redacted] ability to perform flexible cystoscopies

5.2.2 Concerns from the Consultant Urologist relating to Dr [redacted] operative skills.

5.2.3 Some concerns from nursing staff around prescription issues.

5.3 BEHAVIOURAL CONCERNS

5.3.1 It has also been alleged by nursing staff that Dr [redacted] has difficulty multitasking and prioritising tasks and is reluctant to make decisions which has led to delays in the delivery of care to patients.

5.3.2 Concerns from the supervising consultant around Dr [redacted] evel of insight with regard to his level of clinical competencies associated with his seniority.

6. Findings Gathered

6.1 Dr [redacted] provided a substantial response to all the allegations and statements. Some of the pertinent points have been included below. However the full detail of his response should be considered and has been included as an appendix to this report. (Appendix 6)

Flexible Cystoscopies

6.2 A nurse advised that in the flexible cystoscopy lists, doctors are presented with all the medical history of the patient, recent bloods and all the results so it should be clear for the doctor to enable them to make a decision. The nurse reported that Dr

Personal Information redacted by the USI *"appeared to create a lack of confidence in patients and patients would have asked nurses if he was a doctor at all and how long ago did he train."* She stated further that based on her personal experience of working with him, she would have serious concerns about him as a SHO or SpR given that this clinic was an organized and methodical environment. She confirmed that she observed Dr Personal Information redacted by the USI doing a flexible cystoscopy and felt that he was reluctant to put the camera on so that she would see what he was looking at. She had asked the lead consultant to come and observe him in the clinic so that she could reassure the nurses that he was performing appropriately.

6.3 The lead consultant confirmed that he attended the Haematuria clinic in response to concerns from the nurses that he was bringing back more patients for biopsies than they would have expected. The consultant advised that during this observation *"I felt his treatment was appropriate and his inspection of the bladder was fine. However his technique using the camera on one female could have been better. It was a bit sore to pass the scope and I would have expected someone with his years of experience in Urology to be able to manage this better. This is one area where there may be some technical training required as it wasn't a difficult case. It was confirmed that this was his observation on one day so he couldn't be sure if this was a consistent pattern or he was just having a 'bad day'".*

6.4 Another consultant who was employed by the Trust on a long term locum placement advised in their statement that *"I am aware that he can be quick to refer patients from flexible cystoscopy to GA, which shows me he may not always be confident in what he sees".*

6.5 Dr Personal Information redacted by the USI provided a response to each of these statements and advised that *"out of nearly 300 flexible cystoscopies I did at Craigavon during my eight and a half months work there, I had encountered difficulty in passing the scope with two patients."* He advised the one described by the lead consultant was a lady who had a previous anterior vaginal repair with deviation of the urethra and he had encountered difficulty and had asked the consultant for help. He stated in such situations, he used to pass the scope through the urethra under vision as if passing a scope in a male, but that day it didn't work. He stated that he learnt to lift the urethra with his left index finger while holding the end of the scope with the right hand.

6.6 In response to the comment from the nurse that some patients asked the nurses whether he was a doctor, Dr [redacted] advised this allegation is false. He advised *"patients are usually very happy with me because I listen to them, explain the diagnosis very well using atlas or models of the prostate & bladder and involve them in further investigations and decision making."* He went on to state that *"in fact patients in the clinic at the end of consultation are so happy with me that they thank me abundantly, ask me about* [redacted] *and tell me about places to visit in Northern Ireland."* He stated further that *"This allegation is false and (the nurse) is using a figment of her imagination and her sentiment and projecting it to show that patients are stereotyping me. In reality the above statement is her stereotyping."*

6.7 In response to the statement from the above nurse during the flexible cystoscopy, Dr [redacted] advised that the nurse had asked him to teach her flexible cystoscopy and she had never attended his sessions before. Out of courtesy despite his time restraints, Dr [redacted] showed her about two pointing at the landmarks. He stated therefore that *"her statement shows she is not trustworthy and her statements should not be taken seriously." "The accusation that I was reluctant to put the camera so she could see what I was looking at is another example of typical hyper scrutiny and unwarranted supervision. It is typical of her stereotyping attitude. I don't use the camera because when I started in the day unit, there was no camera or TV monitor to use there, every urology doctor uses his eye ball and when I started running Haematuria clinic, I did the same, however I am comfortable using both my eye ball and camera."* The case investigator noted that during this interview with this witness it had been clear that she had asked Dr [redacted] to teach her flexible cystoscopy as this gave her an opportunity to see how the procedure was performed by him.

6.8 In response to the concern from the consultant advising that Dr [redacted] was quick to refer patients for GA cystoscopy from flexible cystoscopy, Dr [redacted] advised that *"no one had ever pointed to me that I was quick at referring patients to GA cystoscopy from flexible cystoscopy. However I did refer patients to GA cystoscopy or other GA procedures if necessary in the following situations":*

6.8.1 *"Patients coming for bladder cancer surveillance who have suspicious lesions, especially if they look velvety like carcinoma in situ..."*

6.8.2 *"Patients who have stricture or severe meatal stenosis and flexible cystoscopy was not possible"*

6.8.3 *"Patients with significant debris in the bladder making vision difficult"*

6.9 Dr [redacted] also advised in his response *"the comment about my skill of flexible cystoscopy is false, because the (lead consultant) came one day and supervised me and commended me. I looked for his help in one patient and he was satisfied with that. If there was a concern about my skills, a senior nurse would not have asked me to teach her flexible cystoscopy which I gladly did and recorded in my ISCP website. Patients were generally happy and satisfied with the information I used to give them and they shake me and liked asking about family and myself. Please refer to testimonials."*

6.10 With reference to the testimonials provided by Dr [redacted] the case investigator had asked in what context these testimonials had been collected. (Refer to minutes of meeting held on 28.6.12). Dr [redacted] had confirmed that if a patient had verbalized and were excited by the treatment he had provided, he would ask them if they would like to put it in writing at that time. Dr [redacted] had also provided a testimonial sheet which he would ask Trust staff to sign if they were happy with his performance. The Case investigator asked who came up with the form of words and was this volunteered by the individuals or written by Dr [redacted] Dr [redacted] confirmed he came up with the text and asked staff if they were happy to sign their name.

Operative skills

6.11 A consultant Urologist reported in a statement that Dr [redacted] lack of experience, competence and confidence in some aspects of practice became progressively apparent. He advised that the aspect of practice so particularly affected was operative ability. The consultant confirmed that *"I asked him to perform a circumcision on a young adult male whilst I had coffee during a day Surgical list. He assured me that he was happy to do so. When I returned I found that he had performed an excessively radical circumcision. When he proffered explanations of cordee as being the cause, I came to appreciate his inexperience and his lack of insight as to the role of his inexperience in the inappropriate performance of a procedure which I would have expected a trainee of his inferred experience to have been able to perform competently"*. He stated further that he *"had experience where his consultant colleague had requested a penile MRI scan in the staging of a*

penile carcinoma and requiring an intracavernosal injection of alprostadil. He advised (Dr [redacted]) that he had never done this. This surprised me greatly given the years he had spent in Urology in the UK." This consultant praised Dr [redacted] in other areas and the diagnosis reached in some cases. He advised however that his overall view would be *"that he has a good knowledge of Urology but his competence is low and he is not at the level of a registrar. I believe it would be inappropriate if he were to be signed off as a SPR/LAT and feel he is more akin to a ST1 level starting off in Urology."*

6.12 Another consultant commented in his statement that *"he had clinical knowledge – in fact this was very good. However I did have some doubts about the application of this knowledge. He did need supervision even for cases were you would expect others with the same level of experience to deal with"*. He stated further that *"after working with Dr [redacted] I believe his years' of experience to date has not prepared him to work at registrar level. I would say Dr [redacted] is best suited to SHO level. The initial levels of ST3/4 are ok but with caution as I feel he requires supervision to work at registrar level.*

6.13 The lead consultant in urology also commented on his experience of his operative ability. He stated that *"he was with me last week doing a TURP. I showed him what to do and it was evident after 10 minutes he was performing it well. He virtually completed the operation himself although I completed the resection. My experience of his endoscopic operations has been fine although I am aware there may be some issues with other surgical procedures. I know he operated with (my consultant colleague) who has raised concerns. In my opinion he is short in operative experience and is not fully conversant in some techniques, considering the years he has spent in Urology."*

6.14 Within Dr [redacted] detailed responses, he indicated that *"both at interview and first meeting (the lead consultant) I clearly stated that I was brought up in my initial training overseas doing mainly open operations and that I was taught some endourology while in the staff surgeon positions in the UK. However by nature of staff surgeon's positions there are many barriers to development and progress and I told him I needed him to support me to learn more techniques and build on my experience and expertise."*

6.15 Responding to the concerns around his operative ability, he advised that *"I always like to work within the limits of my competence and willing to learn more skills and consolidate what I had already learned."* He commented that when he joined the post, he discussed his operative ability with his educational supervisor and all consultants he had worked with. He advised that he informed them that he wanted to learn more endourology.

6.15.1 The case investigator noted that it is accepted that Dr [redacted] was appointed to a Locum appointment for Training position. This was a training post, however this appointment was offered at a registrar level on the basis of the experience displayed at interview, and as such he was reasonably expected to be competent in a number of procedures and expected to be able to get on with the job fairly efficiently. The same expectations would have been applicable for any doctor coming in at that grade in those circumstances.

6.16 In response to the comments from the Consultant regarding his performance in Theatre in terms of the circumcision, he provided the following remarks. *"He (the consultant) then asked me do you want to do the next circumcision and I said yes please. He said to me I am around. The patient had a dysplastc ventral skin, giving rise to a chordee without hypospadias. I checked the literature after and found its real nomenclature is hypospadias sans hypospadias. I did the operation, although the inner lining skin on the ventral side reached near the corona. (The consultant) then told me that he did not like the way I had removed the inner lining skin and he took over the operation. He made remarks, which made even the nurses to look shocked. Additionally he condemned me for using bipolar diathermy which is actually the accepted diathermy to use in the penis and also for using marker pen which is actually accepted practice in urology. Please refer to atlas of urology by Hinman Jr 2nd edition page 167. He then used monopolar for diathermy. Even though he took over and completed the operation, while we were in clinic, the nurses phoned to tell us that the patient had oozed from the wound while in recovery ward. At the end of the clinic he then told me to go and see the patient, he would join me later. I went and applied some gauze and then admitted the patient for observation overnight however he never came to see the patient. On reflections it would have been better to use another method of circumcision in a situation when there is a dysplastic ventral skin. Since I am not a consultant, I still prefer to follow the accepted safe diathermy method for the penis, which is bipolar".*

6.17 Dr [redacted] stated further in support of assisting in major operations *"I had the privilege of assisting (the consultant) in major open urology operations. I have assisted him diligently in 3 consecutive nephrectomies and an adrenalectomy that involved significant bleeding during hilar dissections. I have also assisted him diligently in 2 major retroperitineal operations. In all those operations, he never found fault with me. In the last nephrectomy I did with him, he asked me to ligate the renal artery and a prominent renal vein. I ligated both very well to his satisfaction. It is unlikely to expect a person with an experience of ST1 to cope in a situation of major bleeding from the hilum on 3 consecutive nephrectomies."* He advised that on 26 June 2012, he and (the consultant) were the only ones on the ground because other colleagues had attended the BAUS meeting in Glasgow. The consultant had asked Dr [redacted] to run the day surgery list because he had to run the main theatre. Dr [redacted] advised he operated on about 5 patients alone without any problem and (the consultant) thanked him that day when they met in the clinic. (He advised the only day he ever thanked him after a task). Dr [redacted] commented that *"As a surgeon I have to be transparent and honest with my abilities. I had learned how to arrange the injection with the old type. I saw adverts of the dual chamber which is in vogue now and (the consultant) showed me how to prepare the new dual chamber one and I then went to MRI and gave the injection. Thus, even though, I had participated in andrology operations like groin dissection, correction of penile deformities nevertheless, it is moral, ethical and legal obligation on me to learn a technology however simple it might seem. In fact that was the essence of taking up the training post."*

Prescriptions

6.18 The nursing staff advised in their statement that Dr [redacted] was reluctant to prescribe medication. One advised *"I remember one occasion when he wouldn't prescribe paracetamol. When he was asked why, his response was that he didn't want to end up in court. I actually never witnessed him prescribing but on many occasions, I witnessed him deferring this duty to a more junior doctor. He didn't like going on ward rounds without a junior doctor. I found it strange that he cited the risk of litigation."*

6.19 Another nurse from the LUTS clinic commented *"I had concerns that he was reluctant to prescribe at the LUTs clinic – he seems to have 'anybody but me'*

approach. He tends to request a review on patients which I believe meant someone else could then make the definitive decision on their management plan. He would concentrate on things like life style changes, if a patient drank 4 cups of coffee a day, he would suggest they drink 3 cups of coffee and then bring the patient back in a number of weeks to review, which in my opinion was a waste of an appointment. He was not a decision-maker."

6.20 The ward manager reported that she did have some issues with Dr [Personal Information redacted by the USI] writing up prescriptions incorrectly for intravesical Chemotherapy. She advised that "*after the first episode, we advised him of the correct procedure and forms on the ward; however he continued to prescribe the treatment on drug kardexs. We have a triplicate form which ensures 1 copy for pharmacy, 1 for the patient record and 1 for the nursing notes. Despite our advice he didn't comply with the ward policy so in the end we just bypassed him and asked one of the other doctors.*"

6.21 Dr [Personal Information redacted by the USI] responded to the comments provided by the nursing staff in relation to their prescription concerns. He advised "*I delegate prescriptions to junior doctors during ward rounds appropriately and I never shy away from prescribing myself in the ward or clinics. I always check the BNF when in doubt and encourage them to check if in doubt*". He stated further "*I take prescription very seriously. For example, a staff nurse rudely shoved a patient's kardex and said to me* [Personal Information redacted by the USI] *prescribe an anti-depressant for a patient because she said she is depressed. This patient was just weak from hypoprotenaemia. I told (the nurse) that I am not happy to prescribe an antidepressant on this patient. I shall discuss with her and if necessary get advice from psychiatrist because of her condition. When I discussed with the patient, she told me that she never told (the nurse) that she is depressed though she felt worn out. I then contacted the psychiatrist for advice but he was busy. Later the house officer got the Psycho geriatrician to see her. He thought it was inappropriate to give her anti-depressants and she did not feel she needed it. I kept on wondering why (the nurse) wanted me to prescribe antidepressants on a very weak elderly women. It is also not true that I don't prescribe medications when necessary. I always prescribe medications when necessary but I take into consideration safety issues.*"

6.22 In response to the concerns raised in the LUTS clinic, Dr [Personal Information redacted by the USI] advised "*when I started, the nurses in the Thorndale unit would want me to prescribe medications to every patient who comes in to the LUTS clinic. I found it strange and against*

established guidelines. For example, a.) I managed many young men in their 30s to 40s who came with lower urinary track symptoms. On assessing their symptomatology, I found that they take up to 3 litres of fluid or more in a day. In such circumstances, I avoid medications and start with life style changes like reducing total fluid intake and caffeine containing drinks. B.) There were some elderly patients with nocturnal polyuria whom I recommended diuretics or else I advise the time to take the diuretic if they are already on it. C.) There was a patient whose LUTS was associated with his chronic poor sleep and snoring. I referred him appropriately. In all this, I explain to the patients very well and involve them in the final decision. The above measures are also in line with established guidelines."

Multi-tasking, Prioritisation & Ward duties

6.23 Concerns were raised regarding Dr [Personal Information redacted by the USI] ability to multitask and prioritize on the busy urological ward in Craigavon. One consultant reported "*in terms of his management abilities, I have witnessed him getting flustered if he is doing something when he gets bleeped. I believe he struggles with multitasking and prioritizing patient management and what needs done first. I have seen him ask a nurse to answer his bleep for him when he is assisting with simple cases in Theatre. He doesn't seem to be keen to answer the bleep. In my experience in SpR training, you answer it and prioritize. If you have to stop a list and go to casualty, you do what you have to do.*"

6.24 Dr [Personal Information redacted by the USI] responded to this statement to advise "*When I am scrubbed up it is only prudent to ask a nurse who was not scrubbed to answer my bleep and take messages. This was also what my supervising consultant advised me to do in theatre. It is also risky to be answering myself when I am holding instruments inside patient's bodies in a situation where there was someone around to answer my bleep because of risk of injuries and infection. (This consultant) did not seem to be aware of an arrangement whereby on the day I work in the theatre my other colleague takes calls in the daytime and vice versa. This also confirms the issue of understaffing because if there a SHO/CT doctors, the middle grade doctor would have time to concentrate in his training in the theatre and clinic and would be called for serious cases and not for every single issue. (This consultant) was wrong for criticizing me about prioritizing and multitasking, because I have worked diligently in all situations. In fact, one notable time was when (this consultant) and another doctor were away during BAUS meeting in Glasgow at the end of June 2012. I multitasked myself and*

covered the department 8am to 8pm. It is unfair ignoring of my contribution to the departmental workload. Moreover, no amount of multitasking will compensate for certain degree of staff shortages."

6.25 The Urology registrar did report concerns about Dr [Personal Information redacted by the USI] He advised "*On occasions I knew he wasn't working during the day. If he had a free session, he would often be working on a project such as an audit when he should have been assisting with the many duties on the ward. I told him that was the type of work that should be done in his own time. He still made very little contribution to ward activities. He made a very limited contribution to the administration duties on the ward during the placement. I was told by one secretary that he had dictated on a total of 7 discharge summaries for the year whilst I am sure I have done approximately 200 for that consultant – that was the variance between us."*

6.26 Dr [Personal Information redacted by the USI] responded specifically to these concerns raised by the registrar. He stated this doctor "*was economical with the truth in his statement, when he said there were times when I was not working in the day. If he was truthful enough let him mention the day. The reality is that both of us covered the ward."* With references to the discharges, he stated *"(This doctor) did not state the truth when he said I made only 7 discharges. I did many discharges. I even made discharges on patients of a consultant that had left the hospital. This is despite the fact that I never had admin session until May 2012."*

6.27 Nursing staff reported that "*he struggled with running the busy ward. He would have left the ward round half way through if he had to be somewhere else leaving the nurses unclear about the arrangements for the completion of the round. He might have said he would try and come back later but may not have been possible. The unit is busy but all our previous registrars have been able to juggle the workload and participate as part of a team to ensure all the patients are seen and a decision taken"* Dr [Personal Information redacted by the USI] provided comments in response to these concerns from the nursing staff. He stated "*it is not true that my clinical decision-making is indecisive. I just work according to the guidelines and within the limits of my abilities. I keep my consultants abreast about decisions".*

6.28 The lead consultant advised "*on ward rounds, I understand that he is perhaps not quick enough in taking decisions and communicating these to the nurses, leaving*

them questioning management plans. He seems to have some difficulty in the day to day management of acutely ill patients and the ability to cope in these demanding circumstances. The urology ward is busy, often with competing demands on a doctor's time. I am aware he had difficulty multitasking when undertaking the ward round and ensuring the flexible cystoscopies are completed. Dr [redacted] *s slow when undertaking tasks so this makes this multitasking even more difficult for him. I would comment however that this is a challenging task with how patients are arranged for the flexible cystoscopies and we are looking at ways internally to improve the running of this, so this is not his fault."*

6.29 Another consultant commented that "*I am aware the nurses have complained that he had been slow and reluctant to make decisions and I have no reason to dispute that. When he first commenced his post with us in November last year, he could go off at 5.30pm, feeling that his day was done and didn't fulfill his role as a team player very well, which didn't help him with the staff on the ward. He has however improved in this regard, as he has realized he is in a training post and/or came to appreciate collective responsibility for patient care. The unit is busy which understandably brings additional challenges to doctors working in Urology. It is important to note that there are issues with managing inpatient care as it hasn't been given adequate priority in job plans or scheduling. There is no 'surgeon of the week' model in urology, so doctors are often juggling the ward work with other commitments and as we are a busy unit, this can be difficult for everyone including Dr* [redacted] *Dr* [redacted] *has tended to have a fixed view of what he should be doing and appears to have a limited ability to multitask and prioritize. I mentioned to him yesterday that I would see him at the M&M meeting and he wasn't aware of it. Although he has been here for some time to my knowledge, he hadn't been to M&M once. M&M meetings occur every month and* they are noted on the urology scheduling which are provided to all the doctors."

6.30 Dr [redacted] advised that he worked diligently during his post in the Urology department and performed the following tasks; ward rounds, attended to referrals and emergencies; ran the following clinics independently to the satisfaction of patients: LUTS clinic, Histology clinic, prostate cancer day 3 clinic, Haematuria clinic. He did flexible cystoscopy lists independently, attended the day surgery GA list and attended main theatre. Dr [redacted] advised that it was not possible to attend the cancer M&M because the work is busy and there is no SHO in the unit. He therefore

stated *"I managed to exercise multitasking and prioritizing within the limits of my ability. However the following factors were detrimental in my opportunity to take full advantage of the training."* Dr [redacted] listed the following factors as detrimental: It is a very busy department, there were obvious understaffing and he had encountered hostility.

Insight & Competency

6.31 The nursing staff reported significant concerns about working with Dr [redacted] Once stated *"In my experience (20 years as a nurse) he is one of the poorest Urology doctors working at this level I have come across in relation to organizational skills and decision making. I would have concerns about him dealing with acutely unwell patients and my concerns are such that I wouldn't want him looking after my relatives. I don't feel he is capable of independent working at SPR and would question his ability at SHO level."* Another nurse advised *"there hasn't been a day that one of the nurses hasn't had some concerns or mentioned something about Dr* [redacted] *practice. I don't believe that he was capable of working at registrar level. Right from our first ever registrar years ago, he is one of the worst we have had. If he had been appointed as an SHO, he would have been ok. However this is a very busy acute ward and we rely on our registrars to be experienced and at the level to take the decisions required and expected of them. It wasn't fair on him to work at this level in a very busy acute ward – as he just wasn't at this level."*

6.32 Dr [redacted] supervising consultant advised in his statement that *"Dr* [redacted] *is more confident than his ability or competency. I did speak to him before his RITA assessment and had a frank discussion about the stage of his development in his career. I believe that he has worked in several kinds of post, in several urological centres in the UK, for ten years or more. Despite these years of experience, I would say there is a degree of experience and competence almost non-existent in some areas. He has a very good knowledge base but that doesn't make a good doctor. I am not confident that he is adequately aware of the extent of his inadequacies in important aspects of his practice. He was certainly reluctant to acknowledge his role in the development of those inadequacies when I discussed these with him at an earlier time. I believe he is more insightful now, but not necessarily adequately so."* The other consultants provided similar comments in relation to his competence being best suited to SHO level.

6.33 The Postgraduate Dean in NIMDTA provided confirmation that Dr [redacted] attended an ARCP panel on 15 June 2012 which covered the training period of 21 November 2011 to 30 July 2012. He advised that the evidence concerning his training was reviewed by the ARCP panel and the outcome score was 7.3 which is inadequate progress by the Trainee. The consequences of this assessment is that he was not considered to have made sufficient progress during this training period for it to be formally recognized towards CCT or CESR. For the trainee to attain the desired competencies, he would be required to repeat this period of training. The Postgraduate Dean also reviewed the MiniPAT/MSF for this period looking specifically at Patient Safety. Six raters felt this was satisfactory and 1 rater felt this needed development. In the comments that might have potential for impact on patient safety, one rater described poor time management, lack of methodical process and decision making resulting in excessive outpatient reviews, a reluctance to prescribe medications and high expectations of the team around him.

6.34 Dr [redacted] responded to these comments to advise that he was surprised that he was not asked for the following record of training which he had brought with him; operative logbook; audit; case based discussions; procedure based assessment; direct observation of procedures; presentations; publications and teaching. He advised that he hadn't been aware of the multisource feedback results but was happy that 6/7 rated him well. He advised that he will reflect and learn from the unexpected comments from one of the raters,

6.35 Dr [redacted] also commented in respect of his competence "*I tried hard some time using my resources to build knowledge base in Urology. I always endeavor to attend courses, workshops, master classes, fellowships and performed audits. This is all to help me develop. I also endeavor to work within the limits of my competence and abilities and I look for help when necessary. I had told my consultants that I was brought up performing open operations in my initial training overseas and I have learned some endourology in Staff Surgeon's position in the UK. However there are barriers to development associated with staff surgeon's positions. That was why I tried and secured a training post to consolidate the experience and learn more skills in order to further develop and progress*".

6.36 Dr [redacted] also concluded that he had reflected on the issues at stake and was trying to recover his confidence in his new post and pursue measures to help him develop and progress.

Additional Issues raised by Dr [redacted]

6.37 Dr [redacted] has raised a sizeable number of concerning issues within the substantial written response he provided as part of the investigation. These new issues include counter allegations against some of the witnesses interviewed including accusations of bullying, harassments, intimidations, ignoring, blame shifting, malicious allegations, counter clinical concerns and implied allegations of discrimination (contempt for overseas doctors in general).

6.38 The Case Investigator noted that none of these concerns were formally brought to the Trust's attention during Dr [redacted] employment and appear only to have been raised after Dr [redacted] has left Trust employment. It therefore makes it extremely difficult for the case investigator to substantiate any of these claims at this stage. There was however no evidence gathered as part of the investigation which would indicate that the views or actions of the witnesses interviewed were in any way racially motivated. The Trust however will raise the issues raised by Dr [redacted] with the relevant witnesses for their consideration and response. Neither is there any evidence of similar accusations being made, investigated or substantiated within the 20 years history of this Urology Department.

7. Summary

7.1 Following this investigation, taking into consideration the information gathered through the witness statements and the response provided by Dr [redacted] it would be my view that Dr [redacted] was insufficiently skilled and experienced to work as an LAT in Urology in Craigavon Area Hospital. I am persuaded on the basis of the evidence that he is not adequately trained to a standard where he is competent to work at the same level as an SpR in Urology. There is ample evidence from the statements taken from a number of professionals that he had difficulties in many aspects of his work. There is no question that he had considerable knowledge but his clinical skills were underdeveloped for this level of post. Whilst he was appointed as a LAT at SpR level it was the view of Consultants and nursing staff that his skills were more aligned to those of a an SHO. It would appear that whilst he had years of employment in urological units on his CV this does not equate with a high level of training, expertise and skills. The job to which he was appointed does require the trainee/appointee to be capable of a degree of independent practice and to take on

responsibilities in line with the experience that would be acquired after several years of intense urological training. It would appear that Dr [redacted] relatively lengthy period in employment did not equate to this degree of training. It was inevitable, therefore, that there would be a significant gap between the expectations of the Department upon his knowledge and skills and what he was able to actually deliver in terms of day to day performance. It always takes a number of weeks or months before difficulties are apparent. One would not expect any alarms to be raised over a couple or indeed a cluster of incidents in anyone's period of employment. Rightly, it was only when a clear pattern emerged that these issues were then brought to the Trust's attention. The fact that a multiplicity of deficiencies were reported by a number of colleagues across the nursing and medical profession is highly supportive of this analysis. During the interviews with the witnesses I did not encounter anyone who felt that his skills and competence were those of a urological trainee working at SpR level. It is also notable that NIMDTA were also of the view that his performance in this post did not constitute a satisfactory period of training. It is noted that when he received the evidence Dr [redacted] has chosen to refute individually almost every accusation and observation. He has chosen to defend his actions by citing understaffing, over work and staff hostility for his observed inadequacies.

7.2 The more specific aspects of the complaints made against Dr [redacted] are discussed in detail in earlier parts of this report and referenced in the individual statements. Nonetheless it is reasonable to comment on the more important of these.

Operative Skills

7.3 It is clear that whilst Dr [redacted] knowledge base was extensive he did not have the training, competence or confidence to perform intermediate surgery unsupervised and his supervising Consultants did not have the confidence in his ability to allow him to carry out unsupervised surgery to any great extent in comparison with other trainees/appointees. I would not wish to question the individual details of specific operations and indeed I accept Dr [redacted] comments about the use of bipolar diathermy or marking pen for circumcision may be perfectly reasonable, however, I cannot ignore it was the view of his Consultant trainers in general that his operative skills were below par.

Flexible Cystoscopy

7.4 The nature of the post is such that the trainees would carry out flexible cystoscopies in a largely unsupervised environment. There were concerns raised from the nurses about over diagnosis and perhaps on occasions some technical difficulties with insertion of the scope. The latter observed by one of the trainers who chose to attend a flexible cystoscopy list. There may have been some degree of over referral to GA cystoscopy for minor lesions seen in the bladder. There is no evidence at this stage that there were significant lesions missed in the bladder however I have to note that if this was the case it may take a long time before that sort of evidence would come to light. It would appear again however, that the nurses, at least, had little confidence in his ability to perform flexible cystoscopy.

General Task Management

7.5 A number of the witnesses were concerned about Dr [redacted] ability to prioritize, multitask and simply to get through the work load. This is compounded by a perceived reluctance to make decisions particularly in respect of prescribing. Again Dr [redacted] may be able to cite one or two occasions when he may have been wise to deliberate over individual prescriptions, but undoubtedly there was a general impression that his attitude to prescribing tended to be deferral, delegation or avoidance. The Urology Department is busy and in small Departments there is no separation of emergency and elective work. It is therefore necessary for trainees to multi-task and prioritize work. During his employment in this Trust, Dr [redacted] was notably deficient in this area and again this is almost certainly as a result of inexperience in working at this level. Being as it was, on the basis of the evidence, I accept the views that he was out of his depth, unable to multitask and unable to prioritize tasks to an acceptable level and one which would gain the confidence of his colleagues, senior staff and nurses.

Attitude

7.6 There was at least one episode whenever Dr [redacted] interaction with a nurse was perceived by the nurse the patient and the relatives as being inappropriate. This appeared to have occurred during one of those days when Dr [redacted] was required to multitask and prioritize. His choice of words and attitude reflect his discomfort in this sort of situation.

Patient and Staff Complements and Citations

7.7 In 20 years as a working Consultant I have never seen documents like this before. I have not come across any clinician at any level commissioning patients to write complements or asking staff to sign citations. When patients are pleased with a doctor's treatment they may choose to send a complement in the form of a card or letter. Staff tend to reflect their views either verbally, or in writing when invited to participate in a training assessment. It is my view that citations and complements collected in this way are inappropriate, very unlikely to be accurate and suggest that the doctor was already preparing his defense ahead of any accusations of inadequacy or incompetence. This behavior may to some extent have been a product of his past experiences, to which he referenced during our meeting.

7.8 In conclusion therefore it would appear that Dr [redacted] was appointed to a post in which he was not competent to perform to the level of expectation required of him despite his experience in other Urological/surgical units. He had acquired a lot of knowledge but had not developed in terms of skills, competence. He is capable of working at SHO Level under supervision but is not competent to working as a trainee in a busy urological unit and in any degree of unsupervised practice.

7.9 I was aware from meeting with Dr [redacted] that there are issues from the past which were investigated by the GMC. I have chosen personally not to read any of this documentation and only to assess this doctor on the evidence that I have collected and on Dr [redacted] response. I therefore remain unbiased with respect of what has gone before and only wish to draw my conclusions from the period of time when he was employed within the Southern Trust. I am advised that the GMC have requested to be kept informed of the outcome of this investigation and I am therefore recommending that this report should be referred back to the GMC. Alternatively, had the doctor been a permanent employee and remained in Trust employment, I would have recommended that a formal referral to NCAS was made and agreement sought to agree a way forward.

8. Conclusion & Action following Doctors Resignation

8.1 Dr [redacted] temporary contract expired on [redacted]. In line with paragraphs 7-9 of Section VI of MHPS, when the termination of employment occurs when procedures are unfinished, the Trust has an obligation to take the investigation to a final

conclusion and performance proceedings must be completed wherever possible, whatever the personal circumstances of the employee concerned. The Trust has made every reasonable effort to ensure Dr [redacted] remained involved in the process. Dr [redacted] has also cooperated well with this investigation process.

8.2 The Trust is required to conclude the processes in so far as possible and then, taking account of Dr [redacted] comments, to make a judgement as to whether the allegations are upheld. If so, the Trust (Case Manager / Oversight Group) must take appropriate action such as referral to the GMC and requesting the issue of an alert letter. As the GMC is currently investigating Dr [redacted] it was always highly likely that all relevant information would need to be shared with them.

8.3 On the basis of this investigation, the case investigator believes the allegations are upheld and as such had Dr [redacted] still been in Trust employment would likely have warranted further investigation/action. Therefore it is recommended that the Case Manager considers referring this report to the General Medical Council and issue an alert letter as per the above procedures.

[redacted]

Mr R Brown MD FRCS

Case Investigator – Consultant Surgeon Clinical Director

Strictly Private and Confidential

Southern Health and Social Care Trust

Screening of Concern

Concerns re Locum Consultant Urologist engaged via Agency

Clinical Manager: Mr Mark Haynes
Associate Medical Director

1. INTRODUCTION

Dr [redacted] is engaged as a Locum Consultant Urologist from [redacted], via NC Healthcare Locum Agency. The contact in his agency is [redacted] His GMC Number is [redacted] His designated Body is [redacted] and Responsible Officer is Dr Francis O'Kelly.

2. DETAILS OF THE CONCERN

Following a meeting on Wednesday 2nd September 2020 and Friday 4th September 2020, the following concerns were discussed with Mr [redacted]

1) [redacted]
Attended South Tyrone Hospital for flexible cystoscopy for haematuria, having had a CTU prior to attendance. CT reported left ureteric stones and hydronephrosis. Attendance letter comments that the CT Urogram showed '…no any malignancy proven in the upper part of her urinary tract' no comment is made on the presence of ureteric stones, and she was discharged back to the care of her GP.
Your response;

- Acknowledged that the scan report must have been looked at given comment in letter.
- Initially suggested that as you had not requested the scan you should not have been expected to look at and action the result.

Concerns;

- CT report apparently not read and incorrect information and advice given to patient and GP.
- No treatment considered for ureteric stones.
- Risk that had this scan result not been checked by me ureteric stones would have gone un managed risking future renal loss.
- Initial response re responsibility of accessing results relevant to the attendance below expectation of a consultant urologist.
- Reduced confidence in the urology service provided by Southern Trust when the mistake is notified to the patients GP.

Action undertaken;

- I have contacted the patient, apologised and organised appropriate management.

Action required;

- Written reflection on case for appraisal / revalidation.

2) Personal Information

Attended for flexible cystoscopy for investigation of haematuria. Letter states '…On the top of the bladder it is not possible to look carefully through because light source is very weak and it is not possible to see.'. No plan for FU is made.

Your response;

- Acknowledged that the letter is inadequate.
- Stated that you had read and corrected all letters, although apparent that this had not been done for this case.
- Initially suggested that appropriate outcome would be GA cystoscopy and biopsy of lesion at bladder base commented on in CT report.

Concerns;

- Attendance outcome letter demonstrating an apparent lack of consideration of further management requirements at time of procedure.
- Concern that despite your insistence that you had corrected all letters, this letter had not been amended, or a second letter containing appropriate arrangements sent, and remained as the only attendance letter visible on ECR.
- Receipt of this letter by GP will reduce confidence in patients receiving adequate care when attending the urology team.
- Your subsequent suggested plan of a GA cystoscopy to biopsy the CT finding at the base of the bladder failed to recognise that you had stated that the only area where inadequate views were obtained was the dome (top) of the bladder, and appearances of the base are therefore presumed to have been satisfactory. This would have exposed the patient to the risks of a potentially unnecessary general anaesthetic.
- Had this letter not come to my attention, a patient with haematuria who had undergone inadequate assessment would have been discharged when in a worst case scenario a bladder cancer could have been missed resulting in treatment delay.
- Both the initial outcome and subsequent plan when brought to your attention are below the standard of management expected of a consultant urologist.

Action undertaken;

- The patient has been contacted and review with me and repeat flexible cystoscopy at the time of attendance arranged.

Action required;

- Written reflection on case for appraisal / revalidation.
- Review of all consultation letters to ensure no further similar cases.

3) Personal Informa

Emergency admission with renal failure, sepsis and ureteric and bladder stone on CT. Emergency theatre, despite abnormal retrograde (hydronephrosis), presence of only one stone in the bladder (noted on CT report in addition to the ureteric stone), eGFR 36 and sepsis no stent inserted. Patient required second GA to insert a stent. Regarding bladder stone not able to use the stone punch, decided not to get the laser to treat the bladder stone and finish procedure. Initially recorded on operation note that procedure couldn't be completed because '…the staff did not find appropriate stone punch to do it.'. Amended operation note when requested by nurse in charge.

Issue; Operation note suggests that the assumption was made that because a stone was seen in the bladder the ureteric stone had passed, despite the CT findings of 2 stones and only one stone being in the bladder. Decision to abandon procedure (not treat bladder stone) despite alternative equipment being available a concern. Failure to stent a patient with hydronephrosis, sepsis and renal failure a major concern and patient subsequently required a second GA to insert a stent.

Your response;

- Did not acknowledge that surgical management was substandard.
- On questioning admitted that you do display scan images in theatre at the time of treatment, despite the ability to do this being available.
- You concluded, and in discussion continued to be of the opinion that the presence of a stone in the bladder and a retrograde ureteropyelogram not demonstrating a stone (although clearly showing hydronephrosis), meant that the 22mm upper ureteric stone had passed.
- You abandoned the cystolitholapaxy because you could not treat it with the stone punch provided and when offered alternative, appropriate equipment elected to refuse and terminate the procedure stating that ''it was already late and it would have taken time to get laser'.
- You acknowledge what you had stated in the operation note and had subsequently amended the note.
- In discussion I have concerns that you failed to recognize that CT report had shown a stone in bladder and an upper ureteric stone, and therefore in a patient with hydronephrosis, sepsis and renal failure the ureteric stone should have been assumed to be present.

Concerns;

- Abandoned procedure (to treat bladder stone)and reasoning behind this is inadequate and below expectation of a consultant urologist.
- Entry in operation note inaccurate when compared with your explanation of decision making and attempts to 'blame' other members of the team for the abandoned procedure. Only amended upon request by the nurse in charge. Behaviour not in keeping with expectation of consultant urologist and not

consistent with effective team working. No insight into this entry being inaccurate or inappropriate in our discussions.

- Failure to recognise that CT had shown 2 stones, one in the ureter and one in the bladder, and that the presence of only one stone in the bladder should have led to an assumption that the 2nd ureteric stone remained present.
- Apparent lack of recognition of the poor sensitivity of Retrograde ureteropyelogram in identification of stones.
- Failure to de-obstruct a patient with hydronephrosis despite the presence of renal failure and sepsis. This is below the standard of care expected of a consultant urologist.
- Patient required a 2nd general anaesthetic exposing the patient to addition risks.

Action undertaken;

- The patient has been appropriately managed and has appropriate ongoing follow-up planned.

Action required;

- Written reflection on case for appraisal / revalidation.

4) Personal Inform

Emergency admission with renal failure and bilateral ureteric obstruction. Unilateral ureteric stent in situ. Proceeded to emergency theatre for attempt at ureteric stent which failed. Transferred to Belfast City Hospital for nephrostomy and subsequent transfer back to Southern Trust. 2nd emergency theatre attendance for TURBT which was performed. EUA (Pelvic examination) performed at end of procedure identifying pelvic mass and vesicovaginal fistula. EUA not performed at initial GA cystoscopy. My recollection is that the EUA occurred on the 2nd operation only when I entered theatre and asked if it had been done and performed it. Your recollection is that you did it without any input from me.

Your response;

- Did not acknowledge that an EUA (pelvic examination) was indicated in a patient undergoing a GA cystoscopy and attempted stent for ureteric obstruction as a standard part of the procedure.
- Stated that the difficulty with performing the cystoscopy was due to a small capacity bladder.

Concerns;

- Omission of an EUA in the initial cystoscopy falls below expectations of a consultant urologist.
- Continued inability to recognise that the bladder capacity was not limited, but that a vesicovaginal fistula resulted in the bladder not filling.
- Diagnosis may have been made earlier had an AEUA identifying the VVF and pelvic mass been performed at the first operation

Action undertaken;

- The patient has been appropriately managed and has appropriate ongoing management planned.

Action required;

- Written reflection on case for appraisal / revalidation.

5) Personal Information

Emergency admission with sepsis and obstructed kidney, required emergency theatre for attempted ureteric stent insertion. Sent for theatre when emergency theatre available (after completion of general surgery case), patient arrived but at same time anaesthetic and nursing team called to resus and maternity to attend to 2 additional emergency situations. Patient sent back to ward. Procedure took place later that night once anaesthetic and nursing staff were available. Entry made in notes by you states '…they refused and sent the patient back to the ward.'

Your response;

- Acknowledge that your entry in the notes was made at the time.
- Stated that you put the entry in the notes to cover yourself in case the patient came to harm.
- Did not recognise or accept that your entry in the notes did not reflect the reality of the staffing difficulties faced by the team managing two life threatening emergencies in other areas in the hospital ie the staff did not 'refuse' anything.

Concerns;

- Entry in the notes was not an accurate reflection of the reasoning / decision making behind the delay in the patients emergency theatre procedure.
- Your response did not illustrate any insight into the impact of competing emergency workloads on the capacity to provide emergency treatments, in particular in the out of hours period.
- Your response did not illustrate to me any insight into what the impact of such an inaccurate entry in the notes would have on the individuals involved in the care of the patient.
- Overall concern from both the documented notes, and the discussion about your ability to effectively work as a consultant urologist within a team.

Action undertaken;

- None.

Action required;

- Written reflection on case for appraisal / revalidation.

6) Personal Information

Patient with small renal mass on surveillance who had undergone a CT in November 2019 showing an increase in size of the renal cancer. Passed through to MDM and a letter also sent to the GP suggesting a follow-up CT in a further 12 months (22months after CT Nov 2019).

Your response;

- Acknowledge that the patient was appropriately referred to the MDM.
- Did not recognise the difficulty posed with regards the letter suggesting a follow-up CT.

Concerns;

- The letter to the GP suggesting a followup CT in 12 months, and 22 months after the CT scan is not appropriate management of an enlarging renal cancer and should not have been sent (no action should have occurred until after the MDM meeting.
- Receipt of this letter by GP will reduce confidence in patients receiving adequate care when attending the urology team.

Action undertaken;

- Patient has been discussed at MDM and appropriate follow-up and management arranged.

Action required;

- Written reflection on case for appraisal / revalidation.

3. RESPONSE TO CONCERN(S)

All the detail of the above concerns were shared with Mr Personal Information - Irrelev He was advised that clinically the standards of care provided fell below the level required of a consultant urologist, which exposed the individual patients to unnecessary risks. As a result of these concerns The Trust would not continue with the locum employment and his contract was terminated with his agency contract with immediate effect.

4. SCOPING OF CONCERN – CONCLUSION

In line with our procedures for managing concerns involving Agency Locum doctors, we have completed our preliminary enquiries and sought the opinion of the doctor. These concerns have resulted in an early termination of a locum agency contract with immediate effect. As our concerns are with regard to clinical decision making (which is below the standard expected of a consultant urologist) the detail of our concerns must be shared with Mr Personal Information - Irrelevant Agency and Responsible Officer.

We would ask that Mr Personal Information - Irrelevant Responsible Officer **Dr F O'Kelly** to urgently consider and investigate these findings to ensure no further risk to patient safety.

Parks, Zoe

From: Haynes, Mark [redacted]
Sent: 31 May 2019 09:08
To: OKane, Maria; Gibson, Simon
Cc: Khan, Ahmed; Hynds, Siobhan; Toal, Vivienne; Parks, Zoe; Montgomery, Ruth
Subject: RE: Action notes from meeting 24-4-19
Attachments: RE: Urology (176 KB); FW: Urology (11.3 KB)

Morning

RE Job Plan;
Mr O'Brien does not have a signed off job plan. Discussion have occurred and the job plan has been 'awaiting doctor agreement' since November 2018. I am second sign off and so would not be requested to sign it off until he and his CD have signed it. I have requested an update on the process from the relevant CD.

RE 2017 action plan;
I am currently not in a position to provide the reassurances requested. I was not party to the action plan at it's inception and have only recently been made aware of it's contents. Having been made aware of it's contents, I am aware of instances where the actions regarding Concern 1 have not been met (see attached emails), specifically;

'…triage of all referrals must be completed by 4pm on the Friday after Mr O'Brien's Consultant of the Week ends. Red Flag referrals must be completed daily.'

Given that I am aware of aspects of the action plan not being met, I am concerned to see the statement that there have been 'no exception reports flagged to case manager'. The implication being that either there has been an agreed deviation from the action plan and monitoring is now occurring against different standards, or that the monitoring and / or escalation process has not functioned as it should.
As I was not party to any of the previous discussions, if I am to become part of this I need an initial briefing with all and also some run through of monitoring to date. Through this briefing I need to understand the process as it is at present, and how, despite evidence that there appear to have been 'exceptions', the reporting process appears to have failed to flag these to the case manager.

Mark

From: OKane, Maria
Sent: 30 May 2019 18:06
To: Gibson, Simon
Cc: Khan, Ahmed; Hynds, Siobhan; Toal, Vivienne; Parks, Zoe; Montgomery, Ruth; Haynes, Mark
Subject: RE: Action notes from meeting 24-4-19

Thanks Simon.
- Ahmed or Mark as his AMD should seek regular assurance rather than me and then inform the MDO
- AOB is still undertaking assessments at private clinic at home as per the requests to sign off on transfers from private to public practice. I brought this to the attention of urology. We have asked for a rationale as to why the GMC has suggested this practice is stopped before this is progressed – please explore with them Simon.

Regards, Maria

Dr Maria O'Kane
Medical Director
Tel: [redacted]

From: Gibson, Simon
Sent: 30 May 2019 13:25
To: OKane, Maria
Cc: Khan, Ahmed; Hynds, Siobhan; Toal, Vivienne; Parks, Zoe; Montgomery, Ruth
Subject: RE: Action notes from meeting 24-4-19

- Conduct panel delayed pending grievance hearing

- Grievance hearing delayed pending further information being requested – **Siobhan Hynds to clarify from Vivienne Toal what this information is**
  Siobhan Hynds is gathering this information under the auspices of MHPS. It was noted that this will take significant time to gather.

- GMC have requested further information – response will be that we have no specific written information/document from AOB **Simon Gibson**
  Response was provided – GMC written again seeking clarification. Siobhan Hynds to draft response

- Working from home – clarification from Joanne Donnelly as to whether this is still required **Dr O'Kane**
  Dr O'Kane wasn't at the meeting to provide an update on this

- Discuss with Shane with regard to organisational review **Dr O'Kane**
  Dr O'Kane wasn't at the meeting to provide an update on this

- Need to seek assurance from Acute **(Dr O'Kane)**:
  - Is there an agreed job plan Simon to check with Mark Haynes on behalf of Dr O'Kane
  - Is the 2017 action plan being followed – and all monitoring arrangements in place Siobhan Hynds reported that Martina Corrigan is ensuring monitoring arrangements are still in place, with no exception reports flagged to case manager. It was agreed that the Case Manager should periodically seek this assurance.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by USI
Personal Information redacted by USI
Personal Information redacted by USI (DHH)

Confidential

Action plan for

Dr

At the request of:

Southern Health and Social Care Trust

1.0 ABOUT THIS PLAN

This action plan has been prepared by Practitioner Performance Advice under case number xx in response to a request from Southern Health and Social Care Trust ('the Trust') for a remediation action plan. The request was received on xx

It is expected that Dr xx and the Trust will:

- agree that in **taking forward this action plan, patient and staff safety and public protection must remain the paramount concerns.** This may mean enhancing supervision levels, slowing progress through the plan or taking other actions to protect safety if required
- discuss the proposed activities
- amend these as appropriate to suit local circumstances and available resources
- agree the final version of the action plan
- recognise that the final action plan represents an agreement between Dr xx and the Trust
- treat this action plan as a living document and update it in response to progress made and the case circumstances, so that it remains focused on the needs of patients, the service and Dr xx development needs.

2.0 AIM

The overall aim of this action plan is to support improvements in Dr xx communication, team-work and leadership skills and assure the Trust of his safe and effective practice at the level expected of a xx

The programme should also support his proposed supervised return to the full range of expected clinical duties at the xx hospital site.

This action plan describes the activities, experience, and support required to facilitate its successful completion. It identifies the evidence required at agreed formal review points to demonstrate the progress required to meet the action plan objective.

It is expected that on completion of this action plan Dr xx will be consistently practising to a satisfactory standard.

3.0 TIMESCALES

It is expected that the objectives of this action plan will be completed within xx months of the implementation date.

Implementation date:

Target completion date:

4.0 ACTIONS

The actions required by the Trust to begin implementation of the plan are set out below:

The Trust should appoint a programme manager to lead on the action plan and to be accountable for its implementation, progress and outcome. To support the implementation of the plan, the programme manager should appoint a clinical supervisor (referred to as supervisor throughout), and agree the appointment of a mentor. Consideration should also be given to the use of a coach experienced in developing communication skills, which may be particularly useful in supporting Dr xx development.

Levels of required supervision can be varied for individual activities throughout the plan (dependent on progress). Due to the uncertainties created by the Covid-19 pandemic, it might be that Dr xx will not be able to treat enough patients to complete the objectives within xx months. Therefore, the plan should be sufficiently flexible to allow Dr xx to address areas of his practice through the presenting patient mix, and address the other areas of practice as and when the patient mix returns to a more usual range and level.

Changes to the timings and structure of the plan should be considered as part of Dr xx regular review meetings and at each formal review within the plan.

Any decisions about the ongoing management of the case rest with the Trust, although Practitioner Performance Advice will provide ongoing impartial advice if this is requested.

4.1 ACTIONS FOR DR XX

To support the achievement of the objective, Dr xx should:

- take ownership of this action plan and engage with the available support (supervisor, coach, mentor) to achieve the agreed objective.
- complete each of the development activities described in the action plan, including workplace based assessments (WPBA), and maintain a reflective learning log.
- meet with the agreed mentor a minimum of monthly.
- work with the appointed coach on a regular basis (frequency to be determined by the coach) and reflect on this activity in a learning log. Discussions should include how to apply new strategies developed through coaching. Dr xx should consider sharing the Practitioner Performance Advice Behavioural Assessment (BA) report (or at least the areas for development highlighted) with the coach to inform coaching sessions.
- work with the appointed supervisor to assist in learning from reflection and effecting practical change in practice.

Reflection on progress at regular intervals throughout the programme is essential to support development, guide next steps, focus learning opportunities, and assist the supervisor in directing feedback. Dr xx should provide the supervisor with a minimum of two recorded reflections (from the learning log) on activities completed each month throughout the programme.

Note: In line with current guidance, all details of those involved in a recorded event – including patients, their relatives, and colleagues – must be fully anonymised. In addition, precise locations, dates and times should not be specified. See the Reflective Practice Toolkit for further information:

5.0 ABBREVIATIONS USED IN THIS ACTION PLAN

Professional Activities	CPD	Continuing Professional Development
Workplace based assessments (WPBA)	CbD	Case-based Discussion
	SbD	Scenario-based Discussion
	A-CEX	Clinical Evaluation Exercise
	MSF	Colleague Multi-source Feedback
Regulators, professional bodies and other organisations	GMC	General Medical Council
	RCo	Royal College
	BMA	British Medical Association
	MPS	Medical Protection Society
Reference documents	BA	Behavioural Assessment (report)
	GMC 'Generic Professional Capabilities Framework'	https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/generic-professional-capabilities-framework

6.0 OVERARCHING INTERVENTIONS TO SUPPORT THE ACTION PLAN

Before commencing this action plan, the Trust should take account of any health issues that potentially may have an impact on Dr xx progress and/or the success of the programme.

Prior to commencing the objective below, Dr xx is expected to meet with the programme manager and supervisor to confirm his job plan and agree any amendments needed to meet the additional requirements of this action plan (e.g. protected time for learning, development and observation of colleagues).

At intervals within the objective, **formal reviews** should be completed. At the agreed intervals, the supervisor is responsible for reviewing all the available evidence and providing a written report to the programme manager. A progress report template is provided for this purpose.

The progress report should indicate whether sufficient progress has been demonstrated, whether the objective has been achieved or whether additional support and/or interventions are required. The outcome of the review should inform the decision by the programme manager to continue with the plan as written, amend it or take alternative action, including management actions where required.

6.1 COACHING AND MENTORING

Coaching

A coach should help Dr xx reflect, develop self-awareness, set goals for change and work towards these goals. A coach may have a psychology background but can also be a clinical colleague with relevant training and experience.

The frequency and content of meetings should be determined by the coach, with input from Dr xx and his supervisor. Dr xx may wish to work with his coach to develop strategies for use in the work place in areas such as **communication, team- work and self-reflection**, as well as other areas highlighted in the BA report.

Mentoring

Dr xx should meet with a mentor separately for the duration of the plan (and beyond, if deemed useful).

He should work with both his supervisor and mentor throughout this reskilling programme to incorporate any learning into his daily practice.

6.2 OBJECTIVE

The areas for development identified by the Trust (with reference to the BA report) in their request for an action plan have been grouped into one objective shown in the table below:

Objective	Description	To be achieved within
1	**For Dr x to consistently demonstrate effective communication, leadership and team-work skills at the level expected of a xx, to facilitate a safe return to the full range of his clinical practice (including unscheduled/on-call work), with a specific focus on:** • **effective multidisciplinary and inter-professional team working** • **clinical judgement and understanding the value of shared decision making** • **situational awareness, including how his own style of communication and team interaction may impact on others, as well as the delivery of patient care** • **responding to challenge and managing unexpected or stressful scenarios** • **developing insight and the ability to learn from and reflect on his personal behaviour and professional practice.**	**9 months**

6.3 ACTION PLAN SUMMARY TABLES

6.3.1 SUMMARY TABLE A:

The table below sets out the frequency and timing of activities to be undertaken by each contributor to the action plan each month. The clinical supervisor may not participate in all the activities listed, but may provide support and feedback only.

Who	[redacted]	Practitioner									
	Supervisor								Programme Manager	Practitioner	Coach	Mentor
What / Month	Progress Report	Supervision: Direct	Supervision: Indirect	Supervision: Ad-hoc	Review Meeting	CbD	A-CEX	MSF	AUDIT- tbc	Formal Review	Reflection	Meet with Coach	Meet with Mentor
1		✓			4	2	2				2	Frequency to be determined by the coach	2
2		✓			4	2	2				2		2
3	1	✓			4	2	2			1	2		2
4		✓	✓*		4	2	2				2		1
5		✓	✓*		4	2	2	1			2		1
6	1	✓	✓*		4	2	2			1	2		1
7		✓	✓*	✓*	2*	2	2		1		2		1
8		✓	✓*	✓*	2*	2	2				2		1
9	1	✓	✓*	✓	2*	2	2			1	2		1

6.3.2 Summary table B:

The table below sets out the key activities that are expected to take place each month of the plan.

Month / Activity	1	2	3	4	5	6	7	8	9
Supervision	Direct			Direct/ Indirect*			TBC		
Review meeting with supervisor	4	4	4	4	4	4	2*	2*	2*
Coaching sessions	Frequency to be determined by the coach			Frequency to be determined by the coach			Frequency to be determined by the coach		
Mentoring sessions	2	2	2	2	2	2	1	1	1
CbD	2	2	2	2	2	2	2	2	2
SbD	2	2	2	2	2	2	-	-	-
A-CEX	2	2	2	2	2	2	2	2	2
MSF	-	-	-	-	1	-	-	-	-
Audit - TBC	-	-	-	-	-	-	1	-	-
Formal reviews			①			②			③

OBJECTIVE 1:

For Dr xx to consistently demonstrate effective communication, leadership and team-work skills at the level expected of a xx, to facilitate a safe return to the full range of his clinical practice (including unscheduled/on-call work), with a specific focus on:

- **effective multidisciplinary and inter-professional team working**
- **clinical judgement and understanding the value of shared decision making**
- **situational awareness, including how his own style of communication and team interaction may impact on others, as well as the delivery of patient care**
- **responding to challenge and managing unexpected or stressful scenarios**
- **developing insight and the ability to learn from and reflect on his personal behaviour and professional practice.**

The roles of the coach and the mentor are of particular importance to this objective to support Dr xx in developing and maintaining positive and effective communication skills. It is essential that Dr xx recognises the value of engaging in developmental activities (including self-reflection) to improve his day-to-day practice.

Dr xx should make effective use of his contact with his mentor and coach to explore difficult situations that may arise, or have previously arisen, such as professional differences or communication breakdowns. Through relevant WPBAs, Dr xx should act upon constructive feedback about his communication skills as well as his approach to team work (in particular relating to working in collaboration with relevant MDTs).

It is important that Dr xx commits to maintaining a comprehensive reflective learning log for the duration of this programme, to assist his self-reflection and note learning points, as well as how these learning points are applied within his practice.

Dr xx is expected to share this log with his supervisor for discussion during regular review meetings.

As the plan progresses, Dr xx is expected to demonstrate consistently positive communication and leadership skills across the range of his practice and in all interactions with colleagues, as well as patients.

The frequency of feedback sessions and number of WPBAs may be reduced once satisfactory practice has been demonstrated - but only after review and agreement by the supervisor and the programme manager.

Should Dr x demonstrate satisfactory practice consistently in the early stages of this plan, and the supervisor and programme manager are assured of sustained safe practice, they may decide to sign off this objective as complete earlier than the suggested x months. An ongoing review of sustained satisfactory practice should be carried out via the usual appraisal process (or equivalent).

It is essential that Dr x demonstrates consistent safe and effective practice for an appropriate amount of time before being considered for inclusion on the on-call rota

Months 1 to 3

- At the start of this action plan, Dr x should re-visit the areas identified for development in the BA report and consider how he intends to approach these, working closely with his supervisor, mentor and coach.
- As part of his proposed return to xx Hospital, Dr xx should re-familiarise himself with local protocols, care pathways and expectations relating to team-work, and should be demonstrating a commitment to involving his colleagues in decision making on all occasions where it would be appropriate, as well as fully engaging in team processes to ensure safety.
- Developmental activity already undertaken since the BA report was issued (such as CPD/online learning, shadowing of colleagues, and feedback obtained following observation of his practice) should be noted in his learning log, including reflections on how he has applied, or intends to apply, this learning in his daily practice.
- Dr xx should work closely with his supervisor, mentor and coach to identify relevant new CPD and development activities to support this action plan. Focus should be given to developing self-awareness, understanding pressure/stress and how it is likely to impact his own behaviour, and the importance and value of considering others' opinions, especially where they may differ from his own. Various online courses and workshops are available from professional organisations such as the GMC, BMA, MPS, RCoA (e.g. RCoA 'Anaesthetists' Non-Technical Skills (ANTS) course), as well as reading suggested in the BA Report ('The rules of EQ' by Yueng R).
- Dr xx should observe his supervisor (and peers') interactions within teams, focusing on their approach to style of communication and any specific techniques utilised. Dr xx should take note of any unusual or difficult interactions, and how approaches were adapted accordingly. Dr xx should proactively compare his supervisor's practice with his own, and make any adjustments to his own approach to communication in order to strengthen his performance in this area.
- For the duration of this plan, Dr xx is expected to take full advantage of his sessions with his coach and mentor in identifying different communication strategies and techniques, including alternative ways of phrasing his suggestions and/or directions to colleagues, depending on the context. He should use this opportunity to further develop his insight into (often unintended) consequences of being direct/authoritative, as well as the potential benefits of adopting a more sensitive style of communication, and the value of building effective team-working relationships (in the longer term).
- In months 1 to 3, as part of his weekly meetings with his supervisor, Dr xx should undertake SbDs relating to potentially difficult scenarios and non-routine cases in terms of his clinical decision making and interaction with colleagues (e.g. management of patients with difficult airways that may necessitate an unexpected change in plan after the commencement of anaesthetic). This should assist him in reflecting on his approach to collaborative team work, and ensure he is aware of local protocols and expectations.
- Dr xx should complete regular CbD with his supervisor (minimum every 2 weeks to explore how he works with the team to promote collective decision making.
- A-CEX will also be useful in providing Dr xx with constructive feedback relating to his team communication, ability to cope with problems, his delivery of post-procedure instructions/handover and his professional standards.

- In addition to his one on one development work, it would be useful for Dr xx to take part in a series of small group discussion sessions. As outlined by his supervisor, these sessions would provide a good opportunity for Dr xx to outline his proposed approach to a set clinical problem, actively listen to and consider others' suggestions in the group, and collectively reach a consensus/plan of action, as a team. Learning points from these sessions should be included in Dr xx reflective log.
- Dr xx should be aiming to foster and maintain effective working relationships with colleagues. Progressively, he is expected to demonstrate his ability to achieve the standards set out in the GMC's 'Generic Professional Capabilities Framework' in terms of his team-work skills, for example, his consistent ability to:

    - demonstrate effective multidisciplinary and inter-professional team working
    - appreciate the roles of all members of the multidisciplinary team, and demonstrate respect for and recognition of the roles of other health professionals
    - listen to and consider opinions and/or concerns expressed by his colleagues in a positive and open way
    - demonstrate an ability to learn from and reflect on his personal behaviour and professional practice and accept constructive and appropriately framed criticism
    - develop situational awareness, including how his own style of communication and team interaction may impact on others, as well as the delivery of patient care
    - demonstrate appropriate insight into the limitations of his practice and the value of utilising the skills and expertise of colleagues, particularly those from other relevant specialties, depending on individual case circumstances
    - ensure continuity and coordination of patient care through the appropriate transfer of information/handover.

- Dr xx supervisor should consider whether it would be appropriate for Dr xx to shadow some unscheduled/on-call sessions. Dr xx should take steps to observe and reflect on how his colleagues interact with the wider team in assessing and managing patients (particularly during busy on-call sessions), and note local expectations and protocols.

Formal review ①

It may be possible for Dr x supervision level (and frequency of WPBAs) to be reduced. Any such decisions should be carefully managed by the supervisor (and programme manager) with due regard to progress demonstrated

Months 4 to 6

- By this stage of the programme, Dr xx should be consistently demonstrating his ongoing commitment to communicating professionally with his colleagues, seeking out practical solutions/new strategies to avoid potential communication breakdowns or ineffective team work.

- Dr X should continue to revisit the GMC's 'Generic Professional Capabilities Framework' to ensure that ongoing WPBAs and other development activities are linked to these standards and expectations.
- Working with his coach, mentor and supervisor, Dr xx should reflect on scenarios where he has felt under pressure or challenged, and how that may have impacted on his interaction with colleagues, particularly in terms of his style of communication. He should use his learning log to consider how he might more appropriately respond to such scenarios, to promote shared decision making and effective delivery of patient care.
- During his elective practice, Dr xx should ensure he communicates any changes to intra-operative plans/processes clearly to the team (including expectations for assistance) and responding to and managing unexpected scenarios in a calm and professional manner. Any ongoing issues or complications should be discussed openly in support of a constructive outcome.
- Depending on development progress and any review/amendment of Dr xx GMC conditions, it may be appropriate to increase the range of Dr xx clinical responsibility. This may include further involvement in the on-call (e.g. observing unscheduled/emergency cases, then presenting a full description of how he would have responded to/managed each patient (with a focus on his collaboration with relevant colleagues), either to the consultant on-call, or during his ongoing CbDs. It is important that Dr xx supervisor (or supervising consultant on-call) provides him with constructive and comprehensive feedback on his decision-making, leadership and team-work, identifying any areas for development.
- Ongoing WPBAs (including a MSF exercise in month 5) should offer Dr x the opportunity to demonstrate positive developments in his communication, team-work and leadership. It is important that Dr xx responds to feedback from WPBAs in a positive and reflective way, and should consider, alongside his coach and mentor, any additional strategies or learning that may support him during the remainder of this action plan.
- As a consultant, Dr xx should be setting an example to the team, demonstrating leadership in this aspect of ongoing professional engagement and personal development.
- As the plan progresses, Dr xx should apply relevant strategies and other learning through coaching and mentoring to his daily practice.

Formal review ②

Months 7 to 9

- Dr xx should reflect on feedback from the formal review, as well as the findings of the MSF. Dr xx is expected to self-assess progress and any areas for improvement relating to this area of his practice, record these and discuss with his supervisor, mentor and coach. (This should include noting steps taken by Dr xx to address areas for development identified through these exercises.)
- Dependent on any ongoing GMC conditions, it may be appropriate to further expand Dr xx role and responsibilities relating to on-call work (e.g. Dr xx might begin to manage on-call work but with pre-planned agreement on the method and

circumstances in which he would be expected to make contact with a named colleague for immediate input or advice).

- Ongoing CbDs (and other WPBAs as required by his supervisor) should indicate that Dr xx is routinely involving the MDT in decision making and that he is working collaboratively with his colleagues, demonstrating appropriate leadership behaviour and an ability to adapt his behaviour to improve engagement and outcomes.
- Dr xx should explore, with his supervisor, if it would be appropriate to undertake a future audit in relation to his unscheduled/on-call work (e.g. outcomes, complications or other quality indicators), and begin collecting data, for completion of the audit in month 7.
- By the end of this action plan, Dr xx should have demonstrated and maintained improvements in his communication and leadership and should be practising at the level expected of a Consultant, meeting the requirements of the GMC and xx , by routinely:
    - demonstrating his ability to consistently communicate effectively and be able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement
    - interacting with colleagues in a way that demonstrates appropriate professional values and behaviours, in terms of supporting colleagues, respecting differences of opinion, and working as a collaborative member of the team
    - engaging with all members of the perioperative and theatre teams to work efficiently and effectively, with sensitivity to the impact of his comments and behaviours on others.
- Any decisions relating to Dr xx return to full independent practice (specifically on-call work) should be carefully managed by the Trust, with due regard to GMC conditions and/or requirements, as well as patient safety.
- Dr xx should discuss and agree with his supervisor whether any ongoing support (particularly continuing contact with his mentor) could assist him in maintaining the positive developments made through this action plan.

Formal review ③

7.0 AGREEMENT

This plan has been developed with the cooperation of all parties who are satisfied that the identified objective reflect the issues identified for improvement.

By signing this agreement, **all parties agree** to the objective set out in the plan and will take forward the programme as presented, adhering to the accompanying *Professional Support & Remediation (PSR) Service Information for practitioners and healthcare organisations about the use of PSR action plans.*

- **All parties** recognise that successful achievement of the progress required at each formal review and upon completion of the action plan will enable the practitioner to practise in the role described on page 3
- **The employing/contracting organisation** agrees to provide access to the support, interventions and learning opportunities included within the action plan.

- **The practitioner** agrees to inform the employing/contracting organisation of any circumstances which may impact on the successful completion of this action plan, including health problems.
- It is expected that any planned absences, including annual leave, will be agreed with the **programme manager** in accordance with local policies and procedures.

Note: If the action plan requires amendment or the addition of further objectives during the course of the programme, a new agreement should be drawn up and signed by all parties.

The programme manager will consider taking management action in the following circumstances if the expected progress towards objectives is not demonstrated:

1. Where failure to progress occurs at the first or second formal review. Continuing with the action plan can be considered, but objectives may need to be re-assessed. A change of objective will only be agreed where there is clear evidence of progress, even though this has fallen short of the performance standard defined in the plan.
2. Failure to progress towards achievement of the agreed objectives may result in formal action and/or a new final employment goal, such as redeployment being discussed with the practitioner. These options will be considered if, in the opinion of the clinical supervisor and the case manager and/or programme manager, the objectives are not likely to be met in the remaining time allocated to the action plan, despite the practitioner having had sufficient opportunity to demonstrate the required progress.
3. If failure to progress raises concerns in relation to **patient or staff safety or public protection or professional probity**, the programme manager and/or case manager or Responsible Officer may make a referral to the GMC.
4. If failure to progress is related to sickness absence, it may be appropriate to defer the completion date of the plan. For any period of sickness absence greater than that covered by self-certification, the employing/contracting organisation's standard sickness absence policy will apply. Taking into account any occupational health advice, the programme manager will consider whether to vary the timings of the action plan.

The following parties agree to the action plan [*Add or amend details of all interested parties prior to the plan being signed*]**:**

Name	Substantive Job Title	Organisation	Role within this programme	Signature	Date
			Programme Manager		
			Practitioner		
			Supervisor		

			Mentor		
			Coach		

Maintaining High Professional Standards In the 21st Century

A framework for managing concerns about doctors and dentists in the HSC.

Department of Health, Social Services & Public Safety
November 2011

MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE 21st CENTURY

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

TABLE OF CONTENTS:

INTRODUCTION

1. This document introduces the revised framework for managing concerns about the conduct, clinical performance and health of medical and dental employees in Northern Ireland's Health and Social Care (HSC) organisations. It covers action to be taken when a concern arises about a doctor or dentist, and any necessary action required to ensure patient safety.

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

3. HSC organisations must notify the Department of the action they have taken to comply with this revised framework by INSERT DATE

4. This framework is in 5 sections and covers:

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   (i) A strategic overview of the system of health and social care delivery in Northern Ireland and regulation of medical and dental employees
   (ii) Identifying Concerns~~Issues~~
   (iii) Investigation
   (iv) Options Following Investigation~~Deciding on what action is needed~~
   (v) Access (where appropriate) to remediation

Background

5. The delivery of safe, effective and high quality care to patients and service users is the priority of every HSC organisation in Northern Ireland. The vast majority of patients receive this standard of care, delivered by healthcare professionals who are up to date, fit to practise and demonstrate commitment to providing excellent healthcare.

6. For a small number of patients, this is not their experience and it is acknowledged that there are times when delivery of care falls below the standards expected and deserved. These failures can be due to a number of factors and HSC organisations have invested in developing systems and processes to identify, analyse and rectify failures in delivery of care to prevent a reoccurrence. Underperformance of healthcare professionals is one of many factors that can impact on the delivery of quality care.

7. The development of *Maintaining High Professional Standards (MHPS)* in 2005 was the response of the Department of Health, Social Services and Public Safety (DHSSPS) to historical concerns about the manner in which complaints about doctors and dentists were addressed. Developing revised arrangements for dealing with medical and dental staff performance has become increasingly important in order to further address these concerns and to reflect development in systems for quality assurance, quality improvement and patient safety in the HSC.

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

Purpose and Coverage of the ~~The~~ Revised Framework

9. This revision of MHPS takes account of reforms to professional regulation set out in the White Paper, Trust, Assurance and Safety (2007)[1] specifically those recommendations relating to identifying and handling concerns about the performance, conduct and health of healthcare professionals. A subsequent paper [2] was published that described a four stage model to follow in relation to identifying and handling concerns :

(i) identifying issues,
(ii) investigation,
(iii) deciding on what action is needed and
(iv) access (where appropriate) to remediation.

10. Patient safety and the determination of immediate or continuing risk to patients and the public should be the primary consideration at both the identification of a concern and periodically throughout the investigatory process.

11. All HSC organisations must have procedures for handling concerns about an individual's performance. These procedures must reflect this ~~e~~ framework ~~in this document~~ and allow for agreed resolution of problems where deemed appropriate.

12. This guidance is applicable to all doctors and dentists employed by one of the five Health and Social Care Trusts, the Health and Social Care Board, Public

[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_06946
[2] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_096482.pdf

Health Agency, the NI Ambulance Trust and the NI Blood Transfusion Service.

~~Concerns about~~

13. Concerns in relation to the performance of doctors and dentists in training should be managed ~~handled~~ by employers in line with those for other medical and dental ~~staff~~ staff. It is, however, essential that ~~with the proviso that the~~ Postgraduate ~~Dean~~Dean, as Responsible Officer for doctors in training, ~~should~~ is~~be~~ involved in these ~~appropriate~~ cases **from the outset**. The onus still rests with the employer for the conduct of the investigation and any necessary action.

~~11.~~**14.** Similarly, if the Northern Ireland and Medical and Dental Training Agency (NIMDTA) are aware of a concern in relation to a doctor or dentist in training, they should notify the employing organisation.

~~12.~~**15.** Where a case involves allegations of abuse against a child or a vulnerable adult, ~~the~~ guidance issued to the HSCNI in 2006 *Safeguarding Vulnerable Adults* and the revised framework *Choosing to Protect Children and Vulnerable Adults 2009* should be referred to and advice sought from the organisations'' Adult and Child Protection officer ~~. Check ref to Guidance~~ [3]

[3] http://www.legislation.gov.uk/ukpga/2006/47/pdfs/ukpga_20060047_en.pdf AND http://www.dhsspsni.gov.uk/choosingtoprotectmarch2009.pdf

SECTION 1- STRATEGIC AND REGIONAL CONTEXT OF THIS FRAMEWORK

~~13.~~16. Since 2005 there has been significant restructuring in the HSC, along with proposals for new regulatory arrangements for doctors and dentists. This, along with the experience gained through implementing the 2005 guidance and procedures of MHPS, has necessitated this revision of the framework.

HSCNI GOVERNANCE AND ACCOUNTABILITY

17. Since the publication of MHPS in November 2005, the DHSSPS has implemented a major programme of reform and modernisation in health and social care. The recommendations from the review of public administration (RPA) in 2002-05 were designed to establish modern, accountable and effective arrangements for public service delivery in Northern Ireland.

~~HSCNI GOVERNANCE AND ACCOUNTABILITY~~

~~14.~~18. As their sponsor, the DHSSPS holds all HSC Bodies directly to account for their good governance responsibilities. This accountability runs through the Minister to the Assembly and its committees.

~~15.~~19. Those responsible within HSC organisations for the implementation of the processes in this framework should be aware of these regional accountability arrangements and ensure that when managing concerns in relation to doctors or dentists, the assessment of risk to patient or public health and wellbeing includes consideration of the need to escalate concerns to the appropriate HSC Body.

PROFESSIONAL REGULATION OF DOCTORS AND DENTISTS

~~16.~~20. The implementation of the processes described in this document should also include consideration of the need to refer the practitioner to their professional regulatory body, for dentists, the General Dental Council (GDC) and for doctors, the General Medical Council (GMC). Referrals made under

fitness to practice proceedings should be made promptly where there is information available that indicates this is necessary. Guidance on areas the GDC consider for investigation can be found on their website[4] and the GMC have published referral thresholds for doctors, which can also be accessed via their website[5].

21. The GMC have appointed Employment Liaison Advisors (ELA) who will provide advice and support to Responsible Officers/Medical Directors in relation to fitness to practice processes and referral thresholds.

REVALIDATION

22. The White Paper, Trust, Assurance and Safety reiterated the previously indentified need for professional regulatory bodies to introduce a process of revalidation for their registrants. Revalidation is a process whereby registrants are required to confirm they are keeping up to date, fit to practice and are practicing to the standards required by their regulator. Revalidation is an ongoing process that should provide assurance to employers, other healthcare professionals and patients and the public about the performance of doctors and dentists.

MEDICAL REVALIDATION AND THE RESPONSIBLE OFFICER

~~24.~~23. The GMC will implement a system of revalidation for it's registrants in late 2012. All registrants who required a Licence to Practise or who sought one in 2009 have been issued with one from the GMC. Renewal of this licence will be subject to the process of revalidation whereby a senior doctor in a healthcare organisation, known as a Responsible Officer (RO), will make a recommendation to the GMC that those doctors with whom they have a prescribed relationship should be revalidated.

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[4] http://www.gdc-uk.org/Dentalprofessionals/Fitnesstopractise/Pages/Conduct-criminal.aspx

[5] http://www.gmc-uk.org/concerns/employers_information.asp

~~18.~~24. Legislation, (and supporting Guidance)[6] to require all designated organisations to appoint or nominate a Responsible Officer came into operation in Northern Ireland on 1st October 2010. The Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010[7] identify the five HSC Trusts, and the NI Ambulance Service Trust, as being designated organisations, the Medical Director of each is now the appointed Responsible Officer. The Northern Ireland Medical and Dental Training Agency is also a designated organisation, making the post-graduate Dean the Responsible Officer for doctors in training.

~~19.~~25. The RO role extends beyond making a revalidation recommendation to the GMC. Paragraph,9 of the Regulations defines the responsibilities of the RO in relation to the evaluation of the fitness to practise of every medical practitioner they have a prescribed relationship with, namely :

a. To ensure that regular appraisals are undertaken

b. To establish and implement processes to investigate concerns about a medical practitioner's fitness to practise raised by staff or any other source

c. Where appropriate, to refer concerns about the medical practitioner to the GMC

d. To monitor compliance with any conditions or undertakings agreed with the GMC

e. To maintain records of medical practitioners fitness to practise evaluations, including appraisals or any other investigations or assessments.

REVALIDATION FOR DENTISTS

22 The General Dental Council (GDC) recently consulted on their proposals for the revalidation of dentists. The proposed framework comprises of a five year cycle, at the end of which dentists will be required to demonstrate compliance

[6] http://www.dhsspsni.gov.uk/index/hss/ahp-confidence_in_care.htm
[7] http://www.dhsspsni.gov.uk/cic-ro-regulations-ni.pdf

with standards set by the GDC. External verifiers will be established and they will be required to review the supporting evidence submitted by dentists and certify the individual's compliance with the Standards.

REVALIDATION AND MANANGING CONCERNS

23 The primary purpose of revalidation is to provide a positive assurance that the practitioner is meeting the requirements of their professional regulator. There have been some concerns expressed by practitioners that performance concerns may only be identified at the point of a revalidation recommendation being made, resulting in the RO being unable to make a fitness to practise recommendation to the Regulator.

24 A key principle in managing concerns, and revalidation, is that of 'no surprises'. Concerns should be addressed as soon as they are identified and not collated and addressed with the practitioner at the point of a revalidation recommendation.

25 The processes upon which revalidation will be based, namely annual appraisal and review of information generated by the organisation in relation to the practitioner's performance, may highlight the presence of a concern at an earlier stage. The processes in place to manage identified concerns as described in this Framework will not change as revalidation is introduced. However, the potential identification of concerns at an earlier stage could allow for earlier intervention and remediation (where appropriate). This will allow practitioners opportunity to address the area/s identified and provide opportunity for these to be improved on wherever possible.

SECTION 2 IDENTIFYING CONCERNS

HOW CONCERNS ARE IDENTIFIED

26 The management of performance is a continuous process to ensure both quality of service to patients and to support clinicians. While numerous ways exist in which concerns about a practitioner's performance can be identified, the key objective should be that they are identified at an early stage. Consequently, remedial and supportive action can be quickly taken before problems become serious or patients harmed. In addition, such an approach will decrease the need for extensive investigation or the implementation of disciplinary procedures.

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

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

Commented [JL2]: Should we provide a short paragraph under each of these bullets? Following 4 paragraphs seem rather disjointed and may be better included here.

28 All concerns, including those made by relatives of patients, or concerns raised by colleagues, must be thoroughly investigated to establish the facts and the substance of any allegations.

29 Concerns raised about a colleague must be based on concern for patient welfare. Individual practitioners should be protected from unfounded or malicious allegations which can cause lasting damage to their reputation and career. Where allegations raised by a fellow HSC employee are shown to be malicious, that employee should themselves be subject to the relevant disciplinary procedures. ~~All~~However, all HSC organisations are required to ensure that they have a *Whistle Blowing* p~~P~~olicy and should ensure that an employee who wishes to raise a concern about a colleague is supported to do so.

30 Each professional regulatory body defines standards of practice they expect from their registrants, which include the requirement to take action if they perceive a risk to patient safety. Thus, there is an additional burden on health care staff subject to statutory regulation to report concerns.

31 There is also a need to ensure lessons are learnt from previously high profile cases where concerns relating to practitioners were widely known by other healthcare professionals but not formally articulated, often resulting in harm to patients. The failure to recognise the significance of concerns expressed, coupled with the failure of different organisations to combine the information they held are discussed in the DH Report *Learning from Tragedy*[8] (2007) , which details the action programme in response to the Shipman inquires and lessons learnt the Ayling and Kerr/Haslam cases.

32 It should be noted that the causes of adverse events should not automatically be attributed to the actions, failings or unsafe acts of an

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8 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@pub/@ppg/documents/digitalasset/dh_065995.pdf

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

~~32~~33 Where a concern is made by a patient, relative or carer, the organisation should ensure that the complainant is informed of the process and outcome of any subsequent investigation. Information shared should be proportionate and be balanced with the need to ensure confidentiality where this is indicated.

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SUMMARY OF KEY ACTIONS NEEDED WHEN A CONCERN ARISES

~~33~~34 When a concern is raised, and throughout the resulting processes, consideration of the concern and action needed should be given equal consideration to patient safety. As such, the key actions needed at the outset can be summarised as follows:

- consider if urgent action, such as restriction of practice or exclusion needs to be taken to protect patients and the public
- consideration should be given to ensuring that all immediately necessary steps have been taken to protect staff, including whistleblowers
- consider who should be informed of the investigation;
- consider necessity of completing Serious Adverse Incident proforma
- undertake a preliminary investigation to clarify the problem or concern
- review findings of preliminary investigation and identify next steps.

PROTECTING PATIENTS AND THE PUBLIC

~~34~~35 A risk assessment should be undertaken when a concern is identified to ensure the continued safety of patients and the public. This risk assessment should be reviewed regularly during the investigatory process and rationale for decisions made documented. Excluding the practitioner from the workplace may be unavoidable; however it should not be the only or first approach to ensuring patient safety. Alternative ways to manage risks, avoiding exclusion, include:

- arranging supervision of normal contractual clinical duties- this can range from observation to indirect or opportunistic supervision ;
- restricting the practitioner to certain forms of clinical duties;
- restricting activities to non clinical duties. By mutual agreement the latter might include some formal retraining;
- sickness absence for the investigation of specific health problems.

36 This risk assessment should include the need to share information with another organisation. As discussed in paragraph X, if the concern is in relation to a medical or dental trainee, NIMDTA should be informed. If the practitioner undertakes any work outside of their substantive HSC post, the need to ensure patient and public safety may necessitate sharing the concern.

SECTION 3: INVESTIGATION

~~35~~37 This section outlines the key principles and best practice in undertaking an investigation of a concern. Actions that may be taken as a result of the investigation are described in Section 3 of this framework.

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~~36~~38 Good practice in carrying out investigations of concerns can be summerised in the following principles, ~~detailed in the Tackling Concerns Locally Report~~[9]:

- The overriding objective should be to protect the safety of patients and the public
- Organisations should have clear policies for local investigation
- The investigation process must be fair, consistent and objective
- The scope and context of the investigation should be clearly defined at the outset
- Roles and responsibilities in relation to the investigation should be clearly defined
- Investigations should be adequately ~~properly~~ resourced
- Organisations must work to agreed timescales
- People raising concerns or making complaints should be supported and kept informed throughout the process
- The doctor or dentist under investigation should be supported and kept informed of progress
- Organisations should consider who else, in or outside the organisation needs to be informed of the investigation
- Organisations should seek expert external advice, including occupational health assessment, recording when they have done so and how it has contributed to decision making.

[9] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_096482.pdf

UNDERTAKING AN INVESTIGATION

~~37~~39 This revised framework identifies a two stage investigatory approach (previously referred to as 'informal' and formal' investigations) when a concern is raised. The first stage comprises a preliminary investigation and the second stage (if required), an extended investigation. Actions that may be taken during and on completion of each stage of the investigation are described in paragraph X of this framework.

~~38~~40 It should be noted that if ~~where~~ the practitioner is the subject of an ongoing investigation by the Police, Counter Fraud Unit or a regulatory or licensing body ~~then~~ , this does not necessarily prevent an ~~local~~ investigation into unrelated matters taking place. It would however, be advisable to consult the relevant organisation before commencing any ~~local investigation~~investigation, for example the GMC's ELAs. If ~~Where~~ an ~~local~~ investigation ~~is~~ has been commenced ~~already underway~~ and the ~~local~~ organisation becomes aware of another investigation, ~~then again~~ liaison with the relevant body should take place.

~~39~~41 The purpose of conducting any investigation is to inform a decision making process that will identify what, if any, action needs to be taken to address the concern. The importance of the investigation should not be underestimated as the concepts of procedural and substantive fairness apply as much to the conduct of the investigation as the decision that results from it.

4042 The following principles from the Labour Relations Agency [10] provide a useful principles when planning and undertaking an investigation:

➢ ***Why is the investigation necessary?***

The application of a process of investigation demonstrates the organisation has a consistently applied, fair approach to investigating concerns

➢ ***What facts do we know for certain?***

It is the intention of the investigation to draw out facts and present them to those with the responsibility of making a decision in relation to any further action required. Thus the investigator needs to remain objective during the process and be working within the defined terms of reference of the investigation. All relevant issues should be encompassed in the terms of reference from the outset. The investigation will lose focus by inquiring into interesting but irrelevant issues that are outside of the terms of reference. If an issue arises that does not fit within the terms of reference, approval should be sought to change them from the case manager or omit the issue from the investigation.

➢ ***Who should conduct the investigation?***

This will vary across organisations and where possible, the investigator should have no connection with the subject of the investigation. Consideration should also be given to resources required by the investigator e.g. secretarial support for note taking.

➢ ***When and Where?***

The investigation should commence as soon as possible when a concern has been identified. Where there are identified timescales, the organisation should adhere to these to maintain momentum but should have a defined process to extend the timescales under exceptional circumstances. In all cases the

[10] http://www.lra.org.uk/index/agency_publications-2/advice_and_guidance_on_employment_matters-3/advisory_guides2/advice_on_conducting_employment_investigations.htm

investigation should proceed as quickly as possible and any delays accounted for. There should be a defined timescale for notice given to the subject of the investigation to attend an interview and consideration should be given to the most appropriate setting for an interview.

COLLECTING EVIDENCE

~~41~~43 The investigator has wide discretion on how the investigation is carried out but in all cases the purpose of the investigation is to ascertain the facts in an unbiased manner. Investigations are not intended to secure evidence against the practitioner as information gathered in the course of an investigation may clearly exonerate the practitioner or provide a sound basis for effective resolution of the matter. The investigator should therefore take account of positive indicators as well as any negative indicators and any relevant national or local benchmarks.

~~42~~44 It is important that the investigation collects all the evidence that may be available relating to the concerns or allegations being made. This will involve interviewing all those who may be able to provide information and making a careful note of their evidence. Where possible and depending on the circumstances, this will include patients, their relatives and the practitioner concerned.

~~43~~45 If any case is to proceed, evidence has to be demonstrated. ~~, whether to the HSC Trust Board, the Tribunal, the GMC or in the courts.~~ While the rules of evidence can become complicated, there are some simple questions that should always be asked:

Commented [PW4]: What tribunal?

- ***What is the evidence and is it written?***

Written evidence is not superior to oral evidence: it is simply more clearly defined and so less prone to (but not immune from – witnesses do alter statements) being changed. And evidence, even if written, needs careful consideration to be sure of exactly what is being said – and how firmly it is being said. Witness statements are best in the words of the witness, signed by the witness and dated.

- ***How recent is the evidence?***

The general rule is that the older the evidence the less the weight that should be given to it. So the fact that the practitioner faced a similar allegation in 1997 to that facing him now is likely to carry a lot less weight than if a previous similar allegation was made only three months ago

- ***Is there a pattern to allegations against the practitioner?***

A pattern of unacceptable behaviour is likely to be more significant evidence than an isolated incident. (But note that if similar allegations have not been dealt with in the past, it may give scope for the practitioner to argue unreasonableness and inconsistency on the part of the HSC organisation and thus offer some defence against the current allegations)

- ***How direct is the evidence?***

Factual evidence is likely to carry more weight than opinions from witnesses and unsupported anecdotal evidence is unlikely to be worth much

- ***How credible and compelling is the evidence, how cogent is the evidence and how likely is the evidence to be impugned?***

STAGE 1-PRELIMINARY INVESTIGATION

~~44~~46 The investigatory process should commence with a preliminary investigation to establish the facts~~identify the issues~~ surrounding the concern that has been identified. This first stage should take account of the evidence to hand, alongside any comments the practitioner wishes to make, and should provide an indication of the substance of the concern and the most appropriate course of action.

~~45~~47 The Clinical Director, Human Resources Director, and Medical Director/Responsible Officer should be informed of the investigation. They may decide to inform the Chief Executive and/or Executive Board at this stage if there is an apparent risk to patient safety, and/or for reputational damage to the organisation:

~~46~~48 The preliminary investigation should be appropriately documented, resourced and recorded from the outset. If further investigation is required, the methodology and findings from the preliminary investigation will be critical in establishing the terms of reference of an extended investigation. Frequent and factual ~~Robust~~ recording will ~~also~~ provide assurance to the ~~organisation~~organisation, and the practitioner ~~that~~, that the appropriate process has been followed and how decisions were reached.

~~47~~49 The preliminary investigation should be undertaken by a senior clinician in the HSC organisation and should include:

- Review of relevant clinical or administrative records
- Review of any report or documentation relating to the concern. If ~~While~~ witness statements may not have been drafted at this stage, the individuals concerned should always make a written record as soon as possible while matters are still fresh in their minds

Commented [JL5]: Check organisational processes

Commented [PW6]: Need to consider how relates to investigation of an adverse incident

- Interviewing of individuals may be appropriate as part of the preliminary investigation where clarification of their comments or nature of their involvement is necessary

~~48~~50 The preliminary investigation should be completed as quickly as possible. The practitioner who is the subject of the investigation should always be given the opportunity to comment on the issues as identified ~~at the end of~~throughout the investigation. Their comments must be taken into consideration before any decision is reached in relation to any subsequent action.

Commented [PW7]: Need a section on conclusion of the preliminary investigation – what triggers a further invest6igation What records are kept, by whom, for how long.

51 The investigator responsible for conducting a preliminary investigation should document their findings and the decision reached. Actions that may be taken following the preliminary are considered in Section 4 of this framework.

STAGE 2: EXTENDED INVESTIGATION

~~49~~52 Where it has been established~~is~~ decided that an extended investigation should ~~needs to~~ be undertaken, that has the potential to lead to conduct or clinical performance proceedings, the CE must, after discussion between the Responsible Officer/Medical Director and Director of HR, appoint a Case Manager, a Case Investigator and a designated Board member. The seniority of the Case Investigator will differ depending on the grade of practitioner involved in the allegation. Several Case Investigators should be appropriately trained, to enable them to carry out this role.

Commented [JL8]: ? THRESHOLD CRITERIA NEEDED

~~50~~53 At any stage of this process, or subsequent disciplinary action, the practitioner may be accompanied to any interview or hearing by a companion. The companion may be another employee of the HSC body; an official or lay representative of the BMA, BDA, defence organisation, or friend, work or professional colleague, partner or spouse. The companion

may be legally qualified but he or she will not, however, be acting in a legal capacity.

~~51~~54 The investigatory approach described in paragraphs 34-42 of this document apply to both preliminary and extended investigations.

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~~TRAINING~~

~~52~~55 Employers must ensure that managers and Case Investigators receive appropriate training in the operation of performance procedures. Those undertaking investigations or sitting on disciplinary or appeals panels must have had formal equal opportunities training before undertaking such duties. The Trust Board must agree what training its staff and its members have completed before they can take a part in these proceedings.

PROCESS FOR AN EXTENDED INVESTIGATION

OVERSIGHT

~~DEFINITION OF ROLES~~

Commented [PW9]: On reflection might be better to describe the process and then see whether there remains a need to define all these roles.

56 The Board of the organisation, through the Chief Executive, has responsibility for ensuring that this ~~ese~~ processsdures ~~are~~ is established and followed. It should be noted that Board members may be required to sit as members of a disciplinary or appeal ~~panel. Therefore~~panel, therefore, information ~~given~~ provided to them ~~to the board~~ should only be sufficient to assure ~~to enable the board to satisfy itself~~ that this~~e procedures~~ process is~~are~~ being followed. The exception to this will be for the ~~Only the~~ "*designated Board member* ~~"should be involved to any significant degree in the management of individual cases.~~whose role is to:

- Oversee the case
- Ensure momentum is maintained
- Consider any representations from the practitioner or others in relation to the investigation.

~~53~~57 The role of other k~~The k~~ey individuals in an extended investigation are defines in the Glossary in this framework. ~~that may have a role in the process are summarised~~

~~54~~58 If the MD/RO is the subject of the investigation, the Chief Executive of the organisation should appoint a suitable medically qualified manager of at least equivalent seniority.

~~55~~59 The CM must be inform the practitioner in writing that an investigation is to be undertaken, the name of the Case Investigator and the specific allegations or concerns that have been raised. The practitioner must be given the opportunity to see any correspondence relating to the case together with a list of the people whom the Case Investigator will interview. The practitioner must also be afforded the opportunity to put their view of events to the Case Investigator and given the opportunity to be accompanied.

Commented [JL10]: Define accompanied in this instance

~~56~~60 If it transpires during the course of the investigation that the case involves more complex clinical issues that cannot be addressed within the organisation, the CM should consider whether an independent practitioner from another HSC body or elsewhere be invited to assist.

~~57~~61 The CM should ensure that they receive progress reports from the Case Investigator at agreed points during the investigation. They must ensure that momentum of the investigation is maintained and be informed if information comes to light during the investigation that may indicate a threat to patient and public safety.

INVESTIGATION

~~58~~62 A Case Investigator (CI) will be appointed to undertake the investigation into the concern by establishing the facts and reporting these to the CM. The CI should be medically qualified where possible.

~~59~~63 The CI has wide discretion on how the investigation is carried out, but in all cases the purpose of the investigation is to ascertain the facts in an unbiased manner. Information gathered in the course of an investigation may clearly exonerate the practitioner, or provide a sound basis for effective resolution of the matter.

~~60~~64 If the concern relates to an issue regarding clinical judgement, the CI should involve a senior member of the medical or dental staff[11] with relevant clinical experience in the investigation.

~~61~~65 The CI must ensure that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided. Patient confidentiality needs to be maintained.

~~62~~66 It is the responsibility of the Case Investigator to judge what information needs to be gathered and how (within the boundaries of the law) that information should be collated. They must ensure that sufficient written statements are collected to establish the facts of the case, and on aspects of the case not covered by a written statement, ensure that there is an appropriate mechanism for oral evidence to be considered where relevant.

~~63~~67 A written record must be maintained during the ~~is kept of the~~ investigation~~,~~ that records the conclusions reached and the course of action agreed by the Medical Director with advice from the Director of HR.

68 The CI must assist the designated Board Member and CM in reviewing the progress of the case. They must ensure that momentum is maintained during the investigation and escalate the reason for any delay to the CM. Should information come to light during the investigation that suggest a risk to patient or public safety, the CI must inform the CM and designated

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

Board member immediately to allow consideration of measures required mitigate this risk.

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

TIMESCALES AND DECISION MAKING

~~64~~70 The C~~ase I~~nvestigator should, other than in exceptional circumstances, aim to complete the investigation within 4 weeks of appointment and submit their report to the C~~ase Manager~~ within a further 5 working days. The C~~ase M~~anager must give the practitioner the opportunity to comment in writing on the factual content of the report produced by the C~~ase Investigator~~.

~~65~~71 Comments in writing from the practitioner, including any mitigation, must normally be submitted to the C~~ase Manager~~ within 10 working days of the date of receipt of the request for comments. In exceptional circumstances, for example in complex cases or due to annual leave, the deadline for comments from the practitioner should be extended.

~~66~~72 The CI's ~~re~~report should give the C~~ase Manager~~ sufficient information to make a decision on whether:

- no further action is needed;
- restrictions on practice or exclusion from work should be considered;
- there is a case of misconduct that should be put to a conduct panel;

- there are concerns about the practitioner's health that should be considered by the HSC body's occupational health service, and the findings reported to the employer;

- there are concerns about the practitioner's clinical performance which require further formal consideration by the NCAS ;

- there are serious concerns that fall into the criteria for referral to the GMC or GDC; there are intractable problems and the matter should be put before a clinical performance panel.

Formal processes are illustrated in the diagram on page 42.

PROCESS FOR SMALLER ORGANISATIONS

~~67~~73 Many smaller organisations may not have all the necessary personnel in place to follow the procedures outlined in this document. For example, some smaller organisations may not employ a medical director or may not employ medical or dental staff of sufficient seniority or from the appropriate specialty. Also, it may be difficult to provide senior staff to undertake hearings who have not been involved in the investigation.

~~68~~74 Such organisations should consider working in collaboration with other local HSC organisations (e.g. other Trusts) in order to provide sufficient personnel to follow the procedures described. The organisation should be sufficiently distant to avoid any organisational conflict of interest and any nominee should be asked to declare any conflict of interest. In such circumstances the HSC organisation should contact the Department to take its advice on the process followed and ensure that it is in accordance with the policy and procedures set out in this document.

TERMINATION OF EMPLOYMENT WITH PROCEDURES INCOMPLETE

Commented [JL11]: Does this refer to resignation?

~~69~~75 Where the employee leaves employment before formal procedures have been completed, the investigation must be taken to a final conclusion in all cases and performance proceedings must be completed wherever possible, whatever the personal circumstances of the employee concerned.

~~70~~76 There will be circumstances where an employee who is subject to proceedings puts forward a case, on health grounds, that the proceedings should be delayed, modified or terminated. In such cases the employer is expected to refer the doctor or dentist to the OHS for assessment as soon as possible. Unreasonable refusal to accept a referral to, or to co-operate

with, the OHS under these circumstances, may give separate grounds for pursuing disciplinary action.

~~74~~77 Every reasonable effort must be made to ensure the employee remains involved in the process. If contact with the employee has been lost, the employer should invite them to attend any hearing by writing to both their last known home address and their registered address (the two will often be the same). The employer must make a judgement, based on the evidence available, as to whether the allegations are upheld. If the allegations are upheld, the employer must take appropriate action, such as requesting the issue of an alert letter and referral to the professional regulatory body, referral to the police, or the Protection of Children and Vulnerable Adults List (held by the Department of Employment and Learning). CONFIRM THIS IS STILL CORRECT TITLE ?ISA

GUIDANCE ON AGREEING TERMS FOR SETTLEMENT ON TERMINATION OF EMPLOYMENT

~~72~~78 In some circumstances, terms of settlement may be agreed with a doctor or dentist if their employment is to be terminated. The following good practice principles are set out as guidance for the Trust:

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

CONFIDENTIALITY

~~73~~79 Employers must maintain confidentiality at all times, and should be familiar with the guiding principles of the Data Protection Act. No press notice can be issued, nor the name of the practitioner released, in regard to any investigation or hearing into disciplinary matters. They may only confirm that an investigation or disciplinary hearing is underway.

~~74~~80 Personal data released to the Case Investigator for the purposes of the investigation must be fit for the purpose, and not disproportionate to the seriousness of the matter.

~~**TRANSITIONAL ARRANGEMENTS**~~

~~**69.** On implementation of this framework, the new procedures must be followed, as far as is practical, for all existing cases taking into account the stage the case has reached.~~

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SECTION 4 OPTIONS FOLLOWING INVESTIGATION

~~75~~81 This section outlines the key principles in relation to decision making following an investigation and the range of measures that may be taken to manage the concern while ensuring patient safety.

THE DECISION MAKING PROCESS

~~76~~82 Once the investigation has established the facts, an entirely separate process is needed to decide what action (if any) is needed. Key principles in relation to decision making can be summarised as follows:

- Patient and public safety must be the foremost consideration
- A decision must be made, recorded and all relevant parties informed
- There should be complete separation between the investigation and decision making process
- The decision making process must be seen to be fair, impartial, consistent and timely
- Expert input should be sought where necessary
- A range of options should be considered based on the circumstances of the individual doctor or dentist
- Organisations should consider opportunities for internal learning ~~their own learning~~ and make appropriate changes
- Individuals should be seek out support

Commented [JL12]: Which individuals?

- The doctor or dentists should have the right to appeal against any decisions made, except for decisions to refer cases to the regulator, to the police or to the counter fraud unit.

OPTIONS FOLLOWING PRELIMINARY INVESTIGATION

~~77~~83 At the conclusion of the preliminary investigation, the information collated should be reviewed and a decision made in relation to what, if any, next steps should be taken. As a first step, this preliminary investigation is essential to verify or refute the substance and accuracy of any concerns or complaints. This can be ~~is a~~a difficult decision and should not be taken alone but in consultation with the Responsible Officer, Medical Director and Director of HR, taking advice from the NCAS or Occupational Health Service (OHS) where necessary.

~~78~~84 At this stage of the investigatory process a range of options are available to organisations. These options are not mutually exclusive - patient protection and action required to manage the concern may require implementation of one or more of the following :

- No action to be taken
- Remedial action required
- Measures to ensure patient safety required – restriction on practice or exclusion
- Local process agreed with the practitioner to be implemented
- Proceed to Stage 2- Extended Investigation

Commented [JL13]: Define local processes

NO ACTION REQUIRED

85 If, at the conclusion of the preliminary investigation, there has been no evidence to support the concern and no identified risk to patient and public safety identified then no further action is required. ~~it has been agreed that no action is required,~~T ~~t~~he practitioner should be informed of this decision as soon as possible and t~~. T~~he record of the investigation ~~should be~~

~~c~~completed. This should ~~and~~ include the rationale for the decision and those involved in the decision made. ~~.~~ This record should be held on the practitioner's personnel file for future record.

~~CHECK POLICY~~

Commented [JL14]: Need HR Input

REMEDIAL ACTION REQUIRED

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~~79~~86 If the outcome of the preliminary investigation is the identification of a performance concern (as per definition in paragraph 2 of this Framework- referring to all aspects of a practitioner's work including conduct, health and clinical performance), consideration should be given to whether a local action plan to resolve the problem can be agreed with the practitioner. The NCAS can advise on the practicality of this approach. Paragraphs 207-215 of this paper outline the service provided by NCAS.

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MEASURES TO ENSURE PATIENT SAFETY

RESTRICTIONS ON PRACTICE

~~80~~87 When significant issues relating to performance are identified at any stage of the processes described in this framework which may affect patient safety, the employer must urgently consider whether it is necessary to place temporary restrictions on an individual's practice. Examples of such restrictions might be to amend or restrict the practitioner's clinical duties and obtain relevant undertakings e.g. regarding practice outside the organisation in another HSC organisation or private practice. Any restrictions on practice must be an interim measure and should be documented and kept under review during the investigatory process. If the concern raised and upheld following a preliminary investigation is of sufficient concern to warrant restrictions on practice or immediate exclusion, an extended investigation should be commenced.

IMMEDIATE EXCLUSION

~~81~~88 An immediate time limited exclusion from the workplace may be necessary to protect the interests of patients or other staff; or where there has been a breakdown in relationships within a team which has the potential to significantly endanger patient care.

~~82~~89 The NCAS must, where possible, be informed prior to the implementation of an immediate exclusion. Such exclusion will allow a more measured consideration to be undertaken. This period should be used to carry out a preliminary situation analysis and to convene a case conference involving the clinical manager, the Medical Director/Responsible Officer and appropriate representation from Human Resources.

Commented [RH15]: ? is this a preliminary investigation

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~~83~~90 The authority to exclude a member of staff must be vested in a nominated manager or managers of the Trust. These should include, where possible, the CE, Medical Director/Responsible Officer and the Clinical Directors for staff below the grade of consultant. For consultants it should include the CE and Responsible Officer /Medical Director. The number of managers involved should be the minimum number of people consistent with the size of the organisation and the need to ensure 24 hour availability of a nominated manager in the event of a critical incident. The clinical manager seeking an immediate exclusion must explain to the nominated manager why the exclusion is justified.

~~84~~91 The clinical manager, having obtained the authority to exclude, must explain to the practitioner why the exclusion is justified (there may be no formal allegation at this stage), and agree a date up to a maximum of four weeks at which the practitioner should return to the workplace for a further meeting.

~~85~~92 Immediate exclusion should be limited to the shortest feasible time and in no case longer than 4 weeks. During this period the practitioner should

be given the opportunity to state their case and propose alternatives to exclusion e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction. The clinical manager must advise the practitioner of their rights, including rights of representation.

~~86~~93 All these discussions should be minuted, recorded and documented, and a copy given to the practitioner.

~~87~~94 The 4 week exclusion period should allow sufficient time for initial or further investigation to determine a clear course of action, including the need for formal exclusion, remediation, disciplinary action and/or referral to the regulator.

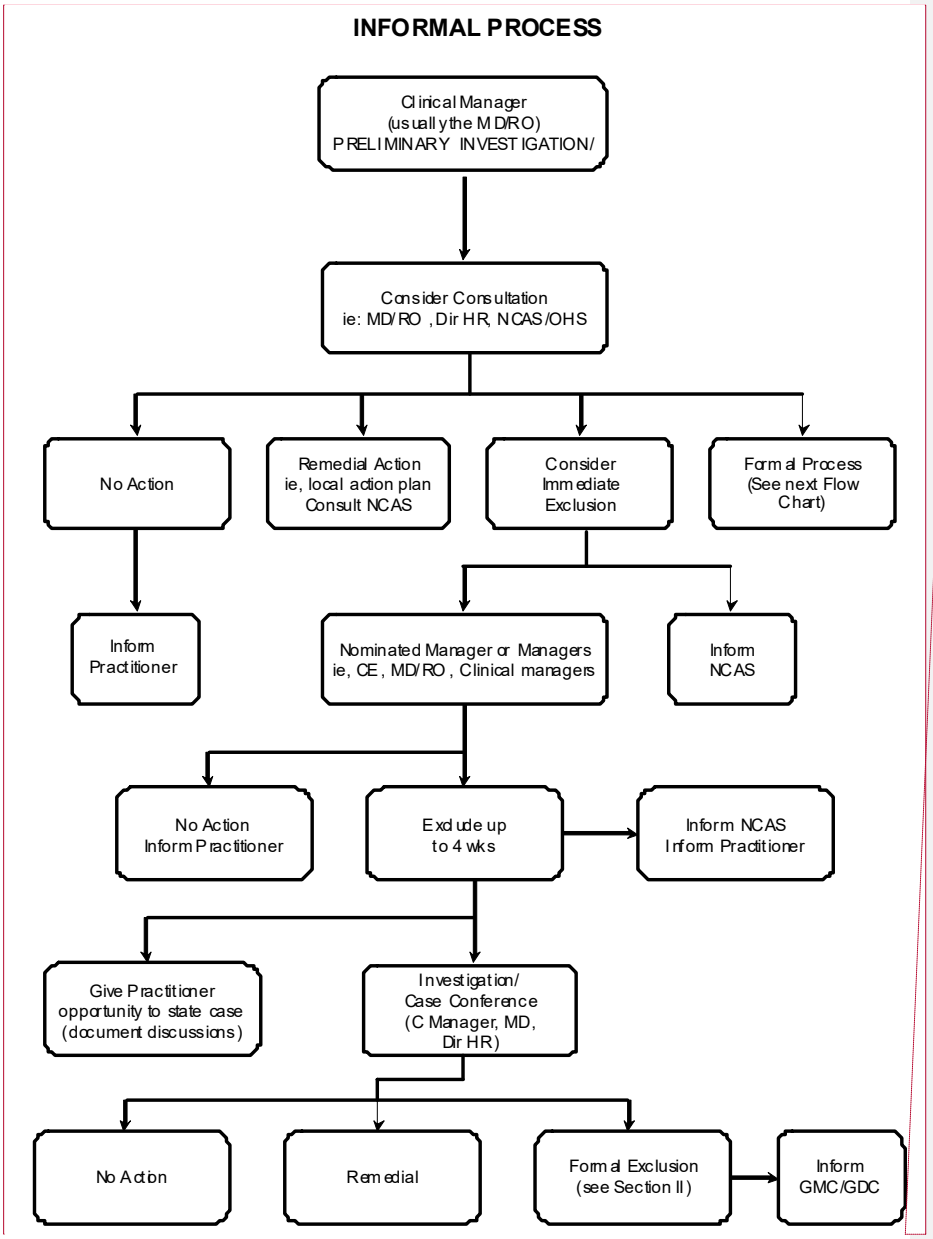
Commented [JL16]: Define immediate and formal at beginning of section.

~~88~~95 At any point in the process where the Medical Director/Responsible Officer has reached a decision that a practitioner is to be the subject of exclusion, the regulatory body should be notified. Users of this Framework should refer to the DHSSPS Guidance Issuing Alert Letters (circular HSS (TC8) (6)/98) and Guidance on Information Sharing to Provide Assurance.

~~89~~96 Paragraphs 109-130 of this framework set out the procedures to be followed should an extended investigation indicate that a longer period of formal exclusion is required.

~~90~~97 The following diagram provides an overview of the informal process.

Commented [JL17]: Remove/revise



OPTIONS FOLLOWING EXTENDED INVESTIGATION.

~~91~~98 Options following an extended investigation are described in this section. As with~~per~~ options following a preliminary investigation, these are not mutually exclusive and ensuring patient and public safety, and action required to manage the concern may require implementation of one or more of the following :

- No further action
- Referral to OHS
- Measures to protect patients - restriction of practice & exclusion from work
- Conduct panel
- Clinical Performance Panel
- Referral to GMC/GDC
- Referral to the NCAS.

NO FURTHER ACTION

~~92~~99 If, at the conclusion of an extended investigation, it has been agreed that no further action is required, the practitioner should be informed of this decision as soon as possible. The investigatory record should be completed and include the rationale for this decision. This record should be held on the practitioner's personnel file for future record.

REFERAL TO OCCUPATIONAL HEATH SERVICE

~~93~~100 When the findings of an extended investigation demonstrate there are concerns about the practitioner's health that should be considered by the HSC body's Occupational Health Service (OHS) and the findings reported to the employer.

~~94~~101 In addition, if at any stage in the context of concerns about a practitioner's clinical performance or conduct it becomes apparent that ill health may be a factor, the practitioner should be referred to OHS. Employers should be aware that the practitioner may also self refer to OHS.

~~95~~102 The principle for dealing with individuals with health problems is that, wherever possible and consistent with maintaining patient safety, they should be treated, rehabilitated or re-trained (for example if they cannot undertake exposure prone procedures) and kept in employment, rather than be lost from the HSC.

HANDLING HEALTH ISSUES

~~96~~103 On referral to OHS, the OHS physician should agree a course of action with the practitioner and send his/her recommendations to the Medical Director/Responsible Officer. ~~A and a~~ meeting should be convened with the Director of HR, the Medical Director/Responsible Officer or Case Manager, the practitioner and case worker from the OHS to agree a timetable of action and rehabilitation (where appropriate)[12]. The practitioner may be accompanied to these meetings (as defined in paragraph 49). Confidentiality must be maintained by all parties at all times.

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~~97~~104 The findings of OHS may suggest that the practitioner's health makes them a danger to patients. Where the practitioner does not recognise that, or does not comply with measures put in place to protect patients, then exclusion from work must be considered. The relevant professional regulatory body must be informed, irrespective of whether or not the practitioner has retired on the grounds of ill health.

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

~~98~~105 In those cases where there is impairment of clinical performance solely due to ill health or an issue of conduct solely due to ill health, disciplinary procedures or misconduct procedures would only be considered in the most exceptional of circumstances, for example if the individual concerned refuses to co-operate with the employer to resolve the underlying situation e.g. by refusing a referral to the OHS or NCAS.

~~99~~106 A practitioner who is subject to the procedures in Sections III and IV may put forward a case on ill health grounds that proceedings should be delayed, modified or terminated. In those cases the employer should refer the practitioner to OHS for assessment as soon as possible and suspend proceedings pending the OHS report. Unreasonable refusal to accept a referral to, or to co-operate with OHS, may give separate grounds for pursuing disciplinary action.

Commented [JL19]: Check original version-what does this refer to?

RETAINING THE SERVICES OF INDIVIDUALS WITH HEALTH PROBLEMS

~~100~~107 Wherever possible the organisation should attempt to continue to employ the individual provided this does not place patients or colleagues at risk. The following are examples of action that may be taken in these circumstances, in consultation with OHS and having taken advice from NCAS and/or NIMDTA if appropriate.

~~101~~108 Examples of action to take:

- sickness absence for the practitioner (the practitioner should be ~~to be~~ contacted frequently to ensure they receive any support they may require ~~on a pastoral basis to stop them feeling isolated)~~);
- remove the practitioner from certain duties;
- make adjustments to the practitioner's working environment;
- reassign them to a different area of work;
- arrange re-training for the practitioner;

- consider whether the Disability Discrimination Act (DDA) applies (see below), and, if so, what other reasonable adjustments might be made to their working environment.
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-

DISABILITY DISCRIMINATION ACT (DDA)

~~102~~109 Where the practitioner's health issues come within the remit of the DDA, the employer is under a duty to consider what reasonable adjustments can be made to enable the practitioner to continue in employment. At all times the practitioner should be supported by their employer and OHS who should ensure that the practitioner is offered every available resource to enable him/her to continue in practice or return to practice as appropriate.

~~103~~110 Employers should consider what reasonable adjustments could be made to the practitioner's workplace conditions, bearing in mind their need to negate any possible disadvantage a practitioner might have compared to his/her non - disabled colleagues. The following are examples of reasonable adjustments an employer might make in consultation with the practitioner and OHS.

~~104~~111 Examples of reasonable adjustment

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

- establish mentoring arrangements.

~~105~~112 In some cases retirement due to ill health may be necessary. Ill health retirement should be approached in a reasonable and considerate manner, in consultation with the practitioner, OHS, and HSC Superannuation Branch.

~~106~~113 Note. Special Professional Panels (generally referred to as the "three wise men") were set up under circular TC8 1/84. This part of the framework replaces those arrangements and any existing panels should be disbanded.

Commented [JL20]: ? Remove para

MEASURES TO PROTECT PATIENTS:
RESTRICTION OF PRACTICE AND EXCLUSION FROM WORK

~~107~~114 This part of the framework replaces the guidance in HSS (TC8) 3/95 (Disciplinary Procedures for Hospital and Community Medical and Hospital Dental Staff - Suspensions). Under the Directions on Disciplinary Procedures 2005, HPSS employers must incorporate these principles and procedures within their local procedures. The guiding principles of Article 6 of the Human Rights Act must be strictly adhered to.

~~108~~115 In this part of the framework, the phrase "exclusion from work" has been used to replace the word "suspension" which can be confused with action taken by the GMC or GDC to suspend the practitioner from the register pending a hearing of their case or as an outcome of a fitness to practice hearing.

~~109~~116 The Directions require that HSC bodies must ensure that:

- exclusion from work is used only as an interim measure whilst action to resolve a problem is being considered;

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

MANAGING THE RISK TO PATIENTS

~~110~~117 Exclusion of clinical staff from the workplace is a temporary expedient. Under this framework, exclusion is a precautionary measure and not a disciplinary sanction. Exclusion from work should be reserved for only the most exceptional circumstances.

~~111~~118 The purpose of exclusion is:

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

~~112~~119 It is imperative that exclusion from work is not misused or seen as the only course of action that could be taken. The degree of action must depend on the nature and seriousness of the concerns and on the need to protect patients, the practitioner concerned and/or their colleagues.

THE EXCLUSION PROCESS

~~113~~120 **Under the Directions, an HSC body cannot require the exclusion of a practitioner for more than four weeks at a time.** The justification for continued exclusion must be reviewed on a regular basis and before any further four-week period of exclusion is imposed. Under

the framework key officers and the Board have responsibilities for ensuring that the process is carried out quickly and fairly, kept under review and that the total period of exclusion is not prolonged.

Key principles ~~aspects~~ of exclusion from work

~~114~~121 Key aspects include:

- an initial "immediate" exclusion of no more than four weeks if warranted as set out in paragraphs 77-84
- notification of the NCAS before immediate and formal exclusion;
- formal exclusion (if necessary) for periods up to four weeks;
- ongoing advice on the case management plan from the NCAS;
- appointment of a designated Board member to monitor the exclusion and subsequent action;
- referral to NCAS for formal assessment, if part of case management plan;
- active review by clinical and case managers to decide renewal or cessation of exclusion;
- a right to return to work if review not carried out;
- performance reporting on the management of the case;
- programme for return to work if not referred to disciplinary procedures or clinical performance assessment;
- a right for the doctor to make representation to the designated Board member

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~~115~~122 The authority to exclude a member of staff must be vested in a nominated manager or managers of the Trust. As described for immediate exclusion, these managers should be at an appropriately senior level in the organisation and should be the minimum number of people consistent with the size of the organisation and the need to ensure 24 hour availability of a nominated manager in the event of a critical incident. It should include the CE, Medical Director/Responsible Officer and the

Clinical Directors for staff below the grade of consultant. For consultants it should include the CE and Medical Director/Responsible Officer.

Exclusion other than immediate exclusion

~~116~~123 A formal exclusion may only take place in the setting of a formal investigation after the Case Manager has first considered whether there is a case to answer and then considered, at a case conference (involving as a minimum the clinical manager, Case Manager and Director of HR), whether there is reasonable and proper cause to exclude. The NCAS must be consulted where formal exclusion is being considered. If a Case Investigator has been appointed he or she must produce a preliminary report as soon as is possible to be available for the case conference. This preliminary report is advisory to enable the Case Manager to decide on the next steps as appropriate.

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~~117~~124 The report should provide sufficient information for a decision to be made as to whether:

(i) the allegation appears unfounded; or
(ii) there is a misconduct issue; or
(iii) there is a concern about the practitioner's clinical performance; or
(iv) the complexity of the case warrants further detailed investigation before advice can be given.

~~118~~125 Formal exclusion of one or more clinicians must only be used where:

a. there is a need to protect the safety of patients or other staff pending the outcome of a full investigation of allegations of misconduct; concerns around the functioning of a clinical team which are likely to adversely affect patients; or concerns about poor clinical performance;

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

~~119~~126 Members of the case conference should consider whether the practitioner could continue in or (where there has been an immediate exclusion) return to work in a limited capacity or in an alternative, possibly non-clinical role, pending the resolution of the case.

~~120~~127 When the practitioner is informed of the exclusion, there should, where practical, be a witness present and the nature of the allegations of concern should be conveyed to the practitioner. The practitioner should be told the reason(s) why formal exclusion is regarded as the only way to deal with the case. At this stage the practitioner should be given the opportunity to state their case and propose alternatives to exclusion (e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction). The practitioner may be accompanied to any interview or hearing by a companion (paragraph 49 defines companion). All discussions should be minuted, recorded and documented and a copy given to the practitioner.

~~121~~128 The formal exclusion must be confirmed in writing immediately. The letter should state the effective date and time, duration (up to 4 weeks), the content of the allegations, the terms of the exclusion (e.g. exclusion from the premises, see paragraph 121, and the need to remain available for work paragraph 122) and that a full investigation or what other action will follow. The practitioner and their companion should be informed that they may make representations about the exclusion to the designated Board member at any time after receipt of the letter confirming the exclusion.

~~122~~129 In cases when disciplinary procedures are being followed, exclusion may be extended for four-week reviewable periods until the completion of disciplinary procedures, if a return to work is considered inappropriate. The exclusion should still only last for four weeks at a time

and be subject to review (see paras 26 – 31 relating to the review process). The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon the employment, as soon as the original reasons for exclusion no longer apply.

~~123~~130 If the Case Manager considers that the exclusion will need to be extended over a prolonged period outside of his or her control (for example because of a police investigation), the case must be referred back to the NCAS for advice as to whether the case is being handled in the most effective way. However, even during this prolonged period the principle of four-week review must be adhered to.

~~124~~131 If at any time after the practitioner has been excluded from work, the investigation reveals that either the allegations are without foundation or that further investigation can continue with the practitioner working normally or with restrictions, the Case Manager must lift the exclusion and notify the appropriate regulatory authorities. Arrangements should be in place for the practitioner to return to work with any appropriate support (including retraining after prolonged exclusion) as soon as practicable.

Exclusion from premises

~~125~~132 Practitioners should not be automatically barred from the premises upon exclusion from work. Case Managers must always consider whether a bar is absolutely necessary. The practitioner may want to retain contact with colleagues, take part in clinical audit, to remain up to date with developments in their specialty or to undertake research or training. There are certain circumstances, however, where the practitioner should be excluded from the premises. There may be a danger of tampering with evidence, or where the practitioner may present a serious potential danger to patients or other staff

Keeping in contact and availability for work

~~126~~133 Exclusion under this framework should be on full pay provided the practitioner remains available for work with their employer during their normal contracted hours. The practitioner should not undertake any work for other organisations, whether paid or voluntary, during the time for which they are being paid by the HSC employer. This caveat does not refer to time for which they are not being paid by the HSC employer. The practitioner may not engage in any medical or dental duties consistent within the terms of the exclusion. In case of doubt the advice of the Case Manager should be sought. The practitioner should be reminded of these contractual obligations but would be given 24 hours notice to return to work. In exceptional circumstances the Case Manager may decide that payment is not justified because the practitioner is no longer available for work (e.g. abroad without agreement).

~~127~~134 The Case Manager should make arrangements to ensure that the practitioner may keep in contact with colleagues on professional developments, take part in CPD and clinical audit activities with the same level of support as other doctors or dentists in their employment. A mentor could be appointed for this purpose if a colleague is willing to undertake this role. In appropriate circumstances Trusts should offer practitioners a referral to the Occupational Health Service.

Informing other organisations

~~128~~135 Where there is concern that the practitioner may be a danger to patients, the employer has an obligation to inform other organisations including the private sector, of any restriction on practice or exclusion and provide a summary of the reasons. Details of other employers (HSC and non-HSC) may be readily available from job plans, but where it is not the practitioner should supply them. Failure to do so may result in further disciplinary action or referral to the relevant regulatory body, as the paramount interest is the safety of patients. Where a HSC employer has

placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer[13] Ref Information Sharing Guidance

~~129~~136 Where the Case Manager has good grounds to believe that the practitioner is practicing in other parts of the HSC, or in the private sector in breach or defiance of an undertaking not to do so, they should contact the professional regulatory body and the CMO of the Department to consider the issue of an alert letter.

~~130~~137 No practitioner should be excluded from work other than through this new procedure. Informal exclusions, so called 'gardening leave' have been commonly used in the recent past. No HSC organisation may use "gardening leave" as a means of resolving a problem covered by this framework.

Existing suspensions & transitional arrangements

~~131~~138 On implementation of this framework, all informal exclusions (e.g. 'gardening leave') must be transferred to the new system of exclusion and dealt with under the arrangements set out in this framework.

KEEPING EXCLUSIONS UNDER REVIEW

Informing the board of the employer

~~132~~139 The Board must be informed about an exclusion at the earliest opportunity. The Board has a responsibility to ensure that the organisation's internal procedures are being followed. It should, therefore:

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

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

Regular review

~~133~~140 The Case Manager must review the exclusion before the end of each four week period and report the outcome to the Chief Executive[14]. The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon their employment, at any time providing the original reasons for exclusion no longer apply. The exclusion will lapse and the practitioner will be entitled to return to work at the end of the four-week period if the exclusion is not actively reviewed.

~~134~~141 The HSC body must take review action before the end of each 4-week period. The table below outlines the various activities that must be undertaken at different stages of exclusion.

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

EXCLUSION REVIEWS

Stage	Activity
First and second reviews (and reviews after the third review)	Before the end of each exclusion (of up to 4 weeks) the Case Manager reviews the position. The Case Manager decides on the next steps as appropriate. Further renewal may be for up to 4 weeks at a time. Case Manager submits advisory report of outcome to CE and Medical Director. Each review is a formal matter and must be documented as such. The practitioner must be sent written notification of the outcome of the review on each occasion.
Third review	If the practitioner has been excluded for three periods: A report must be made by the Medical Director to the CE: outlining the reasons for the continued exclusion and why restrictions on practice would not be an appropriate alternative; and if the investigation has not been completed

	a timetable for completion of the investigation. The CE must report to the Director of Human Resources at the Department, who will involve the CMO if appropriate. The case must be formally referred back to the NCAS explaining: why continued exclusion is thought to be appropriate; what steps are being taken to complete the investigation at the earliest opportunity. The NCAS will review the case and advise the HSS body on the handling of the case until it is concluded.
6 month review	If the exclusion has been extended over 6 months, A further position report must be made by the CE to the Department indicating: the reason for continuing the exclusion; anticipated time scale for completing the process; actual and anticipated costs of the exclusion. The Department will consider the report and provide advice to the CE if appropriate.

~~135~~142 Normally there should be a maximum limit of 6 months exclusion, except for those cases involving criminal investigations of the practitioner concerned. The employer and the NCAS should actively review those cases at least every six months.

The role of the Department in monitoring exclusions

~~136~~143 When the Department is notified of an exclusion, it should confirm with the NCAS that they have been notified.

~~137~~144 When an exclusion decision has been extended twice (third review), the CE of the employing organisation (or a nominated officer) must inform the Department of what action is proposed to resolve the situation.

RETURN TO WORK

~~138~~145 If it is decided that the exclusion should come to an end, there must be formal arrangements for the return to work of the practitioner. It must be clear whether clinical and other responsibilities are to remain unchanged, what duties and restrictions apply, and any monitoring arrangements to ensure patient safety.

CONDUCT HEARINGS AND DISCIPLINARY PROCESSES

~~139~~146 When the outcome of an extended investigation shows that there is a case of misconduct, this must be put to a conduct panel. Misconduct covers both personal and professional misconduct as it can be difficult to distinguish between them. The key point is that all misconduct issues for doctors and dentists (as for all other staff groups) are matters for local employers and must be resolved locally. All misconduct issues should be dealt with under the employer's procedures covering other staff where conduct is in question.

~~140~~147 It should be noted that if a case covers both misconduct and clinical performance issues it should usually be addressed through a clinical performance procedure (paragraphs 149-204 refer).

~~141~~148 Where the investigation identifies issues of professional misconduct, the Case Investigator must obtain appropriate independent professional advice. Similarly where a case involving issues of professional misconduct proceeds to a hearing under the employer's conduct procedures the panel must include a member who is medically qualified (in the case of doctors) or dentally qualified (in the case of dentists) and who is not currently employed by the organisation[15].

~~142~~149 Employers are strongly advised to seek advice from NCAS in misconduct cases, particularly in cases of professional misconduct.

~~143~~150 HSC bodies must work in partnership with universities and ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with joint appointment contracts.

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

CODES OF CONDUCT

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

(i) a refusal to comply with the requirements of the employer where these are shown to be reasonable;
(ii) an infringement of the employer's disciplinary rules including conduct that contravenes the standard of professional behaviour required of doctors and dentists by their regulatory body[16];
(iii) the commission of criminal offences outside the place of work which may, in particular circumstances, amount to misconduct;
(iv) wilful, careless, inappropriate or unethical behaviour likely to compromise standards of care or patient safety, or create serious dysfunction to the effective running of a service.

EXAMPLES OF MISCONDUCT

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

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

of their duties towards patients, the public or other employees. It could also include actions such as deliberate falsification or fraud.

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

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

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

ALLEGATIONS OF CRIMINAL ACTS

Action when investigations identify possible criminal acts

145 Where an employer's investigation establishes a suspected criminal action in the UK or abroad, this must be reported to the police. The Trust investigation should only proceed in respect of those aspects of the case that are not directly related to the police investigation underway. The employer must consult the police to establish whether an investigation into any other matters would impede their investigation. In cases of fraud, the Counter Fraud & Security Management Service must be contacted.? Check accuracy of reference

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

146 There are some criminal offences that, if proven, could render a doctor or dentist unsuitable for employment. In all cases, employers, having considered the facts, will need to determine whether the employee poses a risk to patients or colleagues and whether their conduct warrants instigating an investigation and the exclusion of the practitioner. The employer will have to give serious consideration to whether the employee can continue in their current duties once criminal charges have been made.

147 Bearing in mind the presumption of innocence, the employer must consider whether the offence, if proven, is one that makes the doctor or dentist unsuitable for their type of work and whether, pending the trial, the employee can continue in their present duties, should be allocated to other duties or should be excluded from work. This will depend on the nature of the offence and advice should be sought from an HR or legal adviser. Employers should, as a matter of good practice, explain the reasons for taking such action.

Dropping of charges or no court conviction

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

CLINICAL PERFORMANCE PANEL

INTRODUCTION & GENERAL PRINCIPLES

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

150 Concerns about the clinical performance of a doctor or dentist may arise as outlined in paragraphs 26-27. Advice from the NCAS will help the employer to come to a decision on whether the matter raises questions about the practitioner's performance as an individual (health problems, conduct difficulties or poor clinical performance) or whether there are other matters that need to be addressed. If the concerns about clinical performance cannot be resolved through agreed local processes set out in Section I (paragraphs 15 – 17) the matter must be referred to the NCAS before consideration by a performance panel (unless the practitioner refuses to have his or her case referred).

151 Matters which may fall under the performance procedures include: outdated clinical practice;

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

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

153 Performance may be affected by ill health. Should health considerations be the predominant underlying feature, procedures for handling concerns about a practitioner's health are described in paragraphs 57-60.

How to proceed where conduct and clinical performance issues are involved

154 It is inevitable that some cases will involve both conduct and clinical performance issues. Such cases can be complex and difficult to manage. If a case covers more than one category of problem, it should usually be addressed through a clinical performance hearing although there may be occasions where it is necessary to pursue a conduct issue separately. It is for the employer to decide on the most appropriate way forward having consulted with an NCAS adviser and their own source of expertise on employment law.

Duties of employers

155 The procedures set out below are designed to cover issues where a doctor's or dentist's standard of clinical performance is in question[17].

156 As set out in paragraphs 207-215, the NCAS can assist the employer to develop an action plan designed to enable the practitioner to remedy any limitations in performance that have been identified during the assessment. The employing body must facilitate the agreed action plan (agreed by the

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

employer and the practitioner). There may be occasions when a case has been considered by NCAS, but the advice of its assessment panel is that the practitioner's performance is so fundamentally flawed that no educational and/or organisational action plan has a realistic chance of success. In these circumstances, the Case Manager must make a decision, based upon the completed investigation report and informed by the NCAS advice, whether the case should be determined under the clinical performance procedure. If so, a panel hearing will be necessary.

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

HEARING PROCEDURE

The pre-hearing process

158 The following procedure should be followed before the hearing:

- the Case Manager must notify the practitioner in writing of the decision to arrange a clinical performance hearing. This notification should be made at least 20 working days before the hearing, and include details of the allegations and the arrangements for proceeding including the practitioner's rights to be accompanied, and copies of any documentation and/or evidence that will be made available to the panel. This period will give the practitioner sufficient notice to allow them to arrange for a companion to accompany them to the hearing if they so wish;

- all parties must exchange any documentation, including witness statements, on which they wish to rely in the proceedings no later than 10 working days before the hearing. In the event of late evidence being presented, the employer should consider whether a new date should be set for the hearing;

- should either party request a postponement to the hearing, the Case Manager should give reasonable consideration to such a request while ensuring that any time extensions to the process are kept to a minimum. Employers retain the right, after a reasonable period (not normally less than 30 working days from the postponement of the hearing), and having given the practitioner at least five working days notice, to proceed with the hearing in the practitioner's absence, although the employer should act reasonably in deciding to do so;

- Should the practitioner's ill health prevent the hearing taking place, the employer should implement their usual absence procedures and involve the Occupational Health Department as necessary;

- witnesses who have made written statements at the inquiry stage may, but will not necessarily, be required to attend the clinical performance hearing. Following representations from either side contesting a witness statement which is to be relied upon in the hearing, the Chairman should invite the witness to attend. The Chairman cannot require anyone other than an employee to attend. However, if evidence is contested and the witness is unable or unwilling to attend, the panel should reduce the weight given to the evidence as there will not be the opportunity to challenge it properly. A final list of witnesses to be called must be given to both parties not less than two working days in advance of the hearing.

- If witnesses who are required to attend the hearing, choose to be accompanied, the person accompanying them will not be able to participate in the hearing.

The hearing framework

159 The hearing will normally be chaired by an Executive Director of the Trust. The panel should comprise a total of 3 people, normally 2 members of the Trust Board, or senior staff appointed by the Board for the purpose of the hearing. At least one member of the panel must be an appropriately

experienced medical or dental practitioner who is not employed by the Trust.[18] No member of the panel or advisers to the panel should have been previously involved in the investigation. In the case of clinical academics, including joint appointments, a further panel member may be appointed in accordance with any protocol agreed between the employer and the university.

160 Arrangements must be made for the panel to be advised by:

- a senior member of staff from Human Resources;
- an appropriately experienced clinician from the same or similar clinical specialty as the practitioner concerned, but from another HSC employer;
- a representative of a university if provided for in any protocol agreed between the employer and the university.

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

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

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

Representation at clinical performance hearings

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

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

Conduct of the clinical performance hearing

165 The hearing should be conducted as follows:

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

- the side which called the witness may seek to clarify any points which have arisen during questioning but may not at this point raise new evidence.

166 The order of presentation shall be:

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

Decisions

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

Possible decisions made by the clinical performance panel:

a. a finding that the allegations are unfounded and practitioner exonerated. Finding placed on the practitioner's record;

b. a finding of unsatisfactory clinical performance. All such findings require a written statement detailing:

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

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

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

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

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

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

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

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

APPEALS PROCEDURES IN CLINICAL PERFORMANCE CASES

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

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

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

176 It can also hear new evidence submitted by the practitioner and consider whether it might have significantly altered the decision of the original hearing. The appeal panel, however, should not re-hear the entire case but may direct that the case is re-heard if it considers it appropriate (see paragraph 177 below).

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

The appeal process

178 The predominant purpose of the appeal is to ensure that a fair hearing was given to the original case and a fair and reasonable decision reached by the hearing panel. The appeal panel has the power to confirm or vary the decision made at the clinical performance hearing, or order that the case is

re-heard. Where it is clear in the course of the appeal hearing that the proper procedures have not been followed and the appeal panel determines that the case needs to be fully re-heard, the Chairman of the panel shall have the power to instruct a new clinical performance hearing.

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

The appeal panel

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

- an independent member (trained in legal aspects of appeals) from an approved pool.[19] This person is designated Chairman;
- the Chairman (or other non-executive director) of the employing organisation who must have the appropriate training for hearing an appeal;
- a medically qualified member (or dentally qualified if appropriate) who is not employed by the Trust[20] who must also have the appropriate training for hearing an appeal.

[19] See Annex A.
[20] Employers are advised to discuss the selection of the medical or dental panel member with the local professional representative body eg in a hospital trust the local negotiating committee.

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

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

- a consultant from the same specialty or subspecialty as the appellant, but from another HSC/NHS employer[21];
- a senior Human Resources specialist.

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

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

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

[21] Where the case involves a dentist this may be a consultant or an appropriate senior practitioner.

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

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

Powers of the appeal panel

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

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

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

Conduct of appeal hearing

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

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

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

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

Decision

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

Action following hearing

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

APPEAL PANELS IN CLINICAL PERFORMANCE CASES update section

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

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

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

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

Creating and administering the list

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

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

201 The Department of Health Social Services and Public Safety, in consultation with employers, the BDA and the BMA will provide a job description, based on the Competence Framework for Chairmen and Members of Tribunals, drawn up by the Judicial Studies Board. The framework, which can be adapted to suit particular circumstances sets out six headline competencies

featuring the core elements of law and procedure, equal treatment, communication, conduct of hearing, evidence and decision making. Selection will be based on the extent to which candidates meet the competencies.

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

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

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

REFERRAL TO PROFESSIONAL REGULATOR

205 During the processes described in this framework, reference is made at key stages at which referral to the practitioner's professional regulator should be considered. These include:

- When a finding of misconduct has been upheld
- When a finding of unsatisfactory clinical performance has been reached.

206 Threshold criteria for referral under fitness to practice proceedings are referenced in paragraph 17 of this framework.

REFERRAL TO THE NCAS

207 The NCAS is a division of the NHS Patient Safety Agency and was established to assist healthcare managers and practitioners to understand, manage and prevent performance concerns.

208 At any stage in the handling of a case consideration should be given to the involvement of the NCAS. The NCAS has developed a staged approach to the services it provides HSC Trusts and practitioners. This includes:

- immediate telephone advice, available 24 hours;
- advice, then detailed supported local case management;
- advice, then detailed NCAS performance assessment;
- support with implementation of recommendations arising from assessment.

209 Employers or practitioners are at liberty to make use of the services of the NCAS at any point they see fit. However, where an employing body is considering exclusion or restriction from practice the NCAS must be notified, so that alternatives to exclusion can be considered. Procedures for immediate and formal exclusion are covered respectively in paragraphs 77-84 and 109-130 of this framework.

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

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

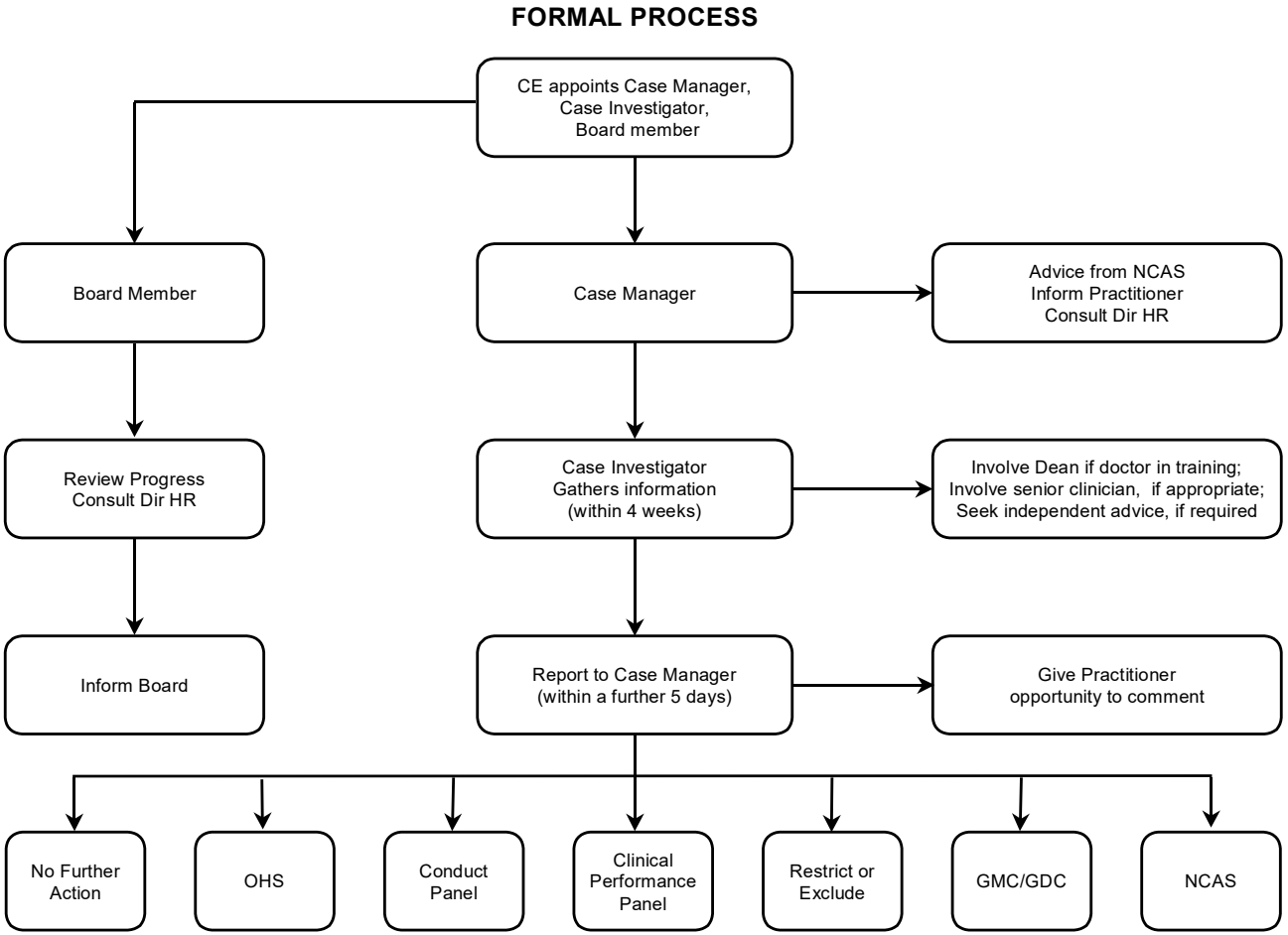
- clinical performance falling well short of recognised standards and clinical practice which, if repeated, would put patients seriously at risk;
- alternatively, or additionally, issues which are ongoing or recurrent.

212 A practitioner undergoing assessment by the NCAS must co-operate with any request from the NCAS to give an undertaking not to practice in the HSC or private sector other than their main place of HSC employment until the NCAS assessment is complete. The NCAS has issued guidance on its processes, and how to make such referrals in its Handbook. 22. See also circular HSS (TC8) 5/04.

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

214 The local action plan should be agreed by both the practitioner and a senior clinician in the organisation. A timescale should be defined for review and completion of the objectives of the action plan and progress documented.

215 Successful completion of the action plan should be documented and this information retained in the practitioner's personnel file



HANDLING OF ILLNESS ARISING DURING EXTENDED INVESTIGATION

151 If an excluded employee or an employee facing any process in Stage 2 of this framework becomes ill, they should be subject to the employer's usual sickness absence procedures. The sickness absence procedures can take place alongside these processes and the employer should take reasonable steps to give the employee time to recover and attend any hearing.

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152 Where the employee's illness exceeds 4 weeks, they must be referred to the OHS. The OHS will advise the employer on the expected duration of the illness and any consequences the illness may have for the process. OHS will also be able to advise on the employee's capacity for future work, as a result of which the employer may wish to consider retirement on health grounds. Should the employment be terminated as a result of ill health, the investigation should still be taken to a conclusion and the employer form a judgement as to whether the allegations are upheld.

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

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Appendix 1 – Glossary

Parks, Zoe

From: Toal, Vivienne <[redacted]>
Sent: 15 March 2018 13:52
To: Parks, Zoe; 'Hynes, Liz' ([redacted])
Cc: Walker, Helen; Hynds, Siobhan; Mallagh-Cassells, Heather
Subject: Re: Review of Maintaining High Professional Standards Policy.

Liz

Can I also add to this that I have some difficulty with the role of the NED in MHPS cases - the document is not clear and at times we have got completely muddled as to what their role actually is and how far they can go when contacted by a doctor going through a process. I think this needs explored as part of any review.

Vivienne

Sent from my Samsung Galaxy smartphone.

-------- Original message --------
From: "Parks, Zoe" <[redacted]>
Date: 15/03/2018 13:24 (GMT+00:00)
To: "'Hynes, Liz' ([redacted])" <[redacted]>
Cc: "Walker, Helen" <[redacted]>, "Toal, Vivienne" <[redacted]>, "Hynds, Siobhan" <[redacted]>, "Mallagh-Cassells, Heather" <[redacted]>
Subject: Review of Maintaining High Professional Standards Policy.

Liz,

Please find attached some comments from the Southern Trust. Please do not hesitate to contact me if you have any queries.

Many thanks

Zoë

Zoe Parks
Head of Medical Staffing HROD
Southern Health & Social Care Trust
[redacted]
My working days are Tuesday-Friday

[redacted] (Internal: [redacted] – prefix by [redacted] if dialling from legacy telephone)
Blackberry [redacted]

You can follow us on:

From: Ferguson, Katherine [mailto Personal Information redacted by the USI]
Sent: 08 March 2018 13:31
To: jacqui.kennedy Personal Information redacted by the USI ; Toal, Vivienne; Weir, Myra; 'McConnell Ann'; NIAS - Michelle Lemon; Paula Smyth
Cc: angela.muldoon Personal Information redacted by the USI ; Mallagh-Cassells, Heather; PA to Eamon Molloy; Lorimer, Joelle; HR Secretary; Hana Russell; Dawson, Andrew; Bailie, Marc; Hynes, Liz; Wallace, Doreen
Subject: Review of Maintaining High Professional Standards Policy.

All

Following discussions at the last HRD Forum on the 12th February, the Department agreed to write to HSC Trusts to seek their comments and views on the issues and barriers arising from the above policy document.

I would be grateful of you could send these to me (Personal Information redacted by the USI) for collation prior to the details being forwarded to the CMO's office for consideration by CoP Friday 16th March.

Kind regards

Liz

_____

Liz Hynes
HR Business Partner (Medical and Dental)
Pay and Employment Unit, Workforce Policy Directorate, Department of Health and The Board Liaison Group, (BLG), HSC Board
Tel: Personal Information redacted by the USI
email: Personal Information redacted by the USI
email Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

Please note that I usually work for the DoH Monday - Thursday and BLG on Fridays.

Maintaining High Professional Standards

Comments from Southern Health & Social Care

Having had experience of working with the MHPS Framework the Southern Trust would be keen for the following comments to be considered as part of the review.

- **Ability to take quick, effective action**

It seems a reasonable expectation that Trusts should be able to take quick effective action where there are serious concerns about the misconduct or capability of medical staff. However the nature and complexity of the existing MHPS framework make this extremely difficult. One would expect a "framework" document to be a high level list of principles to guide local policies. However the fact that MHPS is almost 50 pages long makes the document far too prescriptive to act as a framework. In reality it often leads to many legal challenges and consequently cases derailed meaning they can sometimes take years to conclude. Trusts can also often fall foul of the procedures due to the many complexities contained regarding what needs to be done when, by whom - all within very tight deadlines.

The ability of the Trust to take certain decisions is also very limited in some cases. For example it is impossible to take a doctor to a clinical performance hearing unless is if first considered by NCAS and they (normally after having completed a lengthy NCAS assessment) have determined that the doctors performance is "so fundamentally flawed that no educational and/or organisation action plan has a realistic chance of success". We have had experience of a doctor who clearly fell into this category and was subsequently dismissed from their post – however the case took us years to complete.

The ability to deal fairly but quickly and effectively with a clear case of an underperforming doctor is thus severely hampered by this requirement – particularly when issues arise early in employment given probationary periods are not a common feature in medical/dental contracts. MHPS also includes a recommendation of dealing with mixed conduct and capability issues via the capability route. This is not always helpful as we feel strongly that misconduct is clearly best dealt with through a misconduct route.

- **Achievable Timescales**

Despite extensive procedural requirements, MHPS sets timescales that Trusts can very rarely comply with. Timescales are dotted throughout the document in the context of investigations, exclusions and panels which require line by line attention and often are totally unachievable. This is also problematic when it is set within the context of the enormous list of senior officers required to participate, particularly on capability

and appeal panels with multiple external members required. The inclusion of legal representation throughout the process is also out-with what is afforded to all other NHS employees. Again the entitlement to professional legal representation throughout leads to many cases being delayed and disrupted by solicitor letters and legal argument.

It is important that Trusts can take quick, effective and appropriate action when there are serious concerns about a doctors' performance or conduct. Confidence and trust in the capability and conduct of our medical staff must be at the heart of everything that we do. The recent findings of Mr Justice O'Hara's report only serve to emphasise this. MHPS therefore needs to be reviewed urgently to ensure this remains an absolute priority and the aim should be for a procedure that is succinct, easy to interpret and proportionate to encourage frequent use for quick, early corrective or conclusive action. The Southern Trust has developed their own internal document to clarify and promote the informal stage – which is appended to this document for your information.

Parks, Zoe

From: Parks, Zoe <[redacted]>
Sent: 15 March 2018 13:25
To: 'Hynes, Liz' ([redacted])
Cc: Walker, Helen; Toal, Vivienne; Hynds, Siobhan; Mallagh-Cassells, Heather
Subject: Review of Maintaining High Professional Standards Policy.
Attachments: Maintaining High Professional Standards in the Modern HPSS.DOC; SHSCT - Review of MHPS Comments 15.3.18.docx; DRAFT SHSCT - Trust Guideline for Handling Concerns about Doctors Denti....doc

Liz,

Please find attached some comments from the Southern Trust. Please do not hesitate to contact me if you have any queries.

Many thanks

Zoë

Zoe Parks
Head of Medical Staffing HROD
Southern Health & Social Care Trust
[redacted]
My working days are Tuesday-Friday

☎ [redacted] (Internal: [redacted] – prefix by [redacted] if dialling from legacy telephone)
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Sent: 08 March 2018 13:31
To: jacqui.kennedy[redacted]; Toal, Vivienne; Weir, Myra; 'McConnell Ann'; NIAS - Michelle Lemon; Paula Smyth
Cc: angela.muldoon[redacted]; Mallagh-Cassells, Heather; PA to Eamon Molloy; Lorimer, Joelle; HR Secretary; Hana Russell; Dawson, Andrew; Bailie, Marc; Hynes, Liz; Wallace, Doreen
Subject: Review of Maintaining High Professional Standards Policy.

All

Following discussions at the last HRD Forum on the 12th February, the Department agreed to write to HSC Trusts to seek their comments and views on the issues and barriers arising from the above policy document.

I would be grateful of you could send these to me ([redacted]) for collation prior to the details being forwarded to the CMO's office for consideration by CoP Friday 16th March.

Kind regards

Liz

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Liz Hynes
HR Business Partner (Medical and Dental)
Pay and Employment Unit, Workforce Policy Directorate, Department of Health and The Board Liaison Group, (BLG), HSC Board
Tel: Personal Information redacted by the USI
email: Personal Information redacted by the USI
email: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

Please note that I usually work for the DoH Monday - Thursday and BLG on Fridays.

Parks, Zoe

From: Donaghy, Kieran <[redacted]>
Sent: 15 November 2011 11:56
To: Parks, Zoe; Toal, Vivienne
Subject: FW: Revision of MHPS
Attachments: Revision of MHPS (v4) with changes made 131111.DOC; CiC_Glossary_MHPS.DOC

Importance: High
Sensitivity: Confidential

Zoe/Vivienne any comments you would wish to make?

Kieran

-----Original Message-----
From: Lindsay, Jane [mailto:[redacted]]
Sent: 15 November 2011 10:43
To: Kilgallen, Anne; Roberts, Margot; Mervyn Barkley; O'Carolan, Donncha; Reid, Simon; Donaghy, Kieran
Cc: Beck, Lorraine; Dardis, Pauline; Davey, Noreen; Armstrong, Andrea; Hutchison, Ruth
Subject: Revision of MHPS
Importance: High
Sensitivity: Confidential

Colleagues,

Re: Revision of Maintaining High Professional Standards Working Group, Friday 18th November,11:00,C5.17(Dr Woods' Office), Castle Buildings.

I have attached the current revision of MHPS for your consideration ahead of our meeting on Friday. You will note that this is very much a working draft and we look forward to hearing your feedback and suggestions. Also attached is a Glossary that will be developed as the revision progresses.

Our key aims in developing the framework are:

* Incorporate the learning from those who have used the processes and guidance in HSC organisations
* Develop the guidance element of the framework to ensure it is fit for purpose, clear to follow and compliments existing organisational policies
* Highlight the need to ensure robust recording when addressing concerns including decision made and how they were reached
* Stress the importance of reviewing investigations at key intervals
* Ensuring that measures required to protect patients and the public are considered at the commencement and throughout an investigation, and reviewed to ensure they still address identified risks.

We have been considering a the range of resources provided by the Labour Relations Agency in work undertaken to date that provide succinct guidance in relation to Conducting Employment Investigations, Handling Discipline and Grievances at Work and Advice on Managing Poor Performance. These documents are available on the LRA website should you wish to review prior to our meeting (link below) http://www.lra.org.uk/index/agency_publications-2/advice_and_guidance_on_employment_matters-3/advisory_guides2.htm.

I have received apologies for this meeting from Donnacha O'Carolon and Kieran Donaghay,both very welcome to provide comments to me by email and I will ensure these are considered at Friday's meeting.

Kind Regards

Jane

Jane Lindsay
Project Manager-Confidence in Care
DHSSPS,
C3.20,Castle Buildings

Stormont Estate
Belfast BT4 3SQ
Personal Information redacted by the USI Mobile Personal Information redacted by the USI